Authors:
Roberta Chambers, PsyD
David Klauber MSW
Ryan Fukumori, PhD

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About Resource Development Associates
Resource Development Associates (RDA) is a consulting firm based in Oakland, California, that serves government and nonprofit organizations throughout California as well as other states. Our mission is to strengthen public and non-profit efforts to promote social and economic justice for vulnerable populations. RDA supports its clients through an integrated approach to planning, grant-writing, organizational development, and evaluation.
Dear Community Members,

I am pleased to present the Marin County Suicide Prevention Strategic Plan, a roadmap for reducing suicide deaths and attempts in communities and neighborhoods countywide.

Suicide is a public health issue that deeply affects Marin County residents and communities. We as a county have among the highest suicide rates in all of the Bay Area. In the span of just one month in 2017, we experienced the tragic loss of three high school students to suicide. Families, neighborhoods, and communities across the county continue to feel the grief and confusion that result from these and other suicide deaths and attempts. While much attention has been brought to this issue by the spike in the number of adolescent suicides across the state, we know that suicide affects people of all ages and from all backgrounds. Suicide has now risen to the tenth leading cause of death in the United States across all ages.

However, we also know that suicide is preventable—and that the time for action is now. Research has shown that the public health model for suicide prevention, which brings together different fields of knowledge and expertise, is successful in reducing deaths by suicide and suicide attempts. For this reason, Marin County Behavioral Health and Recovery Services (BHRS) convened a Suicide Prevention Strategic Planning Committee made up of professionals and community members with a variety of perspectives and expertise to craft a way forward. This group included medical and behavioral health experts, school administrators and educators, leaders of social service agencies, representatives from marginalized and underserved communities, and Marin County residents with lived experiences of suicide loss. Together they developed a comprehensive set of strategies, objectives, and activities that promote residents’ wellness and seek to reduce deaths by suicide and suicide attempts countywide.

The Suicide Prevention Strategic Plan is the culmination of this work. At the heart of this plan is the knowledge that preventing suicide is achievable, and that we all have a part to play in saving lives. For this plan to be effective, we will need to challenge conventional thinking, reconsider our previously held approaches, and build new partnerships across agencies and institutions. Importantly, this plan is a living document, and we will revisit these strategies as our understanding of suicide in Marin County continues to grow.

The Executive Summary and the full version of the plan can be accessed using the following link: www.Marinhhs.org/suicide-prevention. We encourage all Marin County residents to participate in the activities outlined in this document: to attend a suicide prevention training, help your fellow community members find support in times of crisis, or simply be willing to talk openly about mental health and suicide with loved ones. Throughout the development of this Strategic Plan, we experienced an outpouring of support and enthusiasm from community members who want to be involved in this effort. As we now turn toward the implementation of this plan, continued involvement and support of community members and partners will be essential for our success. Together we can prevent suicide.

Dr. Jei Africa
Director
Marin County Behavioral Health and Recovery Services
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Preventing individuals, communities and organizations to recognize warning signs for suicide and confidence to intervene with someone at risk.

Strengthen protective factors, including building community connections and reducing stigma around discussing or seeking help for thoughts of suicide, mental health and substance abuse issues.

Improve timely access to supports and services for individuals at risk of suicide, with targeted efforts for groups that are disproportionately affected by suicide.

Marin County residents face the highest rate of suicide among all Bay Area residents.

Certain groups are disproportionately affected by suicide thoughts and behaviors (attempts, deaths)
(including adult men, youth, LGBTQ+ residents, people of color, veterans)

Communities & school districts would benefit from greater coordination of suicide prevention resources & efforts

Many residents find it difficult to talk about suicide, and many hesitate to seek help for their mental health

Younger residents describe hyper-competitive academic environments that are harmful to many youths’ wellness

Community Survey Highlights
1,307 people completed some or all of BHRS’s Suicide Prevention Community Survey in February 2019.

Some of the key results include:

- 72% of respondents know at least one person who has attempted or died by suicide
- 82% perceive that stigma makes it hard to talk about mental health issues and suicide
- 23% could recognize the signs of suicidal behavior in someone whom they know
- 71% want to learn how to help someone who is considering suicide
- 78% are willing to talk to family and friends about the issue of suicide
1. Establish infrastructure to provide leadership, oversight, and accountability to the Strategic Plan.

2. Develop a coordinated system of care to promote suicide prevention and wellness.

3. Implement public campaigns to raise awareness about warning signs, promote available resources, and increase help-seeking.

4. Provide evidence-based training and education to Marin County residents.

5. Provide outreach, engagement, and support to all residents with targeted efforts to groups disproportionately affected by suicide.

6. Foster safe and healthy environments on all school campuses.

7. Reduce access to lethal means for those at risk of suicide.

“We need to support a community culture of caring about our neighbors...Standing by and doing nothing is no longer an option!”

—MARIN COUNTY RESIDENT

**Key Frameworks**

- **Structural/Institutional**
- **Community**
- **Relational/Interpersonal**
- **Personal**

**Social-Ecological Model**

**Prevention** (upstream)
- Promote protective factors and increase residents’ help-seeking behavior.

**Intervention** (crisis response)
- Support for people considering suicide and appropriate care after a suicide attempt.

**Postvention** (after suicide)
- Support for people and communities after a death by suicide.

**The Strategic Plan encompasses all stages in the suicide prevention continuum of care.**

**Marin County Public Health**
**Buckelew Programs**
**Aging Action Initiative**

**Marin County Office of Education**
**Kaiser Permanente**
**Marin County Commission on Aging**

**Marin County School Districts**
**Marin Community Clinics**
**Marin County Youth Commission**

**Marin County Probation**
**MarinHealth**
**Marin City Community Development Corporation**

**Marin County Coroner’s Office**
**NAMI Marin**
**Marin Interfaith Council**

**Marin County Veterans Service Office**

Individual community members, including survivors of suicide attempts and those who have lost loved ones to suicide.

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Executive Summary

Suicide has become a leading cause of death in the United States. Over the last twenty years, 49 out of 50 States have experienced a rise in the number of annual suicide deaths. The communities of Marin County have been among those deeply impacted by the issue of suicide. Though Marin County is one of the healthiest and wealthiest counties in the state, it has one of highest suicide rates among all metropolitan counties in California. Whether directly or indirectly, suicide has touched the lives of most residents of the County. It is important to note that the issue of suicide extends beyond suicide deaths but also to suicide attempts and ideation.

Though it is a complicated issue involving biological, psychological, social, and cultural factors, suicide is preventable. Driven by this understanding, Marin County agencies and community members joined together to develop a countywide roadmap for reducing suicide deaths, improving supports, and reducing pain that leads to thoughts of suicide. The Marin County Suicide Prevention Strategic Plan is the culmination of that effort. The plan builds upon the experience and expertise of public and private agencies currently engaged in suicide prevention activities within Marin County. Objectives include enhancing coordination across providers, increasing impacts of programs and services, and optimizing resources. With this plan, Marin County aligns itself with the State’s mission to Strive for Zero suicides.

In October 2018, Marin County Behavioral Health and Recovery Services (BHRS) Director initiated the suicide prevention strategic planning process in collaboration with Health and Human Services’ Division of Public Health (DPH), the Marin County Office of Education and community partners. The first phase of this effort was a countywide Community Needs Assessment to better understand the specific context of suicidal behavior in Marin County. The assessment team administered surveys, facilitated focus groups, and conducted interviews with service providers and community members to identify the priorities and needs of the community. Data on suicide deaths and attempts were also analyzed to identify trends in suicidal behavior. The major findings of the Needs Assessment are as follows:

<table>
<thead>
<tr>
<th>Identifying Impacts</th>
<th>Middle-aged and older white men die by suicide at the highest rates, but there are many other people at heightened risk for suicide (adolescent and transition age youth, people of color, LGBTQ+ residents, veterans, and others).</th>
</tr>
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<tbody>
<tr>
<td>Assessing Resources</td>
<td>Marin County has several existing suicide prevention resources. However, many residents face barriers to accessing supportive services, and/or do not know how to help others who are contemplating suicide.</td>
</tr>
<tr>
<td>Building Resiliency</td>
<td>While community wellbeing and social cohesion can limit suicide risk and many residents want to be involved in suicide prevention efforts, there is a widespread culture of stigma and difficulty engaging with the issue.</td>
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</table>
In the summer of 2019, BHRS convened a suicide prevention Strategic Planning Committee consisting of professionals in medical and behavioral health, education, and social services; leaders and representatives from marginalized and underserved communities; and community members with lived experiences of suicide loss. Guided by the findings of the Needs Assessment and evidence-based practices in suicide prevention, the committee developed comprehensive strategies, objectives, and activities aimed at promoting wellness and reducing suicide attempts and deaths across the county. The resulting plan is comprehensive in its approach to target individuals across diverse backgrounds and all neighborhoods in Marin County. The strategies and objectives named in this strategic plan follow established and recommended practices that have proven to reduce suicides and suicide attempts.
# Summary of Strategies and Objectives

## STRATEGY 1
**Establish infrastructure to provide leadership, oversight, and accountability to the Strategic Plan**

It is important that Marin County create a strong, visible leadership structure to carry out the strategies, objectives, and activities outlined in this document. The Strategic Plan calls for the formation of a leadership group called the **Marin County Suicide Prevention Collaborative (MCSPC)**. The MCSPC will coordinate the actions that are described in the Strategic Plan, ensure that all partners are accountable to the Plan, and maintain momentum around ongoing suicide prevention efforts.

- **Objective 1.1:** Establish and convene a suicide prevention body to coordinate implementation of the Strategic Plan
- **Objective 1.2:** Establish a dedicated position(s) to support activities of the Strategic Plan
- **Objective 1.3:** Establish and convene subcommittees and/or workgroups to pursue and develop specific efforts outlined in the strategic plan
- **Objective 1.4:** Advance data monitoring and evaluation to support data-driven decision-making

## STRATEGY 2
**Develop a coordinated system of care to promote suicide prevention and wellness**

It is crucial that Marin County’s healthcare system - from hospitals to primary care clinics to student wellness centers - function as a unified whole in identifying and caring for people experiencing suicidal behavior. We envision a system where local behavioral health and primary care providers use a standard patient assessment for suicide risk, create seamless transitions for patients to the appropriate level of care, and share data in order to enhance patients’ recovery.

- **Objective 2.1:** Adopt universal suicide screening protocols for all county entities that conduct health assessments and provide training to ensure fidelity
- **Objective 2.2:** Strengthen communication, linkages, and supports for individuals who may be at risk for suicide and who are transitioning between providers
- **Objective 2.3:** Implement a coordinated support system to provide follow-up care for individuals experiencing suicide ideation and following a suicide attempt
- **Objective 2.4:** Develop, implement, and expand supports for community members after deaths by suicide
- **Objective 2.5:** Explore avenues to improve access to services for residents with private health insurance
STRATEGY 3
Implement public campaigns to raise awareness about warning signs, promote available resources, and increase help-seeking

Many Marin County residents noted that they did not know where to access support for themselves or their peers who are contemplating suicide. In addition, residents noted that many community members experience stigma in talking about suicide or seeking mental health care. A multimedia messaging campaign will be crucial step to raising residents’ awareness about local suicide prevention resources and establishing safe community norms around openly discussing mental health and suicide.

**Objective 3.1:** Develop a broad campaign to increase public awareness about available wellness and mental health resources, promote help-seeking behavior, increase knowledge of warning signs, and inform residents on the county’s commitment to suicide prevention

**Objective 3.2:** Tailor and diversify suicide prevention messaging and programming to improve engagement with groups and communities at heightened risk for suicide

**Objective 3.3:** Work with public information officers and local media outlets to promote effective messaging around suicide prevention

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STRATEGY 4
Provide evidence-based suicide prevention trainings and education to Marin County residents

Many Marin County residents expressed a desire for additional in-person trainings on how to recognize the signs of suicidal risk in others, and how to connect them to help. We envision a comprehensive slate of suicide prevention education and trainings for many different residents: health care practitioners, social service providers, employees in other workplaces, and community members. A community where many residents are well-informed on best practices in suicide prevention will be safer and better connected.

**Objective 4.1:** Provide and promote evidence-based suicide prevention and ongoing care training to service providers

**Objective 4.2:** Provide and promote evidence-based suicide prevention training for community members, including employers and employees
## STRATEGY 5
Provide outreach, engagement, and support to all residents with targeted efforts to groups disproportionately affected by suicide

Because different community members in Marin County are at heightened risk for suicide, it is important that Marin County and its partners consider a number of different approaches to engaging residents. Outreach activities must be appropriate for people of different ages, and attentive to the cultural factors that can shape community members’ attitudes around suicide and mental health. Using targeted approaches, instead of a “one size fits all” approach, ensure that more community members participate in outreach efforts. This is especially important for engaging individuals who are harder to reach.

<table>
<thead>
<tr>
<th>Objective 5.1:</th>
<th>Enhance protective factors and promote coping skills for community members, including targeted outreach for at-risk residents within informal settings</th>
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<td>Objective 5.2:</td>
<td>Strengthen peer support networks for communities and groups at heightened risk for suicide</td>
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<tr>
<td>Objective 5.3:</td>
<td>Implement culturally affirmative approaches in providing suicide prevention and wellness resources to underserved and isolated communities</td>
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<tr>
<td>Objective 5.4:</td>
<td>Utilize local data to identify other residents disproportionately affected by suicide deaths and attempts, and determine targeted approaches in suicide prevention supports</td>
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## STRATEGY 6
Foster safe and healthy environments on all school campuses

Young people, parents, and educators in Marin County have all called for a more comprehensive approach to suicide prevention efforts in local schools. In addition, many residents have called attention to the toxic effects of hypercompetitive academic environments that place inordinate amounts of stress on students. Priority areas include increasing classroom instruction around mental health and suicide prevention, standardizing crisis response practices on all campuses countywide, and ensuring that all school campuses have adequate mental health services and supportive resources.

<table>
<thead>
<tr>
<th>Objective 6.1:</th>
<th>Through collaboration with county, district, and community partners, support school districts in the implementation of a three-tiered continuum of supports in all schools</th>
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<tr>
<td>Objective 6.2:</td>
<td>Support the development of youth-led wellness and suicide prevention initiatives</td>
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<tr>
<td>Objective 6.3:</td>
<td>Build the capacity of schools to engage with and support families</td>
</tr>
<tr>
<td>Objective 6.4:</td>
<td>Support the implementation of evidence-based crisis response and postvention services in schools</td>
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### STRATEGY 7
Reduce access to lethal means for those at risk of suicide

Reducing access to common means of suicidal self-directed violence has proven to be one of the most effective methods for preventing suicide, especially when combined with effective messaging and easy access to supportive services. Activities in this Strategic Plan will align with ongoing efforts to reduce the risk of suicide on the Golden Gate Bridge, on local railways, and with prescription drug use. In addition, we envision a more comprehensive series of efforts to improve gun safety practices and deter access to firearms among residents who are experiencing suicidal behavior.

**Objective 7.1:** Work with partners, existing initiatives, and key stakeholders to reduce access to lethal means for those in crisis and bolster suicide prevention messaging and supportive services.

**Objective 7.2:** Provide education and training to service providers, community members, and gatekeepers on promoting best practices on counseling for lethal means reduction.
Introduction and Context

Background

Over the last twenty years, suicide has emerged as a national public health issue. Suicide rates have steadily increased throughout nearly every state in the U.S. It is now the second leading cause of death for people ages 10 to 34 in the U.S., and the tenth most common cause of death among people of all ages. Suicide rates in California have reflected these national trends. Though California statewide suicide rates are lower than the national average, deaths by suicide in California have been on the rise since the early 2000s, and suicide rates exceed the national average in some areas of the state.

The devastating impacts of suicide are not measurable by the number of suicide deaths alone. For every one adult suicide death, an estimated 25 suicide attempts occur; for every one youth suicide, up to 200 attempts occur. According to the California Department of Public Health (CDPH), in 2017 there were 4,323 suicide deaths in California, with an additional 10,048 hospitalizations and 34,371 Emergency Department visits due to non-fatal self-inflicted injuries. Suicide and suicide attempts also can have lasting, multigenerational impacts on family members and peers, through the experience of psychological trauma, changes in family structure, loss of income, and loss of life opportunities. Suicide attempts and deaths by suicide bear substantial economic losses: in 2010, each death by suicide in California resulted in an average of $1,085,227 in lost productivity and medical costs.

Marin County

In recent years, residents of Marin County have experienced an increase in the tragic and far-reaching impacts of suicide. Though Marin County is one of the healthiest and wealthiest counties in the state, it has the highest suicide rate in the Bay Area, and the highest among all metropolitan counties in California. Between 2015 and 2017, 14.1 people per 100,000 died by suicide in Marin

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1 In 2017, California had a rate of 10.4 deaths by suicide per 100,000 people, compared to a nationwide rate of 14.0
5 CDPH, Preventing Violence in California, Volume 1: The Role of Public Health
6 AFSP, Suicide Facts and Figures: California 2019
County, well above the state average over the same period (10.7). The tragic deaths of three high school students by suicide within the same month in December 2017 left communities and service providers grieving and fearful of additional suicides among local youth. In response, representatives from Marin County Behavioral Health and Recovery Services (BHRS), the Marin County Office of Education (MCOE), the Division of Public Health (DPH), and Buckelew Programs convened a taskforce to advance the implementation of suicide prevention, crisis response, and postvention practices in schools countywide.

The ongoing crises and challenges of addressing suicide in Marin County demanded a more comprehensive initiative to serve young people in schools and to reduce suicidal behavior among all residents. In collaboration with MCOE, DPH, and community partners, BHRS contracted Resource Development Associates, an Oakland-based consulting firm, to conduct a community needs assessment and facilitate the development of a countywide strategic plan for suicide prevention efforts. BHRS intended for the strategic planning process to accomplish three major objectives:

- To reduce suicidal thoughts and behaviors by increasing individual and community protective factors and by promoting wellness, connectivity, and hope.
- To increase community and service provider knowledge of warning signs and skills to conduct effective risk assessments, engage openly about the issue of suicide, and reduce stigma and discrimination associated with seeking support for suicidal thoughts and behaviors.
- To improve accountability, program effectiveness, and coordination of suicide prevention programming.

This Marin County Suicide Prevention Strategic Plan is the culmination of the strategic planning process. It is the result of extensive data collection, community outreach, and collaborative planning efforts. While grounded in evidence-based approaches and best practices in suicide prevention, this Strategic Plan is indebted to the many voices and perspectives of Marin community members. Public officials, service providers, clinicians, community leaders, and residents of all ages participated in the planning process, identified current resources and service gaps, and helped brainstorm new approaches to reducing suicide in Marin County.

The strategic plan also aligns with the requirements of suicide prevention legislation established in statewide policy. In acknowledgement of the important role that schools can play in youth suicide prevention, Assembly Bill 2246 was signed into law in 2016. This legislation requires all local education agencies (LEAs), commonly referred to as school districts, to implement comprehensive suicide prevention policies. In 2019, this mandate was expanded by Assembly Bill 1767 which requires all LEAs that serve pupils from prekindergarten through sixth grade to

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7 CDPH, Preventing Violence in California, Data Brief 1: Overview of Homicide and Suicide Deaths in California
also implement suicide prevention policies by the start of the 2020 school year. These mandates are collectively referred to as Education Code (EC) Section 215.

Public Health Approach to Prevention

An increasing number of public officials, researchers, clinicians, and advocates have called for the need to address suicide as a public health issue. A public health approach offers the following benefits:

- A broad focus on entire populations and the societal factors that heighten or reduce risk for suicide;
- An emphasis on prevention efforts to reduce the number of people who seriously contemplate or attempt suicide, rather than only treating people at the point of crisis;
- Collaboration between public agencies, healthcare systems, service providers, and local communities, to reduce risk factors for suicidal behavior across sectors.\(^8\)

Paving the Way for Countywide Change

Marin County’s suicide prevention efforts maintain one core truth: **suicide is preventable.** The strategies and activities named in this plan follow established practices that have proven to reduce suicides and suicide attempts. With this plan, Marin County aligns itself with the State’s mission to **Strive for Zero** suicides.

There is much work ahead, but Marin County officials will not be alone in their efforts. Throughout the development of this strategic plan, there was an outpouring of enthusiasm and support from stakeholders and community members. Service providers, youth, and county officials all shared their desire to be involved in dialogues about suicide prevention and take part in local suicide prevention efforts. This widespread commitment to creating change is one of Marin County’s greatest assets in pursuing the activities outlined in the plan. It will be essential to continue to engage community members as key partners working towards common goals.

Figure 2, on the following page, presents a **Theory of Change** for the Suicide Prevention Strategic Plan. This Theory of Change is a roadmap for how the activities named in the Strategic Plan will work to reduce suicide thoughts, attempts and deaths. The Strategic Plan is organized around seven major **strategies** that are broad domains in which suicide prevention efforts will be housed. These seven strategies will lead to a series of **direct outputs**, such as the creation of new programs and services. Over time, these outputs will produce **intermediate outcomes**, such as a greater number of residents who are informed of and utilize local suicide prevention resources and supports. **Intermediate outcomes** will lead to **long-term outcomes**: fewer suicide attempts and deaths.

BHRS and RDA worked with community stakeholders to develop the seven strategy areas listed in the **Theory of Change**. To ensure that the strategic plan would be comprehensive and aligned with evidence-based practices, BHRS and RDA drew from two conceptual frameworks for suicide prevention to inform the strategic planning process. The following section describes these frameworks.
Figure 2: Theory of Change for the Marin County Suicide Prevention Strategic Plan

**Strategy Areas**
1. Leadership, oversight, and accountability
2. Coordinated system of care to promote suicide prevention and wellness
3. Public awareness campaigns
4. Evidence-based suicide prevention trainings and education
5. Outreach, engagement, and support
6. Foster safe and healthy environments on all school campuses
7. Reduce access to lethal means for those at risk of suicide

**Direct Outputs**
- Appoint county officials and community leaders to lead critical change efforts
- Increase collaboration between county agencies, community organizations, clinics, businesses
- Standardize policies and procedures around client/consumer care in health systems, schools
- Create new initiatives for training, local outreach, mental health care
- Increase countywide focus on reaching at-risk and under-resourced populations
- Regular public communications about ongoing and upcoming suicide prevention efforts
- Increase activities around means safety for those at risk of suicide

**Intermediate**
- Improve coordination of county programs and services
- Improve coordination in client care during and after crisis
- Increase standardization of policies and procedures in care coordination
- Improve availability and sharing of data on suicide and self-harm among county entities
- Residents are more informed and able to advocate for their care
- Residents are knowledgeable and able to help people in crisis
- More residents with access to preventative mental health care
- Reduction in access to lethal means for those at risk of suicide

**Outcomes**
- Reduction in deaths by suicide among Marin County residents
- Reduction in number of suicide attempts and mental health crises
- Reduction in residents’ stigma around mental health and suicide
- School campuses and local communities offer healthy, safe environments where residents can connect with each other

**Key Assumptions:**
- Individuals, institutions, and systems are capable of change;
- County partners can locate funding for ongoing suicide prevention efforts;
- Many community members will be willing participants in training & outreach efforts;
- County officials and stakeholders will maintain commitment to Strategic Plan strategies, objectives, and activities
Key Frameworks for Suicide Prevention

Two major conceptual frameworks, the Social-Ecological Model and the Continuum of Care, were utilized to understand suicide as a public health crisis, and to organize the priorities and goals in suicide prevention efforts. When examining these frameworks in relation to risk and protective factors for suicide, this process assists in analyzing Marin County’s existing resources and gaps related to suicide prevention, and to organize the activities and goals that comprise the Suicide Prevention Strategic Plan.

I. Risk Factors and Protective Factors

Suicide is typically the result of multiple overlapping factors. While suicide is often attributed to mental illness, more than half (54%) of people who die by suicide in the United States do not have a known mental health condition. This is why improving mental health services alone will not be enough to reduce suicides. Although neurochemical or psychological factors do heighten an individual’s risk for suicidal behavior, external factors such as relationship troubles, financial hardship, or lack of support networks can significantly increase risk as well. Suicide prevention frameworks classify all of these factors—biological, environmental, social, etc.—as potential risk factors for suicidal thoughts and behaviors. Risk factors do not cause an individual to experience suicidal thoughts; however, they can increase the chance that they might. Understanding these risk factors and their interplay is essential for the development and implementation of effective suicide prevention strategies and programs.

Suicide prevention strategies must also include approaches to strengthening a community or individual’s protective factors. In contrast to risk factors, protective factors are sources of healing or wellness, helping individuals build resilience to stressors. Protective factors can help a person to be more resilient from suicidal thoughts and behaviors during times of distress and crisis. Table 1 contains a list of some common risk factors and protective factors.

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
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<tbody>
<tr>
<td>Life stressors (relationship, work, school)</td>
<td>Healthy coping and problem-solving skills</td>
</tr>
<tr>
<td>Loneliness and isolation</td>
<td>Ability to adapt to change</td>
</tr>
<tr>
<td>Discrimination and exclusion</td>
<td>Reasons for living / sense of purpose</td>
</tr>
<tr>
<td>Previous suicide attempt</td>
<td>Social connections</td>
</tr>
<tr>
<td>Exposure to suicide death</td>
<td>Quality behavioral health care</td>
</tr>
<tr>
<td>Substance abuse or mental illness</td>
<td>Safe and supportive community</td>
</tr>
<tr>
<td>Access to lethal means</td>
<td>Membership in local groups and institutions</td>
</tr>
<tr>
<td>Stigma (shame or discomfort) around help for mental health</td>
<td>Cultural, religious, or personal beliefs that discourage suicide and/or promote wellness</td>
</tr>
</tbody>
</table>

While some risk factors and protective factors are universal, other factors are unique to specific age groups or cultural groups. Marin County and its community partners balanced universal and selective approaches in suicide prevention efforts, serving all community members while also weighing the particular needs of those community members at heightened risk for suicide.

II. The Social-Ecological Model

The Social-Ecological Model (SEM) is a framework for better understanding how risk factors and protective factors operate on multiple levels of human experience. Some factors exist at the individual/personal level (i.e. biology, attitudes, preferences), whereas other factors are broader and affect entire populations (i.e., public policies, organizational policies). An effective strategic plan for suicide prevention must target protective factors and risk factors at all levels of the SEM:

- **Structural and Institutional factors** include public policy (county, state, and federal laws), procedures within institutions (health care, criminal justice, housing and homelessness, etc.), and broader societal norms. For instance, Education Code Section 215 referenced above is one example of a structural approach to suicide prevention, requiring schools statewide to implement suicide prevention policies and procedures.

- **Community and organizational factors** involve relationships between organizations, social groups, and individuals at the level of a city, town, or neighborhood. For example, a community-level approach to suicide prevention could involve programs, supports and events that bring community members together to strengthen connectedness, raise awareness about local resources, and/or inform the public.

- **Relational and interpersonal factors** include the interactions between community members in formal (e.g. schools, workplaces, health clinics) and informal (e.g. family, friends, social gatherings) settings. A relational approach to suicide prevention could involve training community members how to recognize signs of suicide risk in their peers, inform about local and crisis resources, and how to encourage others to seek help.

• **Personal and individual factors** include an individual’s health, biology, knowledge, attitudes, skills, and personal development. An example of an individual-level approach to suicide prevention might include the development of an individualized safety plan that lists preferred coping options to reference when suicidal thoughts occur.

Focusing on all levels of the Social-Ecological Model is essential in implementing a comprehensive suicide prevention strategic plan. Because people may experience risk factors across the different tiers of the SEM simultaneously, this plan includes strategies that target each tier of the SEM.

### III. Continuum of Care

It is crucial for the strategic plan to include programs and activities that provide targeted support for individuals who are experiencing suicidal thoughts and behaviors, individuals who survive a suicide attempt, and community members who have lost a loved one to suicide. Approaches to reducing suicidal behaviors must address the entire continuum of care, from prevention to intervention to postvention efforts. Each of these three phases in the continuum is defined below.

**Figure 4: Suicide Prevention Continuum of Care**

- **Prevention (upstream)** services and programs decrease risk factors for suicide and/or increase protective factors. Many prevention activities involve teaching community members how to recognize the warning signs of suicidal behavior and challenge common myths about suicide. Prevention activities are *upstream* measures that intend to decrease
pain and/or stress to reduce the likelihood that people will develop thoughts of suicide and increase protective factors such as resiliency.

- **Intervention (or crisis response)** services respond to individuals who are currently experiencing a behavioral health crisis, including those who are contemplating suicide and/or actively planning to attempt suicide. Intervention resources include community members and clinicians who are trained to recognize the signs of active suicidal behavior, service providers who can help deescalate individuals experiencing crisis, and referral pathways for people in crisis to receive the proper urgent mental health care in a timely fashion.

- **Postvention (or post-crisis)** services are provided following a suicide death to support peers and loved ones who are experiencing grief and distress from suicide loss and to prevent additional suicidal behavior among those impacted.

Prevention, intervention, and postvention efforts are not narrowly defined and often overlap. Some organizations group together support activities in prevention and **early intervention** categories. A Prevention and Early Intervention (or PEI) framework includes all supports and services available to individuals before they experience a behavioral health crisis or attempt suicide. The field of “prevention” itself is open-ended, serving as an umbrella term for a wide range of efforts. It may include formal services such as outpatient mental health care, or informal supports such as interpersonal connections between neighbors and community members. Postvention services are also preventative in nature in that they build resilience and reduce suicide risk amongst those affected by a suicide death.

It is helpful to think of prevention, intervention, and postvention as general markers in a fluid continuum of care around crisis events. A comprehensive suicide prevention plan must address the care and support of individuals at all steps along this continuum.

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11 Early Intervention: identifying and treating individuals in the initial stages of suicidal ideation or suicidal behavior
Methods

The assessment team designed and conducted a mixed-methods approach to gathering data, engaging Marin County residents, and facilitating the strategic planning process. As Figure shows, data collection for the Strategic Plan proceeded through three main phases. The first two phases informed the development of a countywide Needs Assessment, which identified countywide trends in suicide, and surveyed existing assets and resource gaps in suicide prevention. Phase III activities led to the creation of the Strategic Plan itself. The following pages detail these three phases.

**Figure 5: Data Collection Phases for the Suicide Prevention Strategic Plan**

<table>
<thead>
<tr>
<th>Phase I: Situational Analysis</th>
<th>Phase II: Community-based Research</th>
<th>Phase III: Community Feedback and Collaborative Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Literature &amp; document reviews</td>
<td>• Key informant interviews</td>
<td>• Community forum</td>
</tr>
<tr>
<td>• Secondary data research</td>
<td>• Community focus groups</td>
<td>• Strategic planning sessions</td>
</tr>
<tr>
<td></td>
<td>• Suicide Prevention Community Survey</td>
<td></td>
</tr>
</tbody>
</table>

**Phase I: Situational Analysis**

In the first phase of the strategic planning process, existing research was identified to inform data collection activities with Marin County residents. Research efforts focused on best practices in suicide prevention, outlined suicide prevention efforts underway in other California counties, and gathered available data on suicide and suicidal self-directed violence in Marin County.

**Literature, Documentary, and Secondary Data Review**

A wide body of literature on suicide prevention was reviewed to develop a more comprehensive understanding of existing suicide prevention efforts locally, across California, and nationally. In addition, the assessment team located and analyzed county and state data sources on suicide, self-injury, and health and wellness among Marin County residents. Together, these data reviews provided local contexts and informed BHRS’s community efforts for the second phase of the project.

For lists of sources included in the literature and document review, and in the review of secondary data, please see *Appendix A*. 
Data Utilization and Analysis

Data collection efforts during Phase I largely informed the implementation of subsequent activities. The literature review and best practices research provided a framework for BHRS to design questions for the focus groups, key informant interviews, and countywide survey that comprised Phase II. Research into secondary data sources helped to identify populations at heightened risk for suicide who would be targeted outreach and engagement in suicide prevention efforts. In addition, a handout was developed displaying key data points on suicide and suicidal self-directed violence among Marin County residents. This was provided to focus groups and community planning participants, to promote a common understanding of local trends and data-driven decision making.

For a copy of these data visualizations, please see Appendix B.

Phase II: Community Research

In the second phase, the assessment team coordinated, and conducted community-based research activities. County stakeholders, service providers, and residents were engaged about their perspectives on suicide in Marin County, gaps in resources, and potential areas of opportunity for improvement.

Key Informant Interviews

Thirteen phone interviews were completed with key county stakeholders. These key informant interviewees represented several service areas relevant to suicide prevention, including BHRS leadership, public health and education officials, community-based service providers, first responders, clinicians and advocates. The following topics were discussed with interviewees:

- Existing services and programs related to suicide prevention
- Strengths and weaknesses in currently available suicide prevention resources
- Local efforts in cross-systems collaboration to address mental health care and suicide prevention
- Existing programs and future strategies to engage at-risk community members
- Priority areas for the Suicide Prevention Strategic Plan
- Potential participants in the strategic planning process

Together, these interviews helped to identify key structural and cultural barriers to suicide prevention efforts and solicit recommendations for program-level and systems-level changes to suicide prevention approaches. Table 2 includes the full list of key informant interviews.

For a list of key informant interview questions, please see Appendix C.
### Table 2: List of Key Informant Interviews

<table>
<thead>
<tr>
<th>Position / Stakeholder Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 BHRS Division Director</td>
<td>Dr. Jei Africa</td>
</tr>
<tr>
<td>2 BHRS Division Director-Children’s Services</td>
<td>Brian Robinson</td>
</tr>
<tr>
<td>3 BHRS Division Director Adult/OA &amp; Crisis Continuum Services</td>
<td>Connie Moreno-Peraza</td>
</tr>
<tr>
<td>4 Marin County Public Health Officer</td>
<td>Dr. Matt Willis</td>
</tr>
<tr>
<td>5 Marin County of Education: Director, Special Education Local Plan Area (SELPA) and Asst. Superintendent, Special Education</td>
<td>Jon Lenz</td>
</tr>
<tr>
<td>6 Buckelew Leadership and Program Staff</td>
<td>Tamara Player, Kara Connors, Susan Acker, Sarah Chapman</td>
</tr>
<tr>
<td>7 Community Member, Lived Experience</td>
<td>Monica Wooley</td>
</tr>
<tr>
<td>8 Executive Director, National Association on Mental Illness (NAMI) Marin County</td>
<td>Kelli Finley</td>
</tr>
<tr>
<td>9 Ethnic Services Manager</td>
<td>Cesar Lagleva</td>
</tr>
<tr>
<td>10 Marin County Veterans Service Office</td>
<td>Spence Casey &amp; Sean Stevens</td>
</tr>
<tr>
<td>11 Firefighter/Engineer, Southern Marin Fire Protection</td>
<td>Dean Raffaini</td>
</tr>
<tr>
<td>12 Director of Behavioral Health, Marin Community Clinic</td>
<td>Dr. Elizabeth Horevitz</td>
</tr>
<tr>
<td>13 MarinHealth Psychiatry</td>
<td>Dr. Heather Carlberg</td>
</tr>
</tbody>
</table>

### Focus Groups

Nine focus group discussions were completed to survey community members’ perspectives on a range of related topics, including:

- Data on suicide and suicidal self-directed violence among Marin County residents
- Risk factors and protective factors in local communities and school campuses
- Personal experience accessing suicide prevention resources
- Potential avenues and strategies to reach more people in suicide prevention efforts
- Knowledge of available suicide prevention resources
- Common barriers to mental health care for Marin County residents
- Strategies to reduce stigma around mental health care and suicide prevention

BHRS identified participants who represent the demographic diversity of Marin County, including residents of geographically isolated regions and representatives of communities at heightened risk for suicide. A diversity of youth perspectives was included in the focus groups in response to community concerns around youth suicide in Marin County.

Table 3 contains the full list of focus groups.
Table 3: List of Community Focus Groups

<table>
<thead>
<tr>
<th>Focus Group Type</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth-Focused</td>
<td>Marin County Youth Commission</td>
</tr>
<tr>
<td></td>
<td>PEI Provider Meeting</td>
</tr>
<tr>
<td></td>
<td>School Age (6th-8th grade)</td>
</tr>
<tr>
<td></td>
<td>Transition Age Youth (TAY) INN Advisory Committee</td>
</tr>
<tr>
<td></td>
<td>Adolescent/TAY, LGBTQ+ Program</td>
</tr>
<tr>
<td></td>
<td>School administrators/counselors</td>
</tr>
<tr>
<td>Adult-Focused</td>
<td>Older Adults/Providers</td>
</tr>
<tr>
<td></td>
<td>Adult Consumers of mental health services</td>
</tr>
<tr>
<td></td>
<td>Advocates from underserved Communities</td>
</tr>
<tr>
<td>BHRS/Community-based</td>
<td>Prevention and Early Intervention (PEI) Providers</td>
</tr>
</tbody>
</table>

In order to track representation among different communities and age groups in Marin County, focus group participants were asked to complete a voluntary demographic survey. A total of 61 (out of 63) individuals completed some or all of the survey. Figure 6 provides a demographic breakdown of these focus group participants. The majority (63%) were aged 25 or younger, and three in five participants was female. Participants that identified as a person of color participated in focus groups at rates slightly higher than the overall county population. For a more detailed account of focus group demographics, please see Appendix D.

Figure 6: Focus Group Participants by Age (Left), Race/Ethnicity (Center), and Gender (Right) [n=61]

12 Participants in the PEI provider focus group did not complete the demographic survey, and are not counted among the results.
13 Though a majority of suicides occur in adults 50 years and older, youth were more represented in focus group activities due to a) difficulty coordinating adult focus groups, b) poorer turnout to the adult focus groups that were successfully coordinated, and c) particular in interest in capturing youth voices to inform implementation of suicide prevention policies as mandated by Education Code (EC) Section 215.
Suicide Prevention Community Survey

Research efforts from Phase I informed the development of a Community Survey questions, along with a review of survey tools from previous suicide prevention evaluations and needs assessments. The survey gauged community members’ responses, beliefs, and experiences regarding the following topics:

- Personal experience with suicide (including knowing others who are experiencing thoughts of suicide, or experiencing suicidality oneself)
- Knowledge of local mental health and suicide prevention resources
- Perceptions of suicide and stigma among Marin County residents
- Willingness to engage in suicide prevention activities
- Preferred strategies for future suicide prevention efforts
- Demographic information

Spanish and Vietnamese language translations were integrated into the survey in order to reach more members of the county’s two largest non-English speaking communities. Most respondents completed the survey on SurveyGizmo, using a computer or mobile device. BHRS also worked with community partners to distribute paper copies of the survey to residents with limited access to technology, and residents who were less likely to come across the survey through their social networks, such as non-English speakers.

A total of 1,307 people completed all or some of the Suicide Prevention Community Survey in February 2019. Community participation was more concentrated in urbanized parts of the county: the majority of respondents who identified as Marin County residents reside in or around Novato and San Rafael. By comparison, residents in North and West Marin County made up fewer than 10% of respondents.

As Figure 7 shows, adult and older adult respondents comprised nearly all of the survey respondents. While the racial and ethnic breakdown of respondents more closely reflects the overall county population than did focus group participants, the gender imbalance among survey respondents was more extreme: four in five respondents identified as female. A more detailed description of survey respondents’ demographic information can be found in Appendix E.
Marin County Office of Education Survey

The assessment team also collaborated with MCOE to develop a student survey to gauge attitudes, perceptions, help-seeking behaviors, knowledge related to suicide prevention and school climate. MCOE administered the survey in seven high schools across four districts in March 2019. In all, 370 students completed the survey, which provides useful baseline data for the future evaluation of suicide prevention efforts in Marin County schools.

Data Utilization and Analysis

Thematic analyses were used to assess the findings from key informant interviews and focus groups: identifying trends in participants’ observations and perspectives, highlighting Marin County residents’ common priorities and concerns, and noting any discrepancies or contradictions between community members’ experiences. The following statistical approaches were used to analyze the results of the Community Survey: examining major trends across the responses of all community members and disaggregating the data to identify concerns among specific subsections of the community. Responses from populations disproportionately affected by suicide were analyzed to determine whether these data subsets differed from the overall survey results.

Phase III: Community Feedback and Collaborative Planning

The final phase of the strategic planning process involved working closely with community leaders and key community stakeholders. BHRS engaged groups of partners to translate the findings from the Needs Assessment into a series of strategies and actionable tasks. The two main activities in Phase III, a community forum and strategic planning, are described below.
Community Forum

On May 2, 2019, BHRS facilitated a community forum for residents of Marin County to provide input on the strategic planning process. After sharing key findings from the Needs Assessment, attendees participated in a series of brainstorming activities. Forum participants discussed ideas for strategic planning goals, new programs and services, and other key considerations, working in three different breakout groups:

1. Strategies to engage community members disproportionately affected by suicide (i.e., middle-aged and older men, LGBTQ+ residents, people of color, youth in schools, veterans);
2. Strategies to increase community members’ help-seeking behavior, and decrease stigma around discussing suicide and accessing mental health services; and
3. Strategies to enhance resilience and strengthen protective factors for all Marin County residents

Over 40 community members participated in the community forum, and their contributions laid the groundwork for the strategies, goals, and actions included in this strategic plan.

For a set of notes and contributions from the Community Forum, please see Appendix F.

In addition to participating in formal activities, attendees were able to network with each other and strengthen community ties. This spirit of informal connectedness and togetherness will continue to be an essential component of the strategic plan, in addition to the implementation of formal protocols, policies, and practices.

Strategic Planning Sessions

Following the community forum, BHRS convened the Strategic Planning Committee to participate in strategic planning sessions and establish priorities for the strategic plan. Over 30 key stakeholders—representing a variety of public agencies, health clinics, community organizations, neighborhoods, and lived experiences — gathered for a three-part series of strategic planning sessions, between June 3 and July 12, 2019.

Strategic planning participants were integral in the development and refinement of the plan’s core components and areas for action. Planning activities included:

- Developing, validating, and refining particular strategy areas, objectives, and action items
- Identifying ongoing programs and services in Marin County communities that could be linked to broader coordination efforts in suicide prevention
- Identifying barriers to the implementation of evidence-based practices
- Troubleshooting potential challenges in interagency collaboration and cross-systems coordination, e.g., standardizing care practices and data-sharing across providers
- Brainstorming lists of recommended partners for the strategic plan’s priority areas
Participants worked in a trio of breakout groups, which remained intact across all three sessions:

**Figure 8: Strategic Planning Breakout Groups**

| Systems-Level Breakout Group | • High-level, countywide strategies involving interagency collaboration, policy change, and cross-systems partnerships  
|                            | • Ex: enhanced coordination of healthcare systems; standardizing campus programming/policies across school districts; lethal means reduction |
| Community-Level Breakout Group | • Strategies at the mid-level scale of cities, towns, and neighborhoods  
|                                | • Ex: school programs/services; training/education plans for providers, clinicians, and residents; programs to decrease isolation and improve connectedness between residents |
| Individual-Level Breakout Group | • Strategies to enhance individual residents’ knowledge of suicide prevention resources, access to services, and help-seeking behavior  
|                                | • Ex: raising public awareness of resources; targeted approaches to reaching at-risk individuals; reducing cultural & age-specific risk factors |

Each of the three planning sessions prioritized different phases in the suicide prevention continuum of care. The first two sessions emphasized strategies in suicide prevention and intervention; while the third session involved both a discussion of postvention strategies and a collaborative review of the strategies and activities that had been drafted to date.

*For a full list of agencies and organizations represented in the strategic planning sessions, please see Appendix G.*

**Data Utilization and Analysis**

Phase III of the project was an iterative process of gathering community feedback. Following the Community Forum and each of the three strategic planning sessions, participants’ comments were gathered to develop and refine the Strategic Plan. Community input helped to determine the full scope of efforts listed in the plan; add specific activities or programs under a given strategy area; and identify barriers. Participants in Phase III activities were essential in connecting best practices research to the Marin County-specific findings from the Needs Assessment and proposing how to translate evidence-based practices into the specific context of Marin County.

**Data Limitations**

**Underrepresentation of adult men in community outreach and data collection efforts.** As the following section of the assessment report discusses, middle-aged and older white men make up the majority of deaths by suicide in Marin County. Early in the planning process, a need to engage white male community members as a key stakeholder group was identified. The
assessment team outreached to multiple community organizations, including behavioral health service providers, men’s support groups, and religious and faith-based groups.

However, difficulties in establishing focus groups with these community members were encountered. Some organizational representatives expressed concerns that members of their service programs or support groups might find the topic of suicide overwhelming or inappropriate to discuss in the setting. In another case, no members of a men’s church group attended a focus group that had been coordinated with the group’s main organizer, despite the organizer’s personal outreach to group members.

The underrepresentation of men among focus group participants (37% of all participants) and community survey respondents (18%) reflects a difficulty in outreach to this population. This broader trend of male residents opting not to participate in data collection activities may reflect the possibility of a broader cultural barrier of stigma for men around openly discussing suicide and mental health. Research suggests that cultural expectations around masculinity that reinforce independence, competence, and the concealing of emotions that suggest vulnerability, can contribute to difficulty engaging about topics like suicide and needed supports. These tendencies can increase the risk of suicide by impeding help-seeking behavior due to feelings of shame. It may not be surprising then that men, particularly in middle age, are disproportionately affected by suicide according to both national and local statistics.

Based on these findings and informed by the Suicide Prevention Resource Center’s recommended best practices, adult men have been identified as a key target population in this strategic plan. Multiple approaches for engaging with and supporting men are incorporated into the plan’s strategies. A taskforce is planned to continue research, data collection, and engagement with adult men to further build out and refine activities with the goal to support this segment of the Marin County population.

Organization of the Suicide Prevention Strategic Plan

The remainder of this document is organized in two main sections, which are briefly summarized below.

Part I: Needs Assessment

The following section of the Suicide Prevention Strategic Plan offers a survey of Marin County’s existing efforts and needs related to suicide prevention resources. Several local data sources were used to understand the scope of suicide and suicidal self-directed violence and identify populations and communities at heightened risk for suicide. The Needs Assessment also draws


from the insights and attitudes of Marin Community members, over a thousand of whom shared their experiences and opinions through community engagement efforts and a countywide survey.

**Part II: Strategic Plan**

The final section of this document contains the Suicide Prevention Strategic Plan. Following the development of the Needs Assessment, BHRS convened a variety of community stakeholders, clinicians, advocates, and persons with lived experience to form the Strategic Planning Committee. The Committee developed core strategies and actions that reflect the major priorities identified in the Needs Assessment to align to best practices in suicide prevention. This section of the Strategic Plan includes the core strategies, objectives, and activities, as well as rationales for selection of strategies. Community agencies, organizations, and programs that are currently involved in the identified activities or who are poised to be involved in the future are named as key partners within each objective.
Part I: Needs Assessment

Introduction and Overview

The Needs Assessment is the first major component of Marin County’s Suicide Prevention Strategic Plan. It is an analysis of community members’ experiences, attitudes, and identified needs that were used to guide the Strategic Planning process. Understanding local assets and challenges supported the planning committee to apply best practices in suicide prevention to the particular context of Marin County.

The Needs Assessment also allowed the strategic planning process to involve data-driven decision-making. Understanding which residents are most impacted by suicide ensures that the Strategic Plan targets the communities with the most pressing needs. Surveying the landscape of existing suicide prevention resources and identifying major gaps in services helped to ensure that the plan enhances the continuum of care while avoiding a duplication of efforts. Finally, assessing community members' experiences with suicide loss, perceptions of suicide, and interest in participation supported county officials with communicating progress towards Strategic Plan activities with members of the public.

This assessment report seeks to answer six research questions, grouped into three main topics:

### Figure 9: Needs Assessment Research Questions

| Identifying Impacts | • Who dies by suicide in Marin County?  
|                     | • Which communities in Marin County are at increased risk for suicide? |
| Assessing Resources | • What existing resources do residents find effective?  
|                     | • What resources have community members identified as unavailable or in need of improvement? |
| Building Resiliency | • How are community members interested in participating?  
|                     | • What are the foreseeable challenges of engaging community members in suicide prevention activities? |

As the previous section describes, this Needs Assessment is the result of a comprehensive mixed-methods approach that combined quantitative and qualitative methods, and intermixed secondary data on suicide and suicidal self-directed violence with interviews with community members. Marin County residents were key to the development of this Needs Assessment, providing important insight on local risk factors and identifying service gaps that might otherwise go unidentified.
Profile of Marin County

With approximately 260,000 residents, Marin County is the second-least populated county in the Bay Area, behind Napa County. The state of California designates Marin County as a suburban county, a factor behind the county’s low-density housing development and high costs of living.

Marin’s low density (501 people per square mile) is also a result of its geography. The majority of residents live on the east side of the County, proximal to the 101 Freeway and the Golden Gate and San Rafael-Richmond Bridges. The two largest cities, Novato and San Rafael, account for about 44% of the county’s population. By contrast, the west and north regions of Marin County contain large swaths of rural and open land, are sparsely populated, and have comparatively less access to the county’s social service infrastructure. Over one-quarter of residents (26%) live in unincorporated areas of the county, which further constrains residents’ access to local social services in rural, geographically isolated areas.

On average, Marin County residents are older and less diverse than other Bay Area counties. Marin County has the highest median age (46.1) in the nine-county Bay Area, and the largest percentage of persons aged 60 or older (28%) in the Bay Area. This is important to note because nationally, individuals ages 45-65 have the highest number of suicides and those aged 60 years and older have the highest rates of suicide. Marin County also has the smallest percentage of residents of color (28%) in the Bay Area. Latinos and Hispanics make up the largest community of color (16% of all residents). Native Spanish speakers make up 12% of the population.16

Marin County is one of the most educated and wealthiest counties in California. The county’s high school graduation rate (93%) is the highest in the Bay Area and the third highest in California; and the county features the highest rate of residents with a bachelor’s degree (56%) statewide.17 Its median household income ($104,703) consistently ranks among the highest in the state and nation. Accordingly, Marin County has one of the highest costs of living in California. According to the Insight Center’s Family Needs Calculator, which offers a standard measurement of minimum income for family expenses, Marin County has the highest minimum family expenses in all counties statewide.18

However, the county’s overall economic prosperity should not obscure the economic inequalities within the county. The average income for Latino families in Marin County is 36% of the average family income for white residents; for Black families, 48%; and for Asian families, 77%.19 More than half of Black and Latino households, and 100 percent of Native American households, fall

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below the Family Needs Calculator standards for the county, compared to one-quarter of white households.\textsuperscript{20}

According to the Robert Wood Johnson Foundation, which assesses health outcomes across all counties in California, Marin County has ranked as the healthiest county statewide in all but one year between 2011 and 2019.\textsuperscript{21} While Marin County residents generally score as healthy in regards to certain metrics (longevity, adult smoking and obesity rates, rates of uninsured individuals), elevated suicide rates highlight important questions about what is missing from this profile.

**Suicide in Marin County: Key Figures and Outcomes**

The loss of several Marin County teens to suicide in the same month (December of 2017) devastated the community and raised awareness of suicide as a public health crisis. Marin County’s overall affluence, high levels of education, and healthiness offer a contrast to its relatively high rates of suicide. As Figure 10 shows, Marin County residents die by suicide at rates that are the highest among all Bay Area counties.\textsuperscript{22} Marin County’s suicide rate is also the highest among all metropolitan counties in California, trailing only more rural and isolated regions, where suicide rates are structurally higher.

As Figure 11 shows, several dozen residents die by suicide annually. The past five years have seen a low of 30 people in 2015, and a peak of 47 in 2016.\textsuperscript{23} While numbers fluctuate from year to year, male residents consistently make up the majority of deaths by suicide. This gender imbalance is consistent with state and national trends.

Data on suicides by zip code of residence indicate that while the majority of deaths by suicide between 2014 and 2018 occurred in more populated areas (Novato, San Rafael, and surrounding neighborhoods County), suicide rates were higher in the more rural areas of West County. Novato, San Rafael, and surrounding

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{suicide_rates_bay_area.png}
\caption{Suicide Rates in Bay Area Counties, 2015-2017}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{suicide_deaths_marin_county.png}
\caption{Deaths by Suicide Among Marin County Residents, 2014-2018}
\end{figure}

\textsuperscript{21} Marin County ranked second overall in 2017. See: County Health Rankings & Roadmaps: Marin County profile. https://www.countyhealthrankings.org/app/california/2019/rankings/marin/community/outcomes/overall/snapshot
\textsuperscript{22} CDPH, Preventing Violence in California, Data Brief 1: Overview of Homicide and Suicide Deaths in California
\textsuperscript{23} Yearly suicide data courtesy of Marin County Public Health
neighborhoods have suicide rates closer to or below the state average.\textsuperscript{24} The elevated rates of suicide in West Marin mirror the heightened suicide rates in more rural areas of the state.

The Golden Gate Bridge, historically a location with high incidents of suicide, adds complexity to the issue suicide in Marin County. Many people who consider jumping from the bridge are from outside of the County and travel to Marin County or San Francisco specifically to visit the bridge.\textsuperscript{25} Coordinated efforts among law enforcement, first responders, volunteers, and others to prevent individuals from jumping off the bridge have reduced the number of suicides at the Golden Gate Bridge, but a few dozen individuals die by suicide every year. In 2018 there were 187 successful interventions that resulted in lives being saved, and 27 deaths by suicide.\textsuperscript{26} The bridge's proximity adds an additional layer to suicide prevention needs in Marin County. At present, a protective net barrier is being constructed to reduce suicide deaths from jumping from the bridge. This is an example of a local initiative aiming to reduce lethal means for individuals in crisis and/or at high risk of suicide.

\textsuperscript{24} Suicide data by zip code courtesy of Marin County Public Health. County population by zip codes (to calculate suicide rates) based on current population estimates from ZIP-Codes.com. See: https://www.zip-codes.com/county/ca-marin.asp

\textsuperscript{25} Marin County Sherriff's Office Coroner's Reports, 2013-18

The following section of the Needs Assessment offers a more detailed breakdown of deaths by suicide and suicide attempts by race, ethnicity, gender, and age. While this disaggregation of data is crucial to understand which residents are at heightened risk for suicide, it is also important to recognize that suicide incidents affect many residents in Marin County. A sizeable majority of participants in the data collection efforts have known someone who either attempted suicide or died by suicide. Even for residents who do not personally know others who have struggled with suicide, news of suicides can be overwhelming. The issue of suicide has impacts on many community members, not just on those who experience suicidal behavior.

Figure 14: Marin County Residents at the May 2019 Community Forum
Key Findings

Based on data analysis from community engagement efforts and other data sources, three core project challenges were identified, one for each main area of inquiry.

**Identifying Impacts**

*Middle-aged and older white men die by suicide at the highest rates, but there are many other groups of people that can be at heightened risk for suicide (youth, older adults, people of color, LGBTQ+ residents, veterans, and others).*

**Assessing Resources**

*Marin County has several existing suicide prevention resources. However, many residents face barriers to accessing supportive services, and/or do not know how to help others who are contemplating suicide.*

**Building Resiliency**

*While community wellbeing and social cohesion can reduce suicide risk, and many residents want to be involved in suicide prevention efforts, there is a widespread culture of stigma and difficulty engaging with the issue.*

Each challenge presents a complex set of factors that shape residents’ risk for suicide, perspectives on suicide and suicide prevention, and access to formalized support services. Strategic planning efforts have sought to engage and support the many different population groups in Marin County at heightened risk for suicide, address gaps in the continuum of suicide prevention care, and educate more community members on best practices in wellness, help-seeking behavior, and client care.

However, this is not to suggest that Marin County officials and partners will be starting from scratch. Marin County hosts a sizeable array of existing suicide prevention resources that can serve as the foundation for the expansion of suicide prevention efforts. Just as importantly, the County is home to many residents who are enthusiastic about participating in further suicide prevention efforts. This foundation of community members’ commitment will be a key contributing factor to the reduction of suicide deaths and attempts in Marin County.

The following subsections discuss these findings in detail.
Challenge 1: Identifying Impacts

**Main Challenge**
Middle-aged and older white men die by suicide at the highest rates, but there are many other people at heightened risk for suicide (youth, older adults, people of color, LGBTQ+ residents, veterans, and others).

**Deaths by Suicide**

Epidemiological data for Marin County show that middle-aged and older white males account for the highest number of deaths by suicide among residents. Between 2014 to 2018, men aged 50 and older accounted for nearly half (49%), and men of all ages accounted for approximately three-quarters (74%) of all deaths by suicide among county residents. This adds up to 143 total deaths by suicide for men between 2014-2018. In comparison, 49 women died by suicide during that same time period.

![Figure 15: Deaths by Suicide in Marin County (2014-2018), Organized by Age and Gender](image)

![Figure 16: Deaths by Suicide in Marin County (2014-2018), Organized by Gender](image)

Examining differences in Marin County residents’ suicide rates across age groups and genders further demonstrates the severity of this trend. As Figure 17 shows, suicide rates for male residents of Marin County in their fifties, sixties, and seventies are two to three times higher than the statewide rate of suicide for all age groups; for men in their eighties, the suicide rate is nearly seven times the statewide average. Across all age groups, males die by suicide at rates multiple times the suicide rates of females in the same age groups. Despite these significant discrepancies between men and women, suicide rates in Marin County also rise for women in their forties and

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27 Suicide death and attempts 2014-2018-Marin County Division of Public Health
fifties. However, it appears that older men in Marin County continue to experience elevated suicide risk, while suicide rates for older women drop from their peak in middle age.\textsuperscript{28}

**Figure 17: Suicide Rates in Marin County by Age Group and Gender, 2014-2018**

(Deaths by Suicide per 100,000 People)

As Figure 18 shows, between 2014 and 2018, white residents accounted for a slightly higher percentage of all deaths by suicide relative to the overall population, whereas Latino, African-American, and Asian-Pacific Islander residents accounted for slightly lower percentages of suicide deaths, relative to their demographic representation in Marin County.

**Figure 18: Deaths by Suicide in Marin County (2014-2018), Organized by Race; and County Population by Race**

\textsuperscript{28} Suicide rate data calculated using countywide population estimates by age/gender from the 2017 American Community Survey.
Suicide Attempts

As mentioned earlier in this report, the number of suicide attempts is several times that of the number of deaths by suicide. In 2016 and 2017, 420 Marin County residents were hospitalized or visited an emergency department (ED) for injuries stemming from suicidal self-directed violence, compared to 89 confirmed deaths by suicide over the same time span. Importantly, the number of hospitalizations and ED visits is almost certainly an undercount, as these figures do not account for any residents who did not seek medical care following a suicide attempt. Nonetheless, suicide attempt data can indicate other population groups at risk for suicidal behavior.

For instance, Marin County suicide attempt data is consistent with statewide and national trends, which show that women and girls attempt suicide at greater rates than men and boys. Between 2016 and 2017, women and girls accounted for 71% of all county residents who were hospitalized or visited emergency services for suicidal self-directed violence. As Figure 19 shows, the racial and ethnic breakdown of these patients did not diverge substantially from the countywide population. However, female survivors of suicidal self-directed violence were of average younger than male survivors: the mean age of female patients in this group was 32 in 2016 and 31 in 2017; for male patients, the mean age was 40 and 36, respectively.²⁹

In other words, the data suggest that girls and younger women in Marin County account for a larger share of suicide attempts relative to the countywide population. A suicide prevention strategic plan that only focuses on trends in death by suicide can potentially overlook other populations at heightened risk for suicidal behavior.

Other Groups at Risk

Data collection, community outreach, and research efforts revealed the extent to which many Marin County residents besides middle aged and older white men are at risk for suicide. Other demographic groups in the county face different stressors and risk factors that increase the possibility of suicidal ideation or behavior. Suicide ideation, or thoughts of suicide, is also an issue that the strategic plan must address. The community survey reveals that several groups have contemplated and/or attempted suicide at higher rates than the overall survey population, even if some of these demographic groups comprise smaller minorities of Marin County residents overall.

²⁹ suicidal self-directed violence data courtesy of Marin County Public Health.
BHRS identified the five following groups of community members as having potential for elevated risk for suicide ideation and/or suicide behaviors:

**Youth**

Many local youth experience acute mental health challenges; as mentioned earlier, one major reason for the development of a countywide Suicide Prevention Strategic Plan was a series of deaths by suicide among Marin County high school students. Per the 2015-2017 CalSCHLS (previously known as the California Healthy Kids Survey), over one-quarter of Marin County high school students (25% of 9th graders and 28% of 11th graders) reported feeling chronic sad or hopeless feelings in the 12 months prior to taking the survey. Furthermore, around one in eight high schoolers (14% of 9th graders and 11% of 11th graders) had seriously considered attempting suicide in the past 12 months.30

Community survey data also demonstrate that youth can be at elevated risk for suicide: **respondents aged 25 or younger have contemplated suicide (30%) and attempted suicide (20%) at significantly higher rates than the overall survey population (20% and 8%, respectively).**

**NOTE:** Responses to survey questions about incidents of suicidal thoughts and attempts may be inflated since community members who were willing to participate in the survey may likely have higher levels of impacts from suicide incidents than the general population.

**People of Color**

As noted earlier in this report, residents of color in Marin County make less in income and have less in wealth on average than white residents, which can impact access to care. Per key informants who work in Marin County’s communities of color, many residents of color experience heightened stresses from structural and social inequalities, which can negatively affect their mental health and wellbeing.

As well, the 2015-2017 California Healthy Kids Survey also indicates that Black, Latino/a, and Native American youth in Marin County experience depression at higher rates than do their white and Asian peers.31 According to the Marin County Suicide Prevention Community Survey, **Black and Latino/a respondents have attempted suicide at higher rates (14% and 11%, respectively), than the overall survey population (8%).**

**Non-English Speakers**

Residents who do not speak English face additional challenges in accessing mental health services and other supports. Respondents who answered the survey in Spanish or Vietnamese

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31 Ibid., 48
were less aware of supports for suicide prevention. **Only 32% of respondents that completed the survey in Spanish or Vietnamese answered that they knew were to get help for a friend of family member who is having thoughts of suicide, as opposed to 68% of all survey respondents.** In addition, key informants and survey respondents alike indicated a critical need for additional mental health and translation services for the county’s major language communities.

**LGBTQ+ Residents**

Studies indicate that lesbian, gay, bisexual, transgender, and queer or questioning people report a higher prevalence of suicide attempts compared to people who identify as heterosexual\(^{32}\). A host of potential negative external stressors that people that identify as LGBTQ+ experience are associated with higher prevalence of suicidal behavior, such as mistreatment or abuse from peers, institutional discrimination, and family members who are unsupportive or hostile to their sexual orientation and/or gender identity. \(^{33}\) It should be noted that Community Survey respondents that identified as LGBTQ+ reflected this trend as they reported being affected by suicide at a higher rate than any other demographic subset: **52% of LGBTQ+ respondents have seriously contemplated suicide, and 28% have attempted suicide** (as opposed to 20% and 8% of all survey respondent, respectively). During a focus group with young people who identify as LGBTQ+, individuals shared stories of the high levels of stress and isolation they felt during the beginning stages of adolescence and advocated for more support and resources for LGBTQ+ youth during middle school years. They also identified a broader need for more education and dialogue on sexual orientation and gender identity for children and youth at earlier ages and for parents.

**Veterans**

The research literature has established that armed forces veterans in the U.S. die by suicide at higher rates—about 1.5 times as frequently—than the non-veteran adult population.\(^{34}\) Local data on veterans reflect this heightened risk: **between 2014 and 2018, one quarter (23%) of male residents who died by suicide were veterans.** Veteran respondents to the Marin County Community Survey have contemplated suicide (25%) and attempted suicide (13%) at slightly higher rates than rates of contemplation and attempts among all respondents (20% and 8%, respectively). Key informants affiliated with the Veterans Service Office in Marin County also noted that they intercept some clients from the justice system or local Continuum of Care, and

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veterans who are justice-involved and/or experiencing homelessness can experience heightened mental health challenges.

*For a full list of community survey results and responses, please see Appendix E.*

**Summary**

Data collection efforts made it clear that *suicide affects all communities in Marin County*. Nearly three-quarters (72%) of survey respondents noted that they knew at least one person who had attempted or died by suicide. One in five respondents has had serious thoughts about ending their own life, and one in twelve has attempted suicide. These personal experiences with suicide cross socioeconomic divides and affect residents regardless of their age, gender, race, or ethnicity.

Yet, it will important for the strategic plan to offer targeted, culturally appropriate approaches to the different community members and population groups who are at heightened risk for suicide. Approaches to engage white men may not be appropriate for residents of color, LGBTQ+ residents, and/or youth, who can face different risk factors or build resiliency from different protective factors. Targeted outreach is especially important for community members who are both at heightened risk and harder to engage, such as those who experience stigma about discussing their mental health or seeking supportive care. Emphasizing these targeted approaches will help strategic planning efforts reach more of the community members who stand to benefit the most.
Challenge 2: Assessing Resources

Marin County has several existing suicide prevention resources. However, many residents face barriers to accessing supportive services, or do not know how to help others who are contemplating suicide.

Available Resources and Services

Marin County has services and resources across the continuum of suicide prevention, intervention, and postvention supports. Community members involved in outreach and data collection efforts identified a wide range of local organizations, clinics, and programs where they had previously accessed or would access suicide prevention trainings, mental health services, or other related resources and support. The resources and services that were identified spanned the continuum of care in suicide prevention:

Prevention

Marin County residents reported that they had accessed suicide prevention resources in the form of informational materials on suicide prevention or through trainings at a number of different public and community-based organizations. Residents also reported engaging in, or having knowledge of other services and activities that support wellbeing including mental health screenings received in medical and behavioral health settings and community-based supports. Below is a list of organizations and sites that were specifically referenced by participants:
Table 4: Suicide Prevention Services and Sites Identified by Community Members

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Provider/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental/Behavioral Health Services</td>
<td>• Buckelew programs (Counseling and Suicide Prevention)</td>
</tr>
<tr>
<td></td>
<td>• Coastal Health Alliance</td>
</tr>
<tr>
<td></td>
<td>• Huckleberry Youth Programs</td>
</tr>
<tr>
<td></td>
<td>• Kaiser Permanente</td>
</tr>
<tr>
<td></td>
<td>• Marin County Behavioral Health and Recovery Services</td>
</tr>
<tr>
<td></td>
<td>• Marin Community Clinic</td>
</tr>
<tr>
<td></td>
<td>• Marin County School-based services and wellness centers</td>
</tr>
<tr>
<td></td>
<td>• MarinHealth Medical Center</td>
</tr>
<tr>
<td></td>
<td>• Sutter Health</td>
</tr>
<tr>
<td>Community-Based Support and</td>
<td>• Integrated Community Services</td>
</tr>
<tr>
<td>Wellness Services</td>
<td>• Marin Asian Advocacy Project</td>
</tr>
<tr>
<td></td>
<td>• Marin City Fatherhood Council,</td>
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<tr>
<td></td>
<td>• Multicultural Center of Marin</td>
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<tr>
<td></td>
<td>• Opening the World</td>
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<tr>
<td></td>
<td>• San Geronimo Valley Community Center</td>
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<tr>
<td></td>
<td>• The Spahr Center</td>
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<tr>
<td></td>
<td>• Surviving the Odds Project</td>
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<td></td>
<td>• Young Moms Marin</td>
</tr>
<tr>
<td></td>
<td>• WISE Choices for Girls</td>
</tr>
<tr>
<td>Training and Education Sites/</td>
<td>• Buckelew Programs</td>
</tr>
<tr>
<td>Opportunities</td>
<td>• College of Marin, Dominican University, and other higher education institutions</td>
</tr>
<tr>
<td></td>
<td>• Marin County Behavioral Health and Recovery Services</td>
</tr>
<tr>
<td></td>
<td>• Local fire and law enforcement agencies</td>
</tr>
<tr>
<td></td>
<td>• NAMI Marin</td>
</tr>
<tr>
<td></td>
<td>• Places of Worship</td>
</tr>
</tbody>
</table>

35 This list is not intended to comprehensively represent all available suicide prevention and support services in Marin County. Rather, it reflects the range and type of services (and service providers) that community participants had utilized or would utilize if needed.
Intervention

The mental and behavioral health service providers listed previously also provide varying levels of elevated supports that are necessary to assess and respond to a range of suicidal behaviors. Below are examples of services and providers that illustrate the range of available responses to support an individual who may be moving into crisis or who is already actively suicidal.

- County crisis intervention and continuum of care services provided by BHRS
- Five community clinics that provide behavioral health services and assessment in accessible settings
- Suicide and Crisis Hotlines, implemented by Buckelew Programs
- Many private mental health providers, providing individualized ongoing therapeutic services
- Community-based behavioral health organizations (CBOs) working with schools to identify students with mental health needs, provide assessment and services, and/or refer them to higher levels of care as needed

Postvention

Support after a suicide death, also referred to as postvention, is a key element of a comprehensive strategy for suicide prevention and this is reflected in the Marin County Strategic Plan for Suicide Prevention (see objectives 2.4 and 4.1). Research shows that connection to someone who has died by suicide can increase risk of suicide for the suicide loss survivors. However, efforts such as support groups, collaborative response, and effective mental health support, can mitigate this risk.

One area of strength in the area of postvention within Marin County is in the school system. As part of California Education Code Section 215 (suicide prevention policy mandate), Marin County school officials, in collaboration with Marin County Health and Humans Services and Kaiser Permanente, have developed and implemented postvention protocols and procedures for responding to suicide deaths in the school community. The Crisis Response Protocols provide guidance surrounding the formation of Crisis Response Teams (CRTs) and effective postvention response, communication, and intervention strategies. The response, communication, and intervention strategies are meant to help manage the various aspects of the crisis response and reduce the risk of further suicide incidents. Support and resources are provided for students, staff, parents, and the entire community. The protocols are designed to help schools create conditions that will help keep people safe during times of crisis.

Additionally, Buckelew Programs is in the process of implementing support groups for suicide loss survivors. The Suicide Loss Survivor Support Groups will be peer-run and provide a forum for individuals to learn about complicated grief associated with suicide and how it can be different
than other types of losses. Attendees will also learn and share about other helpful resources as they move from bereavement to post-traumatic growth.

**Barriers to Access and Resource Gaps**

Despite the existence of a variety of services, Marin County residents experience barriers to accessing supportive services, and/or do not know how to help others who are suicidal.

**Residents’ Gaps in Knowledge**

**Respondents’ current knowledge of existing resources is uneven.** Over three-quarters (76%) of respondents noted that they knew where to get help if they were contemplating suicide. However, many additional survey results contradict the idea that the majority of residents are knowledgeable about suicide prevention resources and best practices. For instance, fewer respondents (68%) stated that they knew where to find help for a friend or relative who was suicidal. This suggests that some survey-takers were less confident in their knowledge of resources for people whose circumstances might differ from their own.

In addition, only about one-quarter of respondents (26%) have attended a suicide prevention training, which decreases to 17% when omitting respondents who identified as service providers. Less than a quarter (23%) of all survey respondents reported that they could recognize the warning signs if a friend or relative was thinking about suicide. In other words, while the majority (70%) of respondents stated that suicide was a problem in their community, far fewer in number were well prepared to assist people considering suicide.

**On average, respondents assessed their knowledge of suicide prevention resources as higher than that of others.** While the majority of respondents (76%) stated that they knew where to seek help if they had suicidal thoughts, only 15% of respondents believed that other people know where to get help if they are having a hard time. Similarly, while 23% of respondents noted that they could recognize the signs if someone they knew was contemplating suicide, only 7% of respondents believed that other people could do the same. That is, survey respondents indicate that their own knowledge may not be representative of the larger community’s knowledge of suicide prevention resources, and as such education and training needs are even more important.

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**Community Survey Highlights**

- **70%** of respondents felt that suicide was a problem in their community, but only

- **23%** believed they could recognize the warning signs of suicidal risk in others, and only

- **26%** have attended a suicide prevention training
Gaps in Available Resources

While the strategic plan must focus on ways to better educate and connect residents to local suicide prevention resources, community stakeholders, focus group participants, and survey respondents alike noted the scarcity or absence of some other resources and services in Marin County. It will be important for the county and other providers to expand knowledge of and access to existing resources while simultaneously addressing these critical gaps in the network of local suicide prevention resources. The following resource gaps were the most commonly cited in data collection and community engagement efforts:

**Few mental health practitioners in Marin County accept private insurance, Medicare, or Medi-Cal, restricting mental health care access to those who can afford to pay out of pocket.** Marin County has the highest number of mental health professionals per capita in California, but a persistent theme in focus group sessions and key informant interviews was residents’ difficulty in finding affordable mental health services in the area. As a result, clinics that do accept Medicare and/or Medi-Cal, or offer sliding scale costs, can reach capacity quickly and have trouble accepting new clients. The absence of psychiatrists and therapists who accept private insurance also constrains the ability of hospitals to discharge patients with psychiatric distress into less intensive levels of care.

**Limited social services infrastructure in more rural areas, such as North and West County.** Marin County’s geography creates additional challenges for countywide strategies, as rural areas of the county are physically farther and more isolated from many county institutions and community service providers. In times of critical need, Mobile Crisis can take longer to reach residents in West and North County; on a day-to-day basis, said residents may have fewer opportunities to access preventative services, community-based organizations, or other supports that serve as protective factors.

**Limited language interpretation/translation services for some behavioral health services and other critical supports.** County stakeholders and focus group participants alike noted the challenges that non-English speaking residents can face when navigating the network of available behavioral health care. BHRS has invested resources into community-based supports for non-English speakers, including community outreach programs to connect people to mental health supports. However, other gaps in resources—such as the difficulty hiring and retaining Spanish language speakers on the county’s Mobile Crisis Team—can lead to disparities in access to critical services from the county.
Suicide comes in different forms. If we’re going to look at suicide in a cultural context: young people [of color] and street gangs, for example…[is] a form of suicide. When youth are committing crimes or acting homicidal, they’re often suicidal as well. [They have] a lack of hope, an inability to express themselves.

—BHRS Cultural Competence Advisory Board Chair

Services to address nontraditional or less accepted forms of suicidal behavior, especially in communities of color. County stakeholders who work in communities of color called for a more nuanced understanding of how suicidality operates in marginalized spaces. Individuals experiencing multiple, overlapping forms of inequity—marginal employment opportunities, insufficient educational resources, limited access to affordable health care and housing—can engage in self-destructive behavior that does not register under the conventional definitions of suicidal behaviors. These county stakeholders stressed the importance of understanding incidents such as domestic violence, and substance abuse in marginalized communities as potential expressions of suicidality, in order to address the risk factors behind these behaviors.

Gaps in Service Coordination

Community stakeholders and focus group participants also noted how the absence of sustained coordination and collaboration between different entities could impede the implementation of suicide prevention efforts or lead to suboptimal care for individuals experiencing mental health crises. Data collection efforts revealed the following as critical gaps in the countywide coordination of services:

Mental health providers call for increased coordination between providers to enhance supports as clients move through the continuum of care. Currently Marin Community Clinics serve over 35,000 residents offering an array of health services that include counseling and support services for mild to moderate mental illness. When clients require a higher level of care following a mental health crisis, suicide attempt, or hospitalization, they are referred to the BHRS Access Team for screening and placement into a higher level of service. Mental health providers noted the need for increased communication and coordination between hospitals, community clinics, and BHRS to ensure that clients receive sufficient and timely support while transitioning to county services.
Decentralization of Marin County school districts inhibits the exchange of suicide prevention best practices between jurisdictions. The independent operation of the county’s seventeen school districts complicates efforts to coordinate implementation of new practices across the entire region. Without more extensive coordination, innovative and effective ideas from individual school districts may be challenging to scale upwards across other districts, and policy developments from the Marin County Office of Education or other county agencies are difficult to disseminate, monitor, and improve across school districts. The fragmentary structure of Marin County’s K-12 education system means that it will be crucial to generate buy-in among school officials across the entire county, rather than merely issuing directives from a central entity.

Challenges with Community Culture and Climate

There is an overarching need to address the high-stress and demanding school environment, especially for high school students. One youth focus group participant described the prevailing school environment in Marin County as a “culture of effortless perfection,” where the expected norm was to excel in academics and extracurricular activities without publicly demonstrating the exertion that it took them to be successful. This highly competitive and stressful high school atmosphere, in which youth and their families invest ample time and resources in getting students into elite postsecondary schools, can compound students’ mental health challenges or worsen isolation.

Another county stakeholder offered that this culture of success could lead young people to narrow their aspirations to fit a constrained definition of success: going to a prestigious college and pursuing a high-paying career, for instance. Students socialized into this limited framework for achievement could abandon their passions in less lucrative professional fields, such as teaching or nonprofit work; or their self-esteem could be impacted if their individual skills and talents do not conform to normative notions of achievement or success.
My school used to be so high achieving, and such a competitive atmosphere that it wasn’t okay to struggle. It was perceived as you’re a little weaker if you had to ask for help, or take time off school, or get extensions on assignments.

—Marin County Youth Commission member

Notably, some younger focus group participants noted the steps that their school administrators had taken to address the campus climate of overachievement, such as messaging campaigns around the normalcy of making mistakes and failing as a valuable way to learn.

Isolation and loneliness are major concerns for many older adults, as well as other community members. Older adults may experience heightened levels of depression and/or suicidality due to an absence of substantive human connection. Many older adults experience the loss of their life partners and friends; and aging can reduce older adults’ mobility, which in turn can constrain their ability to interact with others. Given that large sections of Marin County are rural, with small numbers of geographically dispersed residents, it is important for the county to recognize the potentially deleterious effects of this isolation, particularly among older residents facing the challenges of aging.

However, loneliness is an issue that other community members face as well. Youth focus group participants who reside in rural areas of West County described the commonplace feelings of feeling isolated. Adult focus group participants with serious mental illnesses (SMIs) also noted that Marin County’s community climate can often feel isolating or enclosed, and advocated for more spaces or events where community members could gather in public. That is, multiple community members offered that something as simple as interpersonal connection and community gathering were critical supports to residents’ wellbeing.

Summary

Community members were able to name a variety of existing clinics, services, programs, trainings, and resources devoted to suicide prevention. The work that individual organizations and agencies have already undertaken is an essential foundation to the additional efforts that will come out of the strategic plan. However, findings also indicated the need for strategic planning efforts to prioritize increased coordination between healthcare providers, clinics, community organizations, and public agencies, in order to fill service gaps in a fragmented network, and facilitate the movement of community members between various levels of services and supports.

There’s a need for affinity messaging in public awareness: someone in 11th grade, versus someone struggling to find housing, versus an older person struggling with their health. We need to articulate those affinity groups and show people that they’re not alone with [their mental health struggles].

—Older adult community member
Findings also suggest a potential need for enhancement of postvention services in the form of a coordinated response system to provide deploy support for bereaved individuals and communities following a suicide death.

In addition, it is important to recognize that challenges around campus climate and community culture are not simply resolvable by changing a policy or creating a new program. Transforming how residents interact with each other, or how students handle success and failure in high-pressure environments, will require patience, persistence, and the active participation of residents from all Marin County communities.
Challenge 3: Building Resiliency

**MAIN CHALLENGE**

While community wellbeing and social cohesion can limit suicide risk, and many residents want to be involved in suicide prevention efforts, there is a widespread culture of stigma and difficulty engaging with the issue.

Suicide prevention initiatives must be capable of mitigating residents’ risk factors for suicide while simultaneously leveraging the protective factors that strengthen community members’ resiliency to mental health challenges, stress, and suicidality. The third challenge in this report focuses on enhancing those protective factors: identifying community strengths that can support those factors, as well as foreseeable challenges to building community members’ resiliency.

Multiple cultural factors, especially stigma, can impede participation among some sectors of the community, even as other community members are eager to learn more about suicide prevention and help others. Creating buy-in and increasing participation will require multiple approaches, recognizing the presence of both eager participants and less enthusiastic community members in messaging and outreach efforts.

**Community Interest in Participation**

Widespread community engagement and participation will be a necessary component of the suicide prevention strategic plan, as community members will be crucial partners in spreading awareness of county initiatives, connecting others to resources, and informing themselves about how they can care for their own mental wellbeing, as well as others’ health.

A sizeable majority of survey respondents indicated their interest in participating in future suicide prevention efforts. Over three-quarters (78%) of respondents indicated that they would be willing to talk to family and friends about the issue of suicide. Over two-thirds (71%) of respondents expressed interest in learning how to help someone who is considering suicide. Respondents prefer in face-to-face interaction, with more participants interested in attending trainings in person (64% of respondents) than accessing information online (45%). That is, while many residents noted the widespread issue of stigma around discussing suicide, many community members are willing to confront that stigma in order to speak openly about suicide and mental health in order to help others.

When asked to rank their preferred prevention strategies, survey respondents largely indicated their interest in greater training and education around recognizing warning signs and connecting people to help. Respondents noted their preference for training young people, parents, and adults who work with young people; as well as increasing access to mental health services for all community members.
Younger focus group participants and survey respondents similarly indicated a widespread desire and need for earlier, and more sustained, education on mental health issues in schools. Many youth residents indicated their desire for more comprehensive and longer-term education on mental health challenges. Particular concerns included:

- **Duration and frequency.** Many focus group participants noted that their mental health education in school amounted to one section of a health class, often required for freshmen. Some students noted that without more regular engagement on the issue, students may forget about how to recognize signs of suicidality or where to find help in the later years of high school.

- **Age and grade.** Multiple focus group participants noted that they had not received substantive educational materials on mental health or suicide prevention in middle school. One youth, who identifies as LGBTQ+, noted that their middle school was characterized by a general “code of silence” regarding discussions about health and wellbeing, including issues such as depression or gender identity and sexual orientation. These participants stressed the importance of upstream educational efforts on mental health and suicide prevention to include middle school students, who are in a formative period of their youth and may carry any stigma around seeking help or discussing mental health care into high school and beyond.

- **Content and Format.** Several focus group participants recalled the limited classroom time that their high schools had devoted to issues around mental health. Some participants also recounted how school administrators had invited guest speakers on mental health with messaging that the students found inappropriate or inaccurate. Instead, many focus group participants mentioned the concrete skills and information that they wanted to learn, such as...
how to recognize the warning signs for suicide in their peers, and how to engage their peers without worsening their peers’ suicidal thoughts.

Barriers to Community Engagement

Stigma. Survey respondents and focus group participants alike identified stigma—shame, fear, and/or embarrassment—as major barriers to Marin County residents’ ability to openly discuss mental health and suicide, and access mental health care for themselves or others. A large majority (82%) of respondents believe that stigma makes it difficult to talk about mental illness and suicide, and 83% believe that people generally feel embarrassed when seeking help for mental health challenges.

It is important to apply the Social-Ecological Model to a discussion of stigma around mental health and suicide prevention, as many different factors at multiple scales can produce that stigma. For instance, a student struggling with their mental health may not seek supportive services, out of a personal belief that seeking help for mental health makes them “weak.” However, these personal beliefs may be tied to broader social patterns or institutional policies: for instance, a school climate where discussions of mental health are infrequent or taboo or standardized curricular plans that include few or no mental health topics.

Efforts to increase access to suicide prevention services or develop new resources will not be wholly effective without deliberate plans to normalize, or destigmatize, the practice of discussing and utilizing mental health care among some community members. For instance, focusing in part on stigma reduction may be a necessary step to increase engagement among male community members, such as those who might perceive seeking help for mental health as a weakness or as counter to traditional notions of masculinity. It is important that the plan addresses stigma at all levels of the Social-Ecological Model, including creating institutional policies that encourage help-seeking behaviors among community members.

Unwillingness or lack of concern. Beyond the issue of stigma, it is possible that suicide prevention efforts will not reach community members who do not perceive suicide to be an issue, or do not see suicide as something relevant to their own lives. Multiple youth focus group members described their concerns and challenges not being taken seriously by others when it came to mental health and that these experiences impeded their education efforts. Specific
examples included teachers who dismissed the importance of hosting student discussions on
difficult topics, fellow students who did not take seriously their classroom materials on mental
health and suicide prevention, and parents of children who identify as LGBTQ+ who downplayed
the emotional challenges that their children face. It will be essential for Marin County and its
community partners to convey the importance of these educational materials and supportive
services, in order to increase participation among community members who are unconvinced why
they should be involved.

**Distrust in County systems.** Underserved communities, including some communities of color,
may have limited trust in public systems due to patterns of systemic neglect or the inequitable
distribution of resources. County stakeholders who work in communities of color noted the
widespread distrust in the county government among community members, particularly as non-
white residents perceive the structural imbalances in a predominantly affluent county. Persistent
gaps in culturally appropriate services can reinforce for some residents the notion that the county
is not invested in their well-being or does not possess the knowhow to best provide services and
supports.

**A more complex relationship with suicidality for some older adults.** Some focus group
participants cautioned that suicide prevention messaging was not necessarily universal across all
age groups. Messaging should take into account older adults who want help to *overcome* their
suicidality, access more mental health resources, or help peers who are struggling with mental
health challenges. It is important that messaging aligns with best practices in engaging with
people from different age groups.

**Summary**

It is a testament to the strength of many Marin County residents that so many community
members—many of whom have had personal experiences with suicidality or suicide loss—
have demonstrated such enthusiasm to participate in future suicide prevention efforts and
provide input. This widespread willingness to collaborate will be essential for the successful
implementation of the strategies and activities that come out of the strategic plan. The ongoing
participation and leadership of Marin County residents is also a crucial step towards cultivating a
safer, more resilient community climate that values the therapeutic benefits of social
connectedness and the importance of help-seeking behavior among all community members.

This enthusiasm among a wide swath of the community will also be a tremendous asset in
bringing less enthusiastic community members into Marin County’s expanding network of suicide
prevention resources. Many residents experience stigma around openly discussing mental health
or may find it difficult to seek help for suicidal ideation. Some residents may be wholly disinclined
to think that they need help, even if they are struggling with emotional issues. Other residents
may come from cultural backgrounds that deemphasize or dismiss the importance of clinical
mental health care. In any case, it will be important for county agencies to engage a variety of
community members as champions, ambassadors, and advocates for systemic change across
the entire region.
Implications for Strategic Planning

Multiple Axes of Change

As mentioned in the introductory section, this Needs Assessment was developed using several frameworks for understanding the field of suicide prevention and treatment. In translating the key findings in this report into concrete plans for action, it is important to plan for activities and programs that cover the multiple stages and scales across these frameworks. For instance, the Strategic Plan must accommodate the *vertical* structure of the Social-Ecological Model, spanning large-scale and small-scale efforts, as well as the *horizontal* structure of the continuum of care, spanning pre-crisis, crisis response, and post-crisis efforts. By planning along multiple axes, Marin County sought to produce a Suicide Prevention Strategic Plan that is multidimensional and comprehensive.

<table>
<thead>
<tr>
<th>Structural/Institutional</th>
<th>Prevention</th>
<th>Intervention</th>
<th>Postvention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard practices in screening for suicide risk among social services providers</td>
<td>Implementation and maintenance of Crisis Response protocols at all middle and high schools</td>
<td>Standardized protocols for schools to respond after a suicide death</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community/Organizational</th>
<th>Prevention</th>
<th>Intervention</th>
<th>Postvention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based programs to provide social supports and connections for isolated older adults</td>
<td>Campaigns to train residents on recognizing the common signs of suicide risk</td>
<td>Community support groups for residents whose loved ones have died by suicide</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal/Individual</th>
<th>Prevention</th>
<th>Intervention</th>
<th>Postvention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased awareness about the importance of seeking mental health care before a crisis</td>
<td>More community members knowledgeable about referring others to crisis care</td>
<td>Training for clinicians in suicide bereavement</td>
<td></td>
</tr>
</tbody>
</table>

Table 5 offers a visual representation of select Marin County community needs, organized in relation to both the Social-Ecological Model and the continuum of care. This table is just an assortment of examples and is not meant to represent a comprehensive list of activities in a strategic plan. Rather, this diagram illustrates how an effective strategic plan must accommodate this multidimensional approach to suicide prevention.
One Size Does Not Fit All

The challenges addressed within the Needs Assessment call for tailored approaches to outreach, engagement, and service provision. The approach to suicide prevention must address the unique needs of different groups and communities across Marin County. As such, a comprehensive and countywide suicide prevention strategic plan must be broad in its outreach and engagement efforts across demographic differences, while also addressing how specific stressors and risk factors for suicide may vary across these demographic differences as well. To achieve this end, it is essential that the development and implementation of strategic plan activities include residents representing diverse communities and lived experiences. Incorporating community members’ input and participation in the planning, implementation, and evaluation process is necessary to ensure a more equitable representation of voices, identities, and local needs in suicide prevention efforts.

Prevention is Possible

As mentioned in the introductory section, suicide is preventable. There is an array of evidence-based practices and available resources that can help communities and local governments reduce suicide risk. It is essential that the county and its community partners promote a sense of hope: to create a widespread understanding that suicide prevention is possible, assure more community members of the county and its partner’s commitment to suicide prevention, and convince more residents to get involved in suicide prevention efforts.
Part II: Suicide Prevention Strategic Plan

Introduction and Overview

This strategic plan is the culmination of an effort to advance Marin County’s mission to reduce suicides in Marin County and the devastating impacts for individuals, families, and communities. This document will guide a comprehensive suicide prevention approach that targets individuals across a diversity of age groups, backgrounds, and neighborhoods. Marin County Behavioral Health and Recovery Services (BHRS) and Resource Development Associates utilized a strategic planning process to develop concrete strategies for expanding the scope and reach of existing culturally responsive suicide prevention resources and systems in Marin County. The strategic planning process drew from the key findings from the Needs Assessment, as well as included participation and input from community members throughout.

To undertake the strategic planning process, BHRS convened an interagency suicide prevention Strategic Planning Committee (SPC) to develop comprehensive strategies, objectives, and activities aimed at promoting wellness, reducing stigma around suicide, and ultimately reducing suicide attempts and deaths across the county. Guided by the understanding that suicide affects many people and that many different systems have a stake in suicide prevention, BHRS ensured that the SPC would include participants with a diverse array of experience, knowledge, and personal backgrounds. SPC participants included experts in multiple medical and behavioral health fields; professionals in education, emergency response, veterans’ services, and social services; leaders and representatives from marginalized and underserved communities; and community members with lived experiences of suicide loss, suicidal ideation, and suicide attempts.

Figure 21: Members of the Suicide Prevention Strategic Planning Committee
Organization of the Strategic Plan

Structure

This strategic plan organizes Marin County’s major goals and action items into a three-tiered structure:

1. **Strategies** are broad, high-level, and long-term priority areas. The seven strategies in this plan represent the major domains through which Marin County agencies and their partners will pursue the overarching mission of preventing all deaths by suicide across the county.

   These seven strategies are the result of multiple factors: the gaps and opportunities identified in the Needs Assessment; a survey of best practices in suicide prevention; and ongoing input from participants in the strategic planning sessions. Each strategy in the following sections includes a brief synopsis of evidence-based practices and a rationale for its inclusion in the plan.

2. **Objectives** are the core goals that drive the achievement of a given strategy. The twenty-one objectives in this plan represent key achievements in program development, cross-systems collaboration, policy implementation, and community outreach and engagement.

   Each objective in the following sections names multiple recommended partners: programs, organizations and institutions whose participation would help to advance Marin County’s progress towards that particular goal. Objectives are intended to be collaborative, with public agencies, community-based organizations, clinicians, and community members partnering across sectors. BHRS worked with participants in the strategic planning sessions to develop the lists of recommended partners.

   In addition, each objective identifies a few potential performance measures that Marin County agencies and their community partners can use to measure progress towards that objective. It will be important for the County to establish procedures for data collection on the activities that emerge from this strategic plan. Consistent collection and review of program data will help to identify issues as they arise, as well as help communicate progress in the county’s suicide prevention efforts to the public.

3. **Activities** are specific action items that fulfill a given objective. The activities in this plan represent individual programs, services, collaborative ventures, and planning efforts. Each activity will involve a particular subset of recommended partners drawn from the larger lists of organizations attached to each objective.

   Marin County community members were essential to the development of these activities. Participants in the community forum and strategic planning sessions identified local needs and existing efforts in suicide prevention, reviewed best practices in relation to their lived experience as county residents, and brainstormed key areas for program development.
Continuum of Care

Different components of the strategic plan target different phases in the suicide prevention continuum:

- **Prevention** activities work to strengthen protective factors and reduce the chance that people will contemplate suicide or make a suicide attempt. These “upstream” activities, intended to reduce the number and rate of behavioral health crises, include efforts to:
  - reduce risk factors, such as mental health stressors and access to lethal means;
  - expand access to mental health services;
  - educate community members and reduce residents’ stigma around mental health and suicide;
  - provide opportunities for community members to connect with each other; and
  - strengthen the county’s infrastructure of suicide prevention programs and policies.

- **Intervention** activities serve people experiencing behavioral health crises or contemplating suicide, working to divert people from suicidal ideation and suicide attempts, and provide appropriate forms of care including after a crisis or suicide attempt. Intervention activities include efforts to:
  - train service providers and residents to recognize and respond to the signs of suicidal ideation and suicide risk;
  - coordinate care for behavioral health crises across systems in Marin County; and
  - expand crisis care, especially for underserved communities and people with low help-seeking tendencies;
  - in the case of a suicide attempt, postvention efforts involve providing appropriate levels of care in the least restrictive manner and ensuring that a person who has attempted suicide has a supportive network that helps them reduce their pain and increase their resiliency.

- **Postvention** activities occur in response to a suicide attempt or a death by suicide.
  - in the case of a death by suicide, postvention activities include timely care and support for those impacted by the suicide;
  - postvention supports can appear in multiple forms, from safe reporting in local media to community support programs and social networks.
The table below maps each strategy area onto the corresponding phases of the continuum of care.

**Table 6: Matrix of Strategies by Phases of the Suicide Prevention Continuum of Care**

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
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</thead>
<tbody>
<tr>
<td>1. Building infrastructure for leadership &amp; oversight</td>
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<td></td>
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<tr>
<td>2. Coordinating &amp; integrating suicide prevention systems</td>
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<tr>
<td>3. Developing public awareness &amp; messaging campaigns</td>
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<tr>
<td>4. Training and educating community members</td>
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<tr>
<td>5. Providing targeted outreach, engagement, &amp; support</td>
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<tr>
<td>6. Fostering healthy &amp; safe environments at all schools</td>
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<tr>
<td>7. Reducing access to lethal means</td>
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</table>
Strategy 1: Establish infrastructure to provide leadership, oversight, and accountability to the Strategic Plan

Description

Marin County will establish the infrastructure to provide leadership, oversight, and accountability to the Strategic Plan. Components of this centralized infrastructure will include a dedicated suicide prevention coordinator position at the county-level; a coordination body made up of diverse community stakeholders, suicide loss survivors, health experts, and private sector representatives; and a workgroup system to advance specific areas of research and intervention. The three components will work together to form a system of shared accountability and leadership to guide implementation and evaluation of this strategic plan. Collectively referred to as the Marin County Suicide Prevention Collaborative (MCSPC), these interworking parts will ensure that suicide prevention work is comprehensive, coordinated, and sustainable. The MCSPC will continually utilize data to inform the strategic plan priorities and decision-making, evaluate current and newly identified trends, and evaluate implementation of the strategic plan.

Rationale

Strong, visible leadership structures are important for the implementation of programs and widespread accountability to the strategic plan. Increased coordination will allow for the leveraging of resources and alignment of priorities across agencies and providers. The public health approach to suicide prevention also calls for involvement and collaboration across many different agencies and systems. Coordinative structures that support regular opportunities for this collaboration are key for sustainability, information-sharing, and the development of diverse partnerships. Best practices in sustaining suicide prevention initiatives recommend collaborative structures that plan for staff turnover in public agencies, care providers, and community organizations.36

Additionally, the California Mental Health Services Authority, through its Each Mind Matters campaign, outlines the following considerations for successful coalition-building around suicide prevention efforts37:

- Determine the optimal organizational, leadership, and staffing structure to engage diverse partners
- Plan for sustainability and the succession of coalition leaders
- Ensure access to data that will inform decision-making and help the coalition evaluate progress on strategic plan efforts
- Develop plans for media, messaging, and local outreach

36 Mental Health Services Oversight & Accountability Commission (2019), Striving for Zero: California’s Strategic Plan for Suicide Prevention 2020-2025
37 Suicide Prevention Resource Center (2013), Leaving a Legacy: Recommendations for sustaining suicide prevention programs
Objective 1.1: Establish and convene a Suicide Prevention body to coordinate the implementation of the Strategic Plan

<table>
<thead>
<tr>
<th>Activities</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
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<tbody>
<tr>
<td>1.1.i Recruit and engage diverse representatives including but not limited to: county and city agencies, community-based organizations, suicide prevention experts, health providers, private entities (including insurers and local business representatives), residents with lived experiences around suicide, as partners in the implementation of Strategic Plan activities</td>
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<tr>
<td>1.1.ii Convene quarterly meetings to monitor progress towards Strategic Plan activities and objectives</td>
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<tr>
<td>1.1.iii Review suicide death and attempt data on an annual basis and make recommendations to the Suicide Prevention Coordinator (SPC)</td>
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<tr>
<td>1.1.iv Identify and leverage a variety of funding resources to support implementation of Suicide Prevention strategies and activities</td>
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Recommended Partners
- Behavioral Health and Recovery Services
- Marin County Office of Education
- Public Health
- Buckelew Programs

Potential Performance Measures
- Establishment of coordinating body
- # of private and public entities represented on coordinating body
- # of private and public entities recruited to partner and participate in suicide prevention efforts
- # of meetings per year of coordinating body

Objective 1.2: Establish a dedicated position(s) to support activities of the Strategic Plan

<table>
<thead>
<tr>
<th>Activities</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
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<tbody>
<tr>
<td>1.2.i The position(s) will support recruitment, engagement and retention of diverse representatives as partners in the implementation of Strategic Plan activities</td>
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<tr>
<td>1.2.ii The position(s) will serve as the primary point of contact between the coordinating body, county, and community partners</td>
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<tr>
<td>1.2.iii The position(s) will coordinate and support the operations of the suicide prevention workgroups stipulated in the Strategic Plan</td>
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<tr>
<td>1.2.iv The position(s) will compile and document progress towards Strategic Plan goals, for communicating and sharing with the public</td>
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</table>

Potential Performance Measures
- Recruitment and hiring of Coordinator position
- Establishment of a schedule of report-outs to Suicide Prevention Coordinating Body and community
- Production of regular progress reports about implementation of Strategic Plan activities
### Objective 1.3: Establish and convene subcommittees and/or workgroups to pursue and develop specific efforts outlined in the strategic plan

<table>
<thead>
<tr>
<th>Activities</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
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</thead>
<tbody>
<tr>
<td>1.3.i Establish a school-based wellness collaborative to support the implementation of activities outlined in Strategy #6</td>
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<tr>
<td>1.3.ii Establish Training and Education Workgroup to provide recommendations for trainings to be implemented and supports at various levels (i.e. community, school-based, professional, etc.)</td>
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<tr>
<td>1.3.iii Establish and convene a workgroup with Marin County, Sonoma County, and the Sonoma-Marin Area Rail Transit (SMART) District to identify and support the implementation of best practices in prevention and postvention strategies along SMART Train railways</td>
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<tr>
<td>1.3.iv Develop targeted workgroups to address identified needs for communities disproportionately affected by suicide (e.g., LGBTQ+ residents, adult men, older adults)</td>
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<tr>
<td>1.3.v Establish a workgroup to support the implementation of activities outlined in Strategy #2 for coordination of care</td>
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<tr>
<td>1.3.vi Additional workgroups will be created as needed</td>
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</table>

**Recommended Partners**
- Behavioral Health and Recovery Services
- Marin County Office of Education
- Marin County School Administrators
- Community-Based Organizations

**Potential Performance Measures**
- Number of affiliated organizations, agencies, and groups participating in workgroups
- Development of regular meeting workgroup meeting schedules
- Number of targeted workgroups convened
Objective 1.4: Advance data monitoring and evaluation to support data-driven decision-making

<table>
<thead>
<tr>
<th>Activities</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4.i</td>
<td>Continually utilize data to inform strategic plan priorities, implementation, and effectiveness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4.ii</td>
<td>Monitor local data to identify existing and emerging trends, factors that may increase or lessen risk, and at-risk population groups</td>
<td></td>
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</tr>
<tr>
<td>1.4.iii</td>
<td>Identify opportunities to enhance data capacity and expand data collection processes (i.e. developing metrics and data collection strategies for aborted or interrupted suicide attempts, developing and/or refining centralized reporting systems, establishing data-sharing protocols)</td>
<td></td>
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<tr>
<td>1.4.iv</td>
<td>Plan and conduct regular evaluation of Strategic Plan implementation</td>
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<tr>
<td>1.4v</td>
<td>Develop and release annual report on status of suicide related behaviors (deaths, attempts, hospitalizations) as well as prevention activities (i.e. calls to crisis lines, trainings, etc.)</td>
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</tbody>
</table>

Recommended Partners
- Behavioral Health and Recovery Services
- Buckelew Programs
- Coroner Division, Marin County Sheriff's Office
- Local Universities
- Marin County Public Health Department
- Marin County Clinics
- Sonoma County Department of Health Services
- Representatives from SMART Train

Potential Performance Measures
- Number of affiliated organizations, agencies, and groups participating in data-sharing and regular report outs
- Development of additional metrics for data collection and analysis surrounding suicide attempts/deaths and life circumstances
- Establishment of evaluation schedule for analysis of implementation progress
Strategy 2: Develop a coordinated system of care and support to promote suicide prevention and wellness

Description

**Marin County will develop a coordinated system of care and support to promote suicide prevention and wellness.** Agencies and service providers across medical and behavioral health systems will work collaboratively to provide seamless support across the continuum of care. To close gaps, agencies will formalize relationships through memorandums of understanding to allow for more information-sharing between providers. Community providers and inpatient facilities will also work to establish referral protocols that clearly define roles and patient follow-up procedures. Behavioral health and medical providers across the continuum of care will work together to develop seamless transitions in patient care as the level of service is escalated during crisis or stepped down following a behavioral health crisis.

Another priority identified by the strategic planning committee is the adoption of the Columbia-Suicide Severity Rating Scale, (CSSRS) as a universal suicide assessment screening tool for health and social services providers. Implementing the CSSRS across service and healthcare systems would provide clinicians and providers with a greater understanding of patients’ suicide risk, increase patients’ access to services within the continuum of care, and allow for greater sharing of information and data between Marin County agencies, clinics, organizations, and schools.

Additionally, supports will be expanded to support those impacted by suicide. Activities may include expansion of support groups for suicide loss survivors, development and implementation of protocols and procedures to support initiation of support services, trainings to expand number of mental health professionals trained in suicide bereavement, and possibly the implementation of a suicide loss survivors outreach model.

Rationale

Many individuals who die by suicide have had recent contact with medical and healthcare systems before their deaths but did not receive any linkage or referral to mental health care. Similarly, many people who receive medical care for suicidal self-directed violence or a suicide attempt do not receive follow-up mental health care. Findings from the 2008–2012 National Survey of Drug Use and Health indicate that of the adults who reported that they had attempted suicide in the past 12 months:

- 43% received no mental health treatment even though 60% of those who attempted suicide had received medical attention for the suicide attempt, and 43% had stayed overnight in a hospital.
- 60% did not participate in any outpatient mental health visit.

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38 Substance Abuse & Mental Health Data Archive (2012) *National Survey on Drug Use and Health*, retrieved from Zero Suicide Safe Transition Toolkit
48% of those receiving mental health treatment received prescription medication for a mental health disorder.

Through the Marin County Needs Assessment, behavioral health clinicians and service providers often expressed related concerns of clients and patients “falling through the cracks” when transitioning between service providers, or upon being discharged from inpatient settings.

Best practices research indicates that implementing “bridge” or “transition” services within and between service providers and clinics can significantly increase the likelihood that a patient will link to outpatient care. Best practices in the development of such transition services include:

- developing internal policies and guidelines within health agencies for safe care transitions;
- integrating electronic health record (EHR) systems across different agencies;
- conducting warm hand-offs when a patient or client is transitioning between providers; and
- providing ongoing support and contact throughout care transitions, from behavioral health providers, physicians, or other staff.

It is estimated that around fifty percent of people will be exposed to suicide at some point in their life, with approximately 115 people exposed from each suicide death. Postvention activities can reduce negative effects of exposure to suicide and facilitate the process of healing from a suicide loss. Therefore, activities included under Strategy 2 will also help to direct services and support to suicide loss survivors.

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### Objective 2.1: Adopt standard suicide screening protocols for all county entities that conduct health assessments and provide training to ensure fidelity

#### Activities

| 2.1.i | Identify agencies, organizations, and key decision-makers to promote countywide adoption of a universal screening tool such as the Columbia-Suicide Severity Rating Scale (CSSRS) |
| 2.1.ii | Develop an implementation support package for agencies and organizations that will adopt the screening tool, including staff trainings and ongoing support |
| 2.1.iii | Improve health care system to provide best practices for individuals at risk of suicide using Zero Suicide as a potential model |

#### Recommended Partners

- Behavioral Health and Recovery Services
- Buckelew Programs, Huckleberry Youth Services, and other community mental health providers
- Department of Health and Human Services, including Aging and Adult Services
- First Responders
- Kaiser Permanente, MarinHealth Medical Center, Novato Community Hospital, and Sutter Health
- Law enforcement and first responders
- Marin County Office of Education
- Marin Community Clinic, Coastal Health Alliance, and other medical clinics
- Private healthcare practitioners
- Private healthcare insurers

#### Potential Performance Measures

- Number of agencies, organizations, and/or clinics that adopt a universal screening tool
- Number of providers and clinicians trained in screening practices
- Number of patients screened for suicide risk (monthly count)
- Number of clinics and organizations that adopt a “Zero Suicide” care coordination model
Objective 2.2: Strengthen communication, linkages, and supports for individuals who may be at risk for suicide and who are transitioning between providers

<table>
<thead>
<tr>
<th>Activities</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.i</td>
<td>Establish standardized transition protocols, such as access to peer navigation supports, for residents referred to services for higher-level care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2.ii</td>
<td>Improve linkages to community-based care settings for individuals with Medi-Cal or low-income uninsured individuals before they are discharged from a hospital setting</td>
<td></td>
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<tr>
<td>2.2.iii</td>
<td>Explore existing crisis response system and how it can be improved to focus on stabilization and linkages to services in least restrictive setting</td>
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</tbody>
</table>

Recommended Partners
- Buckelew Programs, Huckleberry Youth Services, and other community mental health providers
- Department of Health and Human Services, incl. Aging and Adult Services
- Kaiser Permanente and hospitals
- Law enforcement and first responders
- Marin Community Clinic, Coastal Health Alliance, and other medical clinics
- Private healthcare practitioners
- Private healthcare insurers

Potential Performance Measures
- Number of inpatient and outpatient facilities that adopt standardized transition protocols
- Number of clinicians and providers trained in Caring Connections practices
- Number of youth provided with FISP practices in emergency or urgent care settings
- Number of consumers who receive a warm handoff in a “step-down” transition between inpatient and outpatient services (monthly or quarterly count)
**Objective 2.3: Implement a coordinated support system to provide follow-up care for individuals experiencing suicide ideation and following a suicide attempt**

**Activities**

<table>
<thead>
<tr>
<th>Activity</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
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<tbody>
<tr>
<td>2.3.i</td>
<td>Develop standard protocols for providing follow-up calls or visits to patients after discharge from a hospital or clinical setting, following a suicide attempt</td>
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<td></td>
<td>Expand upon existing Memorandums of Understanding (MOUs) between hospitals &amp; community behavioral health providers to encourage or require participation in “root-cause analysis” meetings following a suicide death or attempt to identify system issues and prevent future losses and attempts</td>
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<tr>
<td>2.3.iii</td>
<td>Develop and promote standard reentry protocols for individuals returning to their school, college, or workplace following a suicide attempt</td>
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<tr>
<td>2.3.iv</td>
<td>Identify and implement evidence-based practices for supports including safety planning, counseling on lethal means restriction and brief communications with patients during care transitions (such as “Caring Connections”)</td>
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<tr>
<td>2.3.v</td>
<td>Implement suicide attempt survivor support groups</td>
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**Recommended Partners**

- Behavioral Health and Recovery Services
- Buckelew Programs, Empowerment Clubhouse, and other community mental health providers
- College of Marin, Dominican University, and other higher education institutions
- Community Action Marin and other community-based service providers
- Community health clinics
- Crisis Stabilization Unit
- Faith-based organizations
- Kaiser Permanente, MarinHealth Medical Center, Novato Community Hospital, and Sutter Health
- Marin County Office of Education
- Marin County public, private and parochial schools
- Youth Leadership Institute

**Potential Performance Measures**

- Number of hospitals, clinics, and providers that implement standardized follow-up contact protocols
- Number of patients who receive follow-up contacts following discharge (monthly or quarterly count)
- Number of hospitals, clinics, and providers that establish data sharing agreements to improve care coordination
- Number of schools / workplaces that implement standard reentry protocols for returning students / employees
### Objective 2.4: Develop, implement and expand supports for community members after deaths by suicide

#### Activities

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<tr>
<td>2.4.i</td>
<td>Develop and implement written policies and procedures for coordinated, timely, and respectful responses by service providers following a suicide loss, including formal agreements with local coroners and medical examiners to support the initiation of services</td>
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<tr>
<td>2.4.ii</td>
<td>Work with communities, institutions, organizations, and places of worship, so that all settings have postvention plans and protocols in place to respond quickly and compassionately in the crisis period after a suicide death</td>
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<td>2.4.iii</td>
<td>Identify and implement a suicide loss survivor outreach model (e.g. LOSS Team) and increase access to support groups for loss survivors</td>
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<tr>
<td>2.4.iv</td>
<td>Establishing data-sharing protocols and refine centralized reporting systems</td>
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#### Recommended Partners
- Behavioral Health and Recovery Services
- Community centers
- Faith-based organizations
- Hospice by the Bay
- Libraries
- Opening the World, Young Moms Marin, and other community-based programs for youth and families
- School-based Wellness Centers and counseling programs
- Senior centers and residential facilities

#### Potential Performance Measures
- Number of organizations and agencies collaborating on the development of best practices for supporting suicide loss survivors
- Number/frequency of support groups or events convened for survivors of suicide loss
- Number of individuals receiving peer support or supportive services for processing suicide loss

### Objective 2.5: Explore avenues to improve access to services for residents with private health insurance

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<tr>
<td>2.5.i</td>
<td>Explore avenues to increase access to private behavioral health services</td>
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<tr>
<td>2.5.ii</td>
<td>Engage with private insurers and private behavioral health practitioners to identify barriers to access and potential solutions</td>
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Strategy 3: Implement public campaigns to raise awareness about warning signs, promote available resources, and increase help-seeking

Description:
Marin County will develop and implement culturally responsive public campaigns that promote wellness, provide hope, and raise awareness about suicide prevention efforts and resources. The campaign will include a variety of components to address suicide in an open and safe manner with the goal of decreasing stigma and increasing help-seeking. One component will be widespread public messaging delivered through a variety of media outlets including social media platforms and radio. Messaging will emphasize healing, connectedness, optimism, and the important truth that suicide is preventable. This strategy will also include the development of a Marin County Suicide Prevention website and a communications plan establishing a regular schedule of report outs the public about current suicide prevention efforts.

Messaging and community engagement efforts will be culturally responsive and age-specific. Collaboration with community members and community-based organizations that are representative of the broad range of identities in the County is an essential component of this strategy. Developing specific, tailored, and empowering messaging and community activities is paramount to the success of public campaigns.

Rationale
During data collection efforts for the Needs Assessment, many Marin County residents indicated a need for the county to spearhead tailored messaging around suicide and suicide prevention. These residents suggested that effective messaging campaigns could decrease community members’ stigma and facilitate open dialogue about suicide, mental health, and wellness. Focus group participants, especially youth and older adults, emphasized the need for messaging and activities that are responsive and specific to different age groups, ethnic groups, and language communities. They also shared a desire for uplifting messages of hope that not only focus upon suicide prevention and mental health awareness, but on wellness, belonging, and connectedness.

County staff and service providers who participated in the strategic planning process also noted that visible and widespread messaging should communicate the county’s commitment to advance suicide prevention efforts, promote the wellbeing of residents, and collaborate with community partners on these endeavors.
In developing strategies, objectives, and activities to respond to this need, the SPC referenced the Action Alliance for Suicide Prevention’s key factors in its Framework for Successful Messaging, a research-based resource for developing public messages about suicide:

1. Successful communications efforts are strategic, and require intentional planning
2. Safe messaging is a critical component for any suicide prevention effort
3. It is important for public messaging around suicide prevention to frame narratives on healing, optimism, and connectedness
4. Suicide prevention messaging should be tailored to particular communities, groups, settings, and scenarios

41 http://suicidepreventionmessaging.org/framework
**Objective 3.1: Develop a broad campaign to increase public awareness about available wellness and mental health resources, promote help-seeking behavior, increase knowledge of warning signs, and inform residents on the county’s commitment to suicide prevention**

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<tr>
<td>3.1.i</td>
<td>Develop implementation plan for messaging campaign, including promotion in traditional and social media sources</td>
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<td>3.1.ii</td>
<td>Develop a suicide prevention website and online resource hub, in conjunction with social media campaign efforts</td>
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<td>3.1.iii</td>
<td>Provide resources and incentives for schools and communities to engage in Suicide Prevention Week/Month activities</td>
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</table>

**Recommended Partners**
- Behavioral Health and Recovery Services
- Golden Gate Transit
- Farmers markets, health fairs, and other community events
- Libraries
- Marin County Office of Education
- Multicultural Center of Marin, Canal Alliance, and other organizations serving under-resourced communities
- NAMI Marin
- Parent Teacher Associations, English Learner Advisory Committees, and other family-based groups
- Public Health
- Redwood TV, TAY Radio Marin, and other youth-led media outlets
- School-based Wellness Centers and counseling programs
- Senior centers and residential facilities
- Substance use treatment programs, such as 12-step programs
- Youth Leadership Institute and Marin County Youth Commission

**Potential Performance Measures**
- Number of local media outlets and news websites contacted through the awareness campaign
- Number of followers on social media sites (Facebook, Twitter, and/or Instagram, e.g.)
- Number of unique visitors to the county’s suicide prevention website (monthly count)
- Number of schools, community organizations, and other entities participating in Suicide Prevention Week and Month activities (annual count)
- Number of local media outlets reporting on the county’s suicide prevention efforts
### Objective 3.2: Tailor and diversify suicide prevention messaging and programming to improve engagement with groups and communities at heightened risk for suicide

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<tr>
<td>3.2.i Collaborate with community leaders and stakeholders to develop culturally relevant and age specific messaging</td>
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<td>3.2.ii Engage community stakeholders across the lifespan to identify preferred methods of support</td>
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<td>3.2.iii Support and expand youth-led awareness campaigns such as the Directing Change Program and Film Contest, NAMI on Campus, Active Minds, and others</td>
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<tr>
<td>3.2.iv Train residents as peer advocates and spokespeople to disseminate messaging among key provider groups (e.g., first responders) and harder-to-reach communities through efforts such as a Speakers Bureau/Storytelling Programs</td>
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<td>3.2.v Support and expand utilization of statewide efforts to reach diverse communities including Each Mind Matters and Know the Signs</td>
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**Recommended Partners**
- BHRS Cultural Competence Advisory Board
- Canal Alliance, Community Action Marin, and other organizations serving under-resourced communities
- Community centers
- Farmers markets and other community events
- Interfaith Alliance and other faith-based organizations
- Libraries
- Marin Independent Journal, Pacific Sun, and other local news outlets
- Mental Health Association of San Francisco
- Probation and Juvenile Hall
- West Marin Services Center

**Potential Performance Measures**
- Number of culturally relevant or age specific messaging plans created to engage particular clusters of Marin County residents
- Number of community stakeholders collaborating on targeted messaging approaches
- Number of participants in youth-led awareness campaigns
- Number of residents trained as peer advocates or suicide prevention “ambassadors”
- Number of residents engaged through targeted messaging and/or peer advocacy efforts
### Objective 3.3: Work with public information officers and local media outlets to promote effective messaging around suicide prevention

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<tr>
<td>3.3.i Promote, distribute and provide trainings on guidelines for safe reporting and messaging practices following a death by suicide or suicide attempt</td>
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<tr>
<td>3.3.ii Establish partnerships with local media outlets to ensure implementation of safe reporting practices</td>
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### Recommended Partners
- Aging Action Initiative
- Behavioral Health and Recovery Services
- Buckelew Programs
- Center for Domestic Peace
- Community health clinics
- Community Media Center of Marin
- Faith-based communities
- Kaiser Permanente and hospitals
- KWMR West Marin and other local radio stations
- La Voz, Impulso, and other Spanish-language newspapers
- Marin Independent Journal, Marin County Post, and other local news outlets
- Public Information and Public Relations staff from county agencies, first responders, and law enforcement
- Senior centers and residential facilities
- St. Vincent de Paul Society of Marin

### Potential Performance Measures
- Number of local media outlets that implement safe reporting practices through partnership with the county
- Number of staff trained on best practices in reporting on suicide
Strategy 4: Provide evidence-based suicide prevention trainings and education to Marin County residents

Description

Marin County will expand upon current efforts to provide evidence-based suicide prevention training for community members, health care providers, and behavioral/mental health clinicians. Training that targets gatekeepers and wider audiences of community members will equip Marin residents with the skills and knowledge to initiate conversations about suicide, to recognize the warning signs of suicide, and to provide initial support to those who may be contemplating suicide. The strategic planning committee envisions a future where suicide prevention trainings are as common in workplaces and community settings as first aid trainings. A community trained to recognize the signs of suicide and offer knowledge of support services will significantly increase collective protective factors and the sense of connectedness.

The Marin County Suicide Prevention Collaborative will work to ensure that training programs are culturally responsive and can reach communities and social groups that do not typically access formal behavioral health or support services. Targeting community gatekeepers, faith leaders, and people that interact with at-risk individuals in nonmedical community settings (such as divorce attorneys, public benefits staff, and bartenders) can expand the network of support for those contemplating suicide, and increase the likelihood of referral to either informal or formal support services. This strategy also entails the periodic training of behavioral health clinicians and healthcare professionals in the most up to date, evidence-based practices for assessment and ongoing treatment methodologies for individuals experiencing suicidal thoughts and behaviors.

Rationale

In Marin County, there is widespread community interest in suicide prevention training and education programs. A majority of respondents to the Suicide Prevention Needs Assessment Community Survey indicated a desire to learn more about suicide prevention and how best to support a loved one or peer who is contemplating suicide. Though many training programs are available in the County, few survey respondents had participated in one (26%) and even fewer felt they could recognize and respond to signs of suicidality in those around them (23%). Students in Marin County public high schools also specifically cited the need to engage parents and families with suicide prevention trainings.

There is no shortage of evidence-based suicide prevention trainings available for service providers, behavioral health practitioners, and community members. Some providers in the county already offer these trainings, but it will be crucial for strategic planning efforts to expand the scope and number of trainings. Many of the objectives and activities within this strategy that focus on the expansion of existing training and education efforts draw from methods recommended by the
National Action Alliance for Suicide Prevention such as training of trainer (ToT) models for community gatekeepers.\(^4\)
Objective 4.1: Provide and promote evidence-based suicide prevention and ongoing care training to service providers

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<tr>
<td>4.1.i</td>
<td>Provide and support trainings for clinicians on best practices for culturally competent suicide risk assessments</td>
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<tr>
<td>4.1.ii</td>
<td>Provide and support trainings for clinicians and service providers on best practices in bereavement to support suicide loss survivors</td>
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<td>4.1.iii</td>
<td>Provide and support ongoing trainings for clinicians and healthcare professionals on best-practices in management, intervention, and ongoing care for individuals at risk of suicide (i.e. Collaborative Assessment and Management of Suicidality, Assessing and Managing Suicide Risk)</td>
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Recommended Partners

- BHRS Cultural Competence Advisory Board
- Buckelew Programs
- College of Marin and Dominican University
- Community Institute for Psychotherapy
- Emergency Medical Services
- Fire departments and first responders
- Hospice by the Bay
- Kaiser Permanente and hospitals
- Marin Community Clinic, Marin City Health & Wellness Center, and other community-based medical facilities
- Multicultural Center of Marin, Empowerment Center, and other organizations serving under-resourced communities
- NAMI Marin
- San Geronimo Valley Community Center and other community social spaces
- Senior centers and residential facilities

Potential Performance Measures

- Number of community representatives participating in train the trainers workshops
- Number of community members subsequently trained or educated by peer trainers
- Number of clinicians/providers and clinics/organizations trained on assessing suicide risk
- Number of clinicians/providers and clinics trained on supporting survivors of suicide loss
- Number of clinicians and clinics implementing treatment programs for suicide risk
### Objective 4.2: Provide and promote evidence-based suicide prevention training for community members, including employers and employees

#### Activities

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<tr>
<td>4.2.i</td>
<td>Provide and support training of trainer (T4T) models for gatekeepers in communities with focus on groups disproportionately affected by suicide</td>
<td>Train agencies, organizations, and businesses that work with groups disproportionately affected by suicide as prioritized by data. For example, for men facing financial, legal, relationship, and/or chronic health problems in identifying and referring clients who may be at risk of suicide</td>
<td>Work with local employers to establish and implement suicide prevention protocols and procedures such as training requirements for all employees, training for supervisors and Human Resources on screening for suicide risk and referral for appropriate care</td>
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<td>4.2.ii</td>
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#### Recommended Partners

- Center for Domestic Peace
- Behavioral Health and Recovery Services
- Buckelew Programs
- Faith-based organizations
- Local bars, barbers, and other businesses that serve adult men
- Local Chambers of Commerce
- Marin City Fatherhood Program
- Mill Street Center, Ritter Center, and other organizations that serve people experiencing homelessness
- Multicultural Center of Marin, Side by Side, and other organizations serving under-resourced communities
- NAMI Marin
- Veterans Services Office
- Youth and Family Services

#### Potential Performance Measures

- Number of agencies, organizations, and businesses trained in recognizing suicide risk among adult male clients/consumers
- Number of clients and consumers referred to suicide prevention services or resources
- Number of local employers/employees trained in suicide prevention practices
STRATEGY 5: Provide outreach, engagement, and support to all residents with targeted efforts to groups disproportionately affected by suicide

Description

Marin County will implement specific and tailored approaches to supporting groups that are disproportionately affected by suicide. While the public messaging and awareness-raising activities described in Strategy 3 aim to reach as wide an audience as possible, this strategy entails a more targeted and intensive effort to reach specific individuals and groups who may be at increased risk for suicide. A strength-based approach will drive engagement and support activities. It will focus on reaching people where they are in order to bolster protective factors and coping skills, create connections, and respond effectively to cultural preferences for support and interaction.

Rationale

Similar to state and national trends, Marin County’s male population is impacted by suicide at relatively high rates compared to the rest of the population. Between 2014 and 2018, 73% (143) of suicides were by men and of those suicides, 80% were men above the age of 40. Though white middle-age and older adult males die most by suicide, many others groups are also at elevated risk of suicide including LGBTQ+ youth and adults, Latinx individuals (particularly for self-injury), veterans, older adult women, historically underserved communities of color, individuals with existing mental health challenges, and those that have previously attempted suicide.

As each of these groups’ lived experience differs based on components of identity (gender expression, race/ethnicity), socioeconomic status, experience of trauma, and the intersection of these variables and others, approaches to engagement and support must be responsive to differences and tailored appropriately. Understanding this, the objectives and activities within this strategy emphasize cultural affirmation and competency, recognizing that support and resilience may look different for different communities and individuals. The delivery of support and engagement will also be responsive to differences and seek to build social connections among those with shared experiences. Peer-based support models, community-based support groups, and Promotora outreach models are all examples of such methods.\(^{43}\)

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**Objective 5.1: Enhance protective factors and promote coping skills for community members, including targeted outreach for at-risk residents within informal settings**

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<td>Provide messaging and increase awareness of resources in formal and informal community settings, such as barbershops, rotary clubs, bars, the Veterans of Foreign Affairs, and the American Legion</td>
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<td>Identify and develop partnerships with community leaders to organize programs that promote protective factors among middle-aged and older men with common risk factors, such as unemployment or substance use</td>
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**Recommended Partners**
- Aging Action Initiative & Commission on Aging
- Bars, barbers, and other businesses that serve men
- Behavioral Health and Recovery Services
- Buckelew Programs
- Community centers, especially those in less populated areas of the county
- First Responders
- Interfaith Council and other faith-based organizations
- Libraries
- Local Chambers of Commerce
- Marin County Youth Commission
- NAMI Marin
- Probation, Marin County Jail, and other justice agencies
- Senior centers and residential facilities
- Substance use treatment and recovery programs

**Potential Performance Measures**
- Number of community centers, businesses, and social spaces provided with suicide prevention messaging, information, and/or resources
- Number of partnerships formed with community leaders and organizations to strengthen protective factors among adult men
- Number of adult male residents who engage or participate in community-based efforts regarding suicide prevention or resiliency
**Objective 5.2: Strengthen peer support networks for communities and groups at heightened risk for suicide**

### Activities

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<tr>
<td>5.2.i</td>
<td>Enhance peer connections and peer services for different at-risk populations, including men in middle age, veterans, transition-aged youth, LGBTQ+ residents, older adults, and formerly incarcerated individuals</td>
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<td>5.2.ii</td>
<td>Expand upon Community Connection programs serving under-resourced groups, including Latino/a and Vietnamese communities and veterans</td>
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<td>5.2.iii</td>
<td>Develop support groups and workshops for suicide loss survivors, family caregivers, and residents who are retired or are planning to retire</td>
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<td>5.2.iv</td>
<td>Support informal systems that create opportunities for social connectedness among isolated residents, especially middle-aged men and older adults</td>
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### Recommended Partners

- Alcohol Justice
- Behavioral Health and Recovery Services
- Buckelew Programs
- College of Marin and Dominican University, including student groups
- Community Action Marin
- Community-based health clinics
- The Defenders Marin City
- Employee Assistance Program
- Homeless shelters and homeless services programs
- Huckleberry Youth Programs
- Kaiser Permanente and Hospitals
- Marin Asian Advocacy Project, *Promotores de Salud*, and other organizations/programs serving communities of color
- Marin Center for Independent Living
- Marin City Fatherhood Program
- Opening the World, Side by Side, Young Moms Marin, and other organizations serving young people and families
- Parent Services Project, Inc.
- Senior centers and residential facilities
- Spahr Center and other LGBTQ+ organizations
- Veterans Affairs and Veterans Services Office
- West Marin Services Center and West Marin Collaborative
- Whistlestop
- YMCA, YWCA, and other service providers with mentorship programs
- Youth Court, Juvenile Probation, and other agencies overseeing justice-involved youth
- Youth Leadership Institute and Marin County Youth Commission
Potential Performance Measures

- Number of community members trained as peer advocates or mental health ambassadors
- Number of community members engaged by peer advocates
- Number of support groups/workshops held for residents at heightened risk for suicide
- Number of organizations and agencies collaborating to improve residents’ connectedness
- Number of youth engaged through community-based programming and supportive services
- Number of non-English speakers served through suicide prevention efforts or programs

Objective 5.3: Implement culturally affirmative approaches in providing suicide prevention and wellness resources to underserved and isolated communities

**Activities**

| 5.3.1 | Expand upon existing Promotores model to support suicide prevention efforts among mental health ambassadors in communities of color |
| 5.3.2 | Create opportunities for residents from diverse communities with lived experiences around suicide to share their experiences in safe community spaces |
| 5.3.3 | Promote alternatives to calling 911 for mental health concerns utilizing models such as Crisis Now which includes mobile crisis units, mutual aid networks, and other community-based supports |

**Recommended Partners**

- Behavioral Health and Recovery Services
- Canal Alliance
- Faith-based organizations
- “Ghostbusters” team in Marin City
- The Hannah Project
- Marin City Community Development Program
- Multicultural Center of Marin
- NAMI Marin and speakers bureau
- Promotores de Salud
- Restorative justice programs and healing circles
- St. Vincent de Paul Society of Marin
- TAY Radio and other youth-led programs

**Potential Performance Measures**

- Number of residents trained as mental health ambassadors
- Number of residents engaged through Promotores programming
- Number of suicide prevention-related events held in predominantly non-white communities
Objective 5.4: Utilize local data to identify other residents disproportionately affected by suicide deaths and attempts, and determine targeted approaches in suicide prevention supports

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<tr>
<td>5.4.i</td>
<td>Increase understanding of risk factors and protective factors, and continually refine targeted approaches to intervention and supports</td>
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**Recommended Partners**
- Aging and Adult Services
- Behavioral Health and Recovery Services
- County Administrator’s Office and other county agencies
- Public Health

**Potential Performance Measures**
- Number of agencies and organizations collecting and sharing local data on suicide and mental health
Strategy 6: Foster safe and healthy environments on all school campuses

Description

Marin County will support all schools to expand and strengthen existing wellness and suicide prevention activities with the goal of building safe and healthy environments for students. Efforts will seek to promote resiliency, teaching coping skills, and increase connectedness to minimize risk for suicidal behavior. Through curriculum that teaches mindfulness and Social Emotional Learning (SEL), students will add and strengthen coping skills. With the development of these tools, youth will be better equipped to manage future stressors.

Healthy and safe environments for children and youth also entail meaningful relationships with trusted, and caring adults. Suicide prevention training that focuses on recognizing distress and responding effectively to behavioral health crises will be provided for all faculty, staff, coaches, and volunteers to increase the number of adults on campuses that have the knowledge and skills to support young people. Trainings will also be provided to select students who adopt the role of peer supporters. This will offer multiple opportunities and choices for students to create supportive relationships with the people they feel most comfortable engaging.

The School-based Wellness Collaborative will also be developing recommendations for specific approaches to supporting students at elevated risk for suicidal such as LGBTQ+ youth, justice-involved youth, and survivors of suicide attempts. The Wellness Collaborative will seek to assist schools in developing supportive opportunities for parents and caregivers to learn about suicide and increase their capacity to support children and youth.

Rationale

This strategy was developed to support districts and schools with the implementation of Education Code, Section 215 which mandates comprehensive suicide prevention and postvention protocols and procedures in all public districts serving pupils from prekindergarten through high school. The mandate was enacted due to the increasing rates of suicidal behavior among children and youth: nationally, suicide is the second leading cause of death for youth ages 10-24. In Marin County, 26% of 9th graders and 30% of 11th graders have reported experiencing chronic sadness and/or feelings of hopelessness, and 15% of 9th graders and 13% of 11th graders reported having seriously considered attempting suicide in their life. In 2014, Marin County youth ages 10 to 19 accounted for over one-third (37%) of emergency department visits for non-fatal self-injuries.

44 (2017 CDC WISQARS)  
45 (California Healthy Kids Survey [CHKS] 2015-2016)  
46 EpiCenter Data
Given the increasing trend of suicidal self-directed violence and suicide among young people at local, state, and national levels, participants in the Needs Assessment and Strategic Planning Process repeatedly called for the equitable expansion of suicide prevention, crisis response, and postvention services in schools countywide. As discussed in Education Code, Section 215, since youth spend so much time in school, the personnel who interact with them on a daily basis are well poised to identify warning signs and offer appropriate support. Specific activities, such as SEL/mindfulness, are included in this strategy as they are evidence-based strategies for suicide prevention.
### Objective 6.1: Through collaboration with county, district, and community partners, support school districts in the implementation of a three-tiered continuum of supports in all schools

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<tr>
<td>6.1.i</td>
<td>Develop recommendations around adopting evidenced based Tier 1 supports such as mindfulness and Social Emotional Learning (SEL)</td>
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<td>6.1.ii</td>
<td>Provide recommendations for, and support implementation of, suicide prevention trainings for faculty, staff, on-campus providers, and students</td>
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<tr>
<td>6.1.iii</td>
<td>Implement trainings and education on screening and assessment for suicide risk</td>
<td></td>
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<tr>
<td>6.1.iv</td>
<td>Enhance the provision of individual and group mental health services to students, including targeted strategies for LGBTQ+ and justice-involved youth</td>
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<tr>
<td>6.1.v</td>
<td>Expand wellness supports for middle school students, and capacity building for middle school staff</td>
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<tr>
<td>6.1.vi</td>
<td>Develop standardized recommendations and guidelines for school districts and schools to implement coordination of services teams to streamline referral process and increase access to mental health supports for students</td>
<td></td>
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<tr>
<td>6.1.vii</td>
<td>Increase availability of crisis supports including expansion of Mobile Crisis Team hours to support the entire school day</td>
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</tbody>
</table>

### Recommended Partners
- Behavioral Health and Recovery Services
- Buckelew Programs
- Juvenile Justice and Delinquency Prevention Commission
- Learning Enrichment Afterschool Program and other afterschool programs
- Marin County Office of Education
- Marin County public, private and parochial schools
- Mental Health First Aid trainers
- Opening the World, Young Moms Marin, and other community-based organizations serving young people and families
- Parents Place Marin County
- Probation, Juvenile Hall, and Youth Court
- Spahr Center
- Student leadership in high schools
- Youth Leadership Institute and Marin County Youth Commission

### Potential Performance Measures
- Number of school districts and schools implementing the three-tiered continuum of suicide prevention supports
- Number of school personnel trained in suicide prevention best practices (disaggregated by high school/middle school)
- Number of full-time, on-campus mental health counselors located in each school/school district
- Number of schools implementing targeted strategies to support LGBTQ++ and justice-involved youth
- Number of schools implementing standardized guidelines for coordinating student mental health services
- Number of students served by Mobile Crisis in school settings
### Objective 6.2: Support the development of youth-led wellness and suicide prevention initiatives

#### Activities

<table>
<thead>
<tr>
<th></th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2.i</td>
<td>Establish and strengthen peer-to-peer suicide prevention training, education, and mentoring programs for youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2.ii</td>
<td>Provide school districts and schools with mini-grants and/or funding supports to implement youth-led suicide prevention and mental health awareness activities</td>
<td></td>
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</tr>
</tbody>
</table>

#### Recommended Partners

- Behavioral Health and Recovery Services
- Juvenile Justice and Delinquency Prevention Commission
- Marin County Office of Education
- Marin County public, private and parochial schools
- NAMI Marin
- Opening the World and other community-based organizations serving young people
- Youth Leadership Institute and Marin County Youth Commission

#### Potential Performance Measures

- Number of youth-led wellness and suicide prevention programs active
- Number of youth trained and active as peer mentors
- Number of schools/school districts supporting youth-led suicide prevention activities
- Number of youth participating in youth-led suicide prevention activities
- Number of youth reporting increased understanding of suicide and how to help connect at-risk peers to professional care

### Objective 6.3: Build the capacity of schools to engage with and support families

#### Activities

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<tr>
<th></th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
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</thead>
<tbody>
<tr>
<td>6.3.i</td>
<td>Increase family education and provide resources around suicide prevention and mental health</td>
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</tr>
</tbody>
</table>

#### Recommended Partners

- NAMI Marin
- Behavioral Health and Recovery Services

#### Potential Performance Measures

- Number of schools/school districts with expanded efforts to engage families on suicide prevention efforts
- Number of families participating in educational events or other suicide prevention program
**Objective 6.4: Support the implementation of evidence-based crisis response and postvention protocols in schools**

<table>
<thead>
<tr>
<th>Activities</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4.i Support districts and schools with implementation, refinement, and evaluation of comprehensive suicide prevention, intervention, and postvention protocols, as mandated by Education Code, Section 215</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6.4.ii Ensure annual trainings for school personnel in crisis response measures, memorialize designated school site crisis response point people</td>
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</tr>
<tr>
<td>6.4.iii Continue and expand upon work of cross-system crisis response and postvention response team (MCOE, Health and Human Services, Kaiser Permanente, BHRS, county Mobile Crisis Team, law enforcement) and provide postvention training for school staff</td>
<td></td>
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<tr>
<td>6.4.iv Identify and implement best practice alternatives to 5585/5150 transfers to provide support and care in least restrictive settings</td>
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<tr>
<td>6.4.v Enhance supports and provide guidance to ensure continuity on re-entry after mental health crisis, suicide assessment and/or suicide attempts</td>
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</tbody>
</table>

**Recommended Partners**
- Behavioral Health and Recovery Services
- Community health clinics and primary care providers
- First responders, Emergency Services, and law enforcement agencies
- Kaiser Permanente and hospitals
- Marin County Office of Education
- Marin County public, private and parochial schools
- Mobile Crisis Team

**Potential Performance Measures**
- Number of schools/school districts implemented enhanced crisis response protocols
- Number/percent of school personnel trained in crises response practices
- Number of school personnel trained in postvention practices and student support
Strategy 7: Reduce access to lethal means for those at risk of suicide

Description

Marin County will engage with a variety of partners, organizations, gatekeepers, and community members to enhance efforts to reduce access to lethal means in the County. The MCSPC will leverage the existing efforts and expertise of organizations such as RxMarin, Bridge Angels, and the District Attorney’s office to support methods of lethal means reduction. As well, the MCSPC will develop and implement engagement efforts to build relationships with gatekeepers of lethal means (i.e., pharmacists and local arms vendors) to promote potentially life-saving safe storage practices for their clientele. This strategy will also focus on developing the capacity of clinical and non-clinical service providers to provide lethal means assessment and reduction counseling for their clients.

Rationale and Best Practices

Reducing access to lethal means has proven to be one of the most effective and evidence-based strategies for suicide prevention. Limited or zero access to common methods creates critical time for a suicidal person to reconsider, and/or for other people to intervene. Research shows that most people who receive lethal means interventions during a crisis do not go on to die by suicide at other times or by other methods. The window of time between a person starting to have suicidal thoughts, and their ability to access lethal means, is a critical period to deter said person from suicidal self-directed violence and refer them to the proper level of care. Lethal means reduction helps to extend that critical lifesaving time and direct more people to crisis response services.

Through its Means Matter campaign, the Harvard T.H. Chan School of Public Health emphasizes six key points of understanding that should factor into means reduction efforts:

- **Many suicide attempts occur with little planning during a short-term crisis.** While some suicides are the result of deliberate planning, many people who attempt or die by suicide decide to do so in an hour or less of consideration. Reducing access to common lethal means can deter some individuals from impulsive suicidal self-directed violence.

- **Intent alone does not determine whether or not an attempt will be lethal; means also matter.** Reducing easy access to highly lethal methods of suicide can save lives, especially among individuals with a high intent to die by suicide during brief episodes.

- **90% of people who make a suicide attempt will not go on to die by suicide in their lifetime.** The high rate of long-term survival among survivors of a suicide attempt support

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the understanding that many suicidal crises are short-lived, even if there are underlying, longer-term factors behind shorter-term crises

- **Access to firearms is a risk factor for suicide.** Scientifically validated studies have unilaterally demonstrated that access to firearms is associated with increased suicide risk in the United States

- **Firearms used in youth suicide usually belong to a parent.** Failure to engage in safe storage practices for firearms in the household can have devastating repercussions for families.

- **Reducing access to lethal means saves lives.** Research demonstrates the effectiveness of efforts in lethal means reduction, in the United States and internationally. Combined with practices that reduce the likelihood that individuals experience mental health crises, lethal means reduction is critical to preventing suicide.
### Objective 7.1: Work with partners, existing initiatives, and key stakeholders to reduce access to lethal means for those in crisis and bolster suicide prevention messaging and supportive services

<table>
<thead>
<tr>
<th>Activities</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
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<tbody>
<tr>
<td><strong>7.1.i</strong></td>
<td>Collaborate with RxSafe Marin in their work with pharmacies, medical providers, and law enforcement to reduce access to potentially lethal medications</td>
<td></td>
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<tr>
<td><strong>7.1.ii</strong></td>
<td>Collaborate with and support grassroots groups working to reduce suicide attempts on the Golden Gate Bridge</td>
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<tr>
<td><strong>7.1.iii</strong></td>
<td>Monitor progress of the Golden Gate Bridge Net project through coordination of regular report outs from project representative(s) to the county’s suicide prevention oversight body</td>
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<tr>
<td><strong>7.1.iv</strong></td>
<td>Implement efforts to reduce suicide deaths by firearms such as working with local firearm dealers on prevention strategies (awareness/prevention activities), raise awareness of suicide prevention in the firearm community (including safe storage of firearms)</td>
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<tr>
<td><strong>7.1.v</strong></td>
<td>Collaborate with the District Attorney’s office to conduct gun buy-back events</td>
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<tr>
<td><strong>7.1.vi</strong></td>
<td>Build upon existing partnerships to expand messaging and protective measures on and around railways</td>
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</tbody>
</table>

### Recommended Partners
- Behavioral Health and Recovery Services
- Buckelew Programs
- California Highway Patrol and local law enforcement agencies
- Kaiser Permanente and hospitals
- Local print media, television, and radio outlets
- Marin County District Attorney
- Public Health
- RxSafe Marin

### Potential Performance Measures
- Number of pharmacies, clinics, and other organizations engaged through RxSafe Marin
- Number of firearms relinquished in buy-back events
- Number of deterrent signs or messages posted in high-risk areas (along railways or bridges, e.g.)
Objective 7.2: Provide education and training to service providers, community members, and gatekeepers on promoting best practices on counseling for lethal means reduction

<table>
<thead>
<tr>
<th>Activities</th>
<th>PREVENTION</th>
<th>INTERVENTION</th>
<th>POSTVENTION</th>
</tr>
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<tbody>
<tr>
<td>7.2.i Enhance clinical skills in lethal means assessment and counseling for healthcare providers, social service providers, behavioral health providers, and first responders</td>
<td></td>
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<td></td>
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<tr>
<td>7.2.ii Train nonclinical providers, such as probation and parole officers, in lethal means reduction counseling</td>
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<tr>
<td>7.2.iii Implement efforts to reduce suicide deaths by firearms such as working with local firearm dealers on prevention strategies, raise awareness of suicide prevention in firearm community (including safe storage of firearms), Build relationships with local retailers, firing ranges, and sporting clubs to promote safe storage practices among gun owners</td>
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<tr>
<td>7.2.iv Train providers who work with veterans to develop tailored and individualized approaches to lethal means reduction</td>
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</tbody>
</table>

Recommended Partners
- Behavioral Health and Recovery Services
- Buckelew Programs
- Juvenile Probation
- Kaiser Permanente and hospitals
- Local firing ranges and gun clubs
- Local law enforcement, first responders, and emergency services staff
- Local retailers that sell firearms, such as Big 5 and Wal-Mart
- Marin Community Clinic and other community-based primary care providers
- Marin County District Attorney
- Public Health

Potential Performance Measures
- Number of clinicians and providers trained in lethal means assessment and reduction counseling
- Number of nonclinical staff trained in lethal means assessment and reduction counseling
- Number of organizational and business partners promoting safe storage practices among gun owners
- Number of organizations, agencies, and employees participating in gun violence restraining order trainings
NEXT STEPS

BHRS is committed to sustaining the forward momentum from the strategic planning process and is working with its partner agencies and organizations to implement the strategies outlined in this plan. Critical next steps include:

**TOGETHER WE CAN PREVENT SUICIDE**

Everyone has a role to play in saving lives and bringing together our communities. To achieve the goals of this strategic plan we will need your help. Whether it is providing us with feedback about this plan, learning how to recognize suicide warning signs, or finding new ways to connect with individuals in the community – you can make a world of difference.

With the support of community members, community groups, and our many agency and organizational partners, we can together increase wellness and reduce suicides and suicide attempts across Marin County. Prevention is possible!

To stay connected with current efforts and learn how to get involved, please visit [www.marinhhs.org/suicide-prevention](http://www.marinhhs.org/suicide-prevention).

Photos courtesy of Fabrice Florin (Creative Commons 2.0) and Galen Main
# Appendix A: Sources from the Data Review

## Data Sources Included in the Literature and Document Review

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Sample Sources</th>
</tr>
</thead>
</table>
| **Reports and action plans from local agencies and healthcare organizations** | • Marin County Health and Human Services et al., “Crisis Response: Suicide Prevention and Postvention Protocols” (plans for local schools)  
• MarinHealth Medical Center, 2016 Community Health Needs Assessment  
• Sutter Novato Community Hospital, 2016 Community Health Needs Assessment |
| **Literature on trends and best practices in suicide prevention, including strategies to support people at higher risk of suicide** | • Each Mind Matters, “Creating Suicide Prevention Community Coalitions: A Practical Guide”  
• National Action Alliance for Suicide Prevention, “Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention”  
• National LGBT Health Education Center, “Suicide Risk and Prevention for LGBT People”  
• Suicide Prevention Resource Center, “Zero Suicide” toolkit  
• Suicide Prevention Resource Center and California Mental Health Services Authority, “Creating Linguistically and Culturally Competent Suicide Prevention Materials”  
• U.S. Department of Veterans Affairs, “National Strategy for Preventing Veteran Suicide, 2018-2028” |
| **Suicide prevention strategic plans in other jurisdictions** | • Fresno County Community-Based Suicide Prevention Strategic Plan (2018)  
• San Diego County Suicide Prevention Action Plan (updated 2018)  
• Striving for Zero: California’s Strategic Plan for Suicide Prevention (updated 2019) |

## Secondary Data Sources on Suicide and Wellness in Marin County

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Data Sources</th>
</tr>
</thead>
</table>
| **Rates of suicide and self-harm among Marin County residents**            | • Marin County Public Health (data shared with RDA)  
• EPICenter (California Department of Public Health online database)  
• Marin County Sheriff’s Office Coroner Annual Reports, 2013–2018  
• California Department of Public Health, Overview of Homicide and Suicide Deaths in California (2019) |
| **Statewide surveys and analyses of residents’ health and wellbeing**     | • Robert Wood Johnson Foundation, County Health Rankings & Roadmaps  
• California Health Information Survey (CHIS)  
• California Healthy Kids Survey (CHKS) |
| **Marin County demographic information**                                   | • U.S. Census Bureau QuickFacts  
• American Community Survey |
Appendix B: Data on Suicide Deaths/Attempts in Marin County

Suicides among Marin County Residents by Year (2014–2018)

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
<td>2014</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>2015</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>2016</td>
<td>47</td>
<td>9</td>
</tr>
<tr>
<td>2017</td>
<td>42</td>
<td>9</td>
</tr>
<tr>
<td>2018</td>
<td>34</td>
<td>12</td>
</tr>
</tbody>
</table>

Suicides among Marin County Residents by Sex (2014–2018)

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>143</td>
<td>49</td>
</tr>
<tr>
<td>2015</td>
<td>131</td>
<td>46</td>
</tr>
<tr>
<td>2016</td>
<td>147</td>
<td>43</td>
</tr>
<tr>
<td>2017</td>
<td>141</td>
<td>41</td>
</tr>
<tr>
<td>2018</td>
<td>134</td>
<td>41</td>
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</table>

Suicides among Marin County Residents by Age (2014–2018)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male (%)</th>
<th>Female (%)</th>
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<tbody>
<tr>
<td>10-19</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>20-29</td>
<td>9%</td>
<td>17%</td>
</tr>
<tr>
<td>30-39</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>40-49</td>
<td>26%</td>
<td>11%</td>
</tr>
<tr>
<td>50-59</td>
<td>11%</td>
<td>11%</td>
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<tr>
<td>60-69</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>70-79</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>80+</td>
<td>15%</td>
<td>20%</td>
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</tbody>
</table>

Suicides among Marin County Residents by Race (2014–2018)

- White: 84.8%
- Hispanic: 9.6%
- Other/Unknown: 2.5%
- Black: 1.5%
- Asian/Pacific Islander: 1.5%

Middle-aged and older white men account for the majority of deaths by suicide in Marin County.

Age-Adjusted Suicide Rates among Bay Area Counties (2015–2017)

<table>
<thead>
<tr>
<th>County</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Marin</td>
<td>14.1</td>
</tr>
<tr>
<td>Sonoma</td>
<td>13.1</td>
</tr>
<tr>
<td>Solano</td>
<td>11.6</td>
</tr>
<tr>
<td>San Francisco</td>
<td>11.3</td>
</tr>
<tr>
<td>Napa</td>
<td>10.7</td>
</tr>
<tr>
<td>California (Statewide)</td>
<td>10.7</td>
</tr>
<tr>
<td>Contra Costa</td>
<td>10.5</td>
</tr>
<tr>
<td>Alameda</td>
<td>8.9</td>
</tr>
<tr>
<td>San Mateo</td>
<td>7.6</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>7.5</td>
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Marin County residents face the highest rate of suicide in the San Francisco Bay Area.

Suicide Rates (Suicides per 100,000 Residents) by Year, County & Statewide

<table>
<thead>
<tr>
<th>Year</th>
<th>Marin County</th>
<th>California</th>
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<tbody>
<tr>
<td>2014</td>
<td>10.0</td>
<td>20.0</td>
</tr>
<tr>
<td>2015</td>
<td>15.0</td>
<td>25.0</td>
</tr>
<tr>
<td>2016</td>
<td>20.0</td>
<td>30.0</td>
</tr>
<tr>
<td>2017</td>
<td>15.0</td>
<td>20.0</td>
</tr>
<tr>
<td>2018</td>
<td>10.0</td>
<td>15.0</td>
</tr>
</tbody>
</table>


- Asphyxia/Hanging: 66
- Gun Related: 60
- Substance Related: 26
- Blunt Force: 23
- Other: 17

Marin County residents face the highest rate of suicide in the San Francisco Bay Area.

January 2020 | 99
Residents in East Marin County account for the majority of deaths by suicide. However, residents in less populated areas (West and North County) face some of the highest suicide rates in Marin County.

A nationwide study in 2018 determined that Marin County is the healthiest county in California, and Marin County has the highest number of mental health professionals per capita in the state. However, adolescents report higher levels of mental distress than the overall county population.

DATA SOURCES

- Marin County Public Health data (2014–2018)
- California Department of Public Health, Preventing Violence in California (2019)
- California Healthy Kids Survey (2015–2016)
Appendix C: Key Informant Interview Questions

Introduction

1. What agency do you work for, and what is your role there?
   a. How long have you been working there?

2. How are you and/or your agency involved in suicide prevention?
   a. What kinds of programs or services?
   b. Are you involved in any kinds of coordination or community outreach?

Landscape of Local Resources

1. What has been working well in Marin County when it comes to suicide prevention and crisis services?
   b. How are local services and resources tailored to specific age groups, e.g. youth or older adults?

2. What are key gaps that need to be addressed?
   a. Barriers to consumer access?
   b. Stigma among residents
   c. Underserved populations?
   d. Lethal Means reduction?
   e. Specific to phases? (prevention, intervention, postvention)
   f. Different across age groups?

3. What coordination efforts is your organization involved in? Are you aware of other coordination happening in the county?
   a. Who else is involved in coordination efforts? Service providers, schools, community groups, etc.?

4. Are you aware of any suicide prevention efforts that specifically target out of county individuals who come to Marin County as a destination for suicide?
   a. Any suggestions or recommendations for additional programs or services?

Strategic Plan Input and Design

1. What would a successful strategic plan look like? What actions/next steps should it promote?
   a. *Probe along specific domains*: Services? Coordination? Outreach?
   c. What are some potential short-term goals (w/in 1 year) for the county? How about longer-term goals (3-5 years)?

2. Who else besides BHRS should be included in the planning process? Who are the key players and stakeholders in the county?
3. How should BHRS work to reach voices and populations that are not typically heard, or included in planning efforts?
4. Are you aware of any other suicide prevention activities or models that would be helpful to reference and/or research?

Wrap-Up

1. Is there anything else that you would like to bring up, but have not yet had the chance to say?
Appendix D: Focus Group Questions & Participant Demographics

Adult Version

Introduction
1. Let's go around the circle, and if everybody could state:
   a. Your name;
   b. What brought you to the group -or- what do you hope to get out of it?

Responses to County Statistics

Please take a moment to review the page of statistics and figures on suicide and mental health.
(See Appendix A)
1. What information on this page stands out?
   a. Is anything surprising?
   b. Is there anything here that is different from your previous thinking or understanding of suicide?
   c. If any of these facts/figures are familiar, where did you first learn about them?
   d. Do you think anyone, or any group is not represented here?

Prevention
1. Have you ever been provided information about suicide prevention or participated in any kind of suicide prevention activity in your community or at your workplace?
   a. If so, where did it take place? Where were accessed resources located?
   b. What information was covered?

2. What would be effective ways to engage community members with messaging/education about suicide prevention, e.g. warning signs, ways to support a family member/peer with suicidal thoughts, places to get support, etc.
   a. Where would it make the most sense for adult community members to access these resources: In the community? At home? Places of worship? At work?
   b. What are ways to ensure these informational resources are relevant and accessible to adults?
   c. Are there particular groups of Marin County residents (from certain cultural or religious backgrounds, or gender identities) who would benefit from a customized message or approach?

Intervention
1. What resources are you aware of that are available for adults experiencing a mental health crisis or who are in serious risk of self-harm? Where might people access interventional support?
   a. Community organizations or places of worship?
   b. Online or phone-based resources?
   c. Knowledgeable peers?
2. What might prevent a person from getting support when they are having a tough time?
   a. Accessibility of mental health resources in their workplace?
   b. Accessibility of mental health resources in their day-to-day life?
   c. Embarrassment or shame (stigma)?
   d. Not knowing what is available (lack of awareness)?
   e. Cultural or religious views about mental health/suicide/asking for help?

3. If a friend or family member was having a tough time and/or in crisis and you were concerned about their safety, would you feel comfortable talking to them about suicide and self-harm?
   a. If yes—why?
   b. If no—why? (Probe—lack of information about warning signs, lack of info about available resources, uncertainty about who to inform, etc.)

As you might be aware, one major challenge in suicide prevention is widespread stigma around the issue. Stigma is a feeling of shame, disgrace, or humiliation that is associated with a particular topic or subject. Some people experiencing mental health challenges might feel shame in seeking help. Other people might feel stigma in discussing the issue of suicide openly and publicly.

4. How can we reduce the difficulty (shame/fear/taboo nature) that comes with talking about suicide in homes and in the community? (resources/services/messaging campaigns?)
   a. What would help adults find it easier asking for, and receiving, crisis/mental health care?
   b. What cultural traditions or differences are there to consider when engaging community members about mental health care and the issue of suicide?

Postvention
1. If you have been impacted by someone contemplating, attempting, or completing suicide (and feel you are able to share):
   a. Did you have access to information and/or resources to help you with grieving, or processing what happened? Or, did you have any information/resources to help other people in emotional distress?
   b. If so—where did you access these resources?

2. What else would be helpful to support community members whose life has been affected by suicide?

3. How can we best support an adult returning to their daily life after attempting suicide?
   • At the workplace
   • In the community
   • At home
Wrap-Up
1. Is there anything else that you would like to bring up, that we have not had the chance to discuss?

2. What was it like for you to discuss suicide for an hour?
3. To close out—let’s go around, and share one thing that you do for self-care, or something that helps you when you’re sad or overwhelmed.

Youth Version
Introduction
1. Let’s go around the circle, and if everybody could state:
   a. Your name;
   b. What you hope get out of participating today, and/or what brought you here?

Prevention
1. Have you ever been part of a conversation about mental health and/or suicide prevention – or participated in any kind of suicide prevention learning activity at school or in your community? (e.g. school assemblies, conversations in class, brochures)
   a. At school?
   b. At organizations and social circles in your personal and family life—athletic clubs, places of worship, workplaces, etc.?
   c. Did this include warning signs for people who are contemplating suicide?

2. What would be the best way to reach young people with information about suicide prevention, i.e. warning signs, ways to support a friend with suicidal thoughts, places to get support, etc.
   a. Where would it make the most sense for youth to access these resources: at school? In the community? At home? Places of worship?
   b. What are some ways that we could make resources interesting/relevant and readily available to young people?
   c. Are there groups of youth – say, youth from certain cultural or religious backgrounds/gender identities – who could be better reached through different messages or approaches?

Intervention
1. If a peer at your school was having a tough time (feeling overwhelmed, being bullied, feeling down consistently, having suicidal thoughts) how/where might they get support?
   a. At school: counselor, teacher, coach, trusted adult?
   b. Online resources? / Crisis line?/ Place of worship?

2. From what you have seen or experienced, what might make it hard for a young person to get support when they are having a tough time?
a. Accessibility of resources at school?
b. Accessibility of mental health resources outside of school?
c. Embarrassment or shame (stigma)?
d. Not knowing what is available (lack of awareness)?
e. Cultural or religious views about mental health/suicide/asking for help?

3. If a friend or family member was having a tough time and/or in crisis and you were concerned about their safety, would you feel comfortable talking to them about suicide and self-harm?
   a. If yes—why?
   b. If no—why not? (Probe—lack of information about warning signs, lack of info about available resources, uncertainty about who to inform, etc.)

As you might know, a major challenge in suicide prevention is widespread stigma around the issue. **Does anyone here feel like they have a good definition for the term stigma?**
If required: Stigma is a feeling of shame, disgrace, or humiliation that is related to a particular topic or subject. Some people experiencing mental health challenges might feel shame or embarrassment in getting help. Other people might feel stigma in discussing the issue of suicide openly and publicly.

4. What do you think can be done to make it feel easier and/or less scary/shameful to talk about?
   a. What would help young people to find it easier asking for, and receiving, crisis and mental health care?
   b. What cultural traditions or differences are there to consider when engaging community members about mental health care?

Postvention
As you might know, there was a number of suicide deaths among young people in the county last year. Whether it was through hearing about these cases, knowing those that died, or through other experiences, the issue of suicide has impacted many of us in this room.

1. If you are comfortable sharing: What was helpful to you or peers in dealing with this?
   c. Did you have access to information and/or resources to help you with grieving, or processing what happened?
   d. If so—where did you access these resources? (School? Family?)

2. What can be done to support young people whose lives may have been impacted by suicide?

3. How can we best support a young person returning to their daily life after attempting suicide?
   a. At school?
   b. In the community?
   c. At home?
Wrap-Up
1. Is there anything else that you would like to bring up, that we have not had the chance to discuss?
2. What was it like for you to discuss suicide for an hour?
3. To close out—let’s go around, and share one thing that you do for self-care, or something that helps you when you’re sad or overwhelmed.

Demographics of Focus Group Participants
A total of 61 focus group participants completed the demographic survey.

Race & Ethnicity
- Latino/a, Asian-Pacific Islander, and African American residents participated in focus groups in greater proportions than the overall county population. White residents made up two-thirds of participants, slightly lower than the overall county population.
- Nearly half (43%) of all respondents identified as people of color.
- Native American residents were not represented among focus group participants.

Age
- Residents aged 25 and younger made up nearly two-thirds of focus group participants.
- Older adults made up one-fifth of focus group participants.
- These figures reflect targeted outreach to youth and older adults for the focus groups.
Gender

- About three in five participants identified as female and cisgender, compared to about one in three male cisgender participants.
- A small proportion (5%) of participants indicated that they have another gender identity.

Sexual Orientation: 20% of participants identified as LGBTQ+. Nearly all of these individuals were under the age of 26.

Language: 92% of participants speak English as their primary language. The remaining respondents primarily speak Spanish, Vietnamese, or Portuguese.

Veterans: no focus group participants identified as veterans.

Homelessness: almost all focus group participants did not indicate that they were experiencing homelessness at the time of survey.

Ability: 10% of participants indicated that they have a disability.

Residence: 93% of participants identified as a resident of Marin County.

Note: data privacy laws prohibit sharing disaggregated demographic information for any category with 5 or fewer participants. In cases where there were fewer than 6 participants in a given category, we do not report the number or percentage of participants.
Appendix E: Suicide Prevention Community Survey Questions, Respondents’ Demographics, & Survey Results

Community Survey

The purpose of this survey is to get your opinion on the issue of suicide and what prevention efforts are best suited to your community. The Behavioral Health and Recovery Services Department will use the results of this survey to help inform a county-wide strategic plan aiming to expand and strengthen suicide prevention efforts. All responses are ANONYMOUS. Your opinion is important!

1. How has suicide touched your life (if at all)?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>I'm not sure</th>
<th>Prefer not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have had at least one friend, co-worker, or family member attempt suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have had at least one friend, co-worker, or family member die by suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have had serious thoughts about ending my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have attempted suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know where to get help if I have thoughts about ending my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If you are currently having serious thoughts of suicide or harming yourself, please stop taking this survey and call this number for immediate support:

1-800-273-8255 OR In Marin County, call 415-499-1100
For grief support, call 415-499-1195

2. In your opinion, how true are these statements about your community?

<table>
<thead>
<tr>
<th></th>
<th>Not at all true</th>
<th>A little bit true</th>
<th>Mostly true</th>
<th>Very true</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide is a problem in my community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma (fear/shame) makes it difficult to talk about mental illness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma makes it difficult to talk about suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People feel embarrassed/scared when it comes to getting help.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People can recognize if a friend or family member was planning to end their life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People know where to go for help if they are having a hard time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Please answer the following questions.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>I’m not sure</th>
<th>Prefer not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have participated in a suicide prevention training.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If “Yes,” what organization/group held the training?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have accessed informational resources about suicide prevention.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recognize if a friend or family member was thinking about suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I am concerned that a friend or family member is considering suicide, I would ask them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know how/where to get help for a friend or family member who is having thoughts about suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asking someone if they are thinking about suicide can plant the idea in their head.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only people with a known mental illness attempt suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. How true are the following statements about your interest in participating in suicide prevention efforts?

<table>
<thead>
<tr>
<th></th>
<th>Not at all true</th>
<th>A little bit true</th>
<th>Mostly true</th>
<th>Very true</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am interested in learning how to help someone who is considering suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would be willing to attend an in-person training about suicide prevention.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would prefer to learn on my own about suicide prevention through written or web-based materials.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would be willing to talk with family/friends about the issue of suicide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. What do you think would be the most effective ways to prevent suicide in your community? [Choose your top 4]

- Making it easier to get **mental health** services.
- Making it easier to get **crisis** services.
- Making support services more sensitive to different **cultural/ethnic backgrounds**.
- Teaching adults that work with children and youth how to **recognize suicide warning signs and how to offer help**.
- Increasing education about suicide for first responders (e.g., police/law enforcement, firefighters, emergency medical technicians).
- Decreasing the amount of **stress** students feel at school.
- Teaching **children and youth** in schools about how to recognize suicide warning signs, and how to connect a friend or peer to help.
- Teaching **parents** about how to recognize warning signs and how to connect their child(ren) to help.
- Increasing awareness of warning signs, crisis resources and how to offer support around suicide through media campaigns and outreach.
- Decreasing stigma (shame/embarrassment) around suicide through media campaigns (e.g. billboards, bus advertisements).
- Working with local news media to report on suicides in a way that is respectful and does not cause harm.

6. What services or resources do you know of in your community that can help a person who is considering suicide?

7. What services or resources do you know of for people that want to learn how to support others with mental illness and/or others that may be considering suicide?

8. Is there anything else that you think is needed to prevent suicide in your community?

9. Is there anything else that you would like to share?
Please help us learn a little bit about you. The Mental Health Services Act (MHSA) planning guidelines require that we keep track of some basic information to report on who participated in the community planning process. However, you may decline to answer any of these questions.

1. Do you identify as a mental health services consumer or family member of a consumer?
   - ☐ No
   - ☐ Consumer
   - ☐ Family Member

2. Do you identify as a service provider?
   - ☐ No
   - ☐ Yes
   - Type: _______________________
     (i.e.; Mental Health, Substance Use, Social Services, etc)
   - Affiliation: __________________
     (i.e.; County, Community Based, etc)

3. Other affiliations? (check all that apply)
   - ☐ LGBTQ+
   - ☐ Homeless
   - ☐ Veteran
   - ☐ Disability
   - ☐ Other: _____________________
   - ☐ None

4. Please indicate your age range:
   - ☐ Under 16
   - ☐ 16-25
   - ☐ 26-59
   - ☐ 60 and older

5. What is your race/ethnicity? (check all that apply)
   - ☐ African American/Black
   - ☐ American Indian/Native Alaskan
   - ☐ Asian
   - ☐ Pacific Islander
   - ☐ Hispanic/Latino
   - ☐ White/Caucasian
   - ☐ Multi-Race
   - ☐ Other _____________________

6. If you are a Marin County resident, what zip code do you live in?
   __________________________________________

7. What is your primary language?
   - ☐ English
   - ☐ Spanish
   - ☐ Vietnamese
   - ☐ Other: ________________________________

8. Please indicate your gender:
   - ☐ Female
   - ☐ Male
   - ☐ Transmale/transman
   - ☐ Transfemale/transwoman
   - ☐ Intersex
   - ☐ Questioning or unsure of identity
   - ☐ Genderqueer
   - ☐ Another gender identity
   - ☐ Prefer not to answer
   - ☐ Other: ________________________________
Demographics of Survey Respondents

1,185 people provided some or all of the demographic information requested. The figures below include total counts of individuals who answered each specific demographic question.

Race & Ethnicity (n=1,088)

- The racial & ethnic breakdown of survey respondents was mostly consistent with the overall Marin County population.
- Latino/a residents were slightly under-represented among survey takers.
- Because respondents could select multiple options, the totals in the graph exceed 100%.

Age (n=1,098)

- Nearly three-quarters of survey respondents were between the ages of 26 and 59.
- Adults aged sixty and over made up about one-quarter of survey takers.
- Only 5% of respondents were below the age of 25.

Gender (n=1,097)

- Over four in five respondents identified as female.
- Cisgender men and boys were extremely underrepresented among survey respondents.
- 1% of participants identified with another gender identity (genderqueer, transgender, etc.)
Sexual Orientation: 5% of respondents identified as LGBTQ+. Among these respondents, 21% were under the age of 25, and 13% were 60 or older. 61% identified as white.

Language: 13% of respondents indicated that they speak a primary language other than English. Seven percent of respondents completed the survey in either Spanish or Vietnamese.

Veterans: 2% of respondents over the age of 25 identified as armed forces veterans. Among these respondents, 69% identified as male, and 73% identified as white.

Homelessness: Fewer than 1% of respondents indicated that they were experiencing homelessness at the time of taking the survey.

Ability: 5% of respondents indicated that they have a disability. The survey did not ask respondents to indicate the type of disability.

Residence by Zip Code: 970 respondents indicated that they were a resident of Marin County, or 88% of respondents who answered the question. Of those individuals, 967 provided their zip code. The map below shows survey respondents who are county residents, organized by their zip code of residence.

Figure 22: Survey Respondents, Organized by Zip Code of Residence in Marin County
Survey Results

1. How has suicide touched your life (if at all)?
   *Figures in the table below refer to the percentage of respondents answering “Yes.”*

<table>
<thead>
<tr>
<th>POPULATIONS AT HEIGHTENED RISK FOR SUICIDE</th>
<th>All Surveys</th>
<th>Youth &amp; TAY (&lt;26)</th>
<th>Older Adults (60+)</th>
<th>White Men (26+)</th>
<th>People of Color</th>
<th>Survey in Spanish/ Viet.*</th>
<th>LGBTQ+</th>
<th>Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of responses</td>
<td>1307</td>
<td>56</td>
<td>250</td>
<td>151</td>
<td>311</td>
<td>97</td>
<td>61</td>
<td>26</td>
</tr>
<tr>
<td>I have had at least one friend, co-worker, or family member <strong>attempt</strong> suicide.</td>
<td>66%</td>
<td>66%</td>
<td>69%</td>
<td>70%</td>
<td>59%</td>
<td>31%</td>
<td>77%</td>
<td>56%</td>
</tr>
<tr>
<td>I have had at least one friend, co-worker, or family member <strong>die by suicide</strong>.</td>
<td>59%</td>
<td>50%</td>
<td>62%</td>
<td>66%</td>
<td>47%</td>
<td>22%</td>
<td>65%</td>
<td>58%</td>
</tr>
<tr>
<td>I have had serious thoughts about ending my life.</td>
<td>20%</td>
<td>30%</td>
<td>19%</td>
<td>19%</td>
<td>16%</td>
<td>6%</td>
<td>52%</td>
<td>25%</td>
</tr>
<tr>
<td>I have attempted suicide.</td>
<td>8%</td>
<td>20%</td>
<td>6%</td>
<td>5%</td>
<td>10%</td>
<td>7%</td>
<td>28%</td>
<td>13%</td>
</tr>
<tr>
<td>I know where to get help if I have thoughts about ending my life.</td>
<td>76%</td>
<td>68%</td>
<td>73%</td>
<td>76%</td>
<td>67%</td>
<td>42%</td>
<td>77%</td>
<td>79%</td>
</tr>
</tbody>
</table>

- Cells in red indicate results that are less favorable, compared to all survey responses. (At least four percentage points worse.)
- Cells in green indicate results that are more favorable, compared to all responses. (At least four percentage points better.)
- The darker the cell color, the more the figure diverges from the responses of all survey-takers.

*Respondents who completed the survey in either the Spanish or Vietnamese language versions.*
2. How has suicide touched your life (if at all)?

*Figures in the table below refer to the percentage of respondents answering “Mostly true” or “Very true”*

<table>
<thead>
<tr>
<th>All Surveys</th>
<th>POPULATIONS AT HEIGHTENED RISK FOR SUICIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Youth &amp; TAY (≤26)</td>
</tr>
<tr>
<td>Total # of responses</td>
<td>1307</td>
</tr>
</tbody>
</table>

- **Suicide is a problem in my community.**
  - **70%** overall, **71%** for Youth & TAY, **66%** for Older Adults, **68%** for White Men, **63%** for People of Color, **53%** for Survey in Spanish/ Vietnamese, **72%** for LGBTQ+ and **50%** for Veterans.

- **Stigma (fear/shame) make it difficult to talk about mental illness.**
  - **82%** overall, **79%** for Youth & TAY, **82%** for Older Adults, **82%** for White Men, **80%** for People of Color, **66%** for Survey in Spanish/ Vietnamese, **92%** for LGBTQ+ and **73%** for Veterans.

- **Stigma (fear/shame) make it difficult to talk about suicide.**
  - **82%** overall, **75%** for Youth & TAY, **82%** for Older Adults, **83%** for White Men, **78%** for People of Color, **62%** for Survey in Spanish/ Vietnamese, **89%** for LGBTQ+ and **80%** for Veterans.

- **People feel embarrassed/scared when it comes to getting help.**
  - **83%** overall, **73%** for Youth & TAY, **84%** for Older Adults, **85%** for White Men, **82%** for People of Color, **74%** for Survey in Spanish/ Vietnamese, **87%** for LGBTQ+ and **69%** for Veterans.

- **People can recognize if a friend or family member was planning to end their life.**
  - **7%** overall, **4%** for Youth & TAY, **9%** for Older Adults, **6%** for White Men, **13%** for People of Color, **25%** for Survey in Spanish/ Vietnamese, **7%** for LGBTQ+ and **19%** for Veterans.

- **People know where to go for help if they are having a hard time.**
  - **15%** overall, **25%** for Youth & TAY, **13%** for Older Adults, **18%** for White Men, **18%** for People of Color, **28%** for Survey in Spanish/ Vietnamese, **12%** for LGBTQ+ and **19%** for Veterans.

- **Cells in red indicate results that are less favorable, compared to all survey responses. (At least four percentage points worse.)**
- **Cells in green indicate results that are more favorable, compared to all responses. (At least four percentage points better.)**
- **The darker the cell color, the more the figure diverges from the responses of all survey-takers.**
3. Please answer the following questions.

*Figures in the table below refer to the percentage of respondents answering “Yes.”*

<table>
<thead>
<tr>
<th>Total # of responses</th>
<th>All Surveys</th>
<th>POPULATIONS AT HEIGHTENED RISK FOR SUICIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Youth &amp; TAY (&lt;26)</td>
<td>Older Adults (60+)</td>
</tr>
<tr>
<td>I have participated in a suicide prevention training.</td>
<td>26%</td>
<td>27%</td>
</tr>
<tr>
<td>I have accessed informational resources about suicide prevention.</td>
<td>48%</td>
<td>59%</td>
</tr>
<tr>
<td>I would recognize if a friend or family member was thinking about suicide.</td>
<td>23%</td>
<td>41%</td>
</tr>
<tr>
<td>If I am concerned that a loved one is considering suicide, I would ask them.</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>I know how/where to get help for a friend or family member who is having thoughts about suicide.</td>
<td>68%</td>
<td>64%</td>
</tr>
<tr>
<td>Asking someone if they are thinking about suicide can plant the idea in their head.</td>
<td>7%</td>
<td>23%</td>
</tr>
<tr>
<td>Only people with a known mental illness attempt suicide.</td>
<td>1%</td>
<td>5%</td>
</tr>
</tbody>
</table>
4. How true are the following statements about your interest in participating in suicide prevention efforts?

*Figures in the table below refer to the percentage of respondents answering “Mostly true” or “Very true”*

<table>
<thead>
<tr>
<th>POPULATIONS AT HEIGHTENED RISK FOR SUICIDE</th>
<th>All Surveys</th>
<th>Youth &amp; TAY (&lt;26)</th>
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<td>250</td>
<td>151</td>
<td>311</td>
<td>97</td>
<td>61</td>
<td>26</td>
</tr>
<tr>
<td>I am interested in learning how to help someone who is considering suicide.</td>
<td>71%</td>
<td>77%</td>
<td>60%</td>
<td>69%</td>
<td>76%</td>
<td>72%</td>
<td>82%</td>
<td>54%</td>
</tr>
<tr>
<td>I would be willing to attend an in-person training about suicide prevention.</td>
<td>64%</td>
<td>66%</td>
<td>49%</td>
<td>56%</td>
<td>74%</td>
<td>75%</td>
<td>75%</td>
<td>46%</td>
</tr>
<tr>
<td>I would prefer to learn on my own about suicide prevention through written or web-based materials.</td>
<td>45%</td>
<td>54%</td>
<td>48%</td>
<td>43%</td>
<td>44%</td>
<td>53%</td>
<td>45%</td>
<td>39%</td>
</tr>
<tr>
<td>I would be willing to talk with family/friends about the issue of suicide.</td>
<td>78%</td>
<td>75%</td>
<td>70%</td>
<td>71%</td>
<td>77%</td>
<td>74%</td>
<td>82%</td>
<td>54%</td>
</tr>
</tbody>
</table>

- Cells in red indicate results that are less favorable, compared to all survey responses. (At least four percentage points worse.)
- Cells in green indicate results that are more favorable, compared to all responses. (At least four percentage points better.)
- The darker the cell color, the more the figure diverges from the responses of all survey-takers.
All Survey Respondents:

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Number of Responses</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. Teaching parents about how to recognize warning signs, and how to connect their child(ren) to help</td>
<td>717</td>
<td>61%</td>
</tr>
<tr>
<td>E. Teaching children and youth in schools about how to recognize suicide warning signs, and how to connect a friend or peer to help</td>
<td>711</td>
<td>60%</td>
</tr>
<tr>
<td>A. Making it easier to get mental health services</td>
<td>700</td>
<td>59%</td>
</tr>
<tr>
<td>D. Teaching adults that work with children and youth how to recognize suicide warning signs, and how to offer help</td>
<td>646</td>
<td>55%</td>
</tr>
<tr>
<td>J. Decreasing stigma (shame/embarrassment) around suicide through strong media campaigns (e.g. billboards, bus advertisements)</td>
<td>477</td>
<td>41%</td>
</tr>
<tr>
<td>I. Increasing awareness of warning signs, crisis resources, and how to offer support around suicide through strong media campaigns and outreach</td>
<td>447</td>
<td>38%</td>
</tr>
<tr>
<td>B. Making it easier to get crisis services</td>
<td>435</td>
<td>37%</td>
</tr>
<tr>
<td>H. Decreasing the amount of stress students feel at school</td>
<td>434</td>
<td>37%</td>
</tr>
<tr>
<td>C. Making support services more sensitive to different cultural/ethnic backgrounds</td>
<td>327</td>
<td>28%</td>
</tr>
<tr>
<td>G. Increasing education about suicide for first responders (e.g. police, fire fighters, emergency medical technicians)</td>
<td>204</td>
<td>17%</td>
</tr>
<tr>
<td>K. Working with local news media to report on suicides in a way that is respectful and does not cause harm</td>
<td>130</td>
<td>11%</td>
</tr>
<tr>
<td>L. Other (write in)</td>
<td>129</td>
<td>11%</td>
</tr>
</tbody>
</table>

5. What do you think would be the most effective ways to prevent suicide in your community? (Maximum of 4 answers.)

1,178 respondents completed this portion of the survey.
### At-Risk Populations

#### Youth and TAY (n = 56)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Teach children &amp; youth in school</td>
<td>39</td>
<td>70%</td>
</tr>
<tr>
<td>D. Teach adults working w/ youth</td>
<td>35</td>
<td>63%</td>
</tr>
<tr>
<td>F. Teach parents of youth</td>
<td>34</td>
<td>61%</td>
</tr>
<tr>
<td>H. Decrease student stress</td>
<td>33</td>
<td>59%</td>
</tr>
<tr>
<td>A. Expand mental health access</td>
<td>31</td>
<td>55%</td>
</tr>
</tbody>
</table>

#### Older Adults (n = 250)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Expand mental health access</td>
<td>158</td>
<td>63%</td>
</tr>
<tr>
<td>F. Teach parents of youth</td>
<td>145</td>
<td>58%</td>
</tr>
<tr>
<td>E. Teach children &amp; youth in school</td>
<td>135</td>
<td>54%</td>
</tr>
<tr>
<td>D. Teach adults working w/ youth</td>
<td>134</td>
<td>54%</td>
</tr>
<tr>
<td>I. Awareness media campaigns</td>
<td>109</td>
<td>44%</td>
</tr>
</tbody>
</table>

#### White Adult Men (n = 151)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Teach children &amp; youth in school</td>
<td>93</td>
<td>62%</td>
</tr>
<tr>
<td>F. Teach parents of youth</td>
<td>82</td>
<td>54%</td>
</tr>
<tr>
<td>A. Expand mental health access</td>
<td>81</td>
<td>54%</td>
</tr>
<tr>
<td>D. Teach adults working w/ youth</td>
<td>75</td>
<td>50%</td>
</tr>
<tr>
<td>I. Awareness media campaigns</td>
<td>67</td>
<td>44%</td>
</tr>
</tbody>
</table>

#### People of Color (n = 311)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. Teach parents of youth</td>
<td>185</td>
<td>59%</td>
</tr>
<tr>
<td>E. Teach children &amp; youth in school</td>
<td>181</td>
<td>58%</td>
</tr>
<tr>
<td>D. Teach adults working w/ youth</td>
<td>175</td>
<td>56%</td>
</tr>
<tr>
<td>A. Expand mental health access</td>
<td>175</td>
<td>56%</td>
</tr>
<tr>
<td>C. Culturally sensitive supports</td>
<td>151</td>
<td>49%</td>
</tr>
</tbody>
</table>

#### Survey in Spanish/Viet. (n = 97)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Teach adults working w/ youth</td>
<td>67</td>
<td>69%</td>
</tr>
<tr>
<td>F. Teach parents of youth</td>
<td>67</td>
<td>69%</td>
</tr>
<tr>
<td>E. Teach children &amp; youth in school</td>
<td>56</td>
<td>58%</td>
</tr>
<tr>
<td>A. Expand mental health access</td>
<td>48</td>
<td>49%</td>
</tr>
<tr>
<td>C. Culturally sensitive supports</td>
<td>44</td>
<td>45%</td>
</tr>
</tbody>
</table>

#### LGBTQ+ Persons (n = 61)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Expand mental health access</td>
<td>37</td>
<td>61%</td>
</tr>
<tr>
<td>E. Teach children &amp; youth in school</td>
<td>37</td>
<td>61%</td>
</tr>
<tr>
<td>D. Teach adults working w/ youth</td>
<td>32</td>
<td>52%</td>
</tr>
<tr>
<td>J. Decrease stigma via media</td>
<td>29</td>
<td>48%</td>
</tr>
<tr>
<td>C. Culturally sensitive supports</td>
<td>27</td>
<td>44%</td>
</tr>
</tbody>
</table>

#### Veterans (n = 26)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Teach children &amp; youth in school</td>
<td>14</td>
<td>54%</td>
</tr>
<tr>
<td>I. Awareness media campaigns</td>
<td>13</td>
<td>50%</td>
</tr>
<tr>
<td>D. Teach adults working w/ youth</td>
<td>12</td>
<td>46%</td>
</tr>
<tr>
<td>F. Teach parents of youth</td>
<td>12</td>
<td>46%</td>
</tr>
<tr>
<td>A. Expand mental health access</td>
<td>12</td>
<td>46%</td>
</tr>
</tbody>
</table>
Appendix F: Notes from the Community Forum

Breakout Group 1: Discuss (brainstorm) how to engage community members in prevention and education efforts tailored to specific high risk groups, e.g., LGBTQ+, ethnically / culturally / linguistically diverse community members, age differentials, foster and or homeless youth, white middle age men.

- How to reach those who are isolated:
  - Wellness Centers at schools
  - Mindfulness, yoga
  - More systematic approach
  - Training re: 504
  - Columbia Suicide Severity Screen
  - Speak your truth
  - Student Assistance Programs
  - Prop 64

- Utilizing screen tools/campaigns
  - Lack of standardization of curriculum /best practices
  - Full groups @ SPAHR
  - Competing resources funding CBO’s
  - *MHSA opportunities + growth
  - Leveraging personal connections

- Partnerships w/ Justice System
  - Justice system involved youth/adults
  - CAREER OPTIONS -> Hope
  - Community, sense connection
  - “Students from diff. Planets”
  - Sources of pain/solutions different

Breakout Group 2: How do we increase help seeking and decrease stigma in our community?

- Overture
- Ask/talk
- Reaches out
- Draw attention
- Unintentional/intentional thought, feeling, behavior to invite (seek) someone to help
- Get in the way
  - Fear of judgement

- Adults - men more isolated groups/support for sharing, HOW TO ACCESS groups + help -
  - Workforce promote mental health screening. Look at other models (domestic violence). Create space for people who may not go the traditional route.
    - Barbers “men’s space”
    - Churches, soccer coaches
Breakout Group 3: How do we build on resilience and protective factors in certain communities to protect/help all residents?

- Peer support collaborative services CBO
  - ONE STOP CENTER - Smaller marketing
- Strengthen existing communities (New)
  - Education at all levels

- Messaging + marketing
- More hospital beds
- Individual Protective Factors
  - 1. Faith
  - 2. Family Support
  - 3. 12 Step Groups
<table>
<thead>
<tr>
<th>Peer support groups + network</th>
<th>4. Peer Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile support</td>
<td>Definitions of Protective Factors</td>
</tr>
<tr>
<td>Technology</td>
<td>1. Big group of CBO’s (engaged)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2. Community Effort</td>
</tr>
<tr>
<td>Depression</td>
<td>3. Suicide Hotline</td>
</tr>
<tr>
<td>Connect to older adults</td>
<td>4. Hope Project</td>
</tr>
<tr>
<td>Organizational collaboration (shared resources)</td>
<td>5. Peer Support</td>
</tr>
</tbody>
</table>
Check-Out Question: How can you personally commit to ending suicide in Marin County?

- I can talk about mental health to a new person every day in May!
- Learn learn learn
- Really ask friends how they are doing and listen
- I can commit to supporting myself to be there for others
- Help create and encourage more interactive support (peer support) in youth settings... school activities youth programs as a way of helping to change community identity for upcoming generations
- TALK
- Not shying away from conversations about suicide
- Continuing my work with youth
- Support my friends and my community more!
- Add to my Resources list
- To be a better listener

- Speaking publicly about my story as a loss survivor
- Staying connected to my mom and friends who are struggling
- Spread the word at every chance
- To be the difference I want to see in the world!
- Reach out to family, friends, and co-workers at least 2 times per month, and share ideas about how we can make a change in Marin
- To training + re-training my staff + representing my organization at those events
- Continue to speak up for those who don’t know how to ask for help
- Help a friend more who is grieving the loss of his father
- Care and show it anytime anywhere
- I can commit to training staff self-care, coordinate w/ partner agencies, decrease stigma.
Appendix G: Notes from the Strategic Planning Sessions

Strategic Planning Participant Affiliations

In all, 33 individuals participated in one or more of the three strategic planning sessions. Below is a list of participants’ affiliations:

- Buckelew Programs
- County of Marin Probation Department
- *Cuerpo Corazon Comunidad*
- Empowerment Clubhouse
- Growing Roots: The Young Adult Services Project
- Helping Older People Excel (HOPE) Program
- Kaiser Permanente San Rafael
- Marin Asian Advocacy Project
- Marin City Community Development Corporation
- Marin Community Clinics
- Marin County Behavioral Health and Recovery Services
- Marin County Commission on Aging
- Marin County Office of Education
- Marin County Public Health
- Marin County Veterans Service Office
- MarinHealth Medical Center, Psychiatry Department
- Marin Interfaith Council
- National Alliance on Mental Illness (NAMI) Marin
- *Promotores* (Community Health Advocates)
- Residents with lived experience of suicide loss
- Southern Marin Fire Protection District
- Tamalpais Union High School District
- Youth Leadership Institute