SUICIDE PREVENTION SITUATIONAL OVERVIEW

CalMHSA
California Mental Health Services Authority
Compassion. Action. Change.

PRESENTED BY

ADEASE
EDUCATION DEVELOPMENT CENTER, INC.
YOUR SOCIAL MARKETER, INC.

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EXECUTIVE SUMMARY

The California Mental Health Services Authority (CalMHSA) suicide prevention social marketing program is one component of the MHSA Suicide Prevention initiative, which uses a full range of strategies from Prevention to Early Intervention to prevent suicides across ages and backgrounds. CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families and communities. CalMHSA administers programs funded by the Mental Health Services Act (Prop. 63) on a statewide, regional and local basis. To ensure that the social marketing strategy is grounded in research and evidence, the AdEase/Education Development Center/Your Social Marketer team implemented a variety of research activities in 2011. The attached reports reflect the results from these fact-finding activities.

A **comprehensive review of relevant literature** published between 2001 and 2011 was conducted to summarize what is known about marketing and messaging in suicide prevention in terms of effectiveness and safety. The results show that many campaigns have not been evaluated to learn whether or not the messages reached the target audiences and whether the campaigns were effective in changing behavior, attitudes, or knowledge. The review includes recommendations for the social marketing campaign that are based on the findings and on best practice documents. Most literature examined the effects of messaging on broad "general public" audiences or on youth. Very little has been written on how best to message about suicide to particular demographic, ethnic, racial, or cultural groups.

The second activity was to compile a **catalog of existing suicide prevention campaigns.** This activity took place in the fall of 2011; the catalog represents campaigns that were active prior to the end of the calendar year. Campaigns that have been launched more recently are not included in this compilation. The catalog enabled the creative team to take into account messages that may already be active in the marketplace, as well as to see examples of messaging, both successful and unsuccessful. The catalog describes campaigns that are national in scope, statewide, local, and those that are designed to reach veterans and/or active duty military members. Materials were included whether or not they conform to best practices for safety. Where there was evidence of evaluations, that information was also included. Contact information is provided for additional follow-up as needed. Campaigns in the catalog were assessed to see whether they could offer models or inspiration for a California campaign. Very few campaigns have been created to reach demographic, ethnic, racial, or cultural high risk groups such as LGBTQ individuals, Hispanic girls, African-Americans, TAY, or older adults. None of the existing campaigns could be readily adapted for California: most of them were not robust or diverse enough, very few had evaluation results to show that they were effective, many were too small-scale, and others were intended for a particular audience (such as active military members).

The third activity was to conduct a **random digit dial telephone baseline survey among Californians.** The responses generated baseline results of attitudes, knowledge, and beliefs about suicide, suicide prevention, and warning signs; the ability and willingness to offer help; exposure to news media and public service announcements; and actions respondents would take. A total of 2003 surveys were completed with a 99% confidence level that the results are representative of the state of California, including representation from different regions across the state, from rural and urban populations. Twelve percent of interviews were conducted in Spanish. Demographic information allowed analysis by gender, age groups, urban versus rural residence, veteran and military status, and ethnic/racial groups. This first-of-its-kind sample provides a strong baseline against which future years of the campaign can be measured.

Data from the California Department of Public Health (2011) show that although the statewide suicide mortality rate fell from 1991 to 2005, more recently, rates have risen among Californians over age 24 and the rate now stands at 9.7 per 100,000. Rates are highest among white males and in northern counties. Most decedents had depression and other mental health and substance abuse problems, as well as financial, health, and other problems prior to their deaths. A separate analysis of all survey results for white middle-aged men was also run for the baseline.

The literature review and campaign catalog point the way to creating a safe and effective social marketing campaign. The baseline survey provides needed information on the strengths and gaps that Californians report when it comes to recognizing and helping friends and loved ones in crisis. The data shows that white males in midlife are in urgent need of assistance coping with their life problems. Together, these deliverables form a solid basis for the CalMHSA statewide suicide prevention social marketing campaign.

VOLUME 1 | Literature Review

LITERATURE REVIEW
Social Marketing, Messaging and Suicide Prevention

Contents

I. Scope of this review

This literature review was conducted in the fall of 2011 by the Education Development Center (EDC). Research articles published in the 11- year period between 2001 and 2011 in English were included in this review. The keywords used encompassed suicide prevention media, social marketing, and awareness campaigns. Although the project funded by CalMHSA is intended to be a social marketing campaign, many suicide prevention campaigns are public awareness campaigns, or the literature is unclear as to the kind of campaign.[1] This review is a supplement to a review conducted in 2010 for the San Diego County stigma reduction and suicide prevention campaigns (Your Social Marketer, 2010). In addition, existing websites were reviewed for campaigns that are currently in use regardless of whether the campaign has been evaluated. Recommendations in this report are based on the findings in published articles, presentations by experts, and on two existing best practice documents: "Recommendations for Reporting on Suicide" (Multiple authors, 2011) and "Safe and Effective Messaging for Suicide Prevention" (SPRC, 2006). These guidelines should be incorporated into the planning process of campaign development but should not be used in place of a planning process.

II. Developing successful campaigns

A successful suicide prevention campaign is developed when it achieves all of the following (Langford, 2010):

1) Implements a formative research and a systematic planning process
2) Embeds the communication campaign into an overall suicide prevention strategy
3) Defines clearly specified audiences, goals and a call to action
4) Is informed by audience research
5) Is pre-tested
6) Is evaluated

[1]Social marketing is a program-planning process that uses commercial marketing concepts and techniques to promote voluntary behavior change. It helps facilitate the acceptance, rejection, modification, abandonment, or maintenance of particular behaviors by groups of individuals (i.e., the target audience) (Grier & Bryant, 2005). Social marketing campaigns are developed based on public health theories of behavior change, which assume that awareness, attitudes, beliefs, and intentions need to change before behaviors can shift (Pearson, 2011). The term "social marketing" is often misused in the public health field. Hill (2001) found that health promoters saw social marketing as a promotional or communication activity that did not use the commercial marketing techniques that are the cornerstone of true social marketing. These types of campaigns should be considered as "information awareness campaigns" or "public awareness campaigns." They can be effective in raising awareness and knowledge around a specific topic. Attitude and behavior change, however, are much more difficult to achieve with this method (Your Social Marketer, 2010).

Theories of behavior change that are used in the social marketing planning process also support these guidelines. However, most suicide prevention campaigns—whether social marketing or awareness—have not been sufficiently evaluated to determine whether they reached the intended audiences or resulted in the desired behavior change. Many campaigns have been insufficiently funded and have relied on pro bono, rather than paid placement, with inadequate campaign saturation as a result (Daigle et al., 2006). Those that have been evaluated usually use increased calls to a hotline as their measure of effectiveness (Jenner et al., 2010; Oliver et al., 2008).

In addition, Dumesnil & Verger (2009) conducted an analysis of depression and suicide prevention messaging campaigns in Europe and found that these messaging efforts were more successful when they were focused and sustained, and employed several types of media. Pearson (2011) followed up on Dumensil & Verger's studies by examining U.S. campaigns and agreed with the following:

1) Short-term, broad campaigns are not likely to have a significant impact on any particular group and unintended consequences such as normalization might pose more risk than benefit from the effort.
2) Understanding a target audience's baseline knowledge level, cultural values, and the issue that is most important for the community makes the development of the messages and its implementation more likely to succeed.
3) Sustained and multi-pronged efforts that complement public campaigns are more likely to be successful.
4) Various approaches for pilot testing, such as focus groups, may yield richer results.
5) Implement evaluations to determine the safest and most effective messages and any future media investments.

III. Unique considerations and recommendations for developing suicide prevention messaging campaigns

SAFETY

Messaging on suicide is different from messaging on other public health issues, such as smoking or seat belt use. Irresponsible reporting in suicide prevention social marketing or awareness campaigns can have negative effects on vulnerable populations that could lead to more suicide within the community; this is called the "media contagion" effect. The media contagion effect is based on the behavioral contagion theory, which states that an individual who has a pre-existing motivation to perform a particular behavior (such as to kill oneself) is offset by an avoidance gradient. When suicides are not reported on correctly in the media, it may serve to reduce the avoidance gradient and therefore decrease the internal constraints to performing the behavior (Gould, 2001). In short, irresponsible reporting on suicide in the media or other public venues could serve as an impetus for a vulnerable person to kill oneself by lowering the psychological barriers to doing so.

Exposure to suicide through media as well as the influence of others who have died by suicide can create risk factors for suicide (California Department of Mental Health, 2008). Therefore, suicide prevention social marketing and awareness campaigns should also be cognizant of vulnerable audiences, and how their messages may impact them. It is likely that audience members have experienced a suicide in their life; it estimated that each suicide intimately affects six other people (Shneidman, 1973). Recent evidence (Berman, 2011) suggests that the number of affected survivors varies depending on the person who died by suicide, which estimates as many as 80 individuals can be affected by a single suicide.

Since research has demonstrated that vulnerable individuals can become more likely to attempt suicide when exposed to certain kinds of messages (described in the next section), safety is of utmost importance when developing and implementing a suicide prevention campaign. Effective suicide prevention messaging campaigns are developed with input from community members and survivors through focus groups and questionnaires. Campaign developers use community members and survivors in the development process because of their intimate connection to suicide and their insight into this sensitive topic. While this input is invaluable, developers must recognize that talking about suicide (even in the context of prevention) can be emotionally difficult. For individuals struggling with their own mental health issues, these discussions may trigger reactions.

- **Campaign developers should have resources and counseling services available to assist audience members involved in focus groups and testing who may be experiencing suicidal thoughts or other mental health issues.**
- **Campaign designers should bear in mind how their messages might affect vulnerable audience members, not just the broad audience.**

STIGMA

In addition to contagion, **irresponsible messaging can also lead to the reinforcement of stereotypes, myths, and stigma.** Suicide is highly associated with mental illness, and while stigma toward less severe mental illnesses such as depression and anxiety has lessened over time, fear and stigma against those with more severe mental illnesses such as schizophrenia and psychosis have increased (Your Social Marketer, 2010). Other forms of stigma can include not disclosing that a relative's death was a suicide, and believing that all people with mental illness are incompetent. Exacerbating stigma within these populations can further alienate people from seeking help and receiving support. Isolation and alienation can decrease a vulnerable person's willingness to risk seeking help for their suicidal thoughts and feelings.

Following the consensus recommendations for all forms of messaging that addresses suicide—newspaper articles, radio and TV advertisements, public forums, etc.—will help ensure that media contagion and reinforcement of stigma and stereotypes are limited, while **remaining sensitive to the feelings of the audience and portraying suicide in a respectful manner.**

PLACEMENT

Using data to determine ideal venues for campaign messages is a basic tenet of social marketing. Some campaigns have focused on local "hot spots" with high rates of suicide attempts and/or completions, such as bridges. Although restricting access is ideal in such areas, sometimes that is impossible. Placing help numbers at such locations has had mixed results. King and Frost (2005) found that a simple sign with the number and a brief tagline of support, along with the local press agreeing not to publicize suicides at the location, decreased suicides in particular parks. The National Suicide Prevention Lifeline says that it may be advisable for signs near bridges "to avoid explicitly mentioning suicide." Lifeline supports the dissemination of public education materials and signage, but only as a supplement to, and not a substitute for, bridge barriers. Other research found that only placing signs at bridges resulted in no calls and no change in suicides (Draper, 2008).

RECOMMENDATIONS

Campaign messaging should adhere to the Safe and Effective Messaging for Suicide Prevention:

www.reportingonsuicide.org

All of the following language and framing recommendations are based on "Recommendations for Reporting on Suicide" (Multiple authors, 2011) and SPRC, 2006 as well as other sources, which are named in text.

LANGUAGE recommendations

- **Avoid words such as "committed" suicide, "failed" or "successful" suicide attempt.** "Committed" is usually associated with sins or crimes, and suicide is better understood in a behavioral health context than a criminal context. In addition, "failed"and "successful" suicide implies favorable or inadequate outcomes. Use the phrase "died by suicide" in place of "committed suicide."
- Do not focus on details of how a person died by suicide. This includes excluding suicide notes and other specific details such as location and method of a person's death.

- **Limit use of words such as "suicide" and "stigma."** Suicide prevention experts found that using these words served more to underscore the existence and severity of stigma than to counter it. Focus on creating messages about solutions to stigma and suicide rather than discussing stigma and suicide itself. In some communities the word "suicide" is so stigmatized that the audience will turn away from messages that contain the term (Langford, personal communication). For example, the Veterans Suicide Prevention Hotline has recently been renamed the Veterans Crisis Line in order to reach more veterans and families, who may not consider themselves to be at risk for suicide. www.texvet.org/sites/default/files/blog-attachments/burnett/va_suicide_campaign.pdf)

VISUALS recommendations

- **Avoid use of black and red** in print, broadcast or web design, as these colors are suggestive of death and can elicit strong negative reactions among survivors.
- **Avoid using photographs of specific suicide locations,** such as the Golden Gate Bridge (Multiple authors, 2011; SPRC, 2006).

MESSAGE FRAMING recommendations:

- **Frame suicide as a preventable act.** The National Strategy for Suicide Prevention and the California Strategic Plan on Suicide Prevention emphasize the importance of framing suicide in this manner.
- **Link mental illness with suicide when acceptable to the audience. Emphasize that recovery is possible.** Over 90% of those who die by suicide suffered from a diagnosable mental illness or substance use disorder at the time of their death. The impact of these risk factors can be reduced if the individual is provided effective treatments and are supported in this process by their community. However, there are exceptions to this recommendation. The percentage is much lower (closer to 60%) among adolescents, who are more impulsive. Additionally, some audience members may not identify with mental illness (for themselves or a loved one) and will turn away from the message if the link is over-emphasized.
- **Do not glorify or romanticize suicide** by describing someone who died in this manner as heroic, like "Romeo and Juliet," noble, or so forth.
- **Do not normalize suicide or make it appear common.** Although suicide is more widespread than homicide in many states, it is a relatively rare cause of death within the majority of local communities. Framing it as commonplace may lead to the feeling that it is inevitable or acceptable. Even when suicide is considered a leading cause of death, readers may not realize that this "leading cause" is still a very infrequent event (Pearson, 2011).
- **Do not frame suicide as an inexplicable act or explained as a result of stress only.** Factors leading up to a suicide are multi-faceted and should not be contributed to any single event or feeling.
- **Frame mental illness and suicide in a non-stigmatizing light.** Focus on the facts (Your Social Marketer, 2010). **Do not list "myths and facts" about suicide or mental illness** as a method to reduce stigma around these topics: Research has found that when presented together or sequentially, myths tend to be remembered more than facts, running the risk of spreading misinformation. Simple factual statements increase accurate knowledge retention and positive behavioral intentions over the use of so-called "myth-busting" techniques. Although myths versus facts can be a helpful training exercise, this approach is not appropriate for campaign materials. Use simple factual statements such as "Suicide can be prevented," or "Always take a threat of suicide seriously and get help" while avoiding reinforcing myths (Stout et al., 2008; Schwarz, et al., 2007; Schurz, 2010).
- In public forums, such as websites, personal opinions can be perceived as overly insensitive to the general public and counter the messages of hope and help conveyed in the campaign. In these cases, **websites should be moderated; negative comments should be flagged for review and removed when necessary.** A positive approach to encouraging appropriate online commenting behavior is to encourage readers to create a user profile with a verifiable email address, to hold them accountable for their comments (Multiple authors, 2011).

CALLS TO ACTION recommendations

- Research by Chambers et al. (2005) suggests that the effectiveness of suicide prevention awareness media campaigns can be limited if there are no available supports to turn to after the message is received. It is possible that providing information without resources can be harmful. **Include the National Suicide Prevention Lifeline number [1-800-273-TALK-(8255)] or a local crisis center or hotline as a primary resource.** For youth-targeted messages, research shows that peer-to-peer online chat systems may be effective (Gould et al., 2002), although very few are yet in operation or have been evaluated.
- **Include warning signs of suicide.** Aldrich & Cerel (2009) have found that a key element to suicide prevention is intervention by close others. Some barriers to supporting a friend or family member include not recognizing the problem, not knowing how to approach the person and lack of knowledge of where to seek help (Your Social Marketer, 2010). An increased understanding of how to persuade close individuals to intervene when an individual becomes suicidal is a vital step in suicide prevention. Van Orden et al. (2006) found that reading a list of warning signs was effective in increasing the public's knowledge about and the ability to respond to suicidal crises. Van Orden et al. also found that reading warning signs of suicide did not lead to more stigmatization.

YOUTH recommendations

- **Choose your message channel carefully and pilot test.** Two small studies in Minnesota examined the impact of public service announcements about suicide and its potential benefits and unintended effects on adolescents; Klimes-Dougan & Lee, 2010. The authors found that when ads stated that people should "see their doctor" for help with suicidality, high-risk youth were less likely to express help-seeking intent. Be cautious about use of billboards to reach teens. The billboards were found to be ineffective and could create negative impressions in adolescents. The researchers surmised that billboards may in fact dissuade young people from seeking help because the brevity of a billboard message could be perceived as undermining individual experiences of pain and despair. In the same studies, TV ads showed more effectiveness in increasing awareness about suicide and depression.
- **Provide adult resources for youth.** In another study, evaluators of a three-month school-based intervention in Cincinnati found that the resulting decreased youth suicidal ideation and behavior may have been associated with the program's emphasis on building a sense of school connectedness (King et al., 2011). For example, at three month follow-up, students were more likely to know an adult in school with whom they felt comfortable discussing their problems. This supports the National Longitudinal Study Adolescent Health findings that adolescents' perceived school connectedness was a leading protective factor against student suicidal behavior (Resnick et al., 1997).

LATINOS recommendations

- **Provide additional community resources other than hotlines and health/mental health providers**. Some immigrant populations may be less inclined to turn to formal systems for help, preferring faith providers and other community resources over those affiliated with government agencies or health care (Cabassa et al., 2006) In addition, immigrants and Hispanics were less likely to call suicide hotlines and more likely to call 911 as their first response if someone they knew was suicidal (Larkin et al., 2011). A survey of Californians found more barriers to disclosing depression to primary care providers among Hispanics, females, and those without a family history of depression (Bell et al., 2011). On the other hand, a review of seven studies found that Latinos were less likely than Caucasians with similar mental health problems to visit mental health specialists and instead used general medical providers as their main source of health care (Cabassa et al., 2006).

IV. Summary of recommendations

- Campaign developers should have resources and counseling services available to assist audience members involved in focus groups and testing who may be experiencing suicidal thoughts or other mental health issues.
- Campaign designers should bear in mind how their messages might affect vulnerable audience members, not just the broad audience.
- Campaign messaging should adhere to the SPRC's Safe and Effective Messaging for Suicide Prevention.
- Avoid words such as "committed" suicide and "failed" or "successful" suicide attempt.
- Limit use of words like "suicide" and "stigma."
- Avoid use of black and red.
- Avoid using photographs of specific suicide locations.
- Frame suicide as a preventable act.
- Link mental illness with suicide when acceptable to the audience. Emphasize that recovery is possible.
- Do not glorify or romanticize suicide.
- Do not normalize suicide or make it appear common.
- Do not frame suicide as an inexplicable act or explained as a result of stress only.
- Frame mental illness and suicide in a non-stigmatizing light.
- Do not list "myths and facts" about suicide or mental illness.
- Websites should be moderated; negative comments should be flagged for review and removal when necessary.
- Include the National Suicide Prevention Lifeline number or a local hotline as a primary resource.
- Include warning signs of suicide.
- Choose your message channel to reach youth carefully and pilot test.
- Provide adult resources for youth audiences.
- Provide additional community resources other than hotlines and health/mental health providers for Latino audiences.

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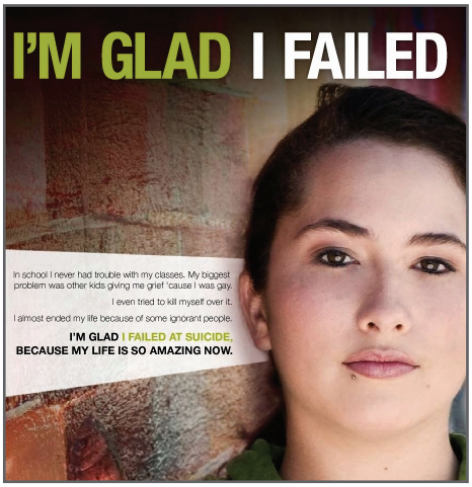
VOLUME 2 | Media Campaign Catalog: Suicide Prevention

CAMPAIGN CATALOG

This section is designed to give a broad descriptive scope of selected suicide prevention awareness and social marketing campaigns throughout the United States. This snapshot is not a historical archive but focuses on current campaigns identified as of November 2011. Although some examples clearly address specific behaviors and barriers, this is not a compilation of best practices. Many campaigns were not evaluated and lack information on any results in terms of reach, resonance with the intended audiences, knowledge gains, or behavior change. Where we could find evidence of an evaluation, we included that information. The catalog is organized by scope, showing national and military campaigns first, followed by state and local campaigns. A few campaigns that are no longer active are included for historical purposes. **Not all campaigns adhere to safe messaging guidelines;** the reader is encouraged to review the catalog entries carefully and contact the campaign organizers for more details as needed. Some additional campaigns in California counties are being identified through a needs assessment process throughout late 2011 and early 2012.

National Campaigns



I'm Glad I Failed

Location: United States
Purpose: To encourage suicide prevention in the LGBTQ community
Media: Research survey, print, billboards, internet, posters, and buttons
Target Audience: LGBTQ teenagers
Evaluation: Not available
Website: www.socialmarketing.com/campaign/i_m_glad_i_failed

Additional Information: This campaign was carried out as a component of the Trevor Project in partnership with Better Word Advertising. An online survey solicited feedback from youth in school.
Key Message: I'm glad I failed at suicide because my life is so amazing now.

Depression: The #1 Cause of Suicide (no longer active)

Location: United States
Purpose: To link suicide to the singular cause of depression
Media: Billboards
Target Audience: General public
Evaluation: Not available
Website: www.afsp.org

Additional Information: This billboard was administered by the American Foundation for Suicide Prevention.

He Saves Lives. You Can Too.

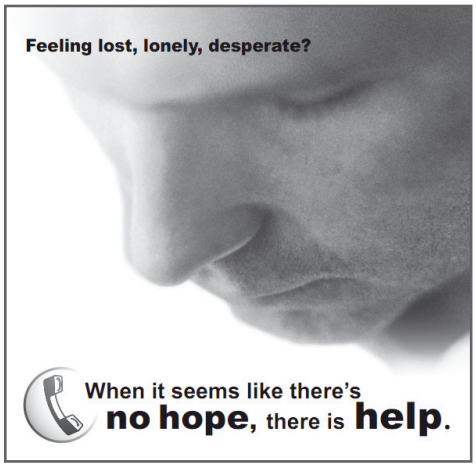
Location: United States, ongoing, SAVE (Suicide Awareness Voices of Education)
Purpose: To educate the public about the symptoms of depression, warning signs of suicide, and the need to seek treatment
Media: TV and radio PSAs, billboards, posters, print ads, classroom curriculums
Target Audience: Gatekeepers (general public)
Evaluation: Not available
Website: www.save.org

Additional Information: This campaign is designed to encourage viewers to regard themselves as being able to save lives, like the firefighters and EMTs portrayed.
Reference: www.save.org/index.cfm?fuseaction=home.viewpage&page_id=3836f2f3-7e90-9bd4-c93aef2b191df58d

Suicide Shouldn't Be a Secret

Location: United States, 2001, American Foundation for Suicide Prevention (AFSP)
Purpose: To prevent teen suicide
Media: TV and radio PSAs, resource guide
Target Audience: Teens
Evaluation: Not available
Website: www.afsp.org (go to educational resources, media campaign)
Secret (60s): www.afsp.org/files/teen//secret.mov
Taking Action (30s): www.afsp.org/files/teen//takingaction.mov

Additional Information: The advertisements target a known barrier to help seeking: it is okay to break the trust of a friend in order to get him or her help for depression and suicide. Research indicated that teens talk with their peers about feeling depressed or suicidal, but these peers often do not know how to help their friends effectively. The campaign raises awareness of teen suicide risk factors for parents, grandparents, siblings, teachers, school counselors, coaches, and other community members and provides information about how to take the next steps in connecting them to help.
Key Message: Suicide shouldn't be a secret.



National Suicide Prevention Lifeline

Location: United States
Purpose: To provide resources and hope for those contemplating suicide
Media: Wallet cards, logos, web banners and buttons, posters, radio PSA, TV PSA, magnets
Target Audience: General public, veterans
Evaluation: Not available
Website: www.suicidepreventionlifeline.org/materials

Additional Information: Because many ads drop in a Lifeline card at the end, it is difficult to tell which ones are originated by the Lifeline. One television spot, which has been around for a couple of years but is still in rotation, features Kevin Hines who survived a jump from the Golden Gate Bridge. (http://www.kevinhinesstory.com) Lifeline is also featured in a PSA from the VA, with actor Gary Sinise, urging veterans to call. It is funded by the U.S. Department of Health and Human Sciences.
Reference: www.suicidepreventionlifeline.org/materials

Military Campaigns

ACT

Location: United States

Purpose: To reach out to suicidal veterans

Media: Workshops, posters

Target Audience: Veterans and active military

Evaluation: Not available

Website: www.public.navy.mil/bupers-npc/support/suicide_prevention/pages/default.aspx

Additional Information: The U.S. Navy conducts this campaign which includes posters designed by sailors (selected through a contest) and warning signs. Materials direct to the Lifeline veterans option. ACT is an acronym standing for Ask, Care, Treat. The campaign is one part of a program that includes 2-day workshops, guidelines, and more. The workshops are intended to provide leadership with available resources and assistance to institutionalize fleet requirements regarding implementation and execution of suicide prevention and awareness polices.

Key Message: Ask, Care, Treat.

Reference: www.public.navy.mil/bupers-npc/support/suicide_prevention/command/pages/posterdownloads.aspx

Have the Courage to Help a Buddy

Location: United States

Purpose: To reach out to active duty soldiers who are suffering from a mental illness

Media: Posters, resources

Target Audience: Active military (Army)

Evaluation: Not available

Website: www.public.navy.mil/bupers-npc/support/suicide_prevention/pages/default.aspx

Additional Information: The U.S. Army created posters for active duty soldiers with the word "courage" hiding in the background, quoting an Army leader and referring to several sources of help. The campaign is supplemented by a leader's guide, pocket guide for spouse and loved ones and other posters with themes "Shoulder to Shoulder: I Will Never Quit on Life," "Don't Deal with a Problem Alone," and "Never Leave a Fallen Comrade."

Reference: http://usaphcapps.amedd.army.mil/hioshoppingcart/searchresults.aspx?hotlist=1

It Takes… a Warrior to Ask for Help

Location: Pilot in Washington, D.C., now expanded to 124 cities; 2009–present, Department of Veterans Affairs

Purpose: Raise awareness among veterans and family members of the VA Suicide Prevention Lifeline

Media: TV, transit, promotional materials

Target Audience: Veterans and their family members

Evaluation: Not available

Website: www.mentalhealth.va.gov/suicide_prevention/index.asp

Additional Information: In response to the specific needs of veterans, the VA has connected its national suicide prevention lifeline to the Lifeline (1-800-273-TALK), so that any veteran calling can press "1" to speak to a counselor experienced in working with veterans. Through the Lifeline website, the VA has also launched a function where veterans can chat anonymously with a VA counselor. The campaign is an effort to publicize these resources to veterans and their family and friends, as well as reducing the stigma of seeking help.

Key Message: It takes the courage and strength of a warrior to ask for help. If you're in an emotional crisis, call the Lifeline (press 1 for veterans).

Yellow Ribbons (no longer active)

Location: United States

Purpose: To draw attention to the toll of suicide in the military

Media: Posters, animated web graphics, yellow ribbons

Target Audience: U.S. citizens and military

Evaluation: Not available

Website: http://wp.yellowribbonamerica.org

Additional Information: Yellow ribbons have been displayed as a symbol to welcome home veterans from combat. This agency-created campaign had a poster and an animated web graphic that attempted to draw attention to the toll of suicide in the military. The yellow ribbon unraveled and tied itself in a noose, with the message "Every Day, Five U.S. Soldiers Try to Kill Themselves." This ad was used for a time by the Kristin Brooks Hope Center.

State Campaigns

Get Right Side Up

Location: Delaware

Purpose: Suicide prevention

Media: Bus posters, DVD, posters, calendars, youth suicide prevention toolkits

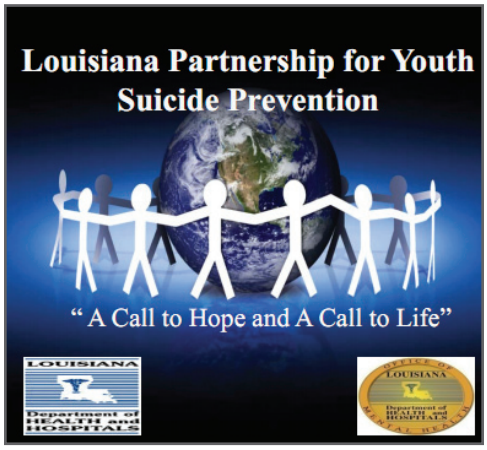
Target Audience: Adults and teenagers

Evaluation: Not available

Website: http://getrightsideup.org

Additional Information: Campaign includes components for teens ("Find balance in an uneven world"), parents ("Your support can help your teen get back on solid ground"), and educators ("Your involvement can help your students get right side up") as well as "community" ("Reaching out to create suicide-safe communities"). This campaign was funded as part of a Garrett Lee Smith SAMHSA grant program.

Reference: http://getrightsideup.org



Youth Suicide. There Is Hope.

Location: Louisiana parishes affected by Hurricane Katrina, 2007–present, Louisiana

Partnership for Youth Suicide Prevention

Purpose: To raise awareness about youth suicide and resources for prevention and intervention

Media: Print, radio, transit, outdoor, PSAs in movie theaters, awareness events,

grassroots outreach in focus parishes

Target Audience: General public living in hurricane-affected areas

Evaluation: Print, billboard, and movie theater ads resulted in increased volume of calls to the local crisis center, while transit and radio ads did not show an increase

Website: www.sprc.org/grantees/statetribe/2009/pdf/7cevanswilliams.pdf

Additional Information: This campaign was funded as part of a Garrett Lee Smith SAMHSA grant program.

Reference: Jenner, E., Jenner, L.W., Matthews- Sterling, M., et al. (2010). Awareness effects of a youth suicide prevention media campaign in Louisiana. Suicide and Life-Threatening Behavior, 40(4): 394–406

It Only Takes One

Location: Illinois
Purpose: Suicide prevention
Media: Print, billboard, web banners
Target Audience: Illinois residents
Evaluation: Not available
Website: www.itonlytakesone.org

Additional Information: It Only Takes One was developed to help create an Illinois where no one is touched by suicide. It is a suicide prevention public awareness campaign funded by the Illinois Department of Public Health and operated by Mental Health America of Illinois.

I Am the Difference

Location: District of Columbia
Purpose: Suicide prevention
Media: Internet, posters, brochures, wallet cards, radio ads
Target Audience: Youth
Evaluation: Not available
Website: www.iamthedifferencedc.org/prevention.html

Additional Information: This campaign encourages youth to speak up when their friends seem depressed because they can make a difference in their lives. It draws awareness to the problem through educating youth about how large of an impact suicide has in D.C. youth and how youth can recognize signs/symptoms in their friends. This campaign was funded as part of a Garrett Lee Smith SAMHSA grant program.

No One Is Better Off Without You. Just Ask Mom.

Location: Michigan
Purpose: Suicide prevention
Media: Billboards
Target Audience: Youth
Evaluation: Not available
Website: www.mlive.com/news/grand-rapids/index.ssf/2011/10/billboards_feature_moms_who_lo.html

Additional Information: Sponsored by Healthy Kent Suicide Prevention Coalition and the Mental Health Foundation of West Michigan, these billboards were displayed around Grand Rapids for a few weeks in October 2011. They show photos of three local mothers who lost their sons to suicide.

If What the World Sees on the Outside…

Location: Minnesota

Purpose: Suicide prevention

Media: Posters, brochures

Target Audience: General public

Evaluation: Not available

Website: www.save.org/index.cfm?fuseaction=home.viewpage&page_id=fdfa295f-e081-2f43-d425ae05ea836d44

Additional Information: Educational brochures for adults and youth are available for community prevention programs, schools, health care professionals, businesses, and for individuals concerned with suicide prevention. These tools provide an opportunity to build community awareness as well as help those in need.

Suicide Proof

Location: Rhode Island

Purpose: Suicide prevention

Media: Website, radio and TV PSAs, brochures, posters

Target Audience: Parents

Evaluation: In a phone survey evaluating the Rhode Island campaign, 72% of parents said it was "very important" to suicide-proof their homes. Of those exposed to the campaign, 33% said they had already made changes to make their homes safer.

Website: www.suicideproof.org/get-involved.html

Additional Information: The goal of this campaign is to encourage parents to suicide-proof their homes. The Suicide-Proofing Initiative is the result of a partnership between the Rhode Island Department of Health and The Center to Prevent Youth Violence. The Suicide-Proof Initiative is based in part on research conducted by the Harvard School of Public Health. Get Materials or learn more at www.suicideproof.org/get-involved.html

Text Today

Location: Nevada

Purpose: Suicide prevention and awareness

Media: posters in school bathrooms, presentations to students and parents, fliers in offices

Target Audience: Students

Evaluation: Available on website

Website: www.sprc.org/grantees/statetribe/2011/2a.pdf

Additional Information: The Nevada Department of Health and Human Services in 2010 conducted a small pilot campaign to advertise "Text Today," its crisis line texting project. This was evaluated with focus groups and cell phone carrier data. This campaign was funded as part of a Garrett Lee Smith SAMHSA grant program.

It's Ok 2 Ask…

Location: North Carolina

Purpose: Suicide prevention

Media: Website, T-shirts, survey, walks

Target Audience: Youth

Evaluation: Not available

Website: www.itsokaytoask.com

Additional Information: The North Carolina Youth Suicide Prevention Task Force, led by the Division of Public Health's Injury and Violence Prevention Branch, developed Saving Tomorrows Today: North Carolina's Plan to Prevent Youth Suicide. The plan was published in October 2004 and offers comprehensive strategies for preventing suicides of youth between 10 and 24 years of age. This campaign was funded as part of a Garrett Lee Smith SAMHSA grant program.

Suicide Prevention: A Florida Imperative

Location: Florida

Purpose: To raise awareness of the toll of suicide in Florida

Media: Billboards

Target Audience: Florida residents

Evaluation: Not available

Website: www.floridasuicideprevention.org

Project THRIVE

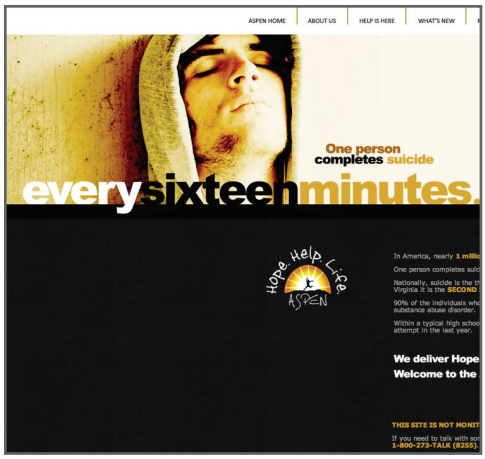
Location: Portland (also available in versions for Idaho, Washington, and Oregon)
Purpose: Suicide prevention and awareness
Media: Logo, posters, wallet cards, T-shirts, window clings, flyers
Target Audience: Teens, Native American community
Evaluation: Not available
Website: www.npaihb.org/epicenter/project/mspi_prevention_media_resources

Additional Information: During 2010, THRIVE worked with a media company to develop a Native American-specific media campaign promoting suicide prevention and awareness. The campaign includes the THRIVE logo, flyer templates, a window cling template, a T-shirt design, posters, and wallet sized tip cards.
Reference: www.suicidepreventionlifeline.org/materials/default.aspx

Suicide is Preventable. Its Causes are Treatable. (no longer active)

Location: Ohio
Purpose: Suicide prevention awareness
Media: Billboards, bus ads, broadcast PSA, posters
Target Audience: General public
Evaluation: See "Additional Information"
Website: Not available

Additional Information: This billboard was part of county campaign with posters, 33 billboards, bus ads, and a broadcast PSA. The visage was "deliberately designed to be of indeterminate age, ethnicity and gender thereby potentially enabling any individual to see himself or herself in the campaign materials." (See Oliver, Spilsbury et al, 2008, SLTB for the evaluation, showing increased calls to the crisis line as a result.)



Hope. Help. Life.

Location: West Virginia

Purpose: Suicide prevention

Media: Interactive website/wall of hope

Target Audience: Students

Evaluation: Not available

Website: http://wvaspen.com/index.html

Additional Information: On September 30, 2006, West Virginia Department of Health and Human Resources' Bureau for Behavioral Health and Health Facilities, in collaboration with West Virginia Council for the Prevention of Suicide and Prestera Center, was awarded approximately $1.4 million for a three-year period through SAMHSA's Garrett Lee Smith Memorial grant in order to fund the Adolescent Suicide Prevention and Early Intervention (ASPEN) Project. The project was specifically developed to provide a comprehensive base support for sustainability of suicide awareness, prevention, and early intervention efforts. Over the last three years, ASPEN has addressed barriers and conditions related to suicide prevention through both direct services in Kanawha County, as well as through marketing and training efforts throughout the state as a whole. Services in Kanawha County touched, at minimum, 300 youth and their families in providing same-day response for identification, suicide assessment, crisis intervention, supportive counseling to increase protective factors, case management, mental health assessment, and referrals to appropriate levels of treatment services. Ultimately, the ASPEN mobile quick-response team services have generated more than 3000 direct contact hours to students throughout the course of the program.

Reference: http://wvaspen.com/wall-of-hope

Local Campaigns

Do You Know Someone Thinking about Suicide?

Location: Cuyahoga County, Ohio, 2005–2006, ADAMHS Board of Cuyahoga County

Purpose: To raise awareness about suicide and encourage community use of crisis services

Media: TV, transit, outdoor

Target Audience: General public (gatekeepers)

Evaluation: Call volume to the crisis center increased during the periods when the
campaign ran

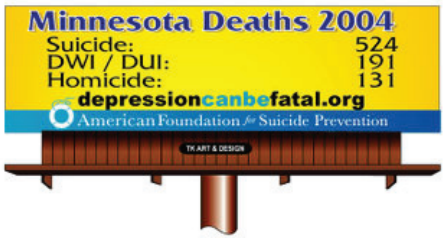
Website: http://adamhscc.org/en-us/video-library.aspx

Additional Information

The county's Suicide Prevention Task Force initiated a campaign to raise awareness about suicide and encourage the community's use of crisis services. The campaign message and accompanying artwork were developed by a gender-balanced, ethnically diverse group that included both suicide survivors and family members of individuals who died by suicide.

Key message: Suicide is preventable. The causes are treatable. For immediate help call (216-623-6888). (Oliver. R.J., Spilsbury. J.C., et al. (2008). Brief report: Preliminary results of a suicide awareness mass media campaign in Cuyahoga County, Ohio. Suicide and Life Threatening Behavior, 38(2): 245–249.)

Reference: http://adamhscc.org/en-us/video-library.aspx



Depression Can Be Fatal

Location: Twin Cities, Minnesota 2007, American Foundation for Suicide Prevention

Purpose: To educate the public about the symptoms of depression and the need to seek treatment

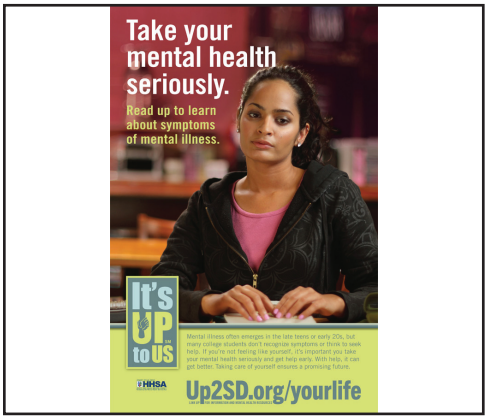
Media: 210 billboards throughout the Twin Cities area

Target Audience: General public

Evaluation: Although this campaign was not aimed at suicidal youth, follow-up evaluation found that high-risk youth responded negatively to the ads, reporting that they felt more suicidal after exposure to the messages

Website: www.depressioncanbefatal.org

Additional Information: Reference SAVE (Suicide Awareness Voices of Education) for further information. www.save.org



It's Up to Us

Location: San Diego and Riverside Counties, California

Purpose: This first-of-its-kind mass media campaign was designed to empower San Diegans to talk openly about suicide and mental illness, recognize symptoms, utilize resources, and seek help. The campaign was grounded in research and each element was tested through focus groups and audience feedback.

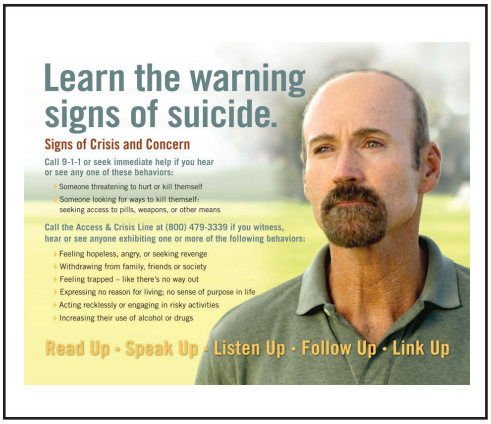
Media: TV, radio, cable, digital, outdoor, print, bulletins, promotional items

Target Audience: General market

Evaluation: Findings from a mid-year awareness study in 2011 indicate that 54% of county residents recalled seeing ads or messages pertaining to mental health challenges or suicide prevention. 83% specifically recognized the "It's Up to Us" campaign. There were significant improvements in knowledge, attitudes, and behavior. There was a 20% and 21% increase in awareness of where to seek help and recognizing the warning signs for suicide, respectively. A significantly larger number of respondents agreed that people with mental illness should be hired just like other people (66% vs. 52%) and stated that they would be willing to socialize (76% vs 64%), or work closely with (67% vs. 59%) a person experiencing mental illness. Since September 13, 2010, there have been over 65,000 unique visitors to the campaign websites and more than 550 calls to the Access & Crisis Line known to be direct results of the campaign. Completed in April 2011.

Website: www.up2sd.org, www.up2riverside.org

Additional Information: The "It's Up to Us" campaign takes a novel approach to suicide prevention based on key findings indicating that depression manifests differently in middle-aged men and that men often don't identify with or respond to traditional mental health language. The "Tough Times SD" microcampaign used messaging around known risk factors (loss of job, financial problems, excessive drinking) rather than emotions to reach this population. Partnerships were formed with key organizations, such as the Suicide Prevention Council and the Access & Crisis Line in order to ensure message alignment and appropriate resource use. Focused on the word "Up," the "It's Up to Us" campaign incorporates the use of "up"-lifting and positive messaging through calls to action to Read Up, Speak Up, Listen Up, Link Up, and the collective responsibility in the campaign name itself.



Tough Times SD

Location: San Diego County, California

Purpose: To raise awareness of warning signs and risk factors for suicide and encourage help-seeking behaviors specifically for middle-aged men experiencing tough times.

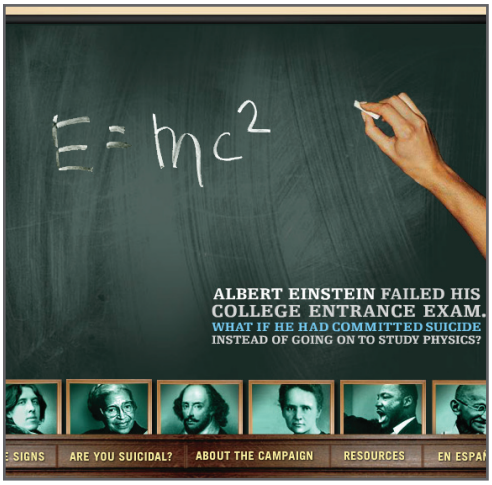
Media: TV, cable, radio, outdoor

Target Audience: Middle-aged men

Evaluation: Not yet available

Website: www.toughtimessd.org

Additional Information: Tough Times SD is a microcampaign spin-off of the "It's Up to Us" suicide prevention and stigma reduction campaign in San Diego County. It specifically targets middle aged men through a different approach. Key research findings indicated that depression manifests differently in middle-aged men, and that men often do not identify with or respond to traditional mental health language. The Tough Times SD campaign uses messaging around known risk factors (loss of job, financial problems, excessive drinking) rather than emotions to better reach this priority population. At-risk men are often disconnected from support networks, and they frequently do not seek help from health care or mental health providers. Focus group testing assured that men would call the Access & Crisis Line and respond to the campaign materials. Media strategy differed for the male-specific target than the general market campaign. Spots were strategically placed on radio stations, cable networks, and specific programming with greater male audiences such as an NFL football TV package. This strategy aided in reaching this under-served population. A targeted microsite was created as well: www.toughtimessd.org



Don't Erase Your Future

Location: UC Irvine; University of Colorado at Boulder; Universidad de Puerto Rico en Cayey; Regis University

Purpose: To encourage suicide prevention among college students

Media: Print, posters, internet, out of home

Target Audience: College students

Evaluation: Not available

Website: www.donteraseyourfuture.org

Additional Information: This campaign was funded by the SAMHSA Garrett Lee Smith grant program with an overall goal to prevent suicide by promoting a campus norm that honors achievement and competition while encouraging and allowing students to seek support when it is needed. The campaign was launched across four universities.

Reference: www.donteraseyourfuture.org/images/donterasefuture_posters.pdf

National Web Based Outreach Tools

- The National Suicide Prevention Lifeline Gallery website features suicide survivor stories presented by avatars. Users can create and design the appearance of their avatars, write a description about their experiences with suicide, and then record their voices or choose a computer-generated voiceover to tell their stories. The innovative use of these avatars provides a personalized, interactive experience while helping users maintain anonymity (Luxton & Kinn, 2011).
  Website: www.lifeline-gallery.org)

- SecondLife is an online virtual world that enables users to interact with each other via avatars. The Survivors of Suicide project has a SecondLife simulation that provides suicide prevention information and support. Visitors who are coping with loss due to suicide can light virtual remembrance candles in honor of their loved ones (Luxton & Kinn, 2011)

- YouTube has also been widely used as a platform to promote suicide prevention messages and personal stories. Most notably, the "It Gets Better Project" allowing people to post personal stories of hope and perseverance for LGBTQ youth. This campaign uses a combination of blogs, video testimonials, and other social marketing components to encourage the LGBTQ community that there is potential for success and happiness.
  Website: www.itgetsbetter.org
  Key Message: You are not alone. It will get better.

VOLUME 3 | Baseline Study Regarding Knowledge, Attitude, and Perceptions of Suicide

California Statewide Awareness of Suicide

Results from a telephone survey

Prepared for AdEase

1/20/2012

action research

Research • Social Marketing • Results

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Executive Summary

Sample and Methods

The present survey assessed baseline responses from residents of California with regard to attitudes and knowledge about suicide and suicide prevention. A sample of 2,003 respondents completed the telephone survey. Overall responses were assessed and then survey items were broken down by demographic variables to look at differences in knowledge and attitudes across groups of interest. Key findings and recommendations are presented below. Between September 26, 2011 and October 20, 2011 telephone interviewers collected information from 2,003 residents of California 18 years of age or older using a CATI system. Based on the 2010 Census data with a total population in California of 37,253,956, the sample size of 2,003 provides a 99% confidence level (+/- 2.9%) that the sample is representative of the target population. Quotas were computed and tracked to insure that the sample contained both urban and rural respondents and respondents representative of all 6 regions of California were included to ensure that respondents were gathered from all counties. Twelve percent (N=241) of interviews were conducted in Spanish. See Tables A and B for a comparison of sample and California population percentages for regions and demographic groups.

Table A. Population and Sample Frequencies for California Regions.

Region	CA Population %	Sample %	N
Bay Area	19.9	19.2	357
Central Valley	6.3	6.0	112
Los Angeles	26.6	27.5	512
North/Mountains	3.3	4.0	74
Southern California	30.9	30.8	574
Southern Farm	12.9	12.5	232

Table B. Population and Sample Frequencies for Demographic Variables.

Demographic Variable	Sample Percent	N	CA Population Percent
Male	39%	780	49.7%
Female	61%	1218	50.3%
Age 18-24	10.5%	210	13.0%
Age 25-64	62.5%	1252	70.0%
Age 65+	16.3%	326	17.0%
Veteran/active military	9.3%	180	6.0%
Never in military	90.7%	1747	94.0%
Urban/Suburban	84.4%	1512	83.0%
Rural	15.6%	280	17.0%
Parent of child aged 10-24	34.1%	659	21.0%
American Indian/Alaska Native	0.7%	14	1.%
Asian	5.6%	105	13.0%
Black/African American	7.1%	134	6.2%
Hawaiian/Pacific Islander	0.6%	13	0.4%
Hispanic /Latino	31.5%	593	37.6%
White	48.2%	908	40.1%
Other	7.7%	145	4.9%

In addition, respondents were asked whether they knew someone who had attempted or died by suicide. Just over half (51.2%, N=1016) said that they did have personal experience with suicide.

Key Findings by Survey Topic

Perceived support from friends and community

In order to assess which groups might benefit from more outreach, several survey items looked at whether respondents felt supported by their families and communities in discussing the potentially sensitive topic of suicide. Overall, people felt that their families (80.3%, N=1531) and communities (72.2%, N=1331) would be supportive. They also disagreed that suicide was not something that could be discussed in their families (62.6%, N=1210).

Knowledge about suicide prevalence and prevention

Another set of questions looked at respondents' knowledge about suicide. Specifically, items assessed their perception of suicide prevalence and the degree to which suicidal individuals usually present warning signs and opportunities to intervene. Most respondents indicated that they saw suicide as a problem in California. They also felt that suicide is preventable, that individuals show warning signs and that intervention can be effective. Respondents overall were less certain about the relative prevalence of suicide versus homicide, whether most people who talk about suicide are serious and whether or not most suicidal individuals tell anyone before ending their lives. See Figures A and B.

Knowledge of suicide warning signs

An open-ended question asked respondents whether they knew up to three warning signs of suicide. Over 80% of all respondents provided at least one warning sign. The three most commonly cited signs were depression, talking about suicide or death, and social isolation. See Table C. "Anticipating death" included giving away possessions, buying insurance, or making a will. Those with personal experience of suicide were more likely to give at least one warning sign. These results suggest that people recognize depression as an important risk factor, but might benefit from more information about other warning signs and behavioral indicators.

Table C. Warning Signs.

Warning Sign	% for Sign 1 N=1615	% for Sign 2 N=1461	% for Sign 3 N=1158
Depression	40.7	17.9	11.1
Anticipating death	8.8	5.1	4.2
Talking about suicide	18.2	19.2	16.8
Substance abuse	1.5	4.0	6.0
Planning/attempt	2.0	3.4	5.5
Isolation	12.6	21.0	16.9
Appetite/sleep disturbance	1.3	2.9	2.9
Self harm	2.1	1.8	2.8
Mood changes	5.8	13.3	14.2
Behavior changes	3.7	6.8	11.1
Other	3.4	4.6	8.2

Perceived efficacy and skills for approaching a suicidal individual

The majority of respondents (77.5%, N=1523) said that they had confidence in their ability to discuss suicide with someone they care about. However, over a quarter of all respondents also felt that this would be difficult to do or a source of worry for them. See Figure A.

Results of regression analysis showed that knowledge about resources was significantly associated with greater confidence in ability to discuss suicide. Those who agreed that they know where they could seek help for a friend or family member (See Appendix A, item 11), were 7.8 times more likely to agree than to disagree that they felt confident. Those who agreed that they know of suicide crisis line they can call (See Appendix A, item 14) were 2.8 times more likely to agree that they felt confident. Those who agreed that they know where to find assistance if a friend was having thoughts of suicide (See Appendix A, item 17) were 6.6 time more likely to agree that they felt confident in their ability to discuss suicide.

Regression analyses were also used to look at the relationship between demographic and other variables and confidence. Those who knew at least one warning sign of suicide were 2.2 times as likely to agree that they felt confident in their ability to discuss suicide. Those in the youngest age group (18 to 24) were 2.7 times more likely to say that they felt confident. Women were 1.4 times more likely to

say that they felt confident. Finally, those with personal experience of suicide were 1.5 times more likely to say that they felt confident.

Actions in response to a suicidal friend or family member

Almost 90% of respondents agreed that they would express concern if a friend or family member was having thoughts of suicide and most also disagreed that it would be none of their business. Knowledge of warning signs was associated being more likely to agree that they would take a specific action in response to concern about a friend or family member who might be considering suicide. See Table D. In response to an open-ended question about what other help they might offer, those who did not report knowledge of any warning signs were significantly more likely to say they would offer nonspecific help or pray.

Table D. Specific Actions by Knowledge of Warning Signs.

Survey Item	Knows signs	Does not know signs
Likely to visit a website for information.*	82.0%	72.1%
	(1359)	(178)
Likely to call a crisis line or hotline.	85.6%	82.2%
	(1444)	(208)
Likely to provide them with a phone number or other resource.*	93.5%	87.9%
	(1579)	(225)
Likely to express your concerns to them.*	94.7%	88.1%
	(1597)	(222)
Likely to express your concerns to someone else.*	92.5%	85.3%
	(1560)	(221)

***p<.01**

Figures A and B show the overall responses for Knowledge, Efficacy, and Action questions. Figure A highlights those questions where we are seeking to maximize levels of agreement and Figure B shows areas where we seek to increase disagreement.

Figure A. Knowledge, Efficacy and Action Items: Agreement Desirable.

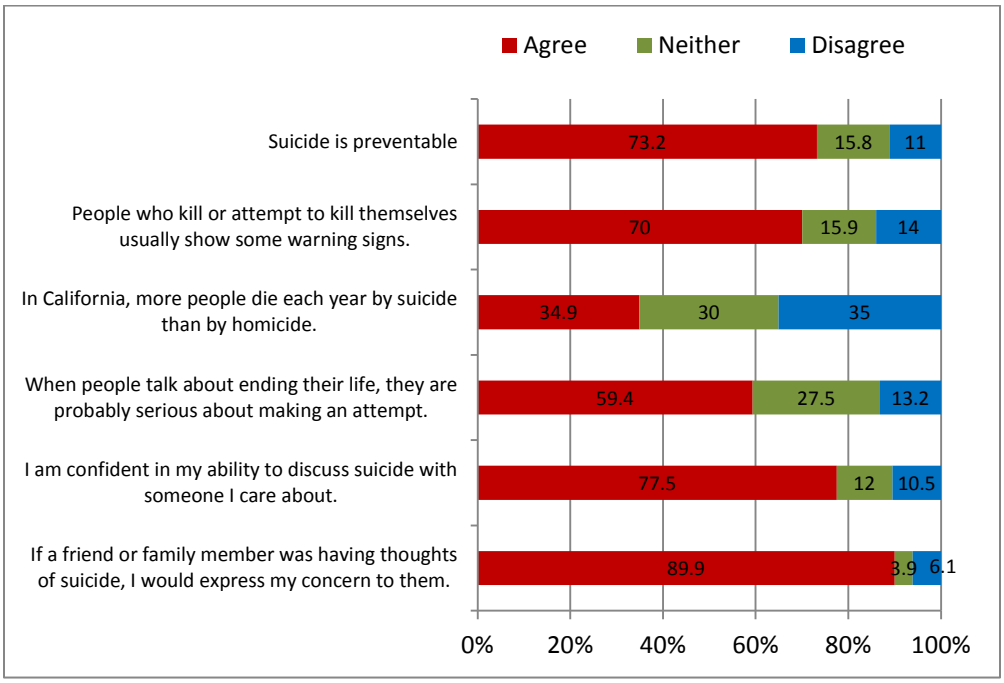
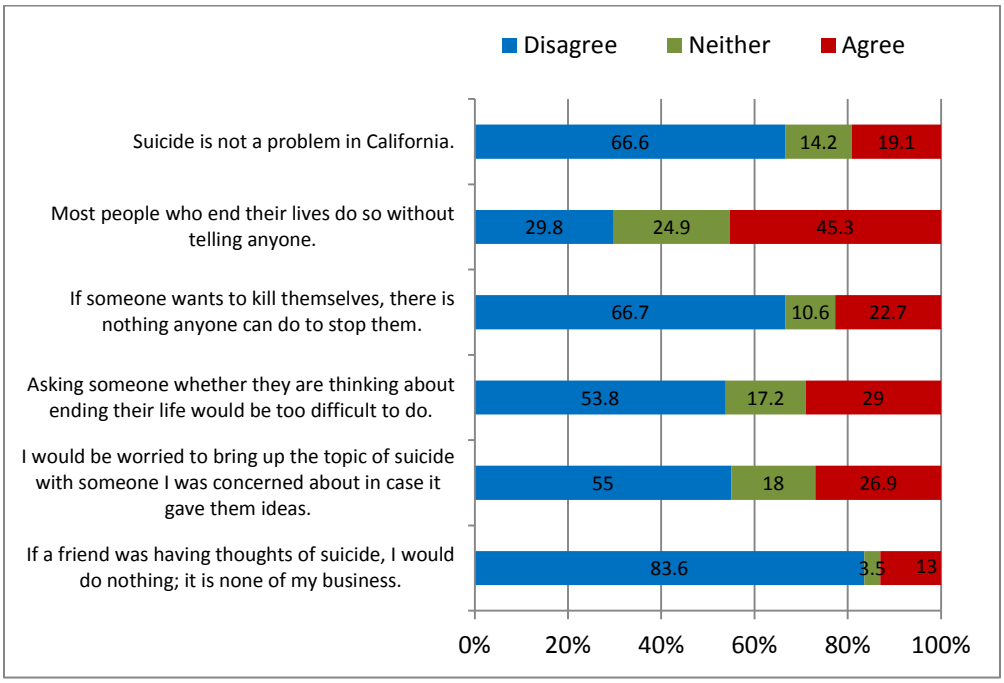


Figure B. Knowledge, Efficacy and Action Items: Disagreement Desirable.



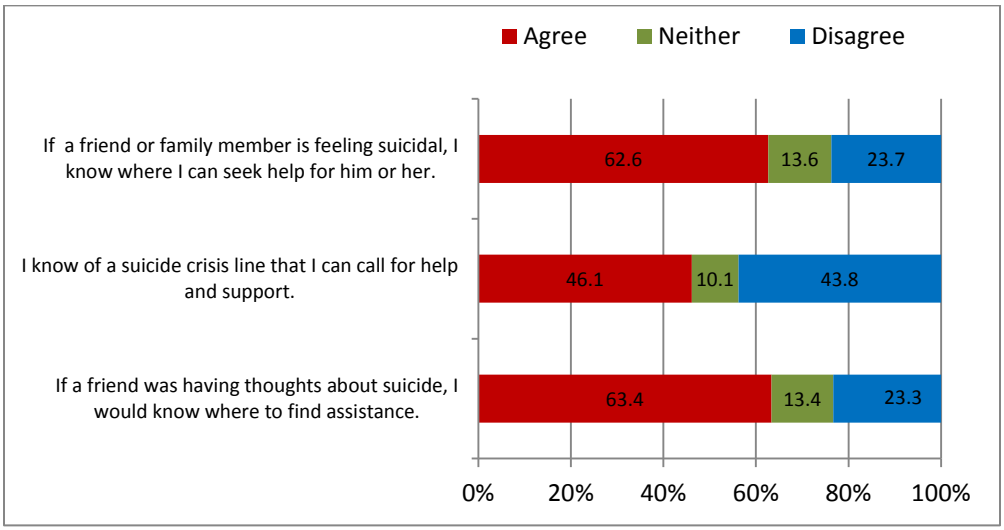
Knowledge about suicide prevention resources

Overall, respondents felt that they knew where to seek assistance for a suicidal friend or family member. However, they were evenly divided about knowing a suicide crisis number to call. Knowledge of prevention resources is a potential target for improvement, however, since almost a quarter of participants indicated that they did not know where to seek help or assistance. See Figure C.

Respondents were asked if they had heard of the National Suicide Prevention Lifeline, 1-800-273-TALK or 1-800-273-8255. They were fairly evenly split in responses with 46.0% (N=887) saying "Yes" and 54% (N=1043) saying "No."

More respondents said "Yes" there was a number other than 9-1-1 that they could call than said "No" (40.7%, N=808 vs. 24.9%, N=495). However, a substantial number of respondents said that they did not know whether there was such a number or not (34.4%, N=683). Overall, 29.5% (N=568) of participants reported being aware of support groups for those coping with suicide.

Figure C. Suicide Prevention Resource Items.



Key findings for Demographic Variables

Race/Ethnicity

Across survey categories Hispanic/Latino and Asian respondents showed the most significant differences from other groups. Asian and Hispanic/Latino respondents were significantly less likely than other race/ethnic groups to feel that they would be supported by family and community in discussing suicide. Hispanic/Latino respondents were also significantly more likely to say that a friend's thoughts of suicide were none of their business. Asian and Hispanic/Latino respondents were significantly more likely to report that they would find it difficult or worrisome to approach a suicidal individual. Hispanic/Latino respondents reported significantly more TV exposure to messages about suicide than other groups and Whites less exposure. However, in spite of this, Hispanic/Latino, and Asian respondents were significantly less likely to have heard of the National Suicide Lifeline, and Hispanic/Latino respondents were significantly less likely to provide at least one warning sign for suicide. This suggests that these groups might be most profitably targeted in increasing public exposure to information about resources. Language may be one of the barriers for some groups.

One other finding was that Black/African American respondents were significantly less likely to believe that more people die each year by suicide than homicide. This belief difference may be related to overall higher homicide rates for Blacks/African Americans, but there is no direct evidence for this provided by the survey. However, Blacks/African Americans expressed significantly more confidence than other

groups about their ability to discuss suicide, their willingness to express concern and their willingness to provide resources such as a phone number.

Age

Overall, respondents in the oldest age group, aged 65+, were significantly less likely to feel that suicide is preventable and that they could be effective in helping someone they care about. They were significantly less likely to agree that suicide could be discussed in their families and communities than were other age groups. Individuals 65 and older also expressed significantly more concern about the difficulty of discussing suicide with a friend or family member and less confidence in their ability to intervene. They were also significantly more likely to say that a friend's thoughts of suicide were none of their business. Finally, those aged 65 or older were significantly less likely to provide at least one warning sign for suicide in response to an open-ended question.

Those in the youngest age group, aged 18 to 24, were significantly more likely to feel that suicide is preventable, to disagree that suicidal people tend not to tell anyone and to disagree that talking about suicide might give someone ideas. They were significantly more positive than other age groups about media messages: They were significantly more likely to say that news stories were helpful in knowing how to prevent suicide and less likely to feel that they sensationalized suicide. They were also significantly more likely to indicate that they would visit a website for information. However, they were significantly less likely to report knowing a number to call if they were concerned about someone.

Both older respondents, those aged 65+, and younger respondents, those aged 18-24 were significantly more likely to recall messages from the newspaper or internet. However, these media were combined in the survey item and it would be useful in future to assess them separately.

Gender

Overall, women were more knowledgeable about suicide, more confident in their ability to discuss it, and more aware of the resources available than were men. Women were significantly more likely to agree that more people die by suicide than by homicide and that people who talk about suicide are probably serious about making an attempt. Men, significantly more than women, felt that asking someone whether they were thinking about ending their life would be too difficult, and they had significantly less confidence in their ability to discuss it. Responses showed that men were significantly less likely to have heard of the National Suicide Prevention Lifeline or any resource number. Women were significantly more likely to agree that they often see stories about suicide on TV. Women were also significantly more likely to indicate that they know were to find help and support for themselves or for someone contemplating suicide.

Veterans/Active Military vs. Non-Veterans

Differences between those with current or past military experience and others in the sample were concentrated in the areas of media exposure and informational resources. Veteran/Active Military respondents reported significantly less exposure to TV messages about suicide. They were also

significantly more likely to feel that suicide in the news is sensationalized and less likely to feel that news stories can help prevent suicide. Non-Veterans were significantly more likely to say that they would visit a website for information about suicide if they were concerned about someone.

Parents of children aged 10 to 24

Overall, parents of children 10 to 24 did not differ from the rest of the sample. However, they were significantly more likely to agree that suicide is preventable than those who were not parents of children in the relevant age range. More research would be required to determine the possible sources of this belief.

Rural vs. Urban/Suburban

Rural respondents were significantly more likely to feel that they would have less family support in discussing suicide. Rural respondents also expressed significantly more concern about their efficacy and less confidence in their ability to discuss suicide. This might be related to the fact that Rural respondents were significantly less likely to feel that those who attempt suicide show some warning signs. They were also significantly more likely to be concerned that bringing up suicide might give someone ideas. Finally, Urban/Suburban respondents were more likely to disagree than were Rural respondents that they would do nothing in response to a friend's thoughts of suicide.

Personal experience with suicide

Just over half (51.2%, N=1016) of the respondents said that they did have personal experience with suicide. Personal experience with suicide was associated with greater overall knowledge and awareness about the facts and resources surrounding the topic. Those with experience were significantly more likely to feel that their families and communities would be supportive. They were significantly more likely to be aware of suicide as a problem in California, but to feel that it is preventable. They expressed significantly greater confidence in their ability to bring up the topic of suicide and to discuss it with someone they were concerned about. They were significantly more likely than others to have knowledge of at least one warning sign and were more likely to report that they knew of a number to call other than 9-1-1, and also that they would know where to find support groups and assistance than were those who had not been through that experience. Finally they were significantly more likely to agree that they would express their concern to someone having thoughts of suicide and to disagree that a friends thoughts of suicide were none of their business. One unexpected finding that might be explored in planning future informational campaigns was that those with personal experience of suicide were significantly less likely to agree that media messages are helpful in suicide prevention.

Regions of California

Significant difference across regions of California centered on Knowledge and Media items. Those in the Bay Area were significantly more likely to agree that suicide is a problem in California and is more prevalent than homicide. Those in the Los Angeles area were significantly less likely than those in other regions to agree that suicide is a problem and more likely to say that most people who end their lives do

so without telling anyone. However, those in the Los Angeles region were significantly more likely to agree that they often see stories about suicide on TV, while those in the Bay Area and Northern/Mountain regions were less likely to do so. In contrast, those in the Los Angeles region were significantly less likely to agree that they often see newspaper or Internet stories about suicide.

Exposure to and recall of media messages about suicide prevention

Respondents were asked whether they recalled seeing stories about suicide on TV or in newspapers or on the Internet and whether they felt such stories were helpful. Only about 36% agreed that they often saw stories in the media about suicide. However, about half (49.6%) did feel that news stories can be helpful for suicide prevention, although 41.7% also felt that suicide is sensationalized in the news.

Recall of media campaigns

A key finding was that over 70% of respondents reported that they did not recall seeing any media message related to suicide in the past several months. Among those who reported having seen any messages related to suicide, TV was the most prevalent source cited. There were no differences reported across the regions of California in recall of exposure to media campaigns. The youngest group of respondents (aged 18 to 24) and those with personal experience of suicide were most likely to recall having seen a message.

The most common content recalled from messages was the presence of a phone number to call. However, respondents were not asked to recall the specific number or sponsor for the message. The second most common message carried away was that suicide is preventable and that friends and family members should reach out to those at-risk.

Conclusions

Taken together response patterns for the survey suggest that several groups might benefit from greater outreach of suicide prevention information and resources. Hispanic/Latino and Asian respondents, those aged 65 or above, and Rural respondents were most likely to hold attitudes that might inhibit them from reaching out to a suicidal friend or family member. These groups also seemed to be reached less often by media messages. Men, as a group, might also benefit from campaigns to increase their knowledge about suicide prevention and confidence in their ability to intervene. Finally, results suggest that increasing the frequency of media outreach may be called for, since most respondents did not recall having seen a recent message. TV appears to be the most memorable medium for messages, but those respondents who did recall a message cited a wide variety of sources.

Factors that Influence Personal Intervention

- Those who knew of a crisis line or other source of assistance were significantly more confident in their ability to discuss suicide with someone they were concerned about, more likely to express concern, and more likely to disagree that a friend's thoughts of suicide were none of their business.
- Those reporting knowledge of at least one warning sign were significantly more likely to agree that they could discuss suicide and less likely to agree that it was none of their business.

- Personal experience with suicide was associated with significantly greater confidence in ability to intervene and less likelihood to agree that a friend's thoughts of suicide were none of their business.

Results of the California Statewide Awareness of Suicide Survey

Background

Research has led to a consensus on the warning signs of suicide (Rudd, et al., 2006), but there is a need to know more about whether the general public is aware of what these signs are. In addition, individuals may vary in their attitudes and beliefs about the appropriateness and effectiveness of intervening when someone they know is showing warning signs. Finally, effective prevention at the level of a public information campaign depends partly on assessing how well public service messages on suicide prevention are being disseminated.

The present survey supplies California statewide baseline data regarding beliefs and attitudes about suicide, media coverage of suicide, knowledge about warning signs of suicide, and awareness of suicide prevention resources. Exposure to and recall of media messages about suicide prevention was also assessed. Finally, respondents were asked whether they had personally known someone who had died by or attempted suicide. A breakdown of the survey topics by gender, age and ethnic group is provided, as well as analysis by groups associated with proportionately higher risk of suicide such as veterans/active military, parents of children in the age group of 10 to 24, and those living in rural areas(California Department of Mental Health, 2008). See Appendix A for the full text of the survey.

Methods

Between September 26, 2011 and October 20, 2011 telephone interviewers collected information from 2,003 residents of California 18 years of age or older using a CATI system. Based on the 2010 Census data with a total population in California of 37,253,956, the sample size of 2,003 provides a 99% confidence level (+/- 2.9%) that the sample is representative of the target population. Quotas were computed and tracked to insure that the sample contained both urban and rural respondents. The definition of urban and rural was based on the California Department of Healthcare Services definition, which specifies a county as rural if 80% of its landmass is rural. In addition, respondents representative of all 6 regions of California (based on the California Department of Social Services recommended groupings) were included to ensure that respondents were gathered from all counties (California Department of Social Services, Research and Development Division, 2002). The sample was also tracked to obtain cross-section of race/ethnicity, gender, past or current military service, age, and parental status. See Appendix B for Urban versus Rural Classifications by county and Appendix C for a breakdown of the 6 regions by county, including a comparison of population and sample percentages. Table 1 shows a comparison of the sample by region to population percentages for each California region. To account for the increasing number of wireless-only households, wireless numbers were included in the sampling method and individuals were invited to participate if the cell phone contacted was not used primarily for business purposes. Twelve percent (N=241) of interviews were conducted in Spanish.

Table 1. Sample by California Regions.

Region	CA Population %	Sample %	N
Bay Area	19.9	19.2	357
Central Valley	6.3	6.0	112
Los Angeles	26.6	27.5	512
North/Mountains	3.3	4.0	74
Southern California	30.9	30.8	574
Southern Farm	12.9	12.5	232

Survey

The survey instrument used in this study was an adaptation with permission of the Kentucky Statewide Awareness of Suicide survey developed by Julie Cerel and Rosalie Aldrich. The survey contained items assessing experience with suicide, as well as attitudes and awareness of issues surrounding suicide prevention. These included Likert-type scaled items pertaining knowledge and attitudes about media coverage of suicide, preventability and warning signs, community attitudes, suicide prevalence, and seeking help for someone else. Respondents were also asked about their knowledge of available resources for suicide prevention. Open-ended items assessed knowledge of the specific warning signs of suicide and memory for the content of ads or messages related to suicide that participants might have encountered. See Appendix A for the complete survey.

Demographic Variables

Table 2 shows the sample breakdown for demographic groups responding to the survey in comparison with the 2010 Census data for California. Overall, the sampling method was successful at achieving an appropriate cross-section. Asian respondents were someone under-represented, however, possibly due to language or cultural factors. Respondents were asked to provide their birth year, and age was computed from this response; however, 10.7% (N=215) percent declined to give their birth year. This response rate is typical of survey research with regard to personal information. Veteran/active military status includes any current or past military service, including reserves. The median age was 48 years with a range from 18 years old to 97 years old.

Interviewers were instructed when contacting respondents to ask to speak to a random member of the household 18 years of age or older in order to increase the likelihood of obtaining an approximately equal number of male and female respondents. In spite of this precaution, surveys were completed by significantly more women than men. This has been found to be typical for both mail and phone surveys (Moore & Tarnai, 2002). For this reason, analyses involving gender were weighted by the known population proportion.

In addition to the above variables, a survey item asked respondents if they knew someone who had attempted or died by suicide. Just over half (51.2%, N=1016) said that they did know someone. Because there were many significant differences on survey items between those with experience of suicide and those without, this variable has been included in the demographic analyses below.

Table 2. Percentages for Sample Demographic Variables Compared to California Population.

Demographic Variable	Sample Percent	N	CA Population Percent
Male	39%	780	49.7%
Female	61%	1218	50.3%
Age 18-24	10.5%	210	13.0%
Age 25-64	62.5%	1252	70.0%
Age 65+	16.3%	326	17.0%
Veteran/active military	9.3%	180	6.0%
Never in military	90.7%	1747	94.0%
Urban/Suburban	84.4%	1512	83.0%
Rural	15.6%	280	17.0%
Parent of child aged 10-24	34.1%	659	21.0%
American Indian/Alaska Native	0.7%	14	1.%
Asian	5.6%	105	13.0%
Black/African American	7.1%	134	6.2%
Hawaiian/Pacific Islander	0.6%	13	0.4%
Hispanic /Latino	31.5%	593	37.6%
White	48.2%	908	40.1%
Other	7.7%	145	4.9%

Measures

Survey items were divided into 6 categories. Questions addressing *Support/Environment* asked respondents about attitudes within their communities and families concerning suicide and suicide prevention. *Knowledge* questions addressed participants' level of factual information about suicide. *Media* items looked at experience with and recall of information presented about suicide in the media. *Efficacy/Skills* questions were aimed at participants' perception of their own ability to discuss or approach the issue of suicide with someone they were concerned about. *Resources* questions addressed knowledge of specific sources of help such as suicide hotlines or support groups. Finally, *Action* questions looked at survey respondents' perceived likelihood of taking specific actions in response to another person who might be contemplating suicide. The following sections will present overall frequencies for respondents. Where there were significant differences across demographic categories, these will also be discussed.

An open-ended question asked participants to indicate whether they could name any warning signs that might indicate that someone was thinking of ending their life. If they were able to name one sign, interviewers probed to see if they could name up to two more signs. One research question was

whether those who were aware of suicide warning signs would differ from those who could not name any signs in terms of actions they would be likely to take in response to a person at risk. Because preliminary analyses indicated that there were significant differences for these two groups, results will be reported separately where significant differences were found.

Other open-ended items asked what further actions respondents might take other than the ones already specified in the survey items, and what content they recalled from messages heard or seen in the media related to suicide or suicide prevention.

Results

This section describes the results for the survey items by question topic, broken down by demographics. Descriptions of results include only those differences that reached statistical significance**. It is important to note that in some cases percentages of comparable size did not achieve significance due to small cell sizes or lack of response variability for that comparison. Probability (p) values denote the statistical likelihood that a particular significant difference occurred by chance. Lower p values represent less likelihood of a difference having occurred by chance.**

Support/Environment

Table 3. Overall Responses to Support/Environment Questions

Question	Disagree	Neither Agree nor Disagree	Agree	Don't Know/Refuse
Q1. Suicide is not something I can talk about in my family	61.3%	10.2%	26.1%	2.5%
	(1227)	(204)	(522)	(50)
Q4. People in my family, in general, would support my decision to talk to someone who I thought was suicidal.	11.4%	7.2%	77.5%	3.9%
	(228)	(145)	(1552)	(78)
Q8. People in my community, in general, would support my decision to talk to someone who was suicidal.	10.7%	14.6%	67.1%	7.6%
	(215)	(292)	(1344)	(152)

Table 3 shows overall responses to survey items addressing perceptions of how participants felt their communities and families might respond to their concerns about suicide. Questions asked whether or not respondents felt that suicide was a topic that could be openly discussed and approached in their families and communities.

There were differences between Racial/Ethnic groups on all three Support/Environment questions. See Figures 1 through 3. Hispanic/Latino and Asian respondents were significantly more likely to agree that suicide is not something that can be talked about in their families. Asians and Native Hawaiians/Pacific

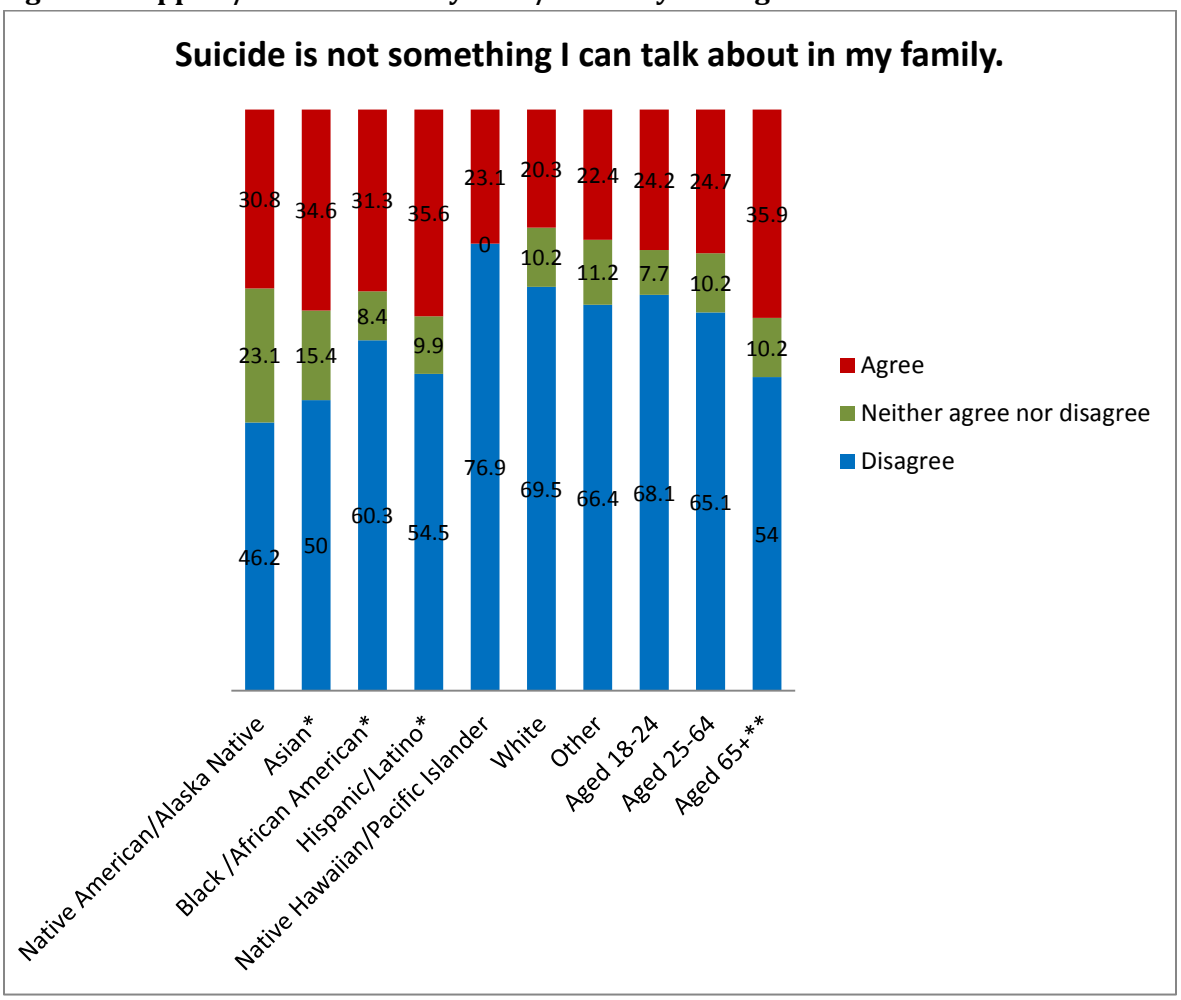
Islanders were significantly more likely to disagree that their families would support a decision to talk to someone who was suicidal, while Whites were significantly less likely to disagree with this statement. Finally, Asians and Hispanic/Latino respondents were significantly more likely to disagree that their communities would be supportive, while Whites were significantly less likely to disagree.

People 65 years or older were significantly more likely to indicate that suicide was not something they could talk about in their families. However, although the majority of respondents felt that their families and communities would support their decision to talk to someone they were concerned about, respondents aged 65 and older were significantly more likely than those in other age groups to disagree with these statements. See Figures 1-3.

Rural respondents were significantly more likely than Urban/Suburban individuals to agree that suicide could not be discussed in their families. However, they did not differ from each other on responses to the other questions in this category. See Figure 4.

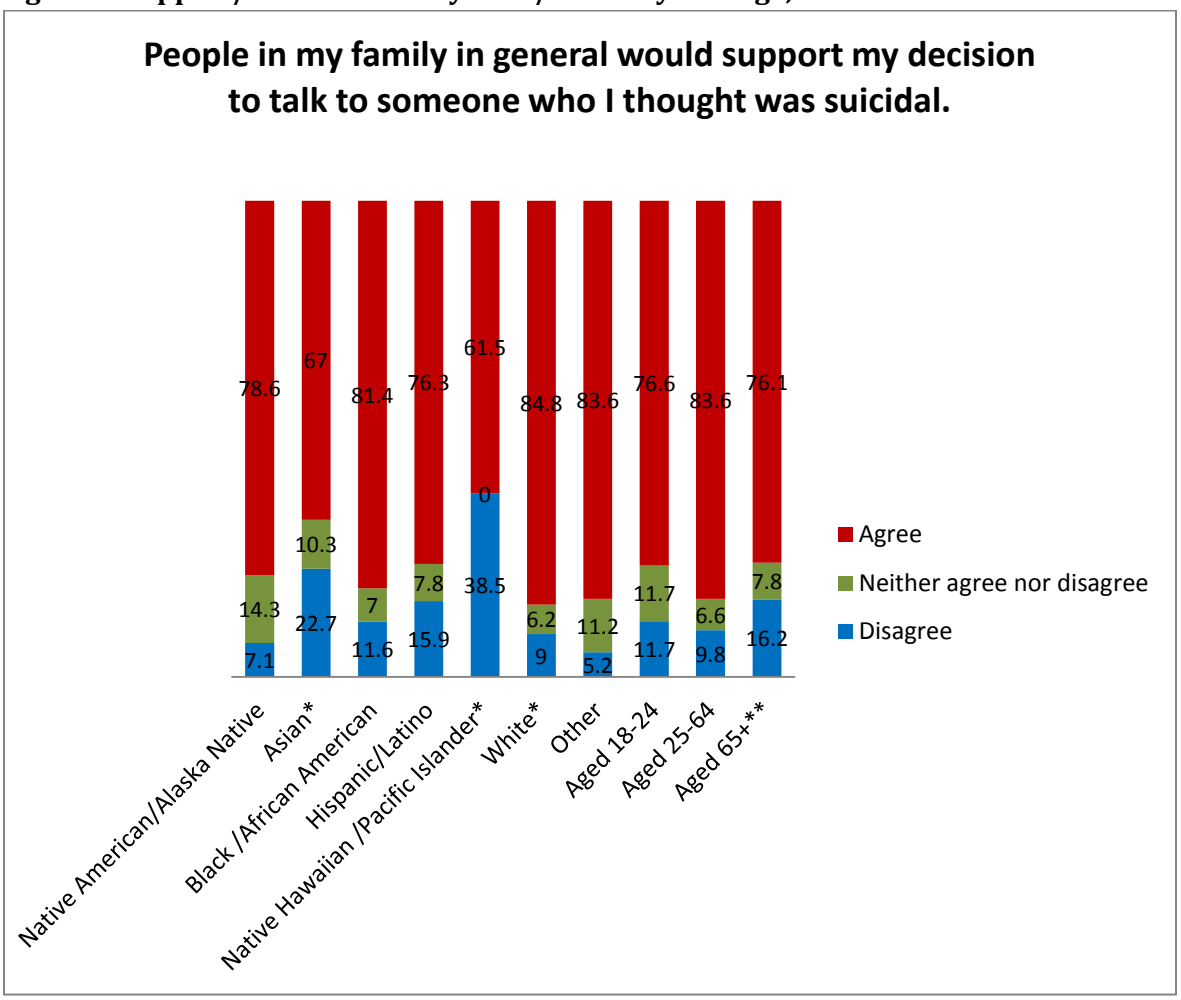
Persons with experience of suicide differed from those with no experience on all three Support/Environment questions. They were significantly more likely to disagree that suicide is something they cannot talk about in their families. They were significantly more likely to agree that their family would support a decision to talk to a suicidal person and also that their communities would support such a decision. See Figure 5.

Figure 1. Support/Environment by Race/Ethnicity and Age.



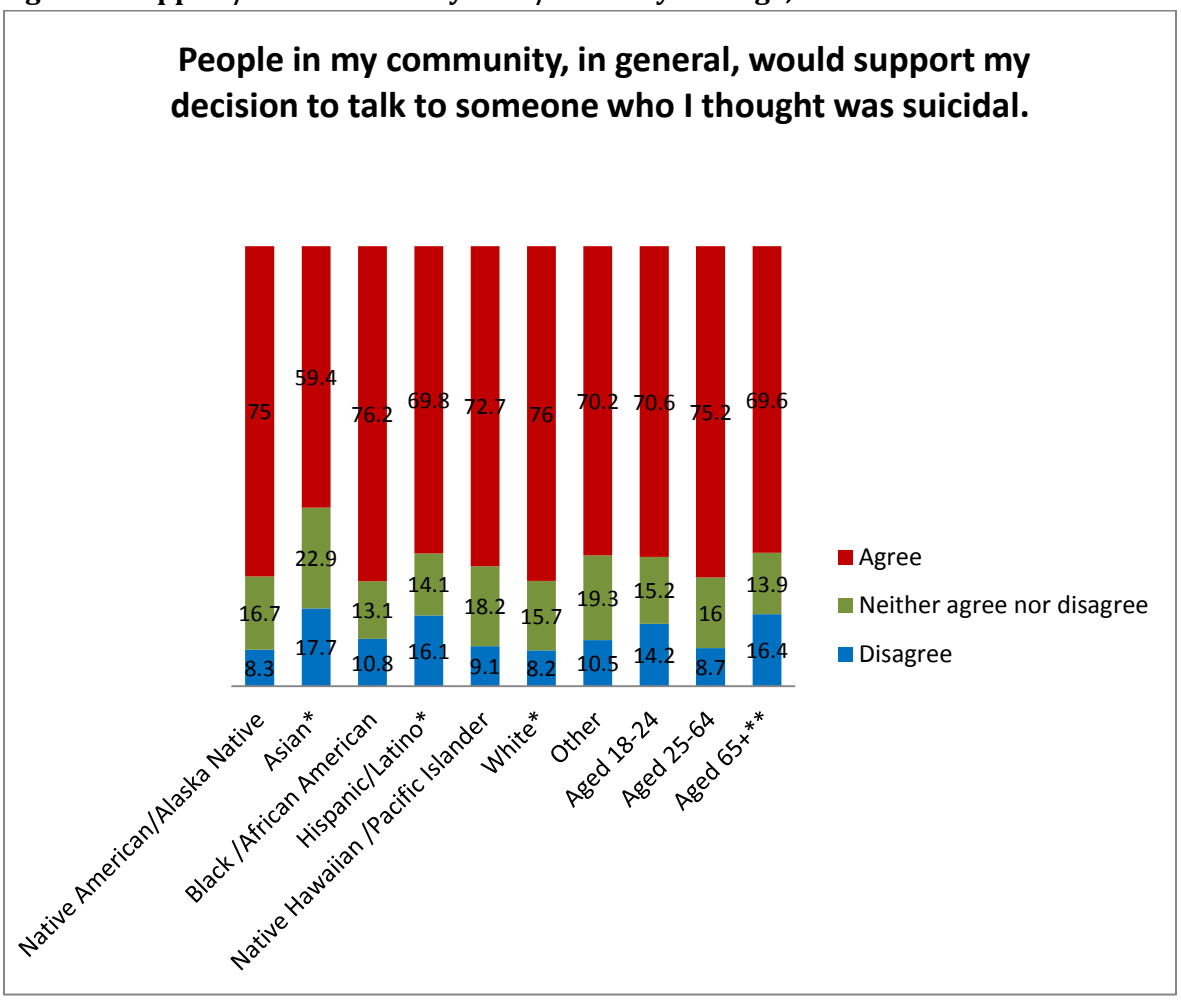
***p<.05, **p<.01**

Figure 2. Support/Environment by Race/Ethnicity and Age, cont.



*p<.001, **p<.01

Figure 3. Support/Environment by Race/Ethnicity and Age, cont.



***p<.001, **p<.05**

Figure 4. Support/Environment by Urban/Rural.

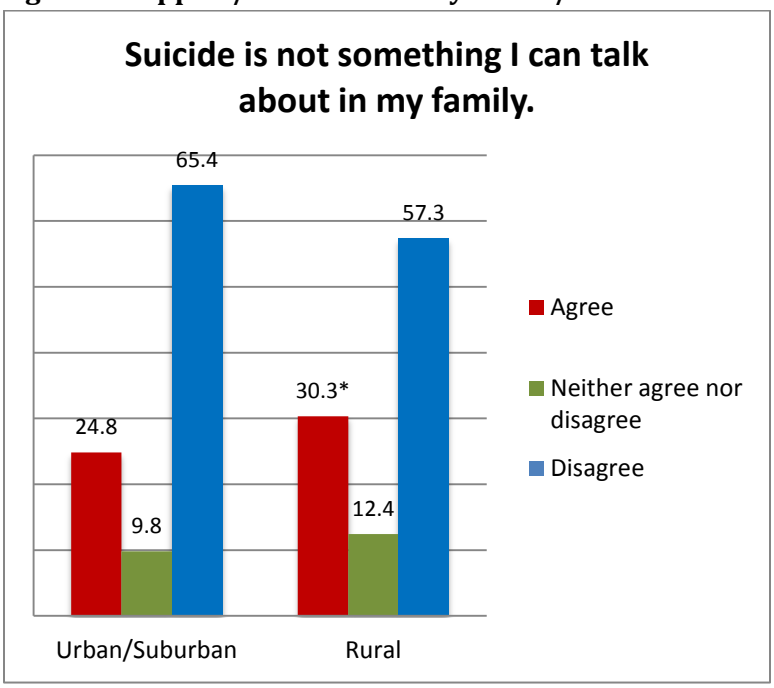


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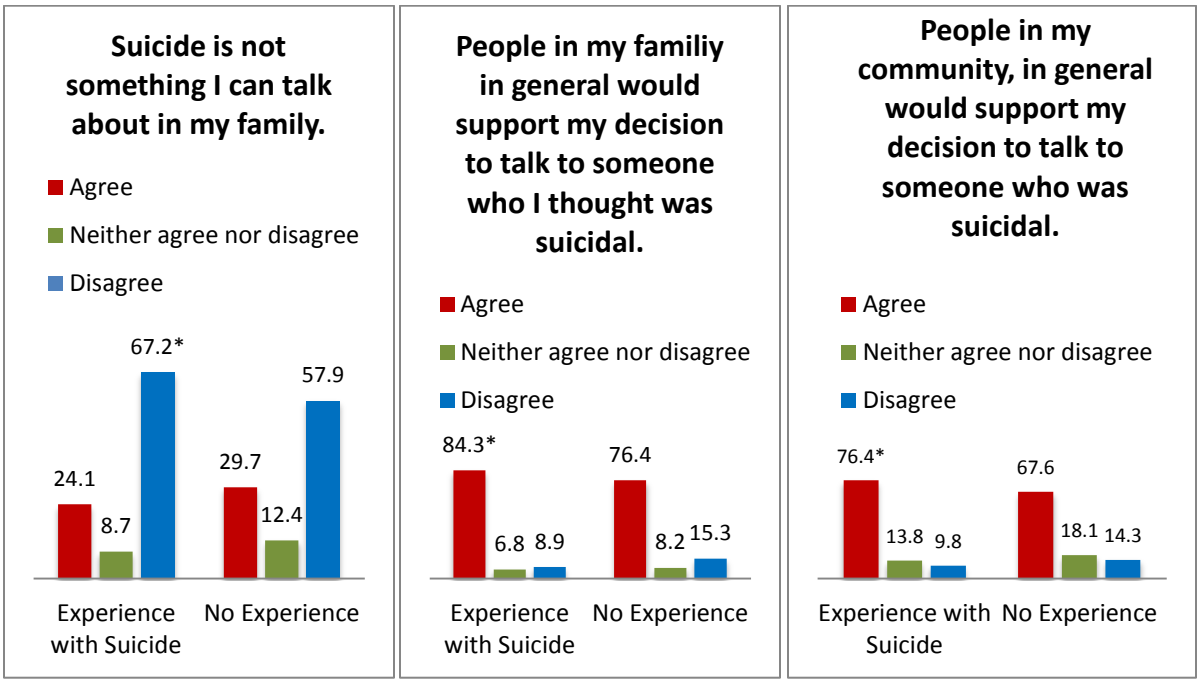
Figure 5. Support/Environment by Experience with Suicide.



*p<.001

Knowledge

Table 4. Overall responses to Knowledge questions.

Question	Disagree	Neither Agree nor Disagree	Agree	Don't Know/Refuse
Q2. Suicide is preventable.	10.8%	15.6%	71.1%	2.5%
	(216)	(312)	(1425)	(50)
Q6. Suicide is not a problem in California.	61.3%	13.3%	17.6%	7.8%
	(1228)	(266)	(352)	(157)
Q7. People who kill or attempt to kill themselves usually show some warning signs.	13.6%	15.5%	66.8%	4.0%
	(272)	(311)	(1339)	(81)
Q10. In California, more people die each year by suicide than by homicide.	24.6%	21.7%	25.6%	28.2%
	(492)	(434)	(512)	(565)
Q13. Most people who end their lives do so without telling anyone.	27.8%	23.1%	42.1%	7.0%
	(556)	(463)	(843)	(141)
Q16. When people talk about ending their life, they are probably serious about making an attempt.	12.5%	26.0%	58.5%	3.0%
	(250)	(521)	(1171)	(61)
Q18. If someone wants to kill themselves, there is nothing anyone can do to stop them.	65.4%	10.6%	22.2%	1.8%
	(1310)	(212)	(444)	(37)

Knowledge items asked survey respondents about specific facts regarding issues surrounding suicide prevention. They were also asked about suicide prevalence in California. Table 4 outlines responses to these items.

There were a number of differences across Race/Ethnicity in the Knowledge category. See Figures 6-9. Hispanic/Latino respondents were significantly more likely to agree that suicide is preventable, and Whites were significantly less likely to agree. Hispanic/Latino respondents were significantly more likely to agree that suicide is not a problem in California. White respondents were significantly more likely than other racial/ethnic groups to disagree with this statement. Black/African Americans were significantly more likely to disagree with the statement that more people die by suicide than by homicide each year. Hispanic/Latino respondents were significantly more likely to agree that most people end their lives without telling anyone. White and Native Hawaiian/Pacific Islanders were significantly more likely to disagree with this item.

Several differences appeared for the Knowledge questions across age groups. Respondents aged 65 or older were significantly more likely to disagree that suicide is preventable, while those between 18 and 24 were significantly more likely to agree. See Figure 6. Those aged 65+ were significantly more likely to agree that most people who end their lives do so without telling anyone (Figure 9). Those 18-24 were significantly more likely to disagree. Respondents aged 18-24 were significantly more likely to disagree

that nothing can be done to stop someone who wants to kill themselves. Those aged 65+ were significantly more likely to agree with this statement. See Figure 10.

People who listed themselves as living in an Urban or Suburban environment were significantly more likely to agree that people usually show some warning signs before a suicide or suicide attempt than were people in a Rural environment. See Figure 11.

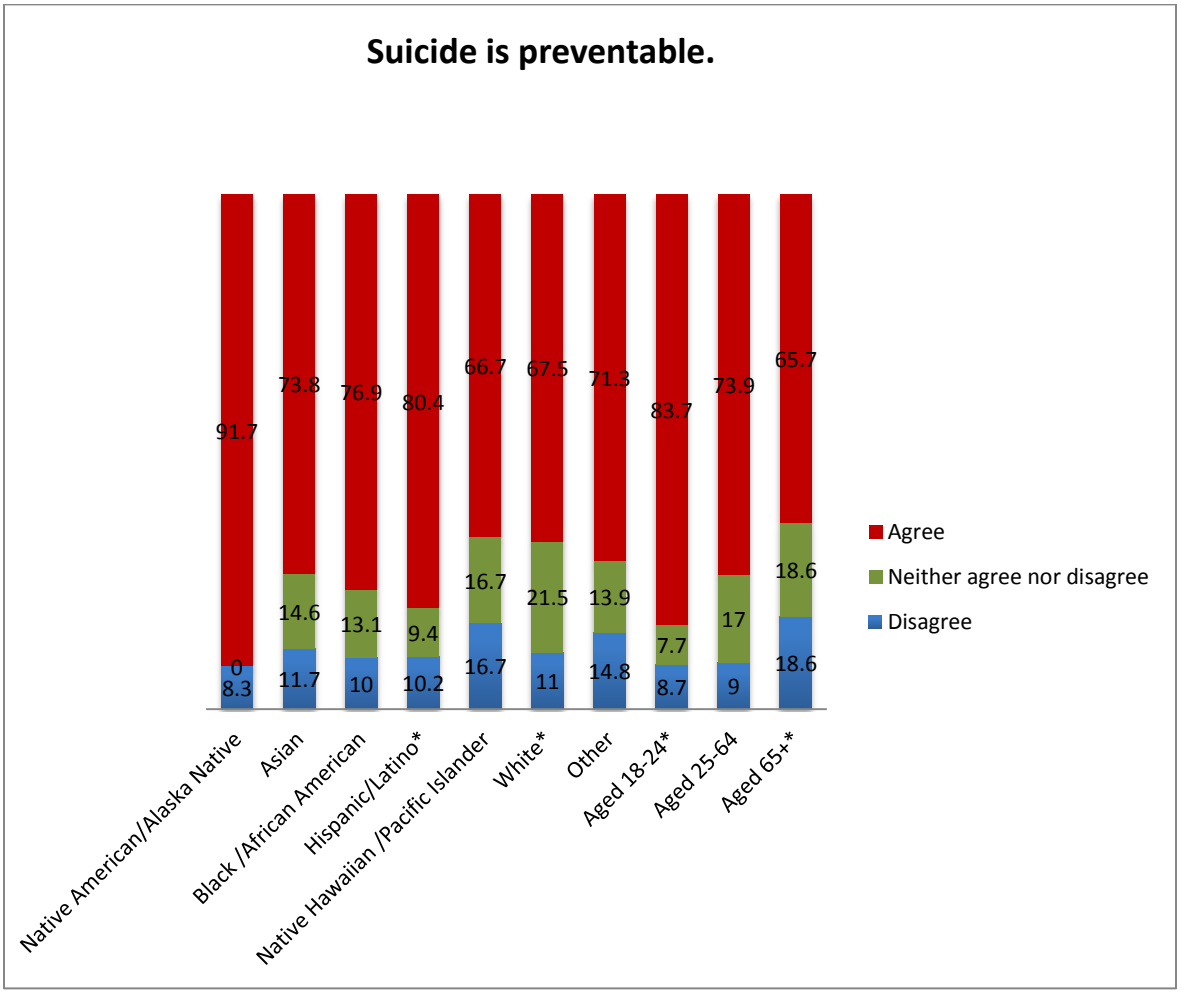
Individuals who were not parents of children 10-24 years of age were significantly more likely to disagree with the statement that "Suicide is preventable" than were parents. However, most respondents overall agreed that suicide is preventable. See Figure 12.

Weighted analyses found that men and women differed on two of the Knowledge items. Although opinion was fairly evenly spread across response options, women were significantly more likely to agree that more people die by suicide than homicide each year than were men. In addition, women were significantly more likely to agree that when people talk about ending their lives, they are probably serious. See Figure 13.

Persons with experience of suicide were significantly more likely to disagree that suicide is not a problem in California. They were significantly more likely to indicate that they were unsure of whether more people die by suicide than homicide in California, choosing, "Neither Agree nor Disagree" more often, in comparison with respondents with no experience. Finally, those with experience of suicide were significantly less likely to agree that there is nothing anyone can do to stop someone who wants to kill themselves. See Figure 14.

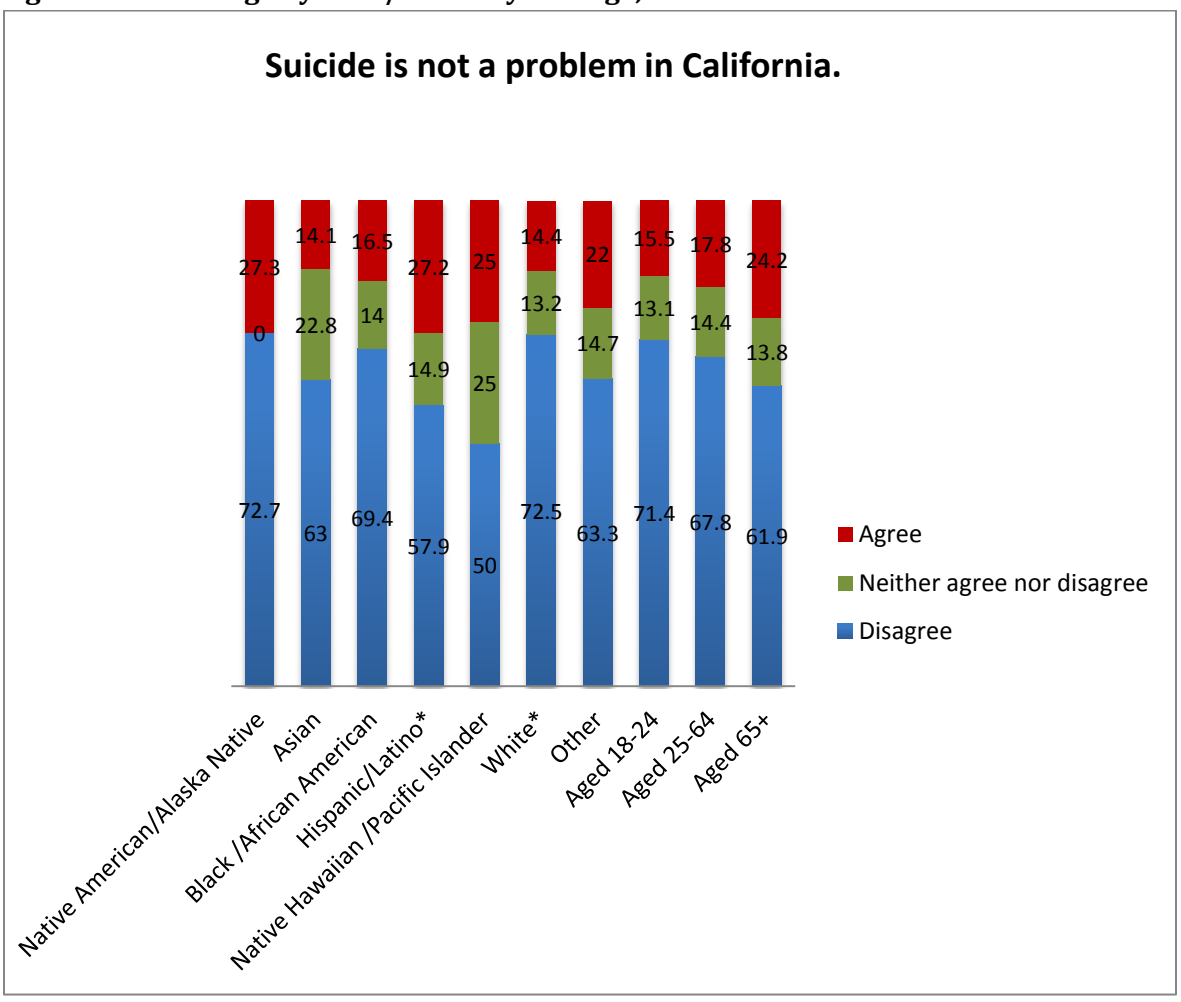
People in the Los Angeles region were significantly more likely to agree that suicide is not a problem in California, while People in the Bay Area and Central Valley were significantly more likely to disagree with this item. People in the Bay Area were also significantly less likely to agree that more people die by suicide than by homicide each year, while people in the Southern California and Southern Farm regions were significantly more likely to indicate that they neither agreed nor disagreed. People in the Bay Area were evenly split in their responses to the statement that most people who end their lives do so without telling anyone, a pattern that differed significantly from other regions. People in the Los Angeles region were significantly more likely to agree with this statement. See Figures 15-17.

Figure 6. Knowledge by Race/Ethnicity and Age.



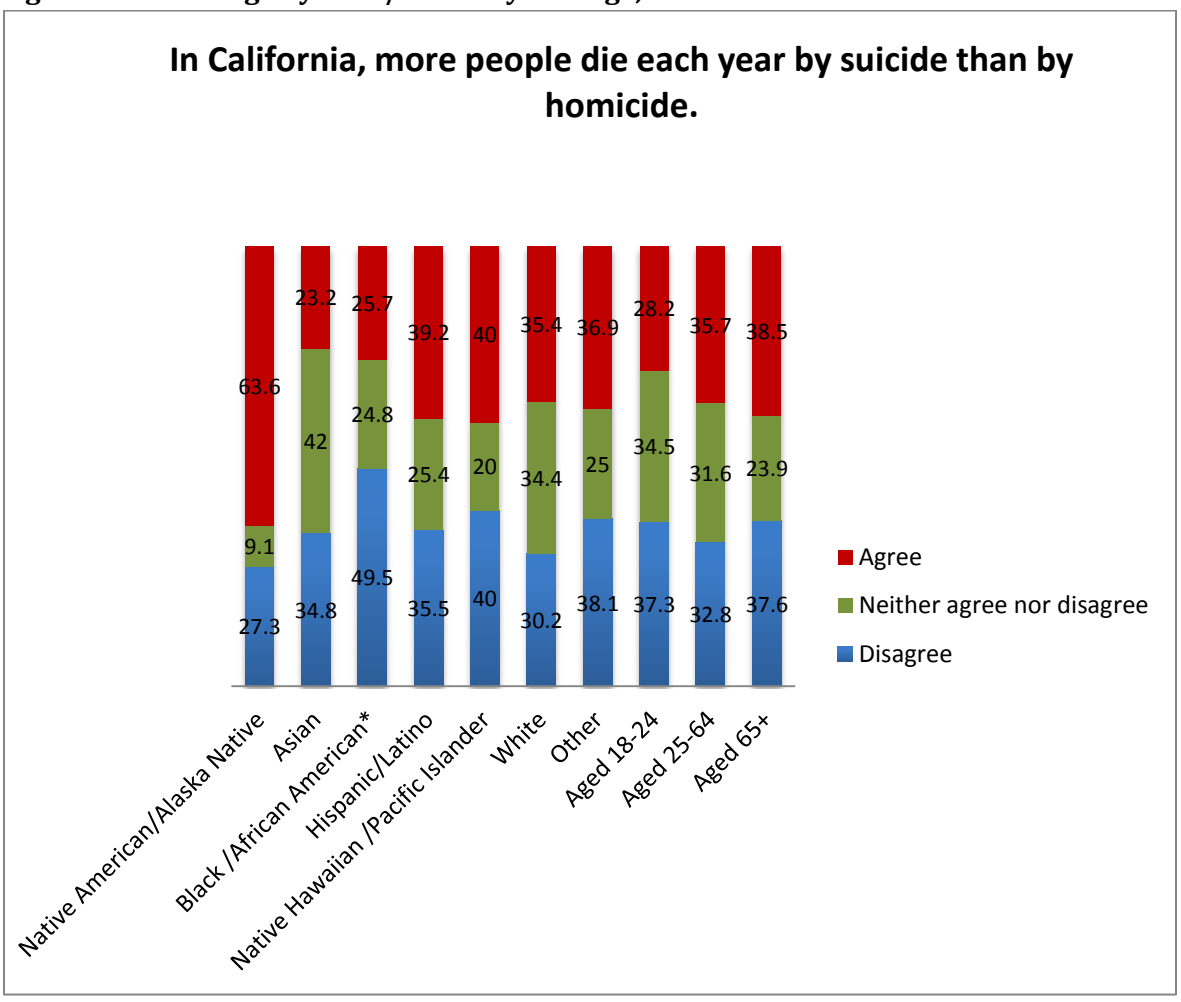
***p<.01**

Figure 7. Knowledge by Race/Ethnicity and Age, cont.



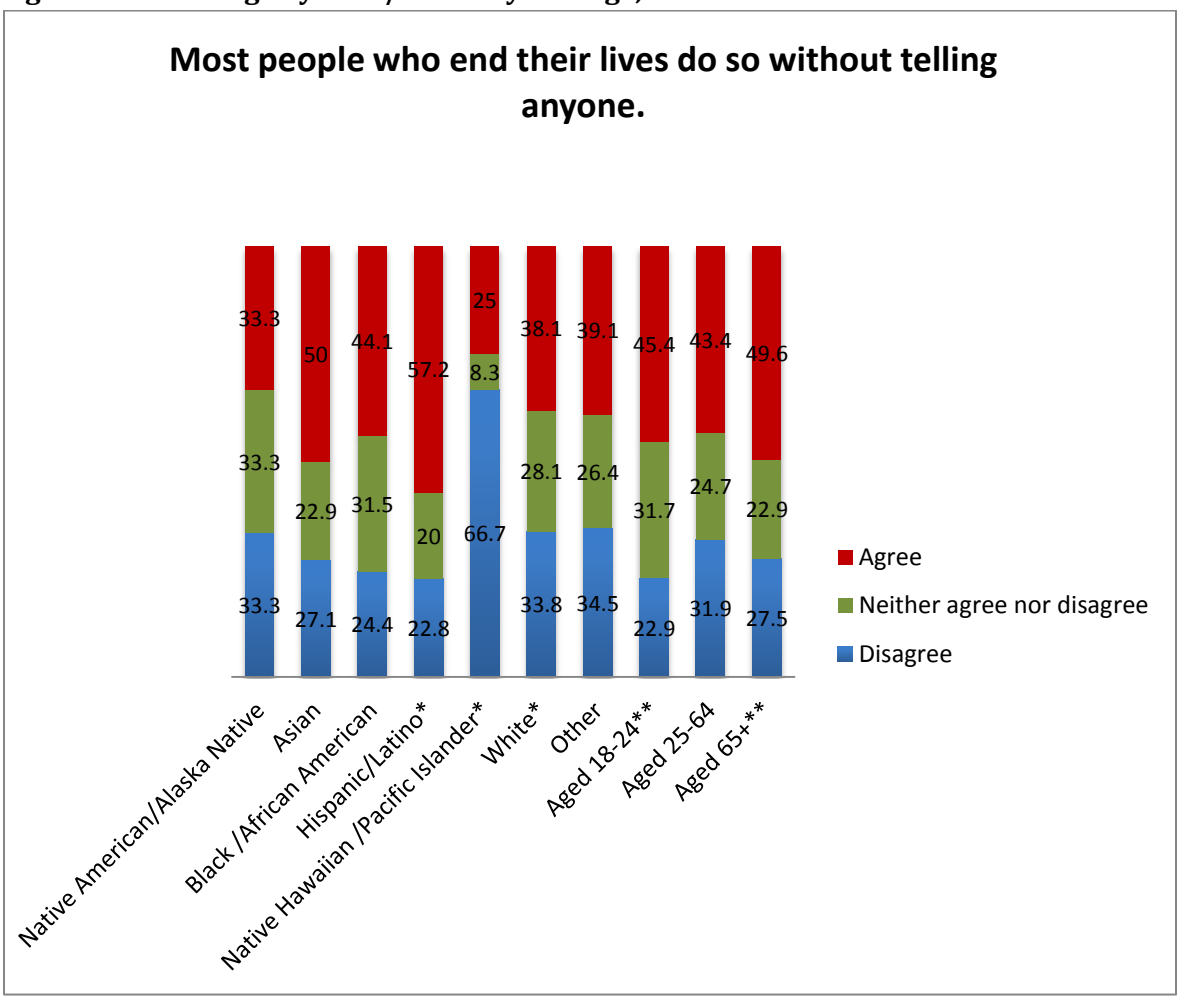
*p<.001

Figure 8. Knowledge by Race/Ethnicity and Age, cont.



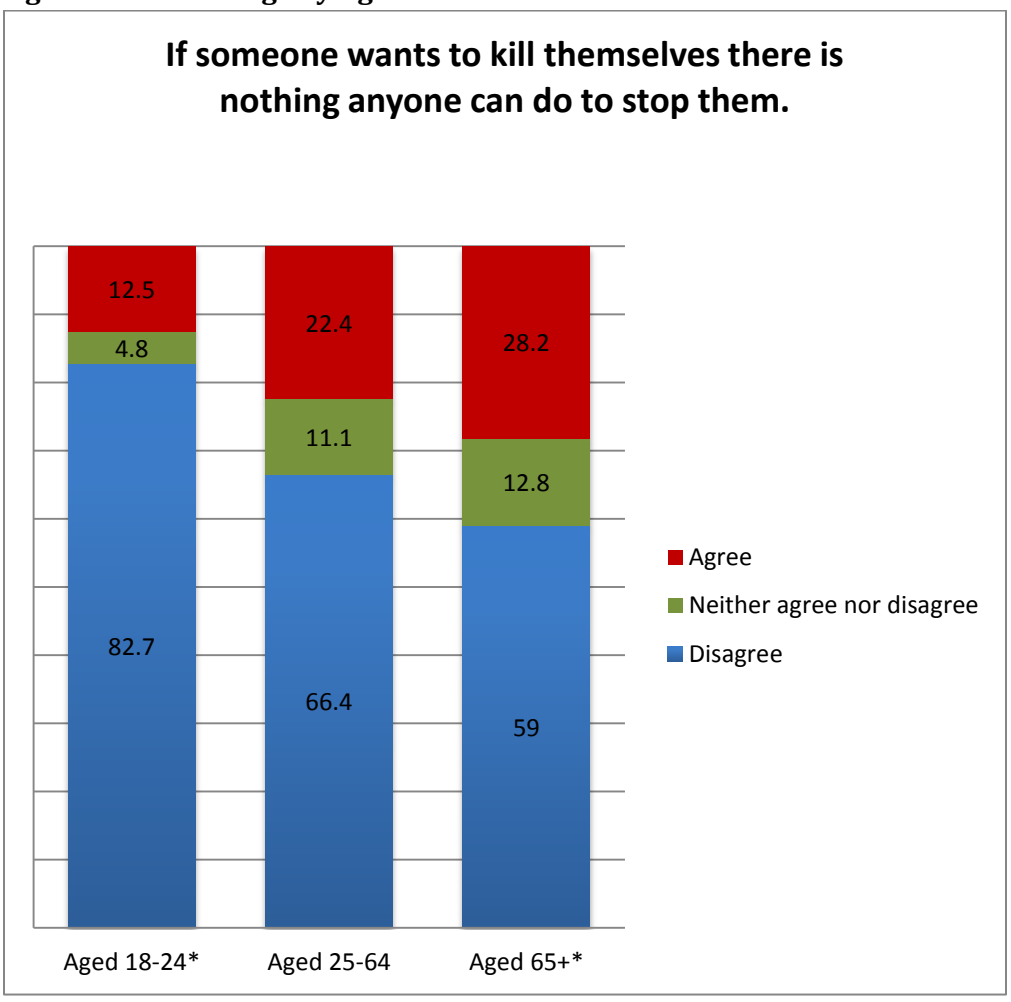
*p<.01

Figure 9. Knowledge by Race/Ethnicity and Age, cont.



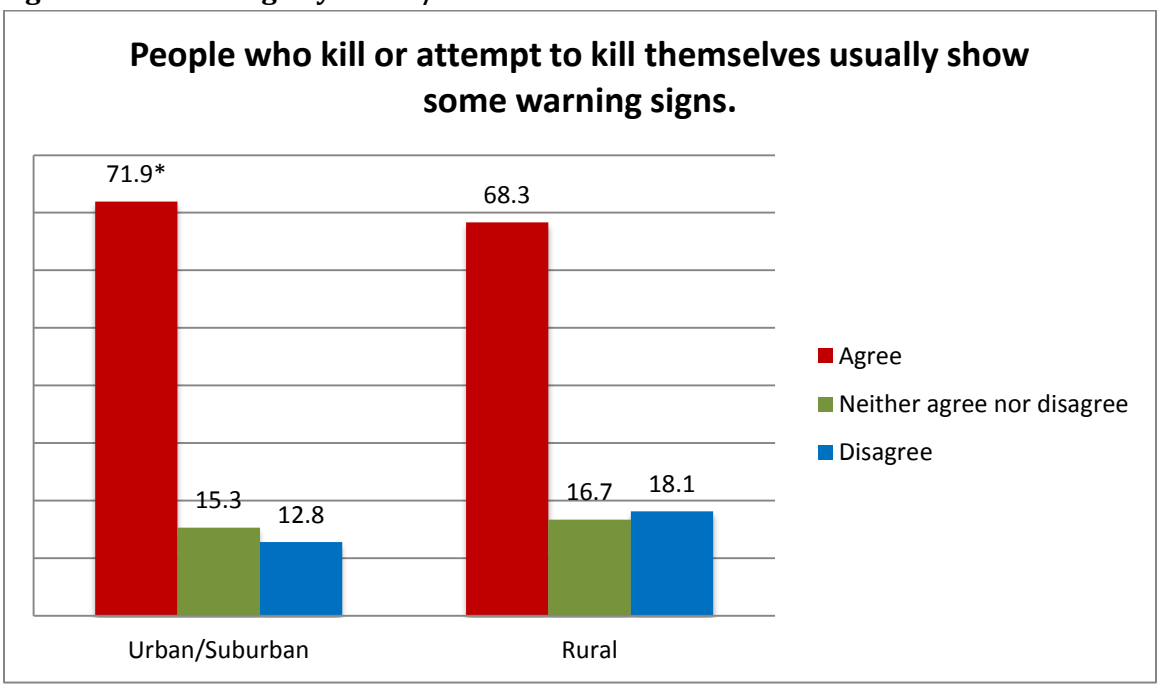
*p<.001, **p<.05

Figure 10. Knowledge by Age.



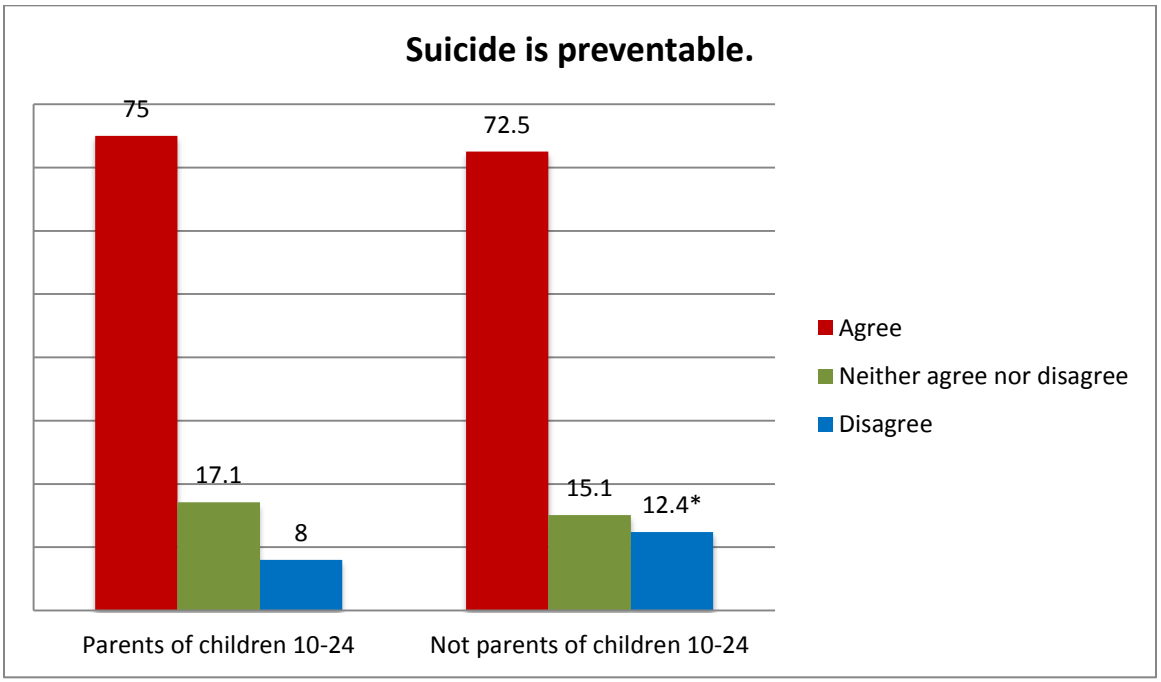
***p<.001**

Figure 11. Knowledge by Urban/Rural.



***p<.05**

Figure 12. Knowledge by Parental Status.



***p<.05**

Figure 13. Knowledge by Gender.

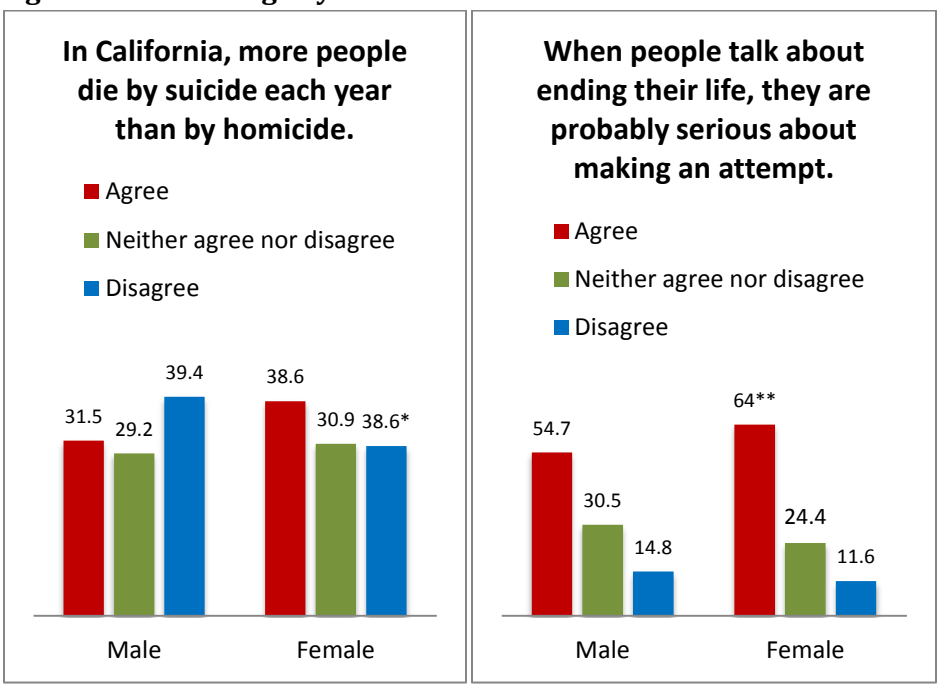


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Figure 14. Knowledge by Experience with Suicide.

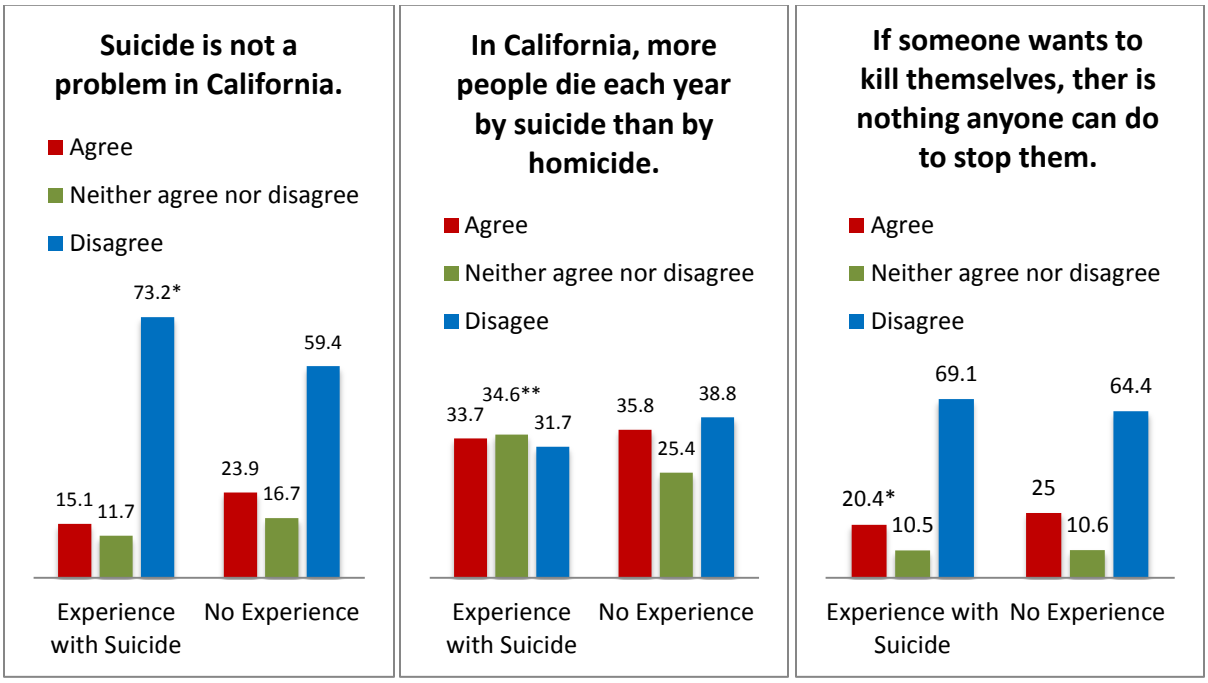

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Figure 15. Knowledge by Region.

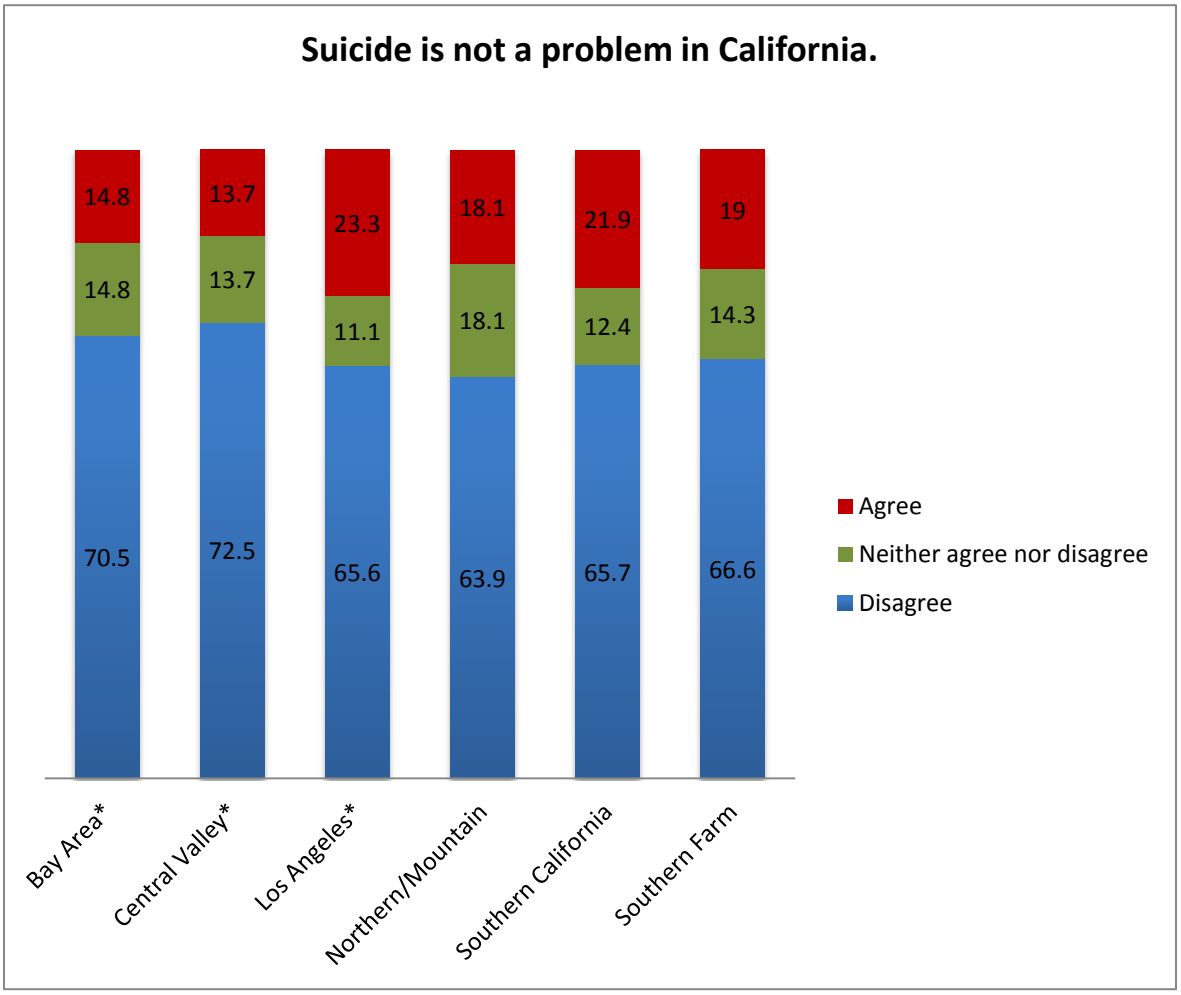

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Figure 16. Knowledge by Region, cont.

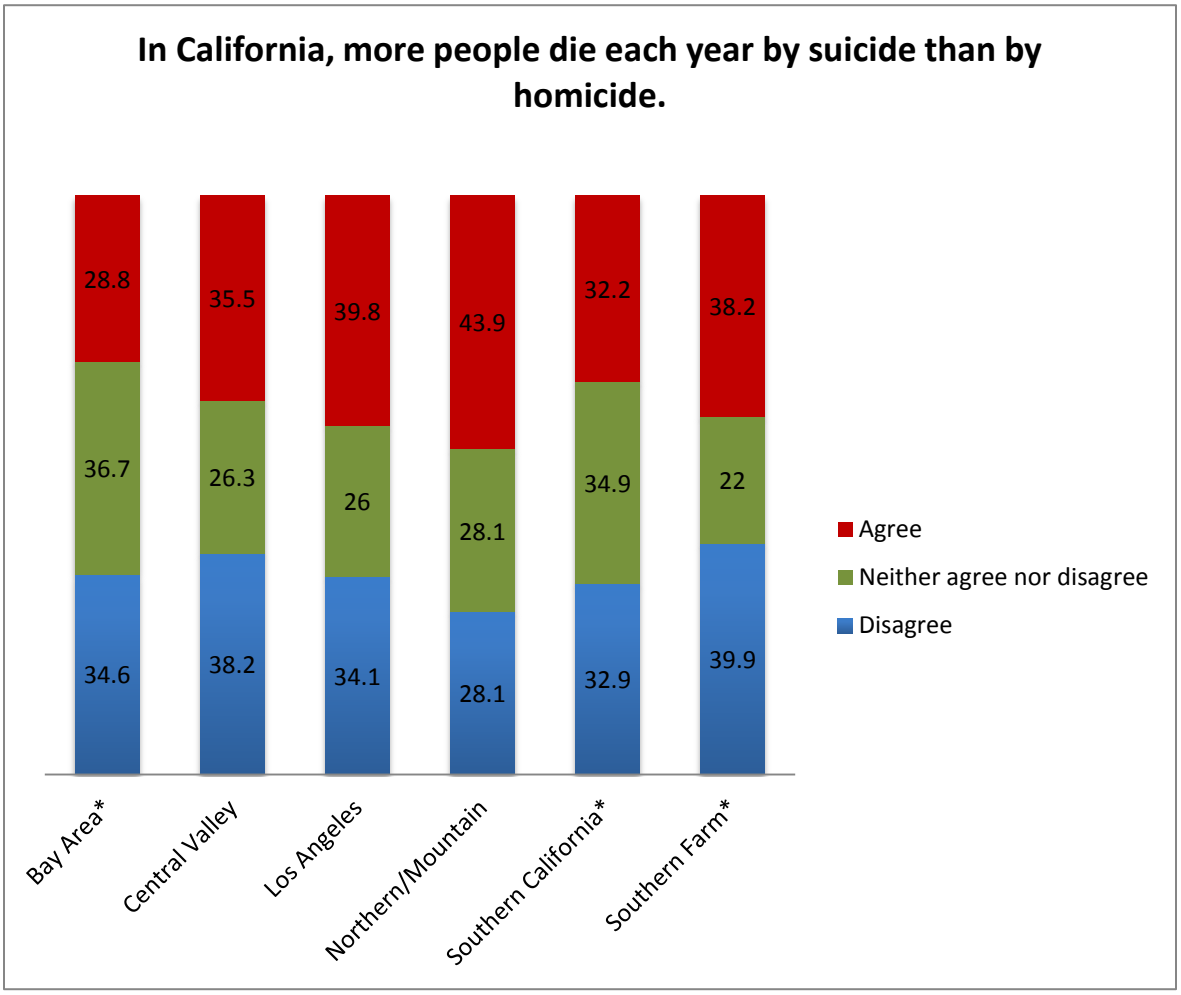

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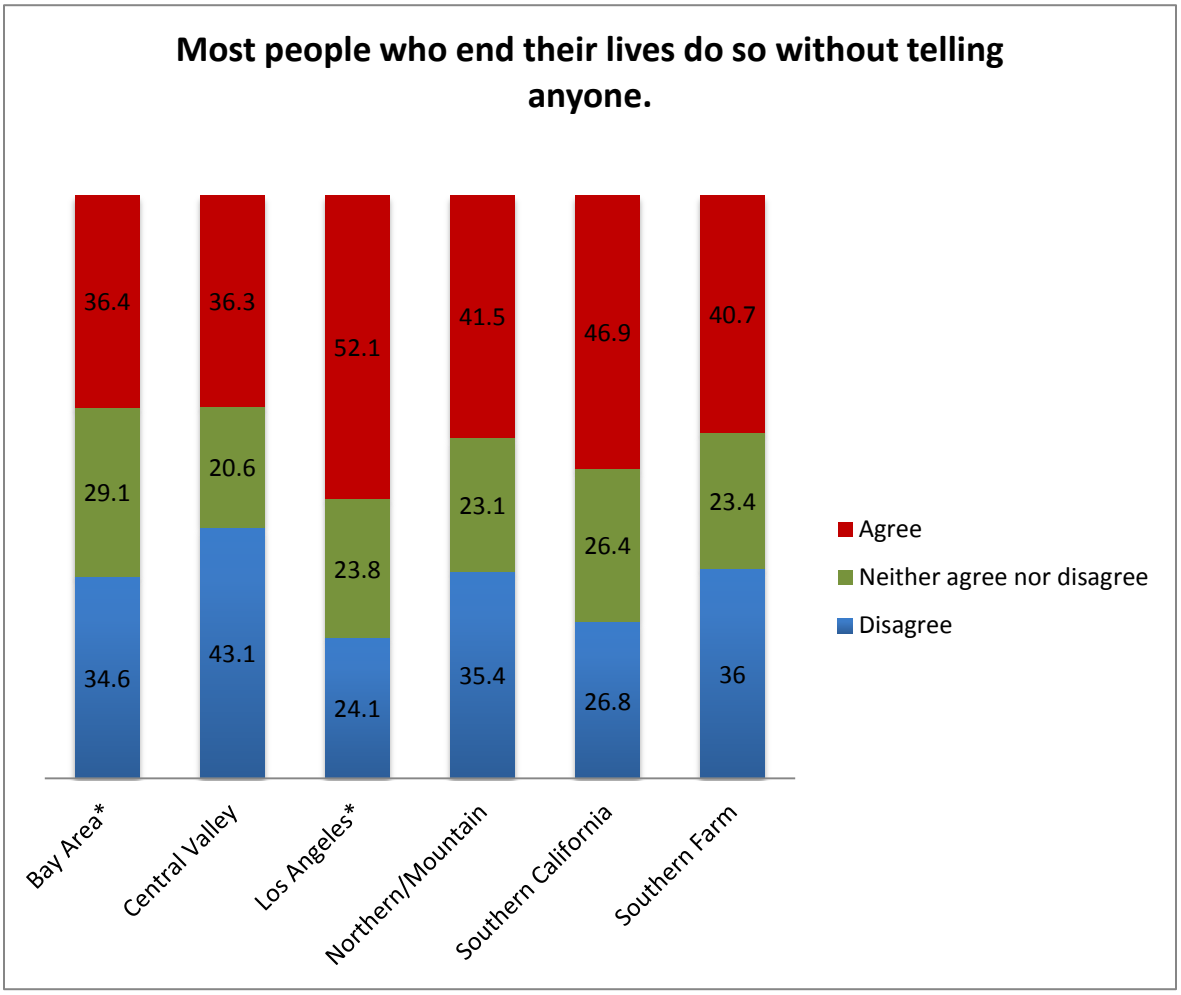
Figure 17. Knowledge by Region, cont.



***p<.001**

Knowledge of Suicide Warning Signs

Respondents were asked if they could name three warning signs of suicide. Most respondents (80.6%, N=1615) provided at least one response to this question. Table 5 shows the breakdown for number of warning signs given.

In addition, there were differences in knowledge of at least one warning sign across age and Racial/Ethnic groups. Hispanic/Latino respondents and those over 65 years of age were significantly more likely not to list any warning signs. See Figure 18.

Respondents also differed depending on whether or not they had personal experience with suicide. Those without personal experience were significantly less likely to report knowing any warning signs. See Figure 19.

Table 5. Knowledge of Warning Signs.

Number of Warning Signs Given	N	Percent
0	388	19.4
1	152	7.6
2	315	15.7
3	1148	57.3

Figure 18. Knowledge of Warning Signs by Race/Ethnicity and Age.

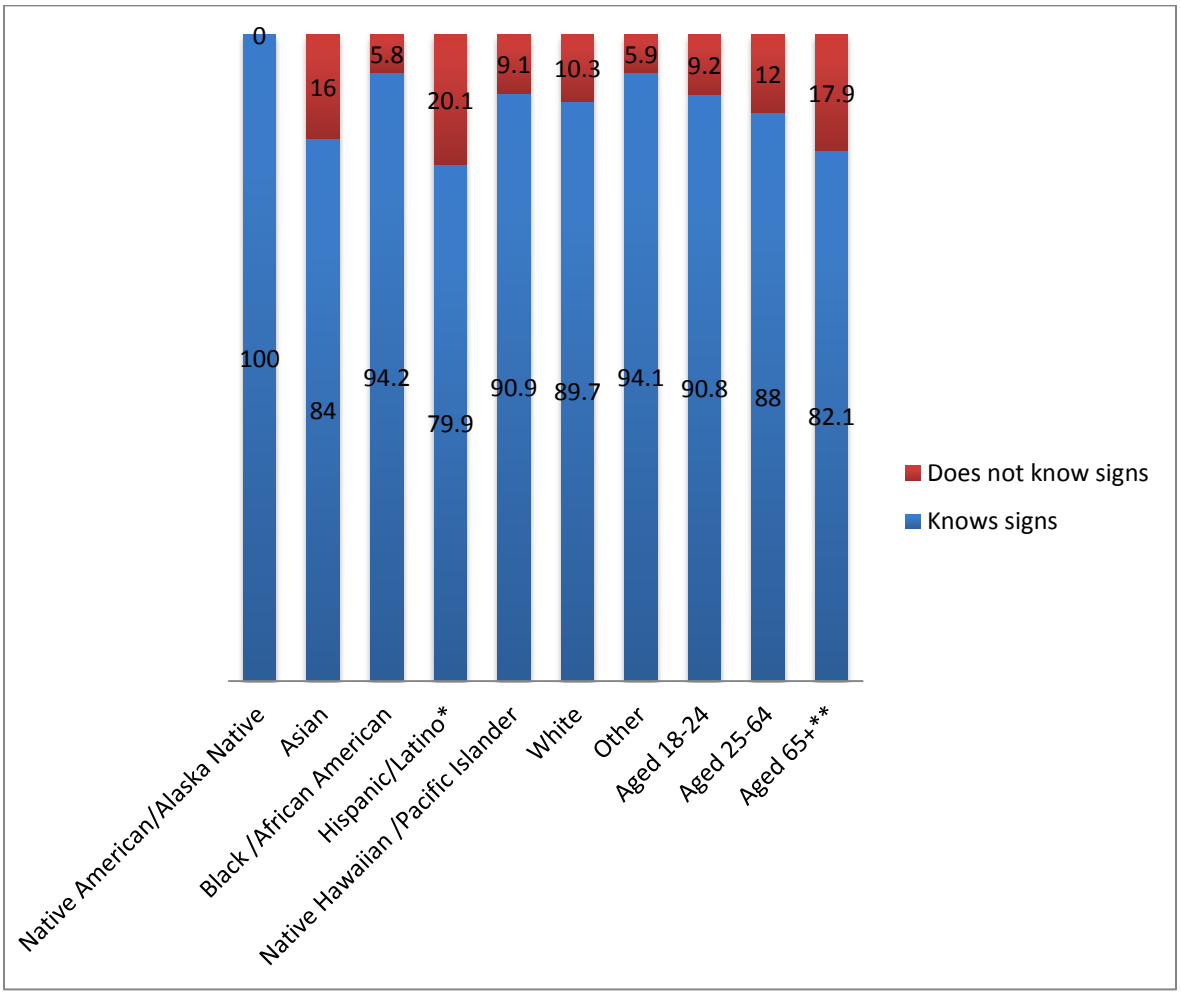


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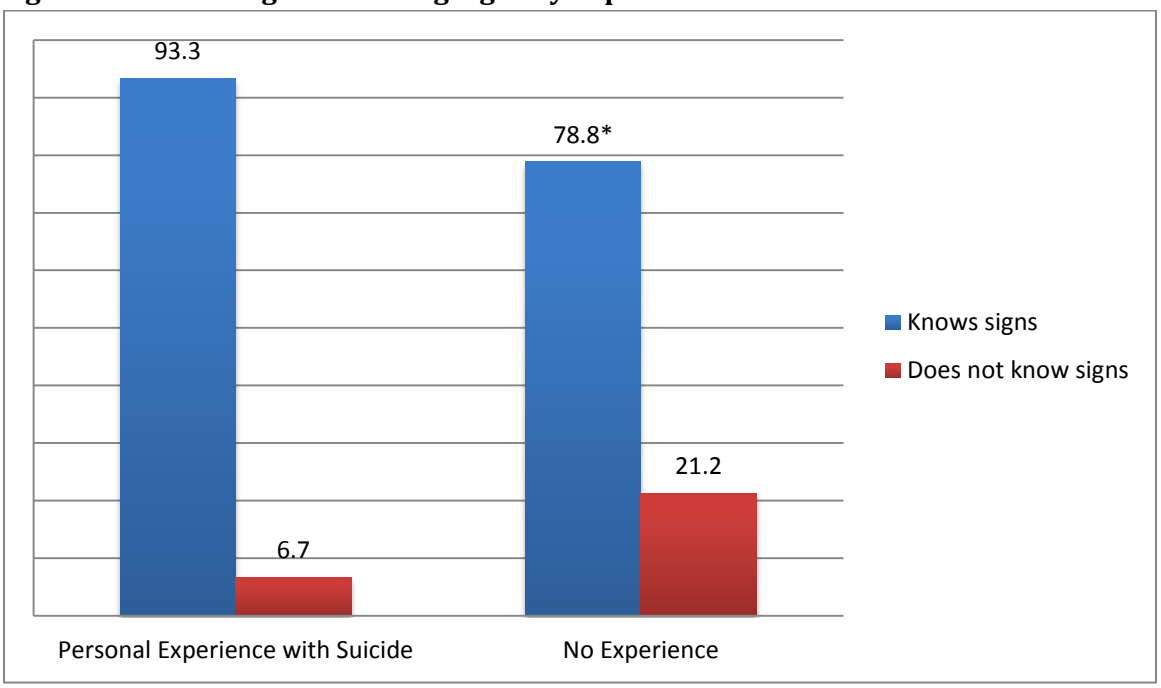
Figure 19. Knowledge of Warning Signs by Experience with Suicide.



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Open-ended responses were coded for the type of sign, and the outcomes for respondents' first, second and third responses are presented in Table 6. By far the most common sign cited was "depression", which included "sadness" and "hopelessness." Talking about suicide or death, and isolation or withdrawal from others were the second and third most common responses.

Table 6. Types of Warning Signs.

Warning Sign	% for Sign 1 N=1615	% for Sign 2 N=1461	% for Sign 3 N=1158
Depression	40.7	17.9	11.1
Anticipating death	8.8	5.1	4.2
Talking about suicide	18.2	19.2	16.8
Substance abuse	1.5	4.0	6.0
Planning/attempt	2.0	3.4	5.5
Isolation	12.6	21.0	16.9
Appetite/sleep disturbance	1.3	2.9	2.9
Self harm	2.1	1.8	2.8
Mood changes	5.8	13.3	14.2
Behavior changes	3.7	6.8	11.1
Other	3.4	4.6	8.2

The category of "Anticipating death" included actions such as giving away possessions, making a will or taking out insurance. "Talking about suicide" included notes and other written messages and messages

posted on social media such as Facebook. Planning included researching methods of suicide, buying weapons or other lethal means, and hoarding drugs. Behavior changes included aggression or recklessness. Mood changes included anger, anxiety and nervousness. The "Other" category included mention of specific life events, such as a job loss or marital problems. There were no significant differences in the prevalence of warning sign categories across any of the demographic groups.

Resources

Table 7. Overall responses for Resources questions.

Question	Disagree	Neither Agree nor Disagree	Agree	Don't Know/Refuse
Q11. If a friend or family member is feeling suicidal, I know where I can seek help for him or her.	22.3%	12.7%	62.4%	2.6%
	(446)	(254)	(1250)	(53)
Q14. I know of a suicide crisis line that I can call for help and support.	41.0%	9.5%	44.8%	4.6%
	(822)	(191)	(897)	(93)
Q17. If a friend was having thoughts about suicide, I would know where to find assistance.	22.9%	12.9%	61.5%	2.7%
	(458)	(259)	(1232)	(54)

This set of items looked at whether or not respondents felt they knew of resources they could turn to for themselves or for someone contemplating suicide. Responses are shown in Table 7.

Respondents aged 65 or older were significantly more likely to disagree that they knew where to seek help for a suicidal friend or family member. Those aged 18-24 were significantly less likely to agree that they know of a suicide crisis line to call for help and support. Individuals aged 65+ were significantly more likely to disagree that they would know where to find assistance. See Figures 20-22.

Men and women showed significant differences in their responses to all three of the Resources questions. Women were significantly more likely than men to agree that they know where to seek help, that they know of a suicide crisis line, and that they know where to find assistance for someone having thoughts of suicide. See Figure 23.

Respondents with experience of suicide were significantly more likely to say that they know of a suicide crisis line than those with no experience. Similarly, they were significantly more likely to agree that they know where to find assistance. See Figure 24.

Figure 20. Resources by Age.

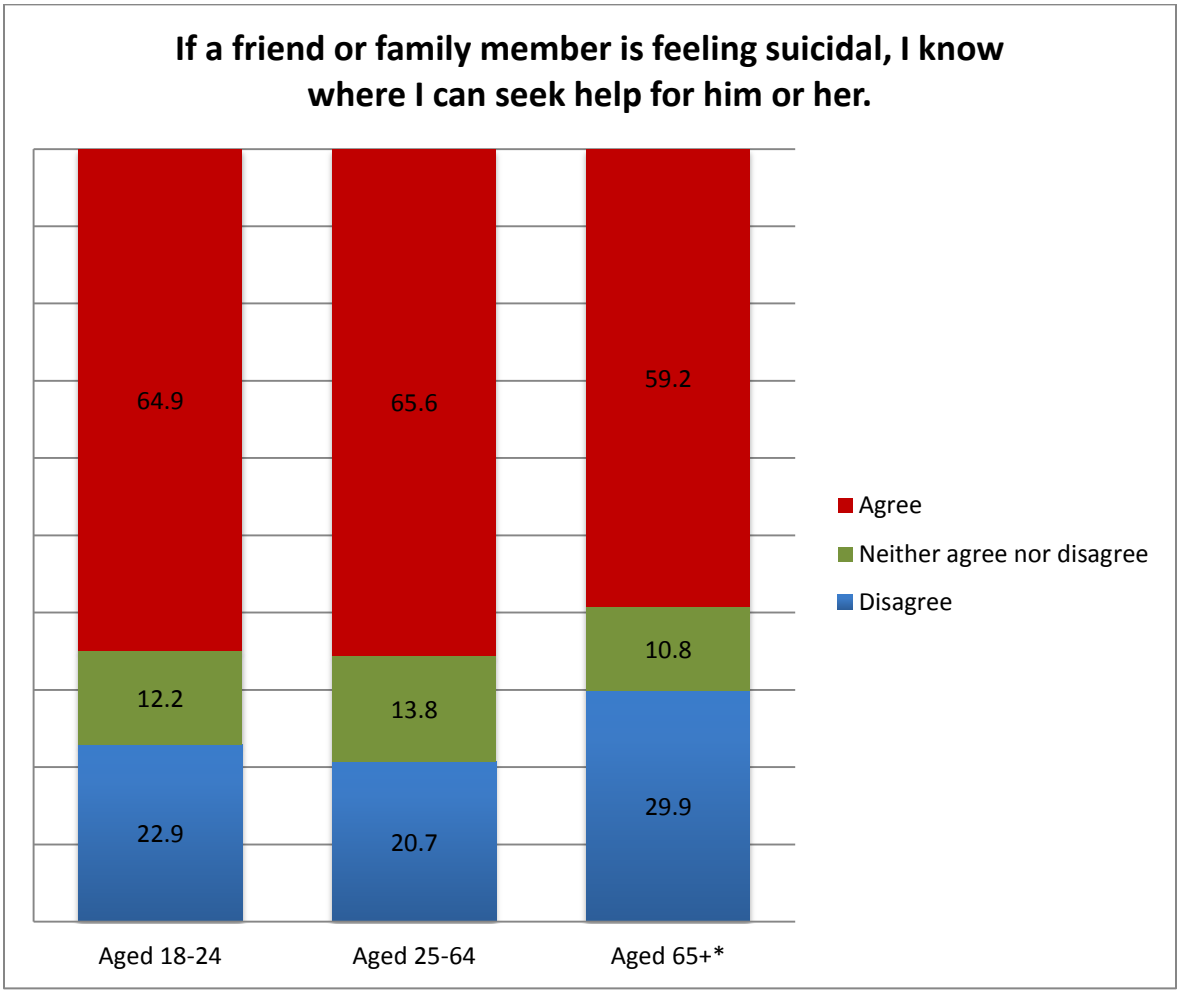

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Figure 21. Resources by Age, cont.

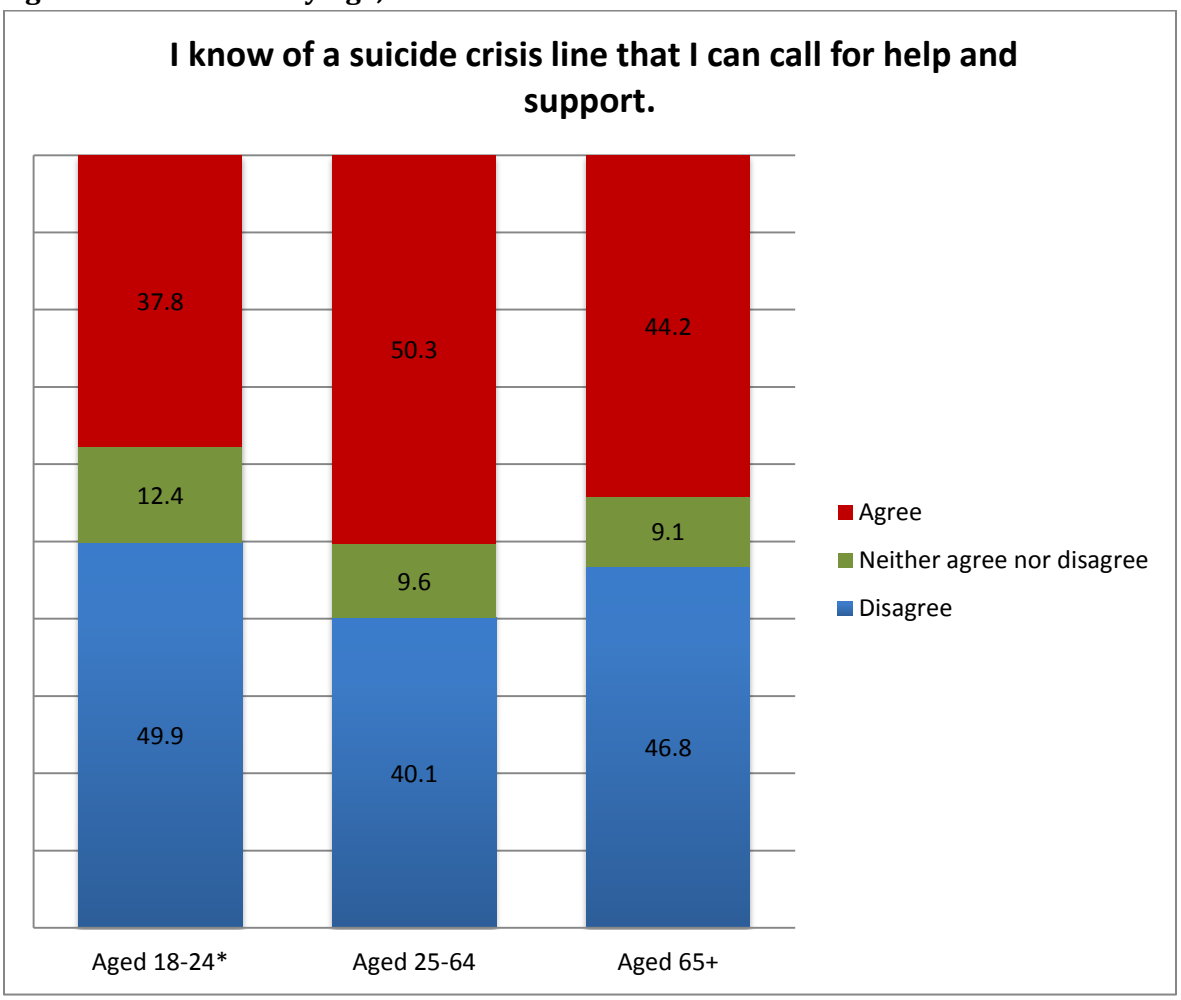

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Figure 22. Resources by Age, cont.

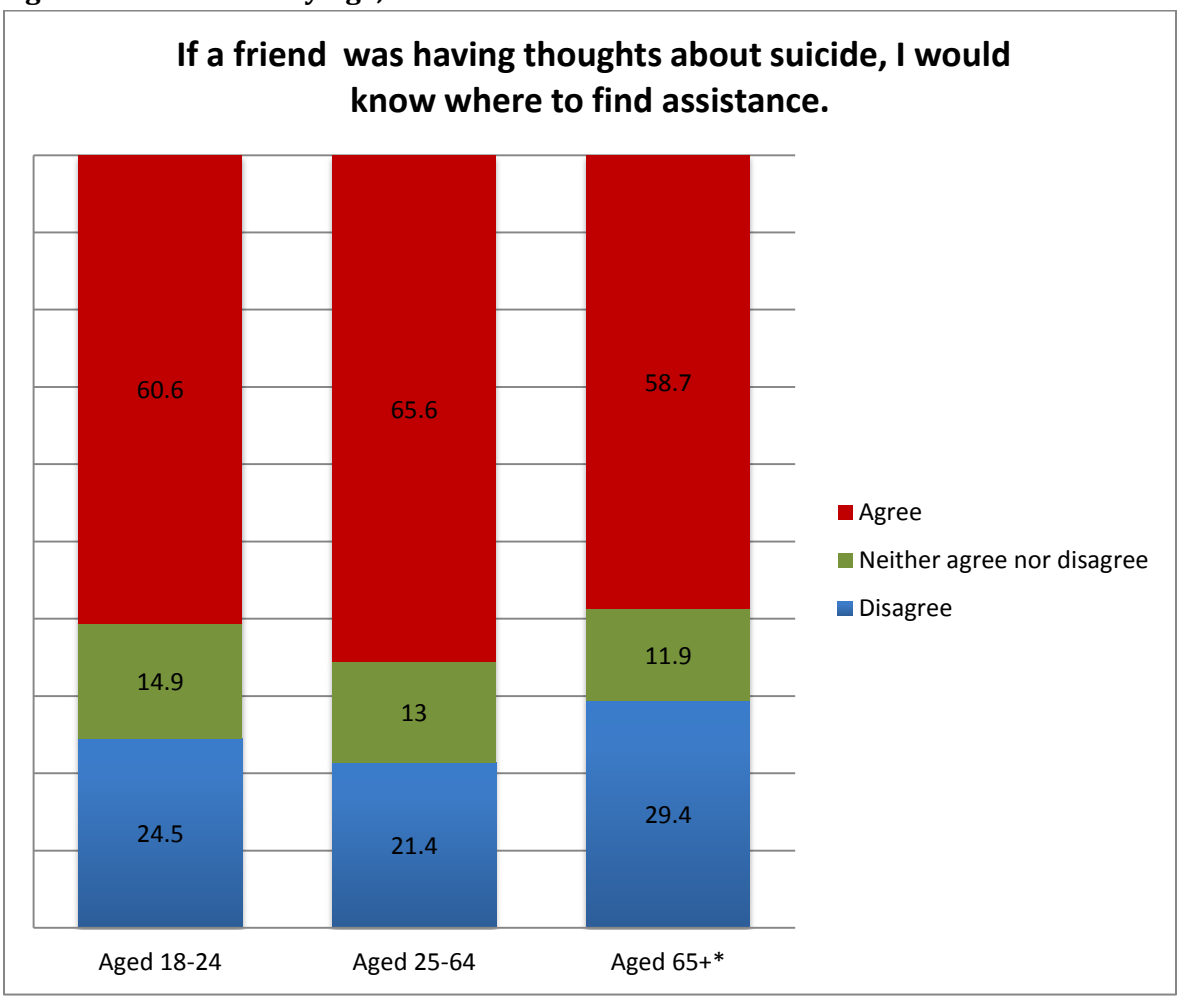

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Figure 23. Resources by Gender.

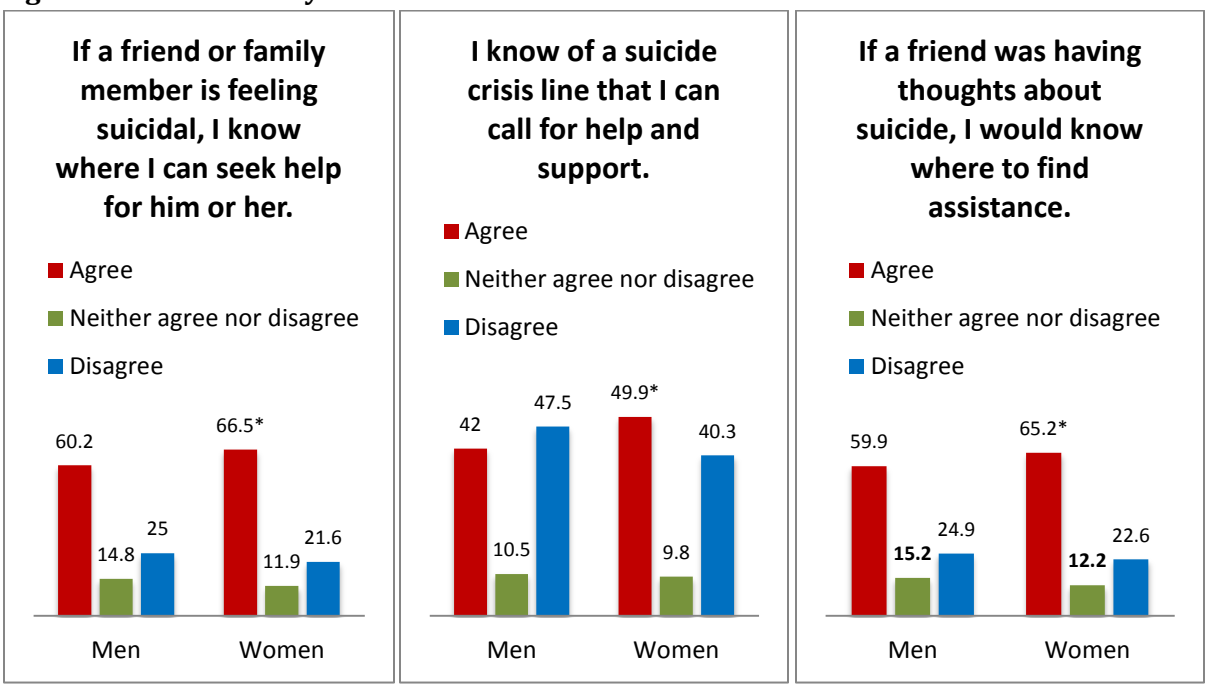

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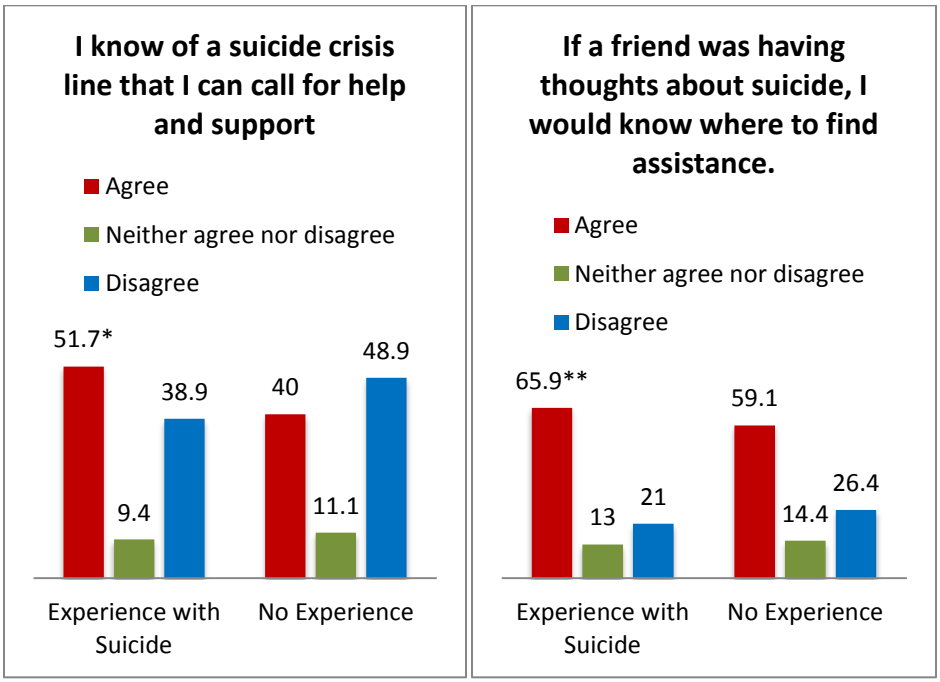
Figure 24. Resources by Experience with Suicide.



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Other Resources

National Suicide Prevention Lifeline

Respondents were asked if they had heard of the National Suicide Prevention Lifeline, 1-800-273-TALK or -800-273-8255. They were fairly evenly split in responses with 46.0% (N=887) saying "Yes" and 54% (N=1043) saying "No." Hispanic/Latino and Asian participants were significantly more likely than others to say that they had not heard of the Lifeline, while Whites were significantly more likely to say that they had heard of the Lifeline. Women were significantly more likely than men to have heard of the Lifeline. Those with experience of suicide were significantly more likely to have heard of the Lifeline than those with no experience. See Figures 25-27.

Figure 25. National Suicide Prevention Lifeline by Racial/Ethnic.

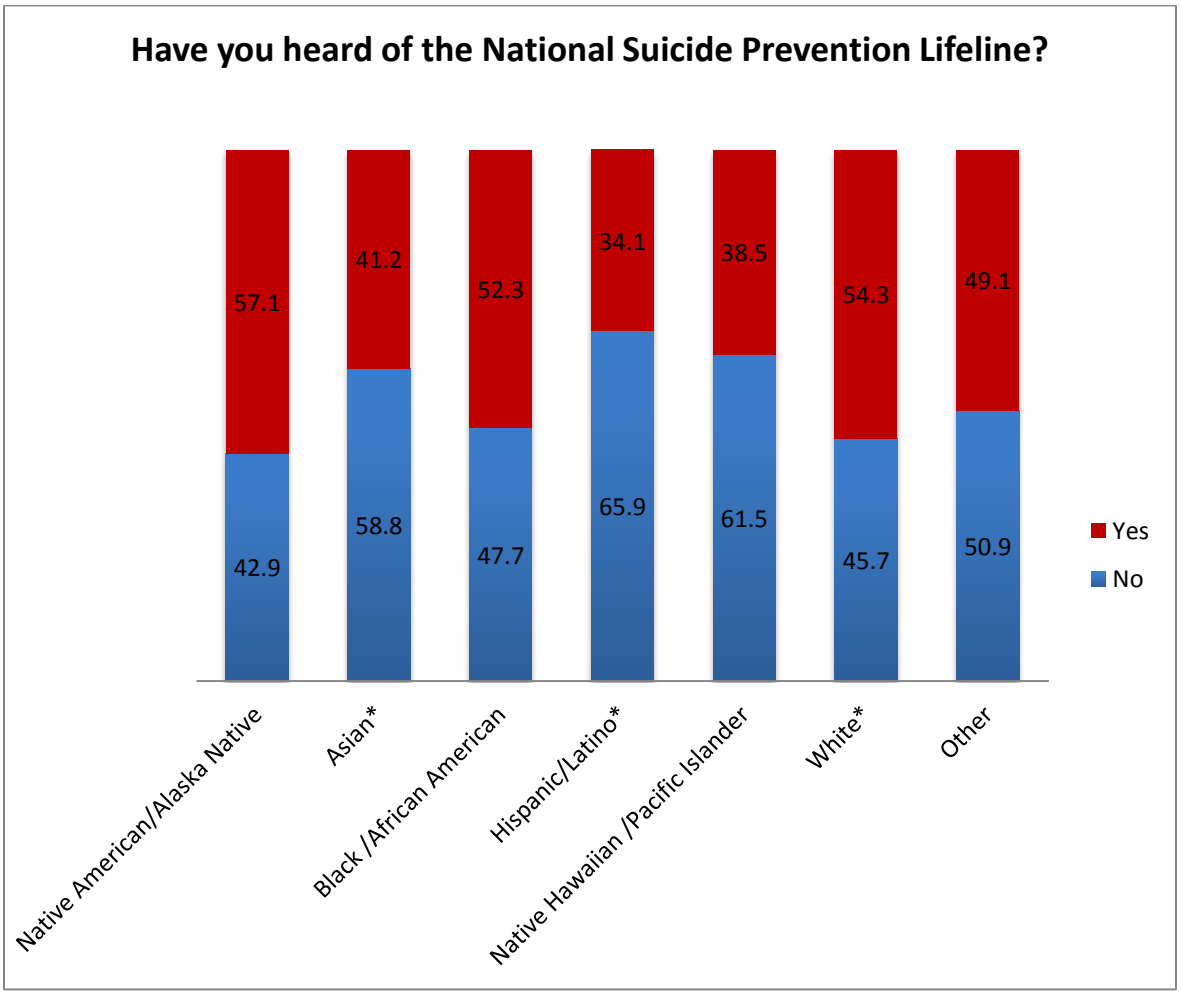

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Figure 26. National Suicide Prevention Lifeline by Gender.

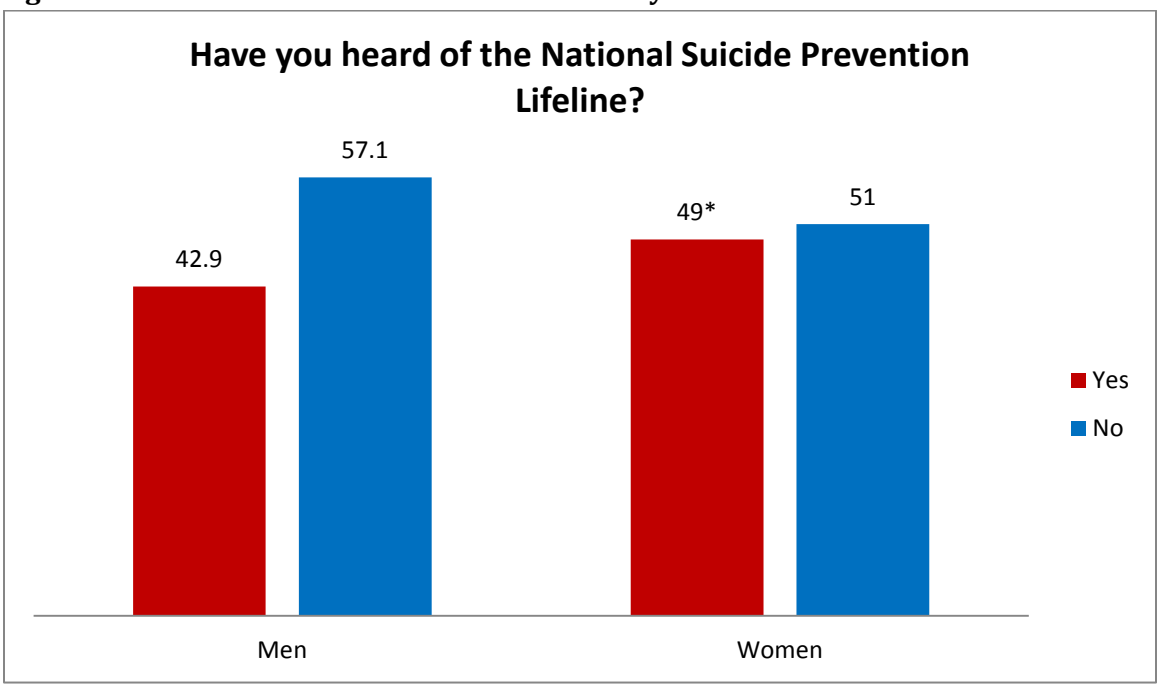

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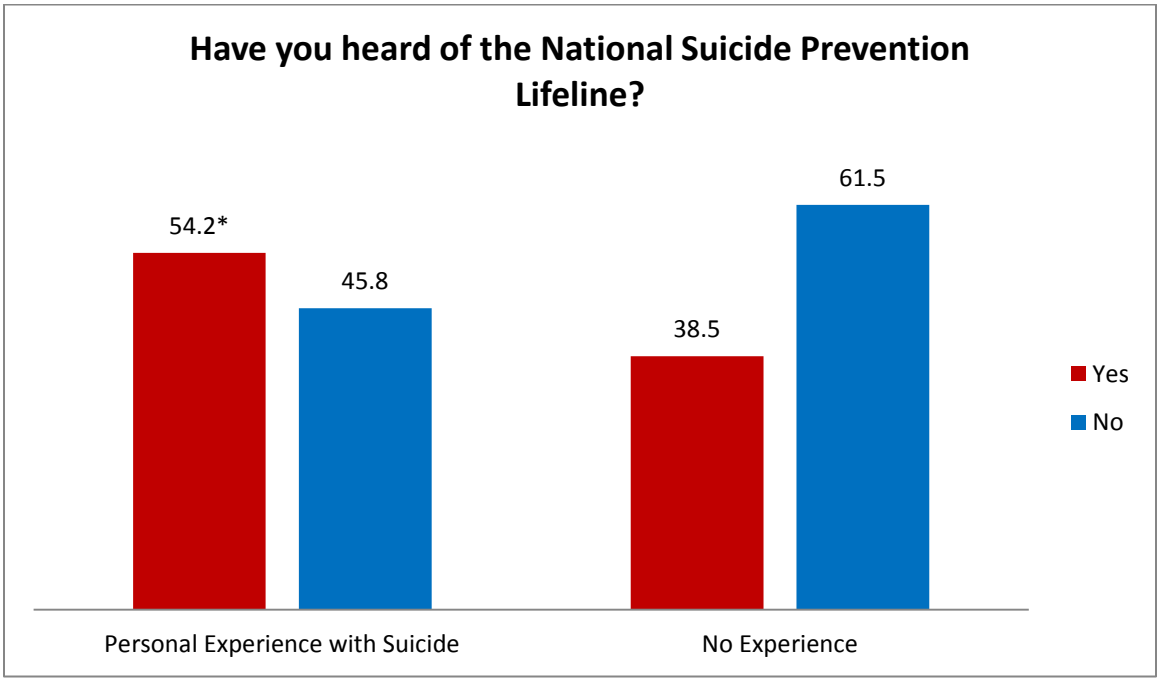
Figure 27. National Suicide Prevention Lifeline by Personal Experience with Suicide.



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Local numbers other than 9-1-1.

More respondents reported that they have heard of a number other than 9-1-1 that they could call than did not (40.7%, N=808 vs. 24.9%, N=495). However, a substantial number of respondents overall said

that they did not know whether there was such a number or not (34.4%, N=683). Within those responding "Yes" or "No" to this item, Hispanic/Latino and Asian respondents were significantly less likely to have heard of a number. Significantly more women were likely to have heard of a number. Those with experience of suicide were also significantly more likely than others to have heard of a number. See Figures 28-30.

Figure 28. Phone numbers other than 9-1-1 by Racial/Ethnic.

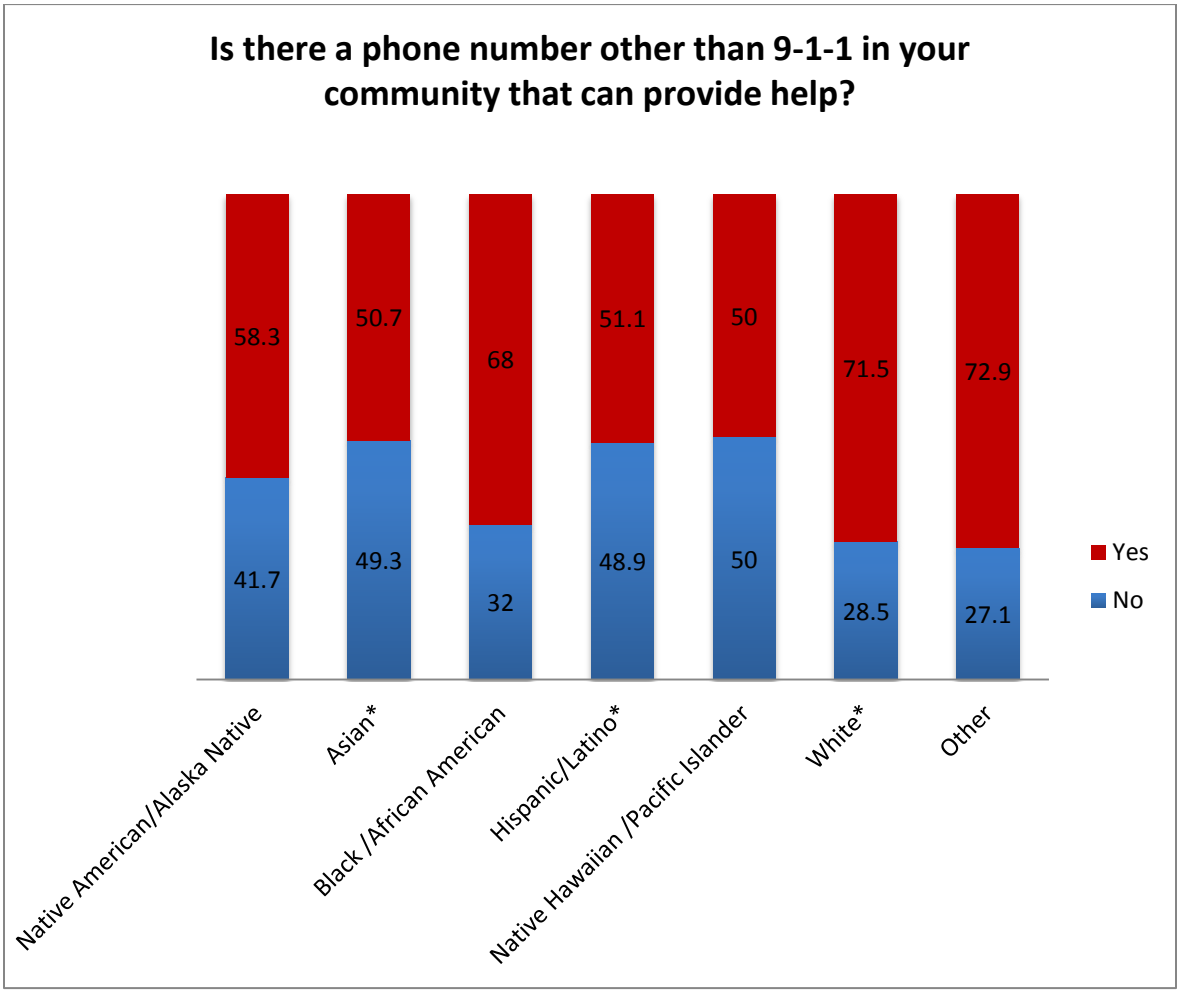

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Figure 29. Phone numbers other than 9-1-1 by Gender.

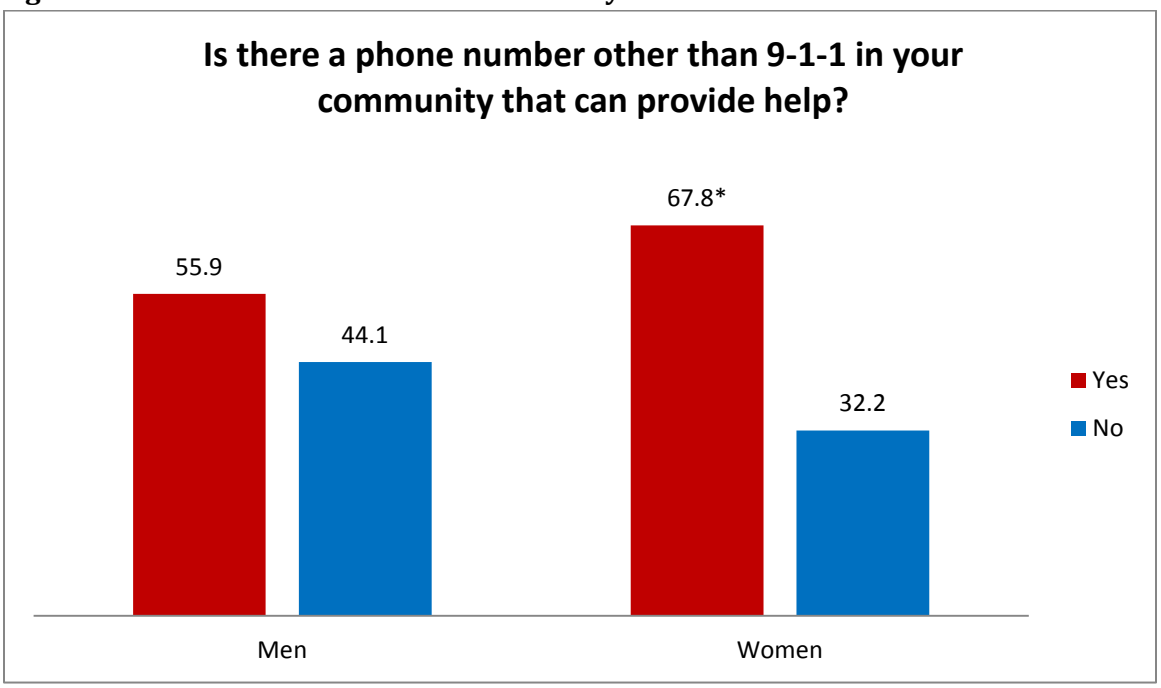

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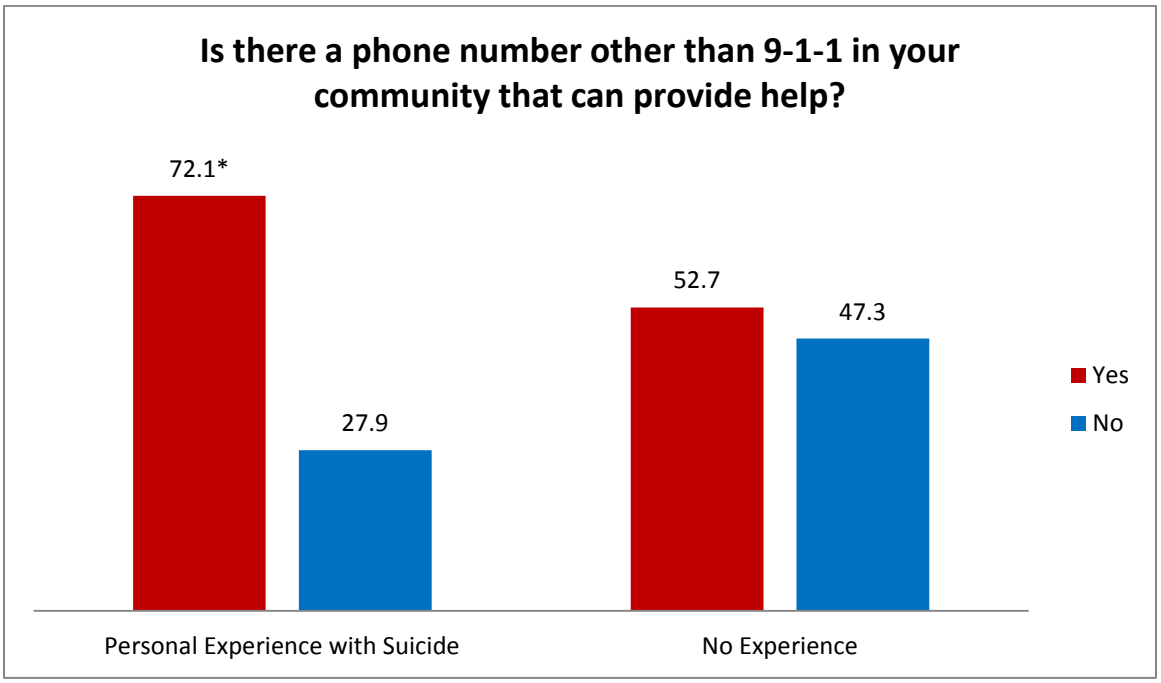
Figure 30. Phone numbers other than 9-1-1 by Personal Experience with Suicide.



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Support groups for those coping with suicide

Another resource explored in the survey was knowledge of support groups for those coping with a suicide. Overall, 29.5% (N=568) of participants reported being aware of such a group. Across Racial/Ethnic groups, White and Other individuals were significantly more likely to know about a support group while Asian and Hispanic/Latino respondents were significantly less likely. Women were also significantly more likely than men to say they were aware of support groups. As might be expected, those who had personal experience with suicide were significantly more likely than the overall population and more than twice as likely as those without personal experience to know about support groups. There were no other significant demographic differences on this item. See Figures 31-33.

Figure 31. Support Groups by Racial/Ethnic

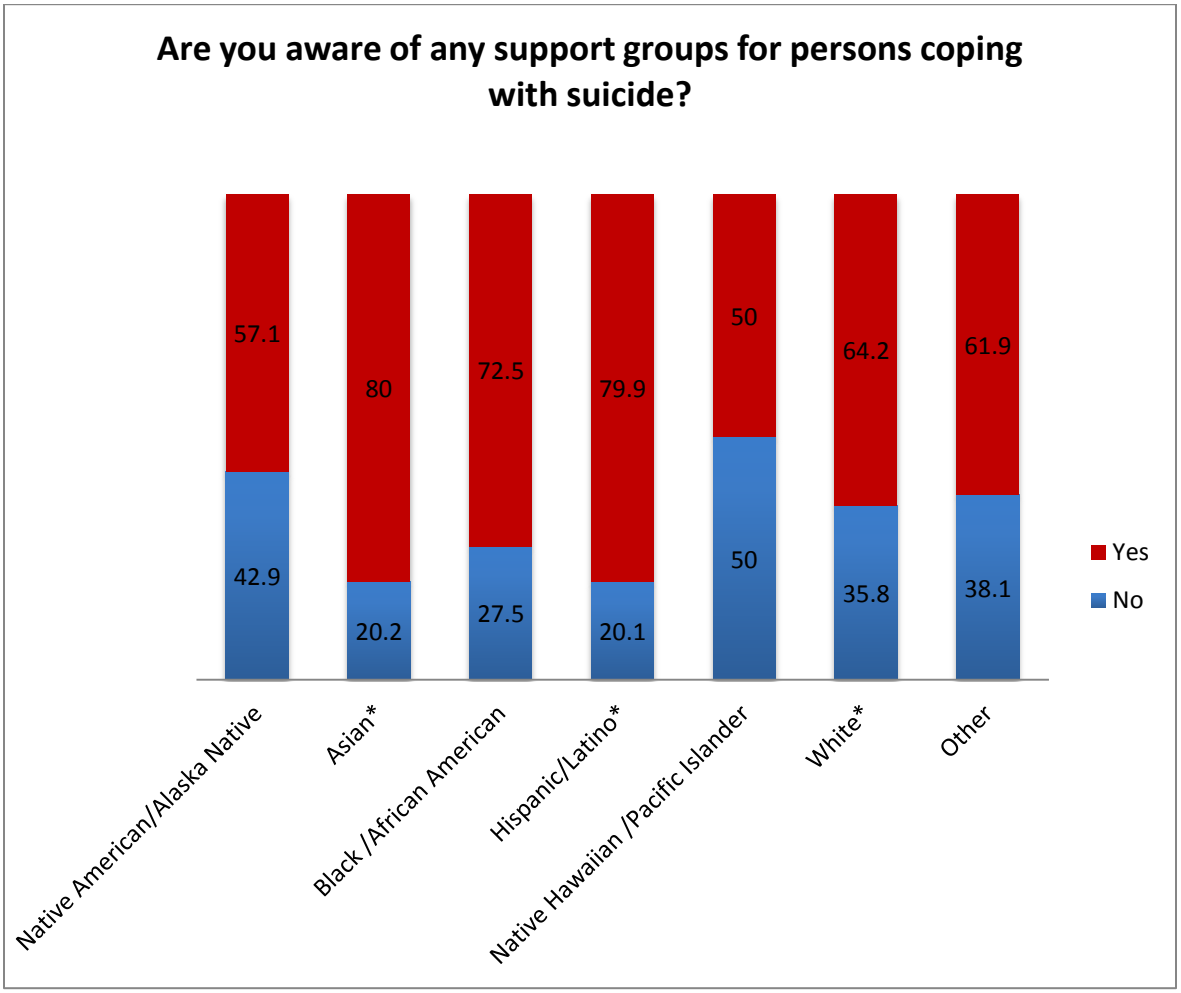

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Figure 32. Support Groups by Gender.

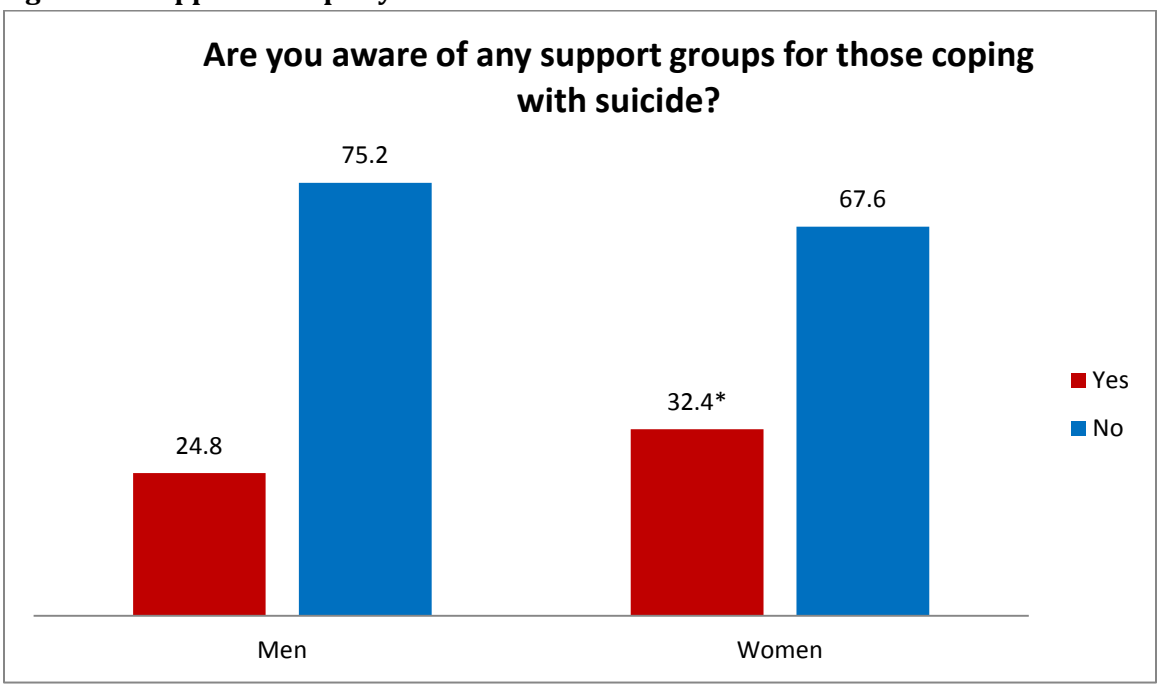

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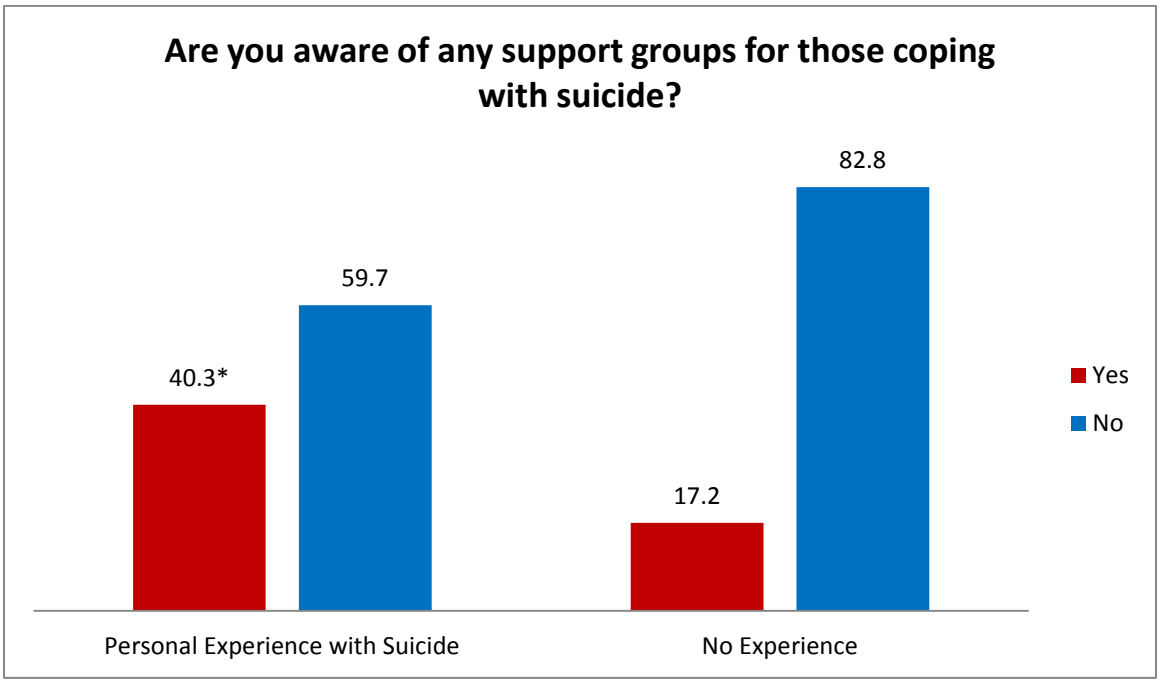
Figure 33. Support groups by Personal Experience with Suicide.



***p<.001**

Efficacy/Skills

Table 8. Overall responses to Efficacy/Skills questions.

Question	Disagree	Neither Agree nor Disagree	Agree	Don't Know/Refuse
Q3. Asking someone whether they are thinking about ending their life would be too difficult to do.	52.9%	16.2%	27.9%	2.9%
	(1060)	(325)	(559)	(59)
Q12. I would be worried to bring up the topic of suicide with someone I was concerned about in case it gave them ideas.	53.8%	17.3%	25.8%	3.1%
	(1078)	(346)	(516)	(63)
Q15. I am confident in my ability to discuss suicide with someone I care about.	10.0%	12.0%	76.7%	1.2%
	(201)	(241)	(1537)	(24)

This set of survey items asked survey participants to assess how difficult it would be for them to approach the subject of suicide with someone they believed to be at risk, and their confidence in their own ability to do so. Table 8 shows responses to these items.

Racial/Ethnic groups showed significant differences on all three questions in the Efficacy/Skills category. First, Asian and Hispanic/Latino respondents were significantly more likely to agree and Whites significantly less likely to agree that it would be too difficult to ask someone about whether they were thinking of ending their life. Whites and Others were significantly less likely to agree that bringing up the topic of suicide might give someone ideas, and Hispanic/Latino and Native American/Alaska Native individuals were significantly more likely to agree. Finally, Blacks were significantly more confident in their ability to discuss suicide with someone they care about. See Figures 34-36.

Those 65 years or older were significantly more likely to feel that asking someone whether they are thinking about ending their life would be too difficult. Those in the 18-24 year age group were significantly more likely to disagree that bringing up the topic of suicide might give someone ideas, or to be neutral about this statement. Those 65+ were significantly more likely to agree. Individuals 65+ were significantly more likely to disagree that they were confident in their ability to discuss suicide with someone. See Figures 34-36.

Rural respondents differed from Urban/Suburban respondents on the issue of bringing up suicide with someone they were concerned about. Rural respondents were significantly more likely to indicate that they would be worried about doing so. See Figure 37.

Women were significantly more likely than men to disagree that asking someone about suicide would be too difficult. Men were significantly more likely than women to disagree that they were confident in their ability to discuss suicide with someone they care about. See Figure 38.

Respondents with experience of suicide differed on all three questions in this area. They were significantly less likely than those with no experience to agree that asking someone about their suicidal intentions would be too difficult. They were significantly more likely to disagree that bringing up the topic of suicide might give someone ideas. They were also significantly more likely to express confidence in their ability to discuss suicide. See Figure 39.

Figure 34. Efficacy/Skills by Race/Ethnicity and Age.

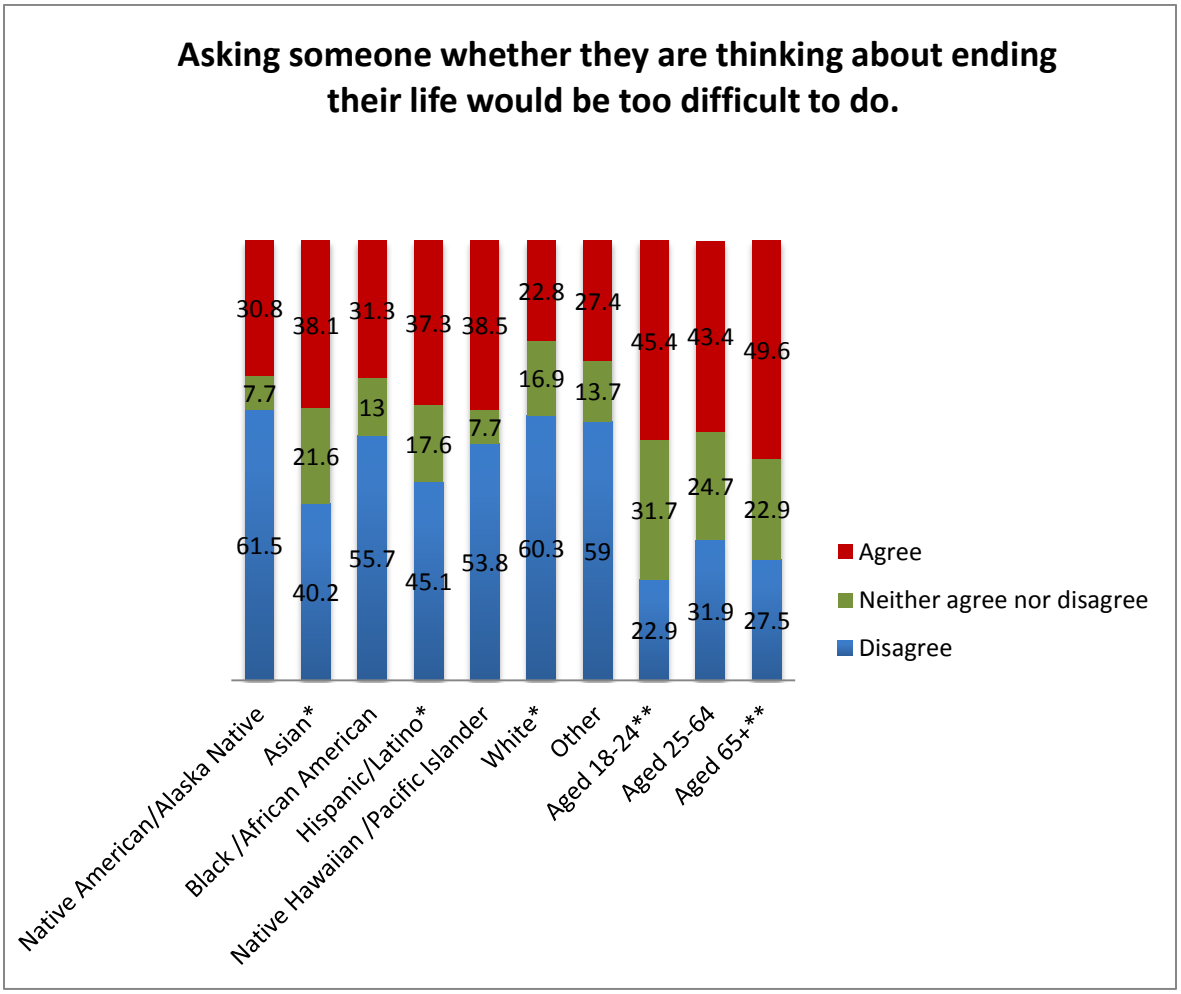


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Figure 35. Efficacy/Skills by Race/Ethnicity and Age, cont.

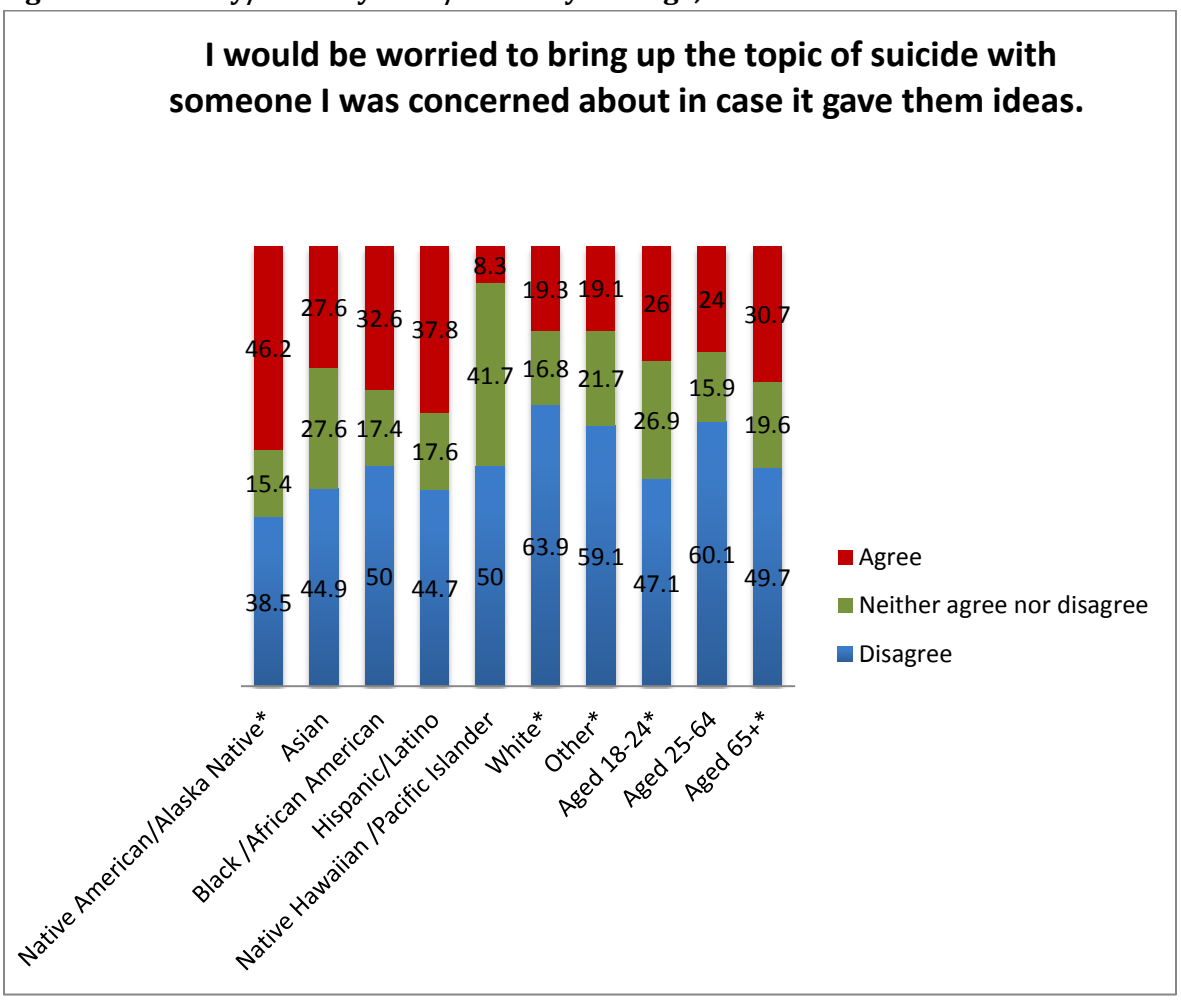

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Figure 36. Efficacy/Skills by Race/Ethnicity and Age, cont.

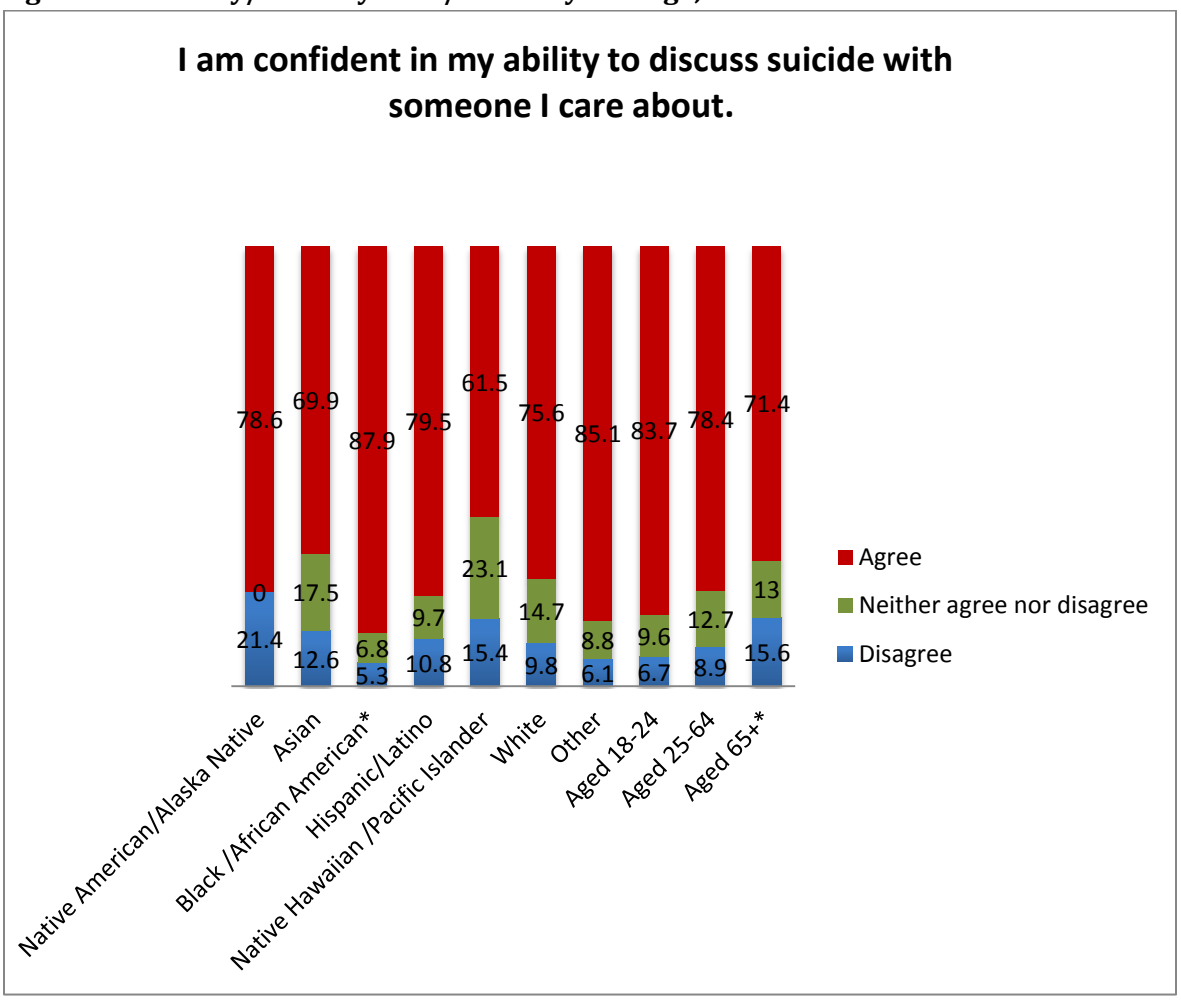

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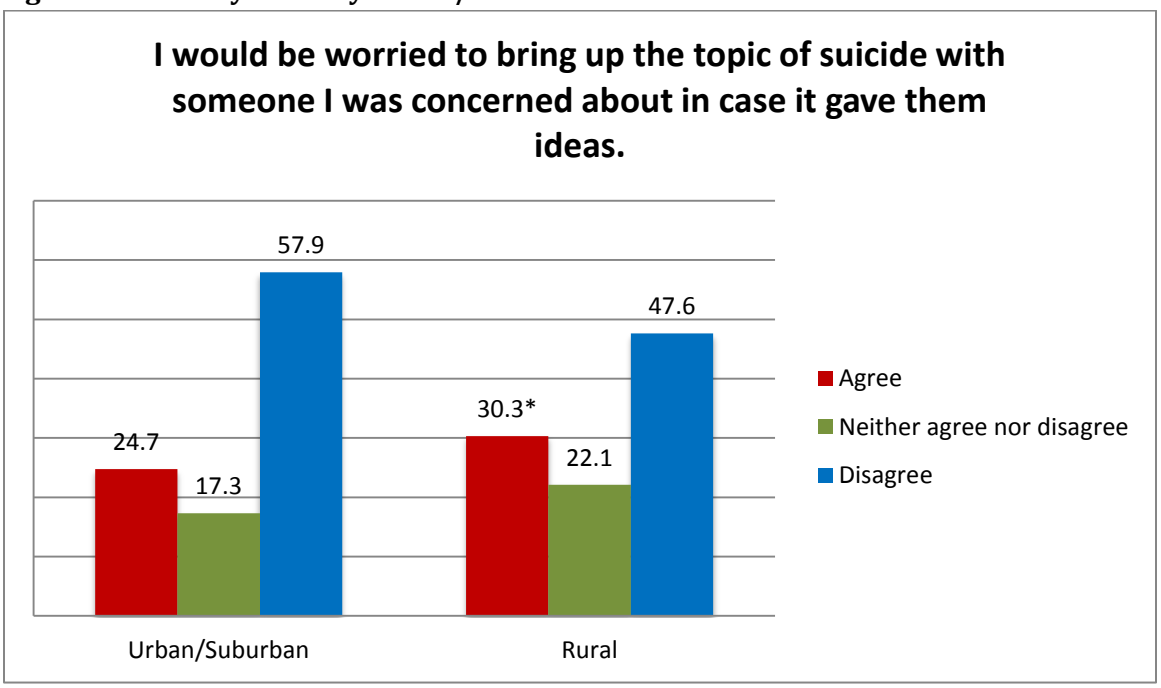
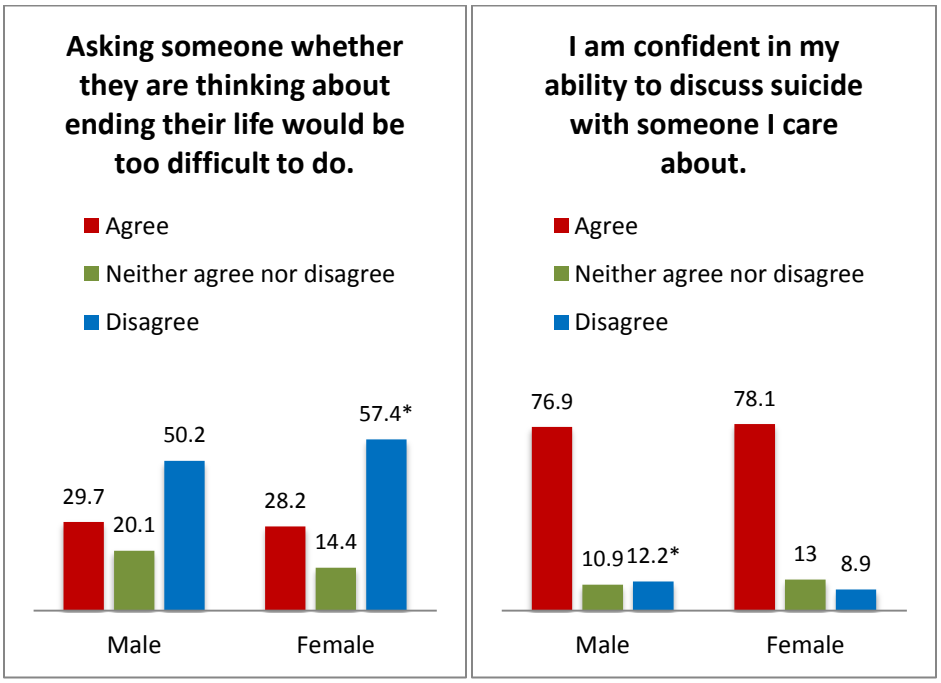
Figure 37. Efficacy Skills by Urban/Rural.



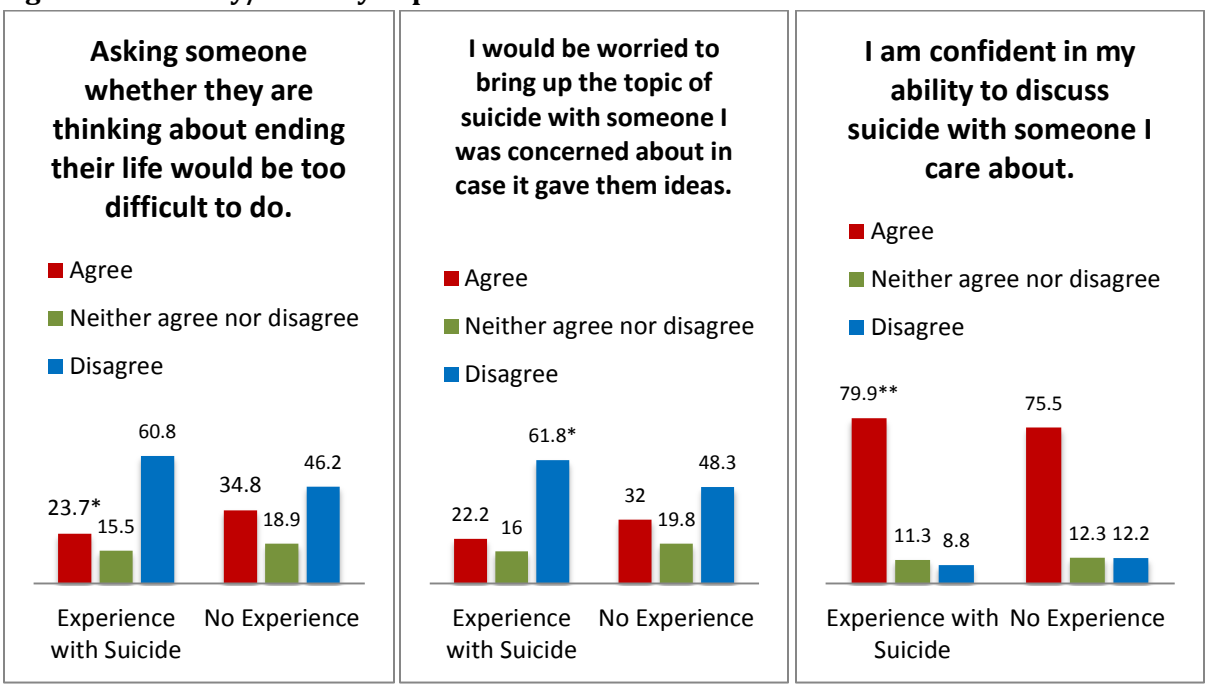
*p<.05

Figure 38. Efficacy/Skill by Gender.



*p<.05

Figure 39. Efficacy/Skills by Experience with Suicide.



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Action

Table 9. Overall responses to Action questions.

Question	Disagree	Neither Agree nor Disagree	Agree	Don't Know/Refuse
Q19. If a friend or family member was having thoughts of suicide, I would express my concern to them.	22.3%	12.7%	62.4%	2.6%
	(446)	(254)	(1250)	(53)
Q22. If a friend was having thoughts of suicide, I would do nothing; it is none of my business.	41.0%	9.5%	44.8%	4.6%
	(822)	(191)	(897)	(93)

At several points in the survey, respondents were asked whether or not they would consider taking action if they suspected that a friend or family member was considering suicide. Table 9 shows responses to two of these items. A breakdown of responses by demographic variables follows.

Whites and Blacks were significantly less likely to agree that a friend's thoughts of suicide would be none of their business. Hispanic/Latino respondents were significantly more likely to agree with this statement. See Figure 40.

Respondents 65 and older were significantly more likely to agree that it would be none of their business and they would do nothing if a friend was having thoughts of suicide. Similarly, respondents aged 65 or

older were significantly more likely to disagree that they would express their concern to friend or family member having thoughts of suicide. See Figures 40 and 41.

Although the great majority of respondents disagreed that they would do nothing in response to a friend's thoughts of suicide, significantly more Rural than Urban/Suburban respondents agreed with this item. See Figure 42.

Those with experience of suicide were significantly more likely than those without experience to say that they would express concerns to a friend or family member contemplating suicide. See Figure 43.

Figure 40. Action by Race/Ethnicity and Age.

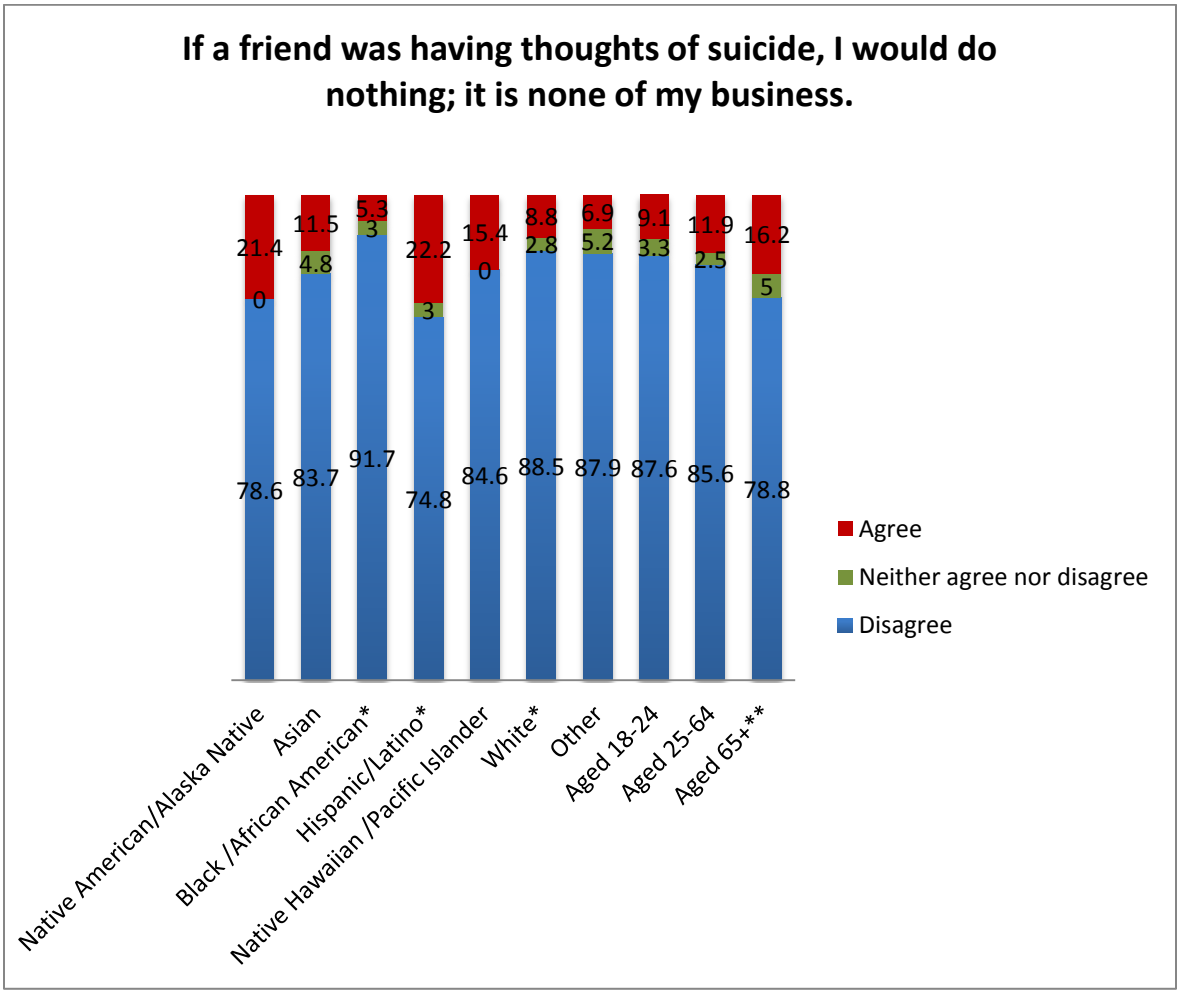

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Figure 41. Action by Age.

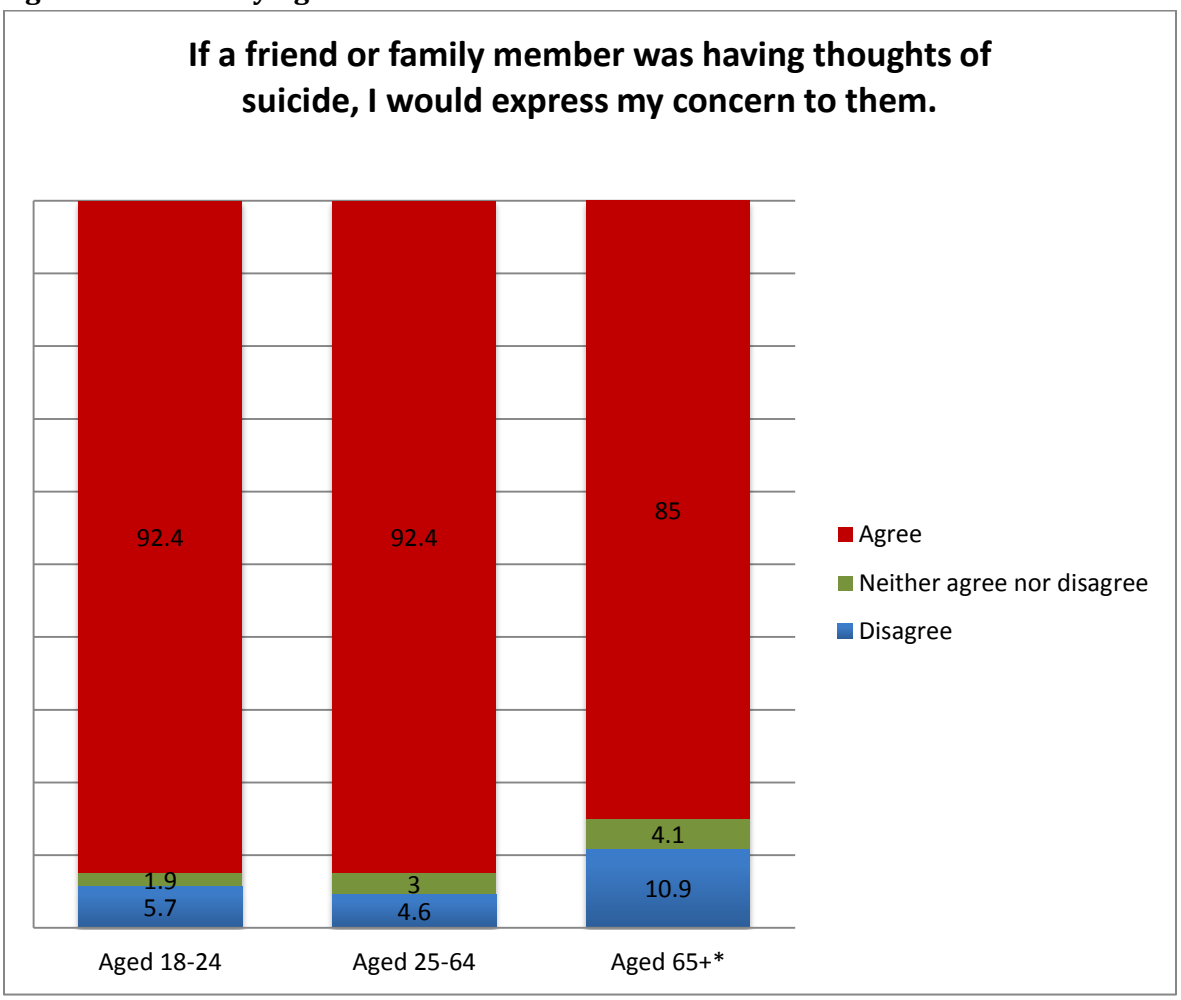

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Figure 42. Action by Urban/Rural.

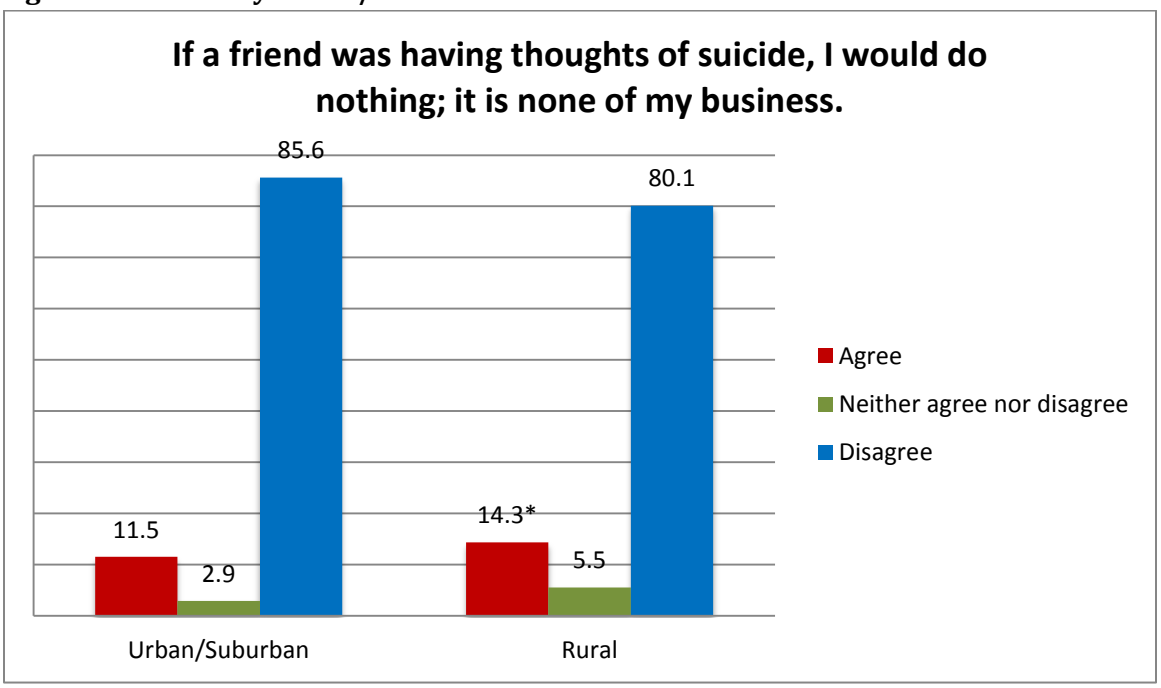

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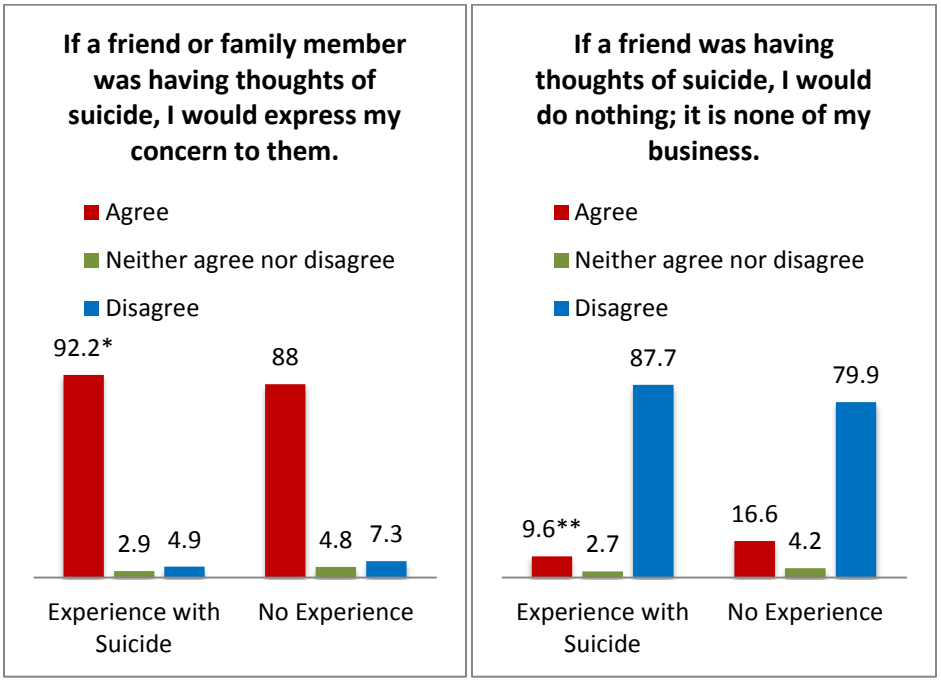
Figure 43. Action by Experience with Suicide.



*p<.01, **p<.001

Likelihood to Take Specific Actions

Respondents were also asked to say whether they were likely to perform specific actions if someone they knew did something to make them think he or she was suicidal. They were divided in the analysis of these action questions depending on whether they did or did not know at least one warning sign of suicide. Significant differences in likely actions depending on knowledge of warning signs are noted in Table 10. Most respondents stated that they would be likely to perform all of the listed actions and most also cited at least one warning sign for suicide. Where differences occurred, those who knew at least one warning sign were significantly more likely to say they would take a given action. There were no significant differences between those who knew one warning sign and those who knew two or more warning signs on responses to other likely action items.

Table 10. Specific Actions by Knowledge of Warning Signs.

Survey Item	Knows signs	Does not know signs
Likely to visit a website for information.*	82.0%	72.1%
	(1359)	(178)
Likely to call a crisis line or hotline.	85.6%	82.2%
	(1444)	(208)
Likely to provide them with a phone number or other resource.*	93.5%	87.9%
	(1579)	(225)
Likely to express your concerns to them.*	94.7%	88.1%
	(1597)	(222)
Likely to express your concerns to someone else.*	92.5%	85.3%
	(1560)	(221)

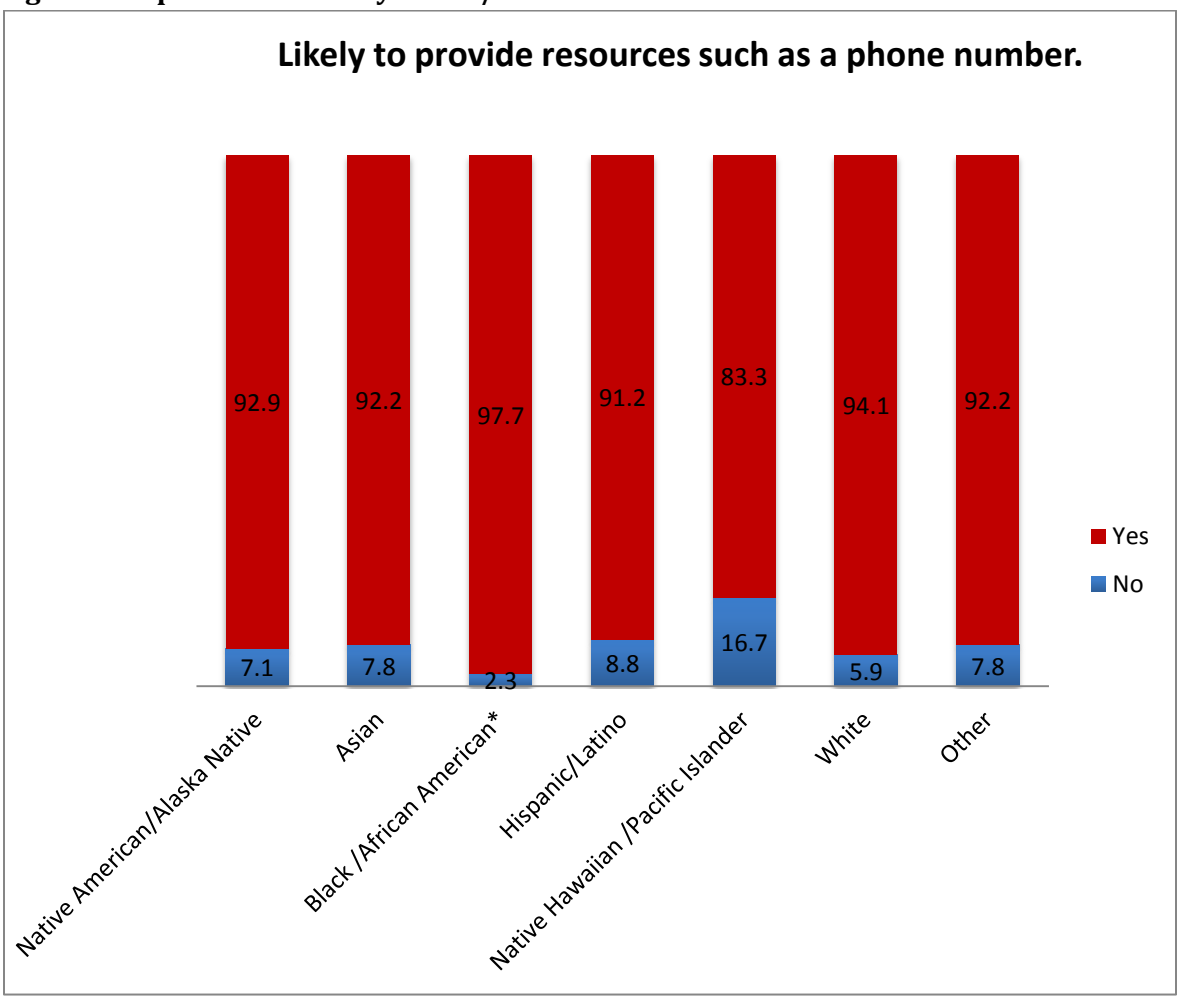
***p<.01**

Significant Racial/Ethnic differences appeared on two of the questions. First, Black respondents reported that they would be significantly more likely than others to provide resources such as a phone number. However, over 90% of all respondents all said this was a likely action. Black respondents were significantly more likely and Hispanic/Latino respondents significantly less likely to say that they would express their concerns to the person. See Figures 44 and 45.

A few other demographic differences were noted on the specific action questions. Most differences occurred in reference to likelihood of visiting a website for information. Parents of children ages 10-24 were significantly more likely to say they would visit a website than others. Veterans/active military were significantly less likely than those never in the military to say they would visit a website. Respondents 18 to 24 years old were significantly more likely than other to anticipate visiting a website, while respondents 65 or older were significantly less likely than average. See Figures 46-48.

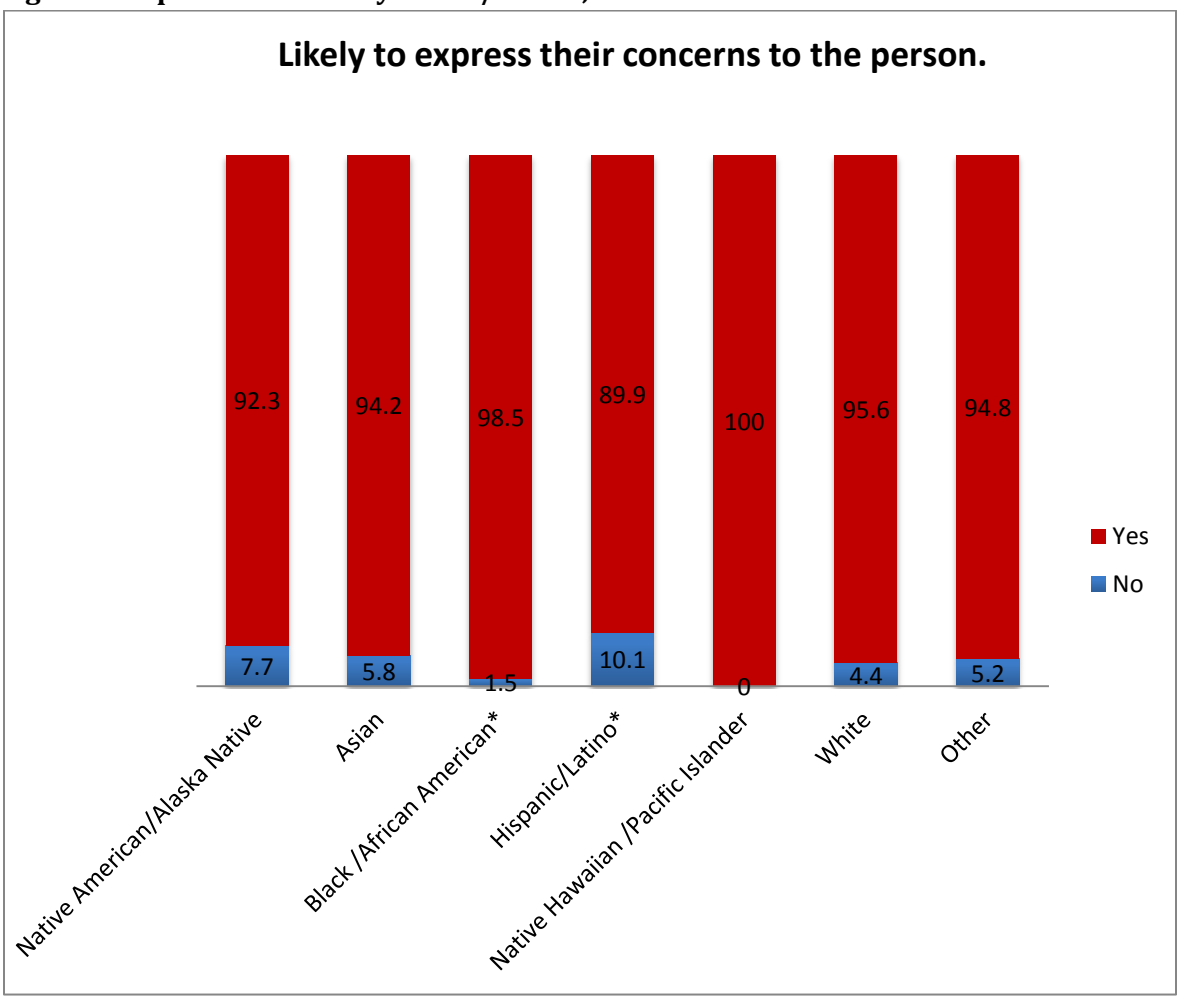
Those 65 and older were significantly less likely than the other two age groups to say that they would express their concerns about a suicidal friend to someone else. See Figure 49. There were no other demographic differences across likely specific action items.

Figure 44. Specific Actions by Racial/Ethnic.



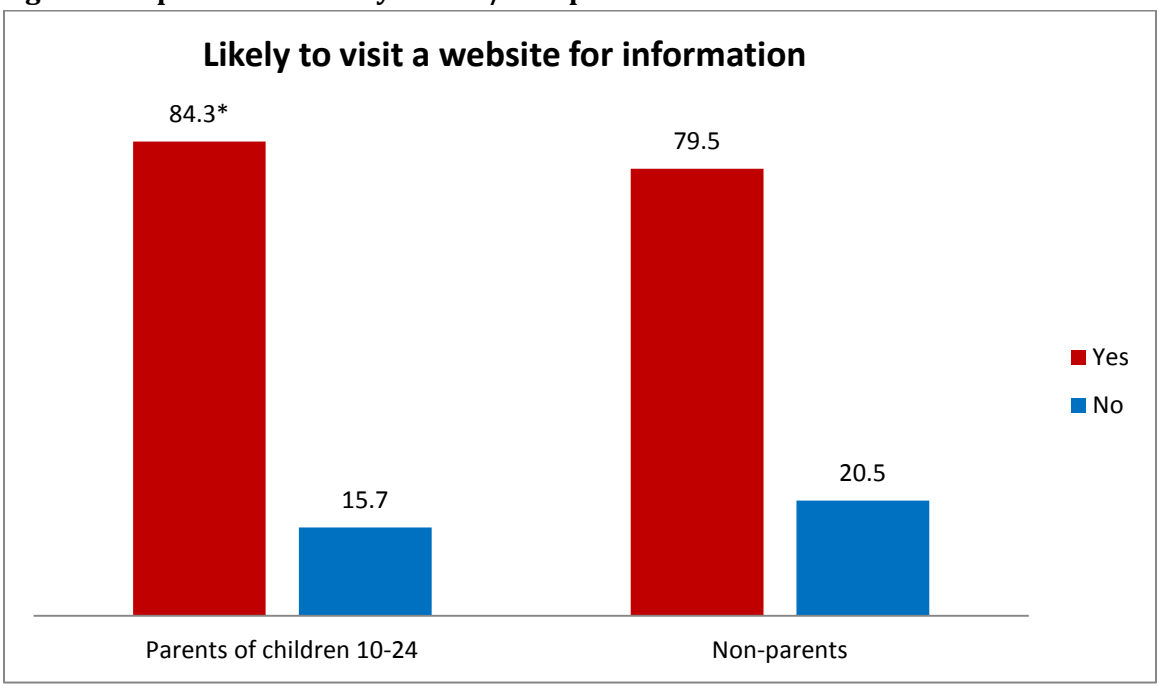
*p<.05

Figure 45. Specific Actions by Racial/Ethnic, cont.



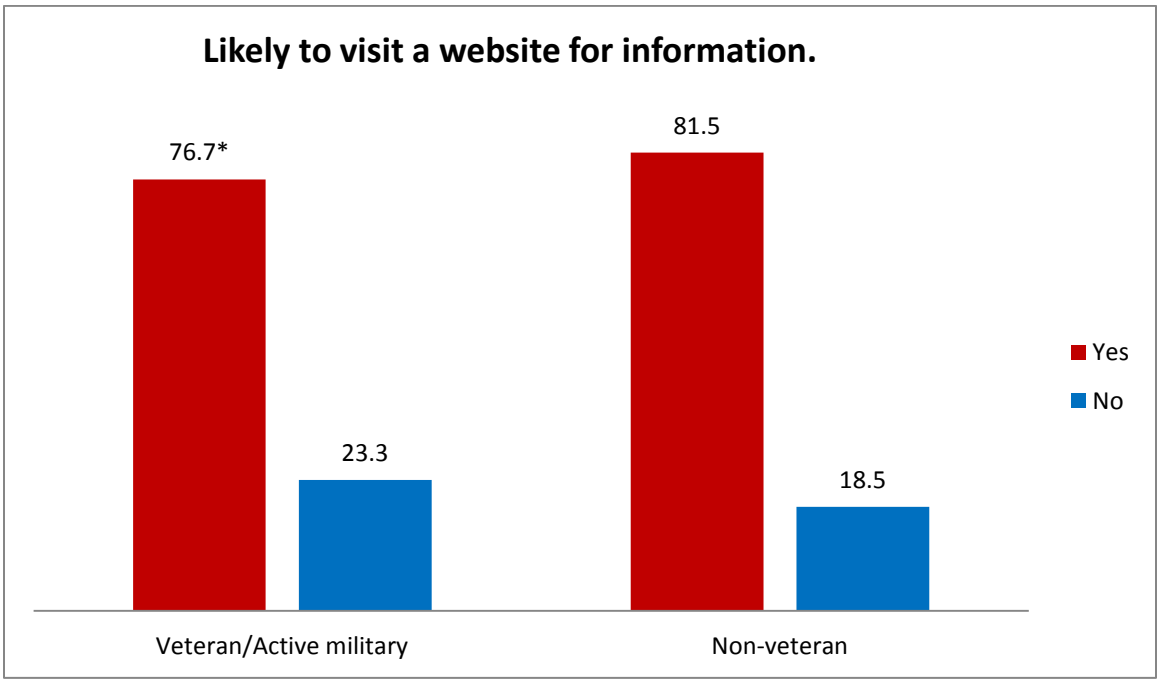
*p<.001

Figure 46. Specific Actions by Parent/Non-parent



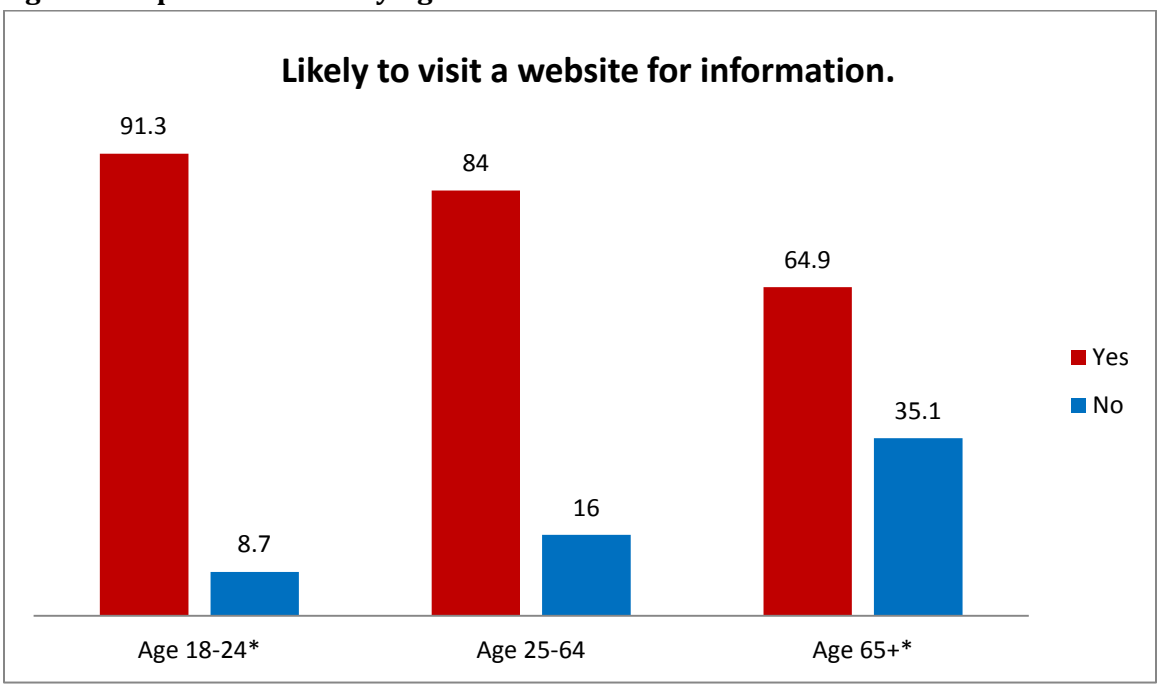
***p<.05**

Figure 47. Specific Actions by Military Status



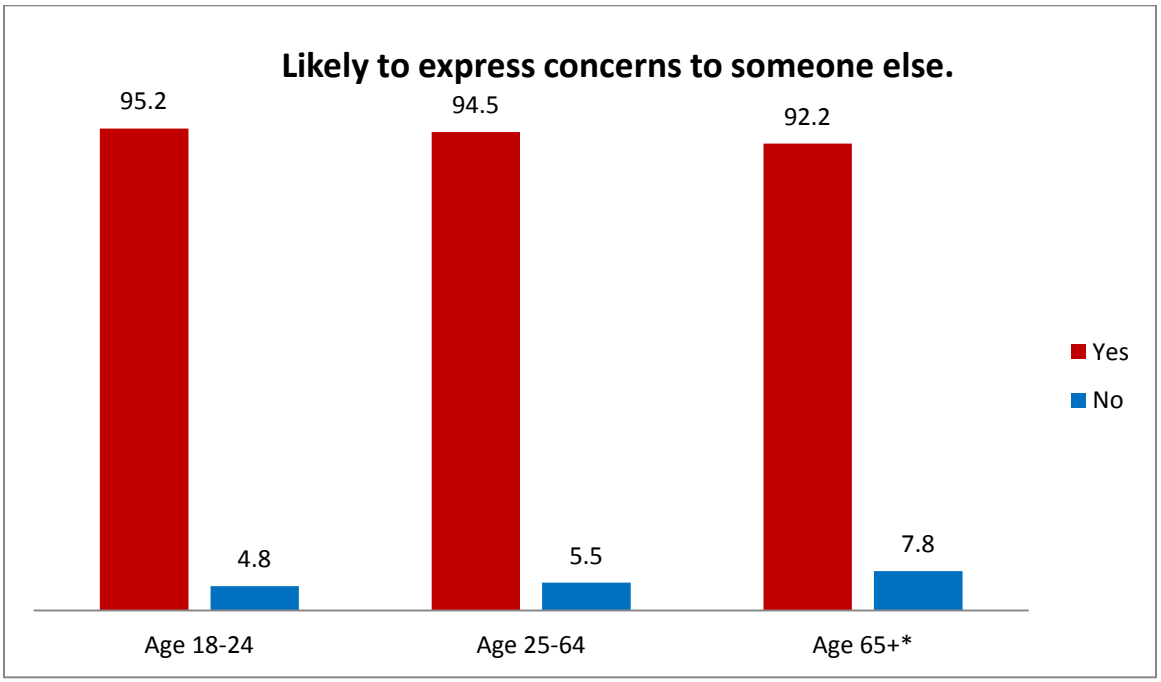
***p<.05**

Figure 48. Specific Actions by Age



***p<.01**

Figure 49. Specific Actions by Age, cont.



***p<.05**

Finally, an analysis explored whether there were significant differences between those who had personal experience with suicide and those who did not on other likely actions they might take. Table 11 shows this comparison. In all cases where there was a significant difference, those who had personal experience with suicide were more likely to say that they would perform the indicated action.

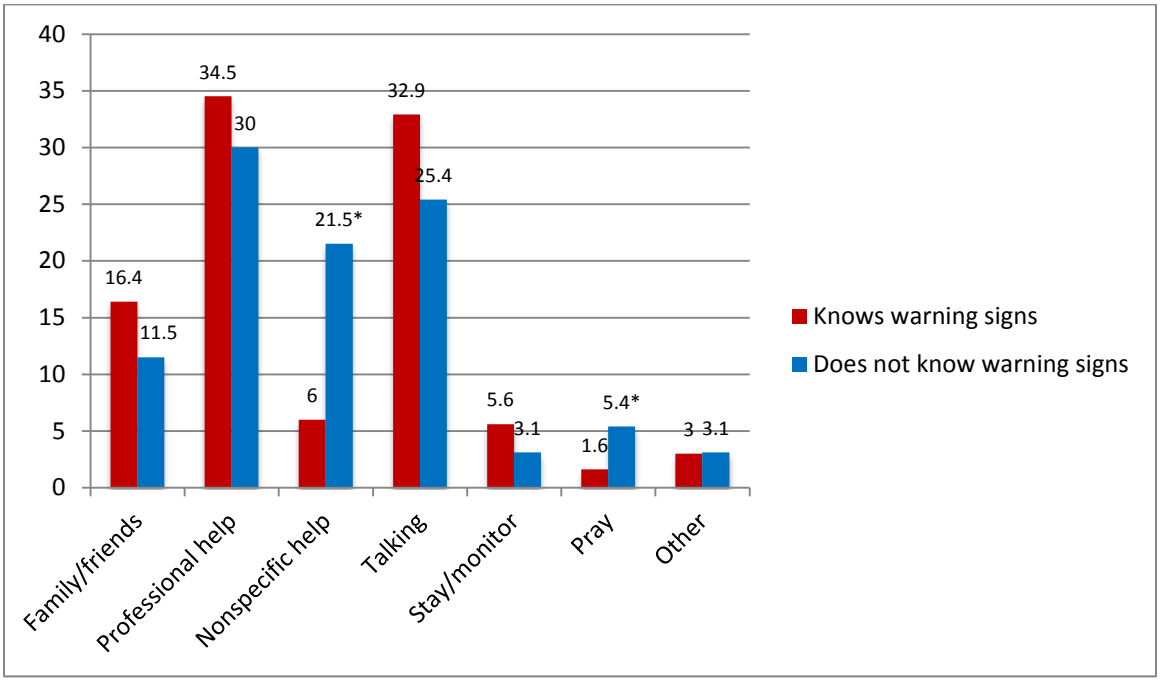
Table 11. Other Likely Actions by Personal Experience with Suicide.

Survey Item	Experience with Suicide	No Experience
Likely to visit a website for information.*	83.6%	78.2%
	(842)	(685)
Likely to call a crisis line or hotline.	87.2%	85.0%
	(892)	(764)
Likely to provide them with a phone number or other resource.*	94.5%	91.5%
	(969)	(826)
Likely to express your concerns to them.*	95.6%	92.2%
	(978)	(828)
Likely to express your concerns to someone else.*	93.8%	89.5%
	(956)	(814)

***p <.01**

An open-ended question at the end of the Likely Response items allowed participants to indicate if there were any further actions they would take, beyond those already mentioned. Approximately 66% of all respondents gave an answer to this question. Several of the response categories repeated or expanded on those listed in the preceding survey items. Response categories included telling family or friends; seeking or recommending professional help (e.g. calling a counselor, doctor, the police, or a hotline), non-specific help (e.g., "Anything,", or ""Whatever I can do."); talking to the person or advising them personally; staying with the person or monitoring them closely; and praying for them (alone or with others). Figure 50 shows the percentages of respondents offering each additional type of action, broken down by whether or not the respondents reported knowing any warning signs of suicide. Those who did not report knowledge of any warning signs were significantly more likely to say they would offer nonspecific help or pray.

Figure 50. Other Actions by Knowledge of Warning Signs.



***p<.001**

Factors related to Personal Intervention

One important research question looked at whether resources and other factors, including demographic variables were related to respondents' stated confidence in their ability to discuss suicide with someone they cared about and their willingness to express concern or otherwise intervene with a friend or family member. Regression analyses were conducted to assess the strength of the relationship between demographic and other variables to three personal intervention items.

I am confident in my ability to discuss suicide with someone I care about.

Results of regression analysis showed that knowledge about resources was significantly associated with greater confidence in ability to discuss suicide. Those who agreed that they know where they could seek help for a friend or family member (See Appendix A, item 11), were 7.8 times more likely to agree than to disagree that they felt confident. Those who agreed that they know of suicide crisis line they can call (See Appendix A, item 14) were 2.8 times more likely to agree that they felt confident. Those who agreed that they know where to find assistance if a friend was having thoughts of suicide (See Appendix A, item 17) were 6.6 time more likely to agree that they felt confident in their ability to discuss suicide.

Regression analyses were also used to look at the relationship between demographic and other variables and confidence. Those who knew at least one warning sign of suicide were 2.2 times as likely to agree that they felt confident in their ability to discuss suicide. Those in the youngest age group (18 to 24) were 2.7 times more likely to say that they felt confident. Women were 1.4 times more likely to

say that they felt confident. Finally, those with personal experience of suicide were 1.5 times more likely to say that they felt confident.

If a friend or family member was having thoughts about suicide, I would express my concern to them.

Those who agreed that they know where they could seek help for a friend or family member were 4.2 times as likely to agree that they would express concern. Those who agreed that they know of suicide crisis line they can call were 2.4 times as likely to agree that they would express concern. Those who agreed that they know where to find assistance if a friend was having thoughts of suicide were 5.4 times as likely to agree that they would express concern.

Those in the 25-64 year old age group were 2.6 times as likely to agree that they would express concern. Regression analysis showed that those who reported knowing at least one warning sign were 2 times as likely to say they would express concern. Those who had personal experience with suicide were 1.6 times as likely to agree.

If a friend was having thoughts about suicide, I would do nothing; it is none of my business.

Regression analysis were done to assess the relationship of demographic and other factors to likelihood of disagreeing that they would do nothing in response to a friend's thoughts of suicide. Those who agreed that they know where they could seek help for a friend or family member were 1.5 times more likely to disagree that they would do nothing. Those who agreed that they know where to find assistance if a friend was having thoughts of suicide were 1.6 times more likely to disagree that they would do nothing.

Black respondents were 1.7 times as likely to disagree with this statement. Those with personal experience were 1.9 times as likely to disagree. Those who reported knowing at least one warning sign were 2.5 times more likely to disagree that they would do nothing.

Media

Table 12. Overall responses to Media questions.

Question	Disagree	Neither Agree nor Disagree	Agree	Don't Know/Refuse
Q5. I often see stories about suicide on TV.	38.5%	22.3%	35.5%	3.7%
	(771)	(447)	(711)	(74)
Q9. I often see stories about suicide in the newspaper or on the Internet.	36.4%	22.5%	35.9%	5.1%
	(730)	(451)	(720)	(102)
Q20. News stories about suicide help people understand what they can do to prevent it.	24.0%	22.3%	49.6%	4.1%
	(481)	(446)	(994)	(82)
Q21. In the news, suicide is often sensationalized.	25.5%	24.3%	41.7%	8.5%
	(511)	(487)	(835)	(170)

Media items assessed exposure and attitudes toward the topic of suicide as it is presented in the news media. Responses are outlined in Table 12.

Hispanic/Latino individuals were significantly more likely to report often seeing stories about suicide on TV. Whites were less likely to agree with this statement. Racial/Ethnic groups did not differ in their recall of stories in the newspaper or on the internet. Hispanic/Latino respondents were significantly more likely to agree that news stories help people understand how to prevent suicide. Whites were significantly more likely to disagree with this statement. Blacks and Others were significantly more likely to disagree that suicide is sensationalized in the news. See Figures 51, 53 and 54.

Those 65 and older and those 18-24 years old were significantly more likely than others to agree that they often see stories in the newspaper or on the internet about suicide, though groups did not differ on their TV exposure. Respondents between 18 and 24 were significantly less likely to disagree with the statement that news stories about suicide help people understand how to prevent it. This group was also significantly less likely to agree that suicide was sensationalized in the news and were significantly more likely to indicate neither agreement nor disagreement with this item. In contrast, respondents 65 and older were significantly more likely to agree that suicide was sensationalized in the news. See Figures 52-54.

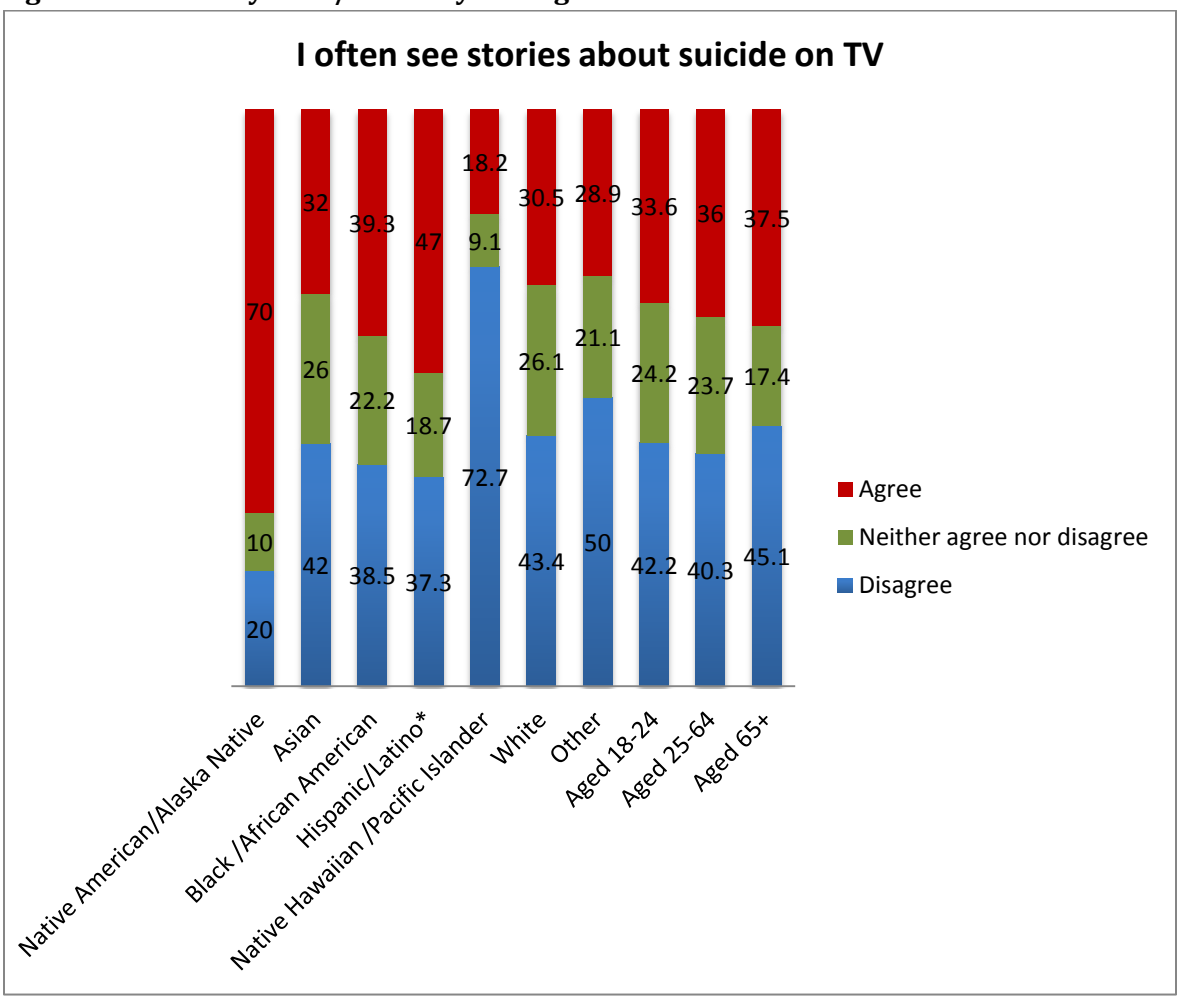
Those never in the military were significantly more likely to agree that they had seen stories about suicide on TV than were veterans/active military. Non-veterans/active military were also significantly more likely to agree that news stories help people understand how to prevent it than were veterans/active military, and were significantly less likely to agree that suicide was sensationalized than were veterans/active military. See Figure 55.

Women were significantly more likely than men to report often seeing stories about suicide on TV. However, they did not differ in their recall of stories about suicide in the newspaper or on the internet or on any of the other Media questions. See Figure 56.

Individuals with experience of suicide were significantly less likely than those with no experience to agree that news stories are helpful in understanding how to prevent suicide. See Figure 57.

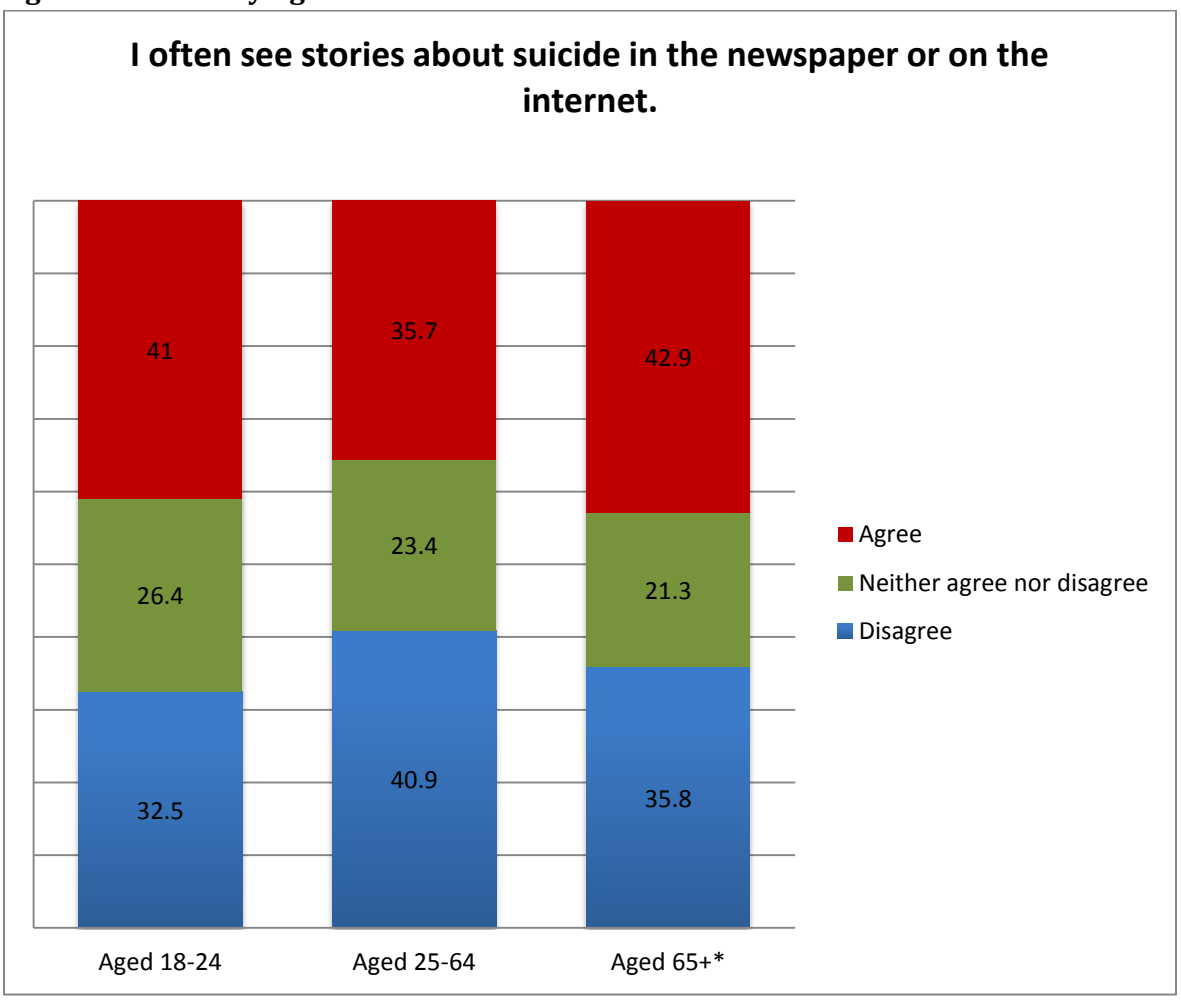
A further research question concerned whether responses to the media items differed across California regions. Results showed that respondents did not differ by region with regard to whether they thought news stories helped people understand what to do to prevent suicide or whether they thought stories about suicide were sensationalized. However, there were some significant differences in response to the questions relating to TV, the newspapers and the internet. Specifically, respondents from counties in the Bay Area and Northern/Mountain regions were significantly less likely to agree that they had seen stories on TV, whereas those in Los Angeles County were significantly more likely to agree with this item. Those in the Los Angeles region were also significantly more likely to agree that they had seen stories in the newspapers or on the internet than were those from other regions. See Figures 58 and 59.

Figure 51. Media by Race/Ethnicity and Age.



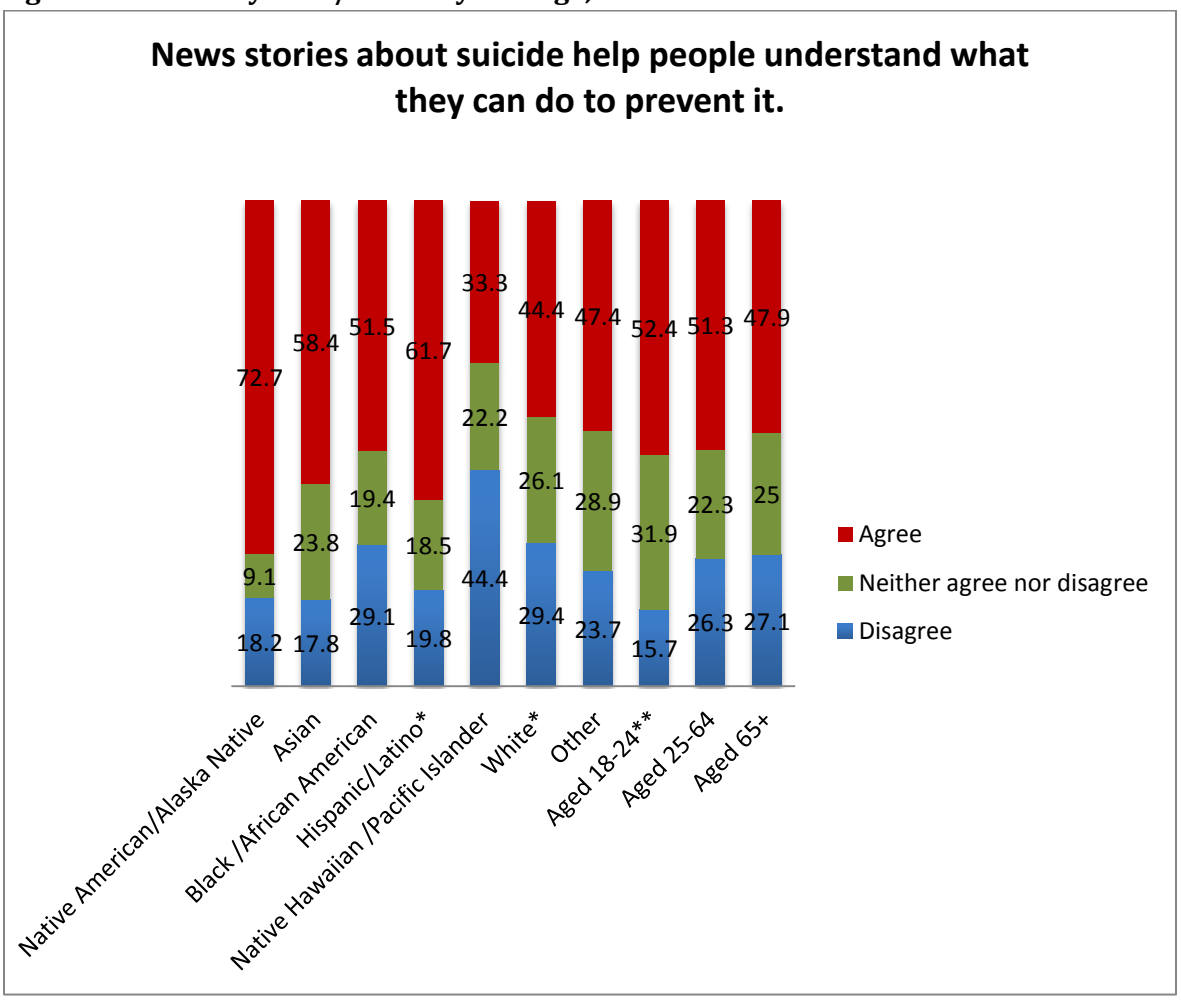
***p<.001**

Figure 52. Media by Age.



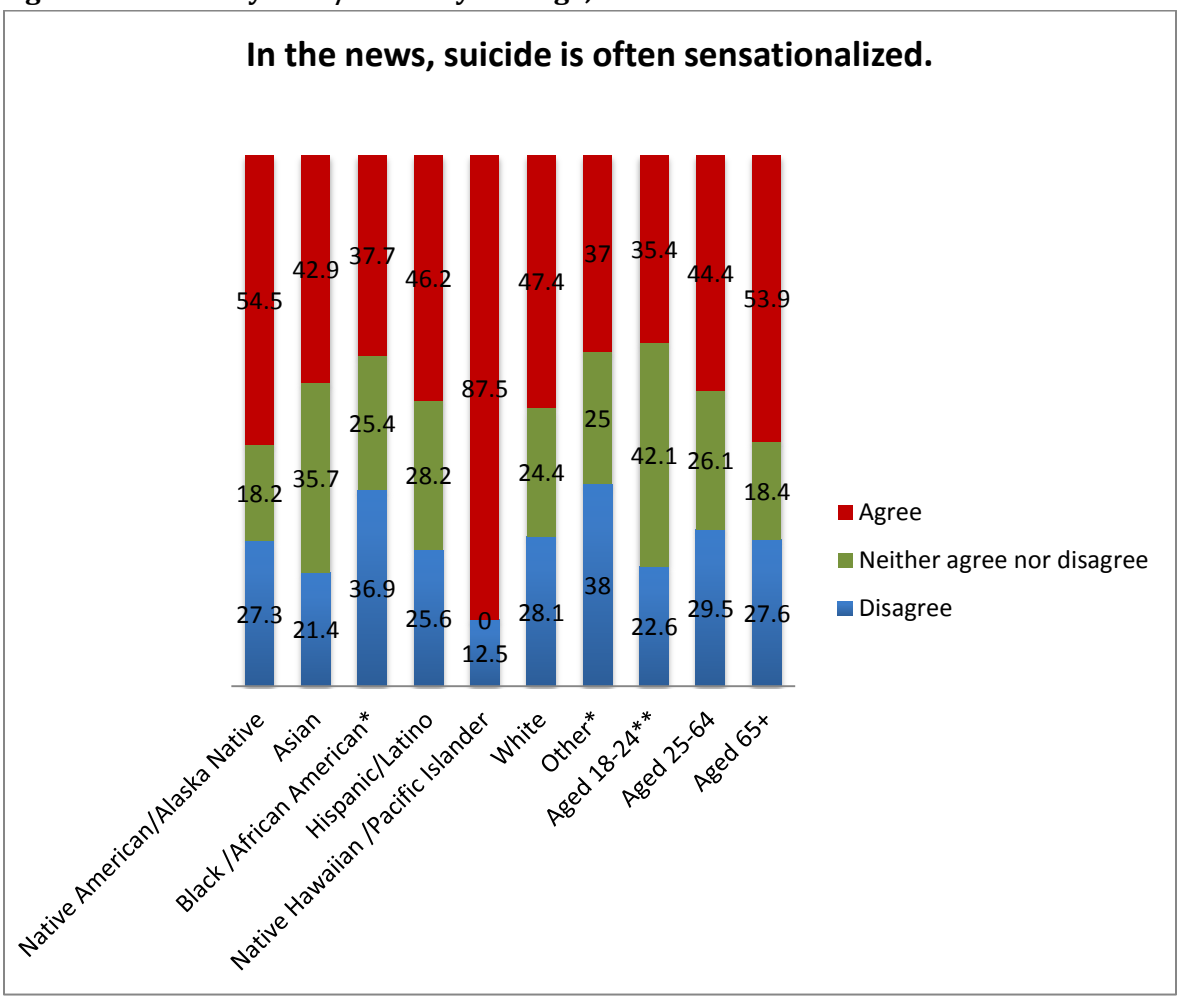
***p<.05**

Figure 53. Media by Race/Ethnicity and Age, cont.



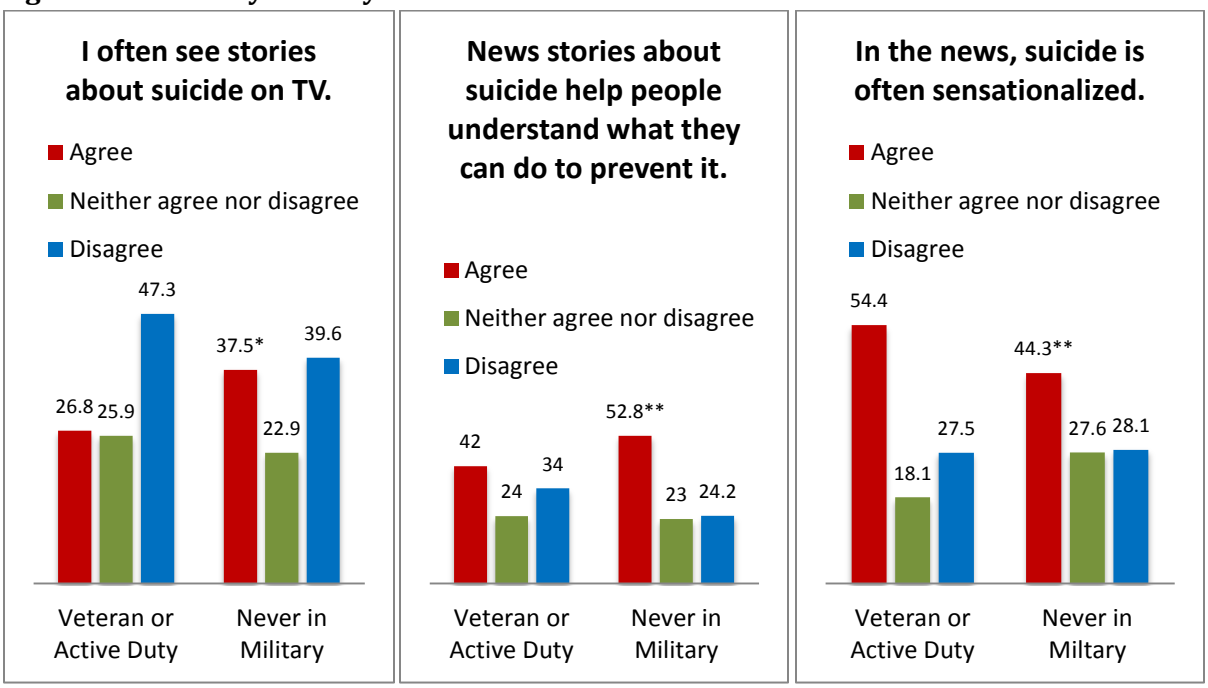
*p<.001, p<.01

Figure 54. Media by Race/Ethnicity and Age, cont.



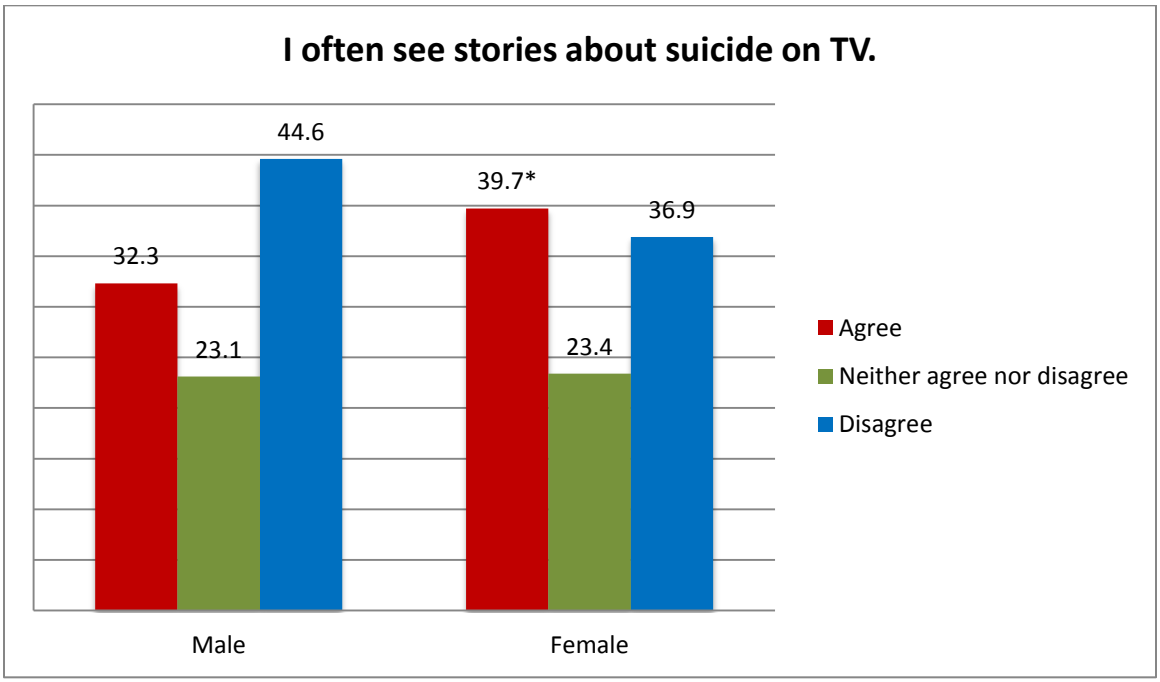
*p<.05, **p<.01

Figure 55. Media by Military Status.



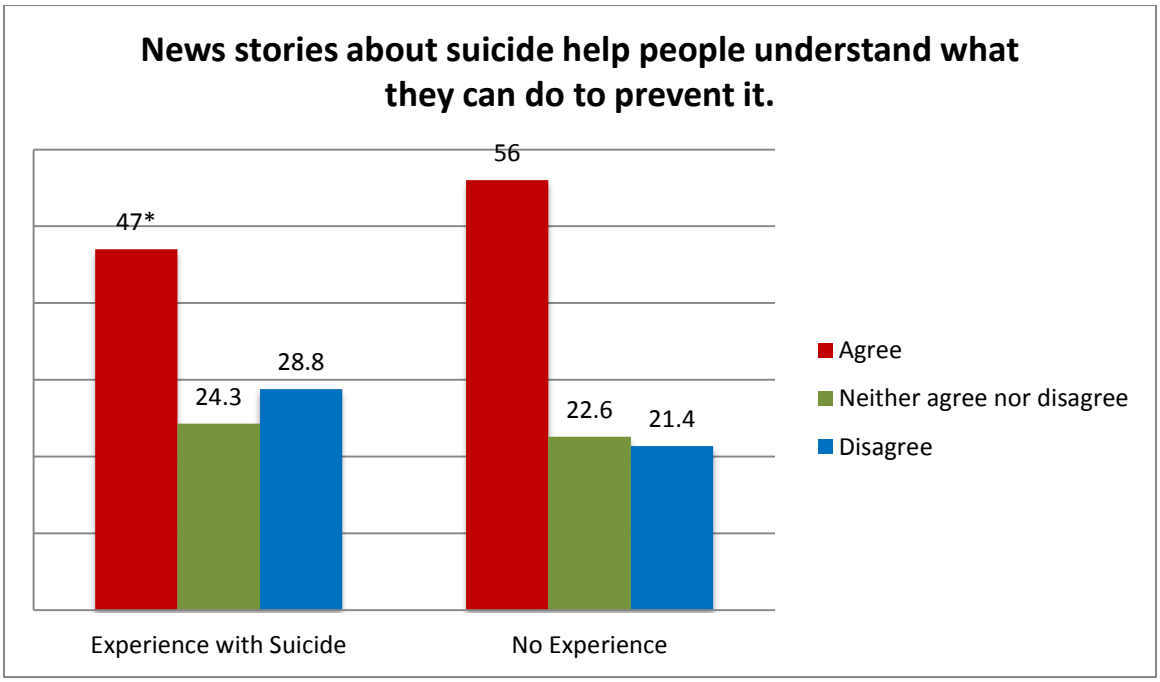
***p<.05, **p<.01**

Figure 56. Media by Gender.



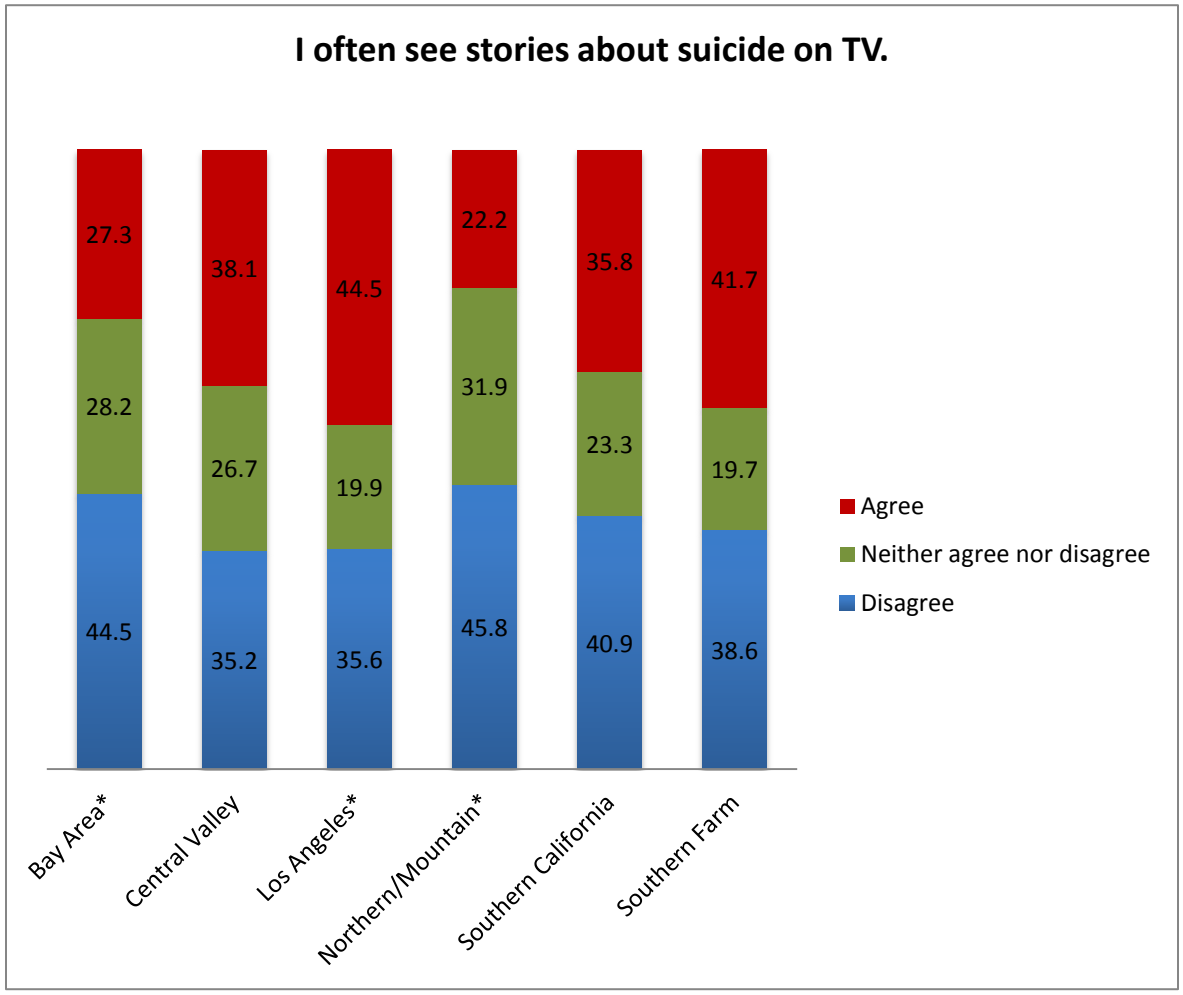
***p<.05**

Figure 57. Media by Experience with Suicide.



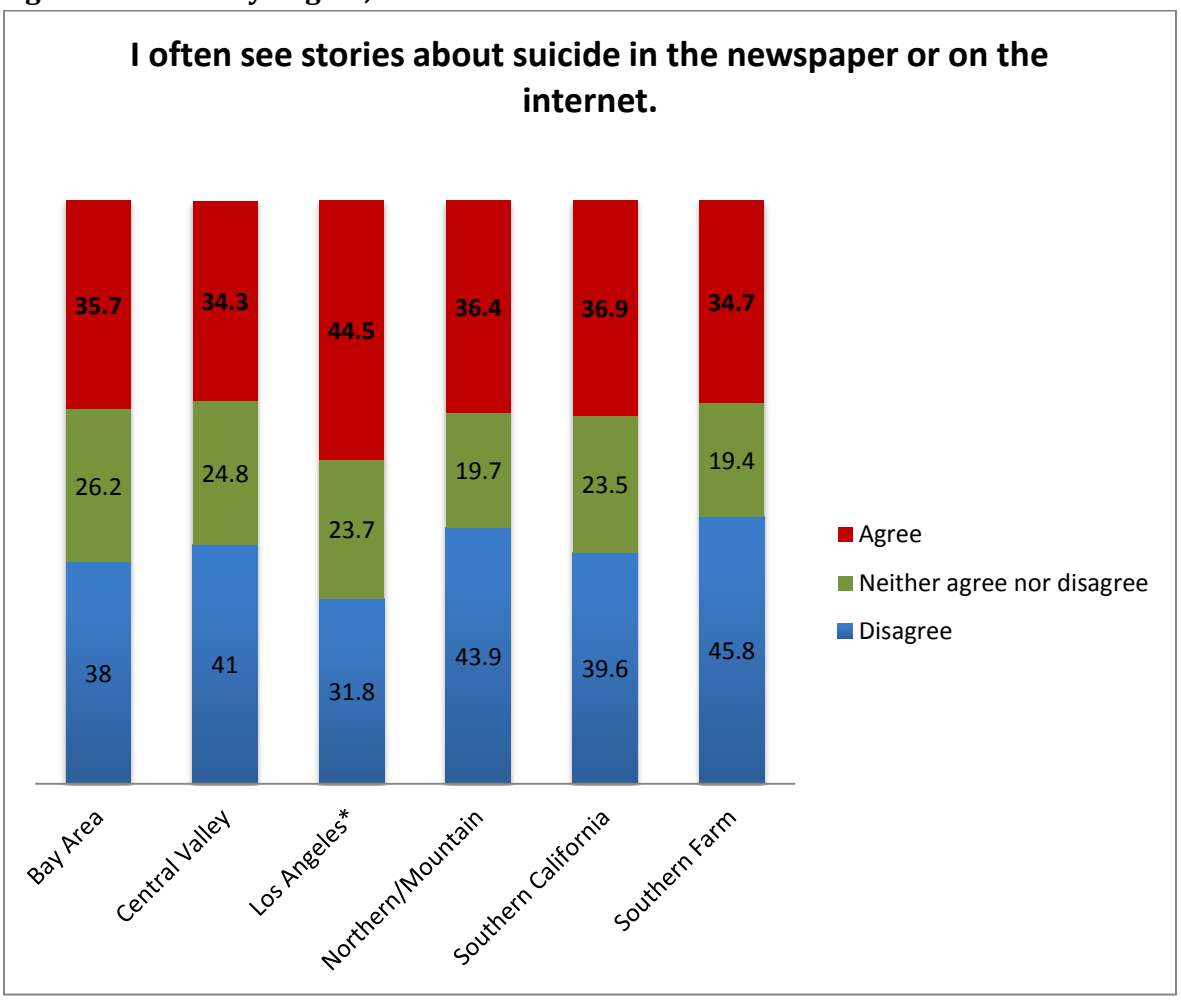
***p<.001**

Figure 58. Media by Region.



*p<.001

Figure 59. Media by Region, cont.



***p<.001**

Exposure to Media Campaigns

The majority of respondents reported that they had not seen any ads or messages related to suicide in the past several months (72.5%, N=1361). Respondents 18 to 24 years old were more likely to have seen messages (37.1%) than were those aged 25-64 (28.7%) or those aged 65 and older (16.7%, p<.001). Respondents with experience of suicide were more likely to recall having seen messages than those with no experience (32.6% vs. 21.8%, p<.001). There were no differences across regions of California in their reported recall of media campaigns. TV outweighed all other sources of information, with 55.8% (N=289) of those citing any message indicating that it had come from television. Table 13 shows the number of times each source was cited by any respondent.

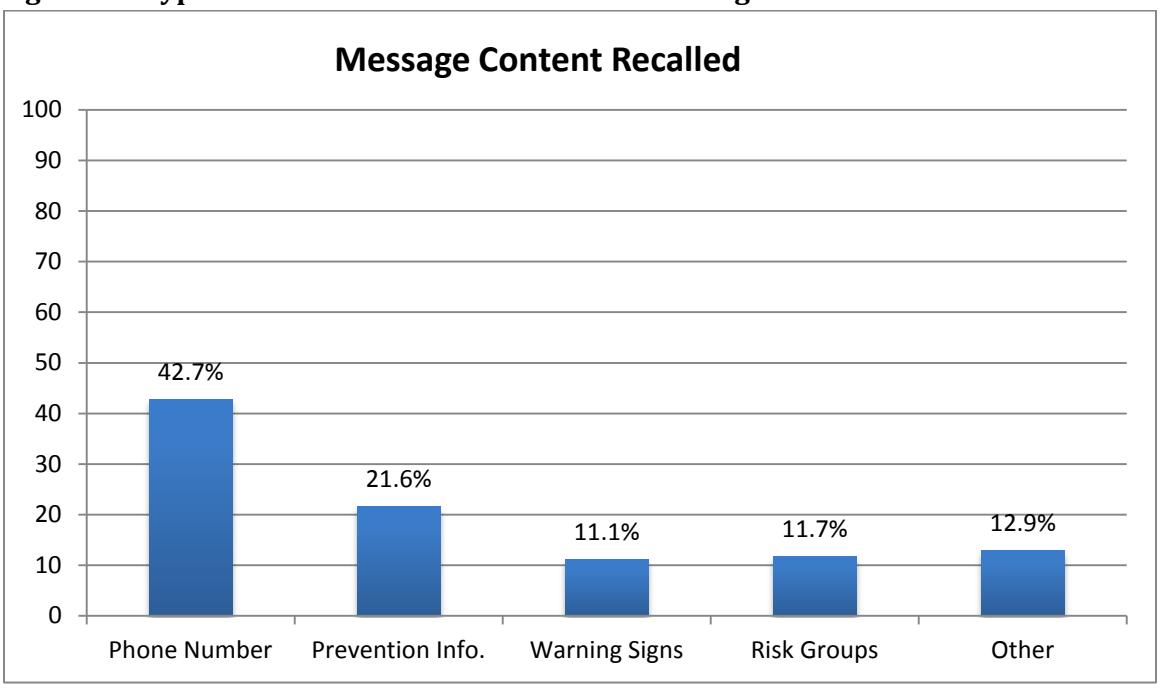
Table 13. Sources of Media Messages

Source of Message	Number of Times Cited
TV	289
Radio	32
Magazine	26
Website	50
Billboard	60
Brochure	30
Newspaper	51
Bus	15
Movie Theater	2

Additional sources of information mentioned by 5 or more individuals included schools or college campuses (N=20), work (N=16), doctor's offices or hospitals (N=9), bridges (N=6), and government offices (N=5). An analysis was run to look at the pattern and frequencies for media message sources across regions. There were no significant differences in the percentage of times each type of source was mentioned by region.

Respondents were also asked to briefly describe any content they recalled from the messages they had seen. Most did not recall any specific content or reported only the source of the message. The largest percentage of those responding (42.7%%, N=146) stated that the message contained or referred to a hotline or other phone number. Figure 60 shows the frequencies for all responses.

Figure 60. Types of content recalled from media messages.



Most respondents who recalled messages as having contained prevention information recalled general information about reaching out to those at-risk for suicide and the assurance that suicide was preventable. Specific risk groups most commonly cited in recalled messages were victims of bullying, teens and lesbian and gay individuals.

Respondents were also asked to give an open-ended response to the question, "What do you think the ad or message was trying to tell people?" Of those responding to this question (N=486), the largest segment (46.7%) recalled a message emphasizing that help was available to those contemplating suicide. The next largest segment (31.1%) said that the message was about prevention, aimed at friends and family of persons contemplating suicide. Other messages recalled by respondents included giving hotline numbers (8.4%), urging people not to commit suicide (8.0%), and citing suicide statistics (2.7%).

Middle-Aged White Males: A risk group

This section presents a brief profile of White men, aged 35 to 64, who have been identified as a group disproportionately likely to die by suicide (Knox & Caine, 2005). Table 14 shows a comparison of these men with survey respondents as a whole. There were four topic questions for which middle-aged white males level of agreement approached 10 percentage points difference from overall responses. Please note, however, that these are exploratory results, and do not represent statistical significance. First, middle-aged White males were more likely to agree that people who attempt to kill themselves show warning signs and less likely to agree that people who end their lives do so without telling anyone. However, they were less likely to agree that people who talk about suicide are probably serious about

an attempt. To further explore this apparent inconsistency, we looked at whether there were differences between the warning signs cited by this group in open-ended survey items and the percentages for warning signs overall. No differences were found. The percentages of men in this group who offered 0, 1, 2, or 3 warning signs in response to the open-ended prompts closely resembled overall percentages. Similarly they did not differ in the pattern of warning signs mentioned or in their likelihood to offer "talking about suicide or death" as a potential warning sign.

Finally, men in this subgroup were less likely to agree that they see stories about suicide on TV. This may reflect the finding that men in general were less likely to say that they had seen TV messages about suicide.

Table 15 show a comparison of men in this subgroup with respondents overall on questions concerning other actions they would be likely to perform. Their responses were similar to total frequencies for all of these items.

One area where middle aged White males differed from the overall frequency was in their likelihood of personal experience with suicide. Men in this group were more likely to say they know someone who has attempted or died by suicide than was true for respondents overall (64.1% vs.51.5%). This might reflect the higher incidence of suicide in their peer group.

Table 14. Middle-aged White men compared to overall responses.

Questions	Disagree	Neither Agree nor Disagree	Agree
Support/Environment			
Suicide is not something I can talk about in my family.			
Middle Aged White Males	68.9	12.1	18.9
Overall	62.8	10.4	26.7
People in my family in general would support my decision to talk to someone who I thought was suicidal.			
Middle Aged White Males	8.4	8.4	83.2
Overall	11.8	7.5	80.6
People in my community, in general, would support my decision to talk to someone who was suicidal.			
Middle Aged White Males	4.7	17.3	78.0
Overall	11.6	15.8	72.6

Questions, cont.	Disagree	Neither Agree nor Disagree	Agree
Knowledge			
Suicide is preventable.			
Middle Aged White Males	8.4	21.5	70.2
Overall	11.1	16.0	73.0
Suicide is not a problem in California.			
Middle Aged White Males	75.3	12.9	11.8
Overall	66.5	14.4	19.1
People who kill or attempt to kill themselves usually show some warning signs.			
Middle Aged White Males	10.9	13.0	76.0
Overall	14.2	16.2	69.7
In California, more people die each year by suicide than by homicide.			
Middle Aged White Males	29.6	31.7	38.7
Overall	34.2	30.2	35.6
Most people who end their lives do so without telling anyone.			
Middle Aged White Males	38.0	26.3	35.8
Overall	29.9	24.9	45.3
When people talk about ending their life, they are probably serious about making an attempt.			
Middle Aged White Males	16.1	35.4	48.4
Overall	12.9	26.8	60.3
If someone wants to kill themselves, there is nothing anyone can do to stop them.			
Middle Aged White Males	68.7	10.8	20.5
Overall	66.6	10.8	22.6

Questions, cont.	Disagree	Neither Agree nor Disagree	Agree
Efficacy/Skills			
Asking someone whether they are thinking about ending their life would be too difficult to do.			
Middle Aged White Males	58.0	21.2	20.7
Overall	54.5	16.7	28.8
I would be worried to bring up the topic of suicide with someone I was concerned about in case it gave them ideas.			
Middle Aged White Males	67.7	14.8	17.5
Overall	55.6	17.8	26.6
I am confident in my ability to discuss suicide with someone I care about.			
Middle Aged White Males	10.8	13.8	75.4
Overall	10.2	12.2	77.7
Media			
I often see stories about suicide on TV.			
Middle Aged White Males	48.7	24.9	26.5
Overall	40.0	23.2	36.9
I often see stories about suicide in the newspaper or on the Internet			
Middle Aged White Males	44.4	25.1	30.5
Overall	38.4	23.7	37.9
News stories about suicide help people understand what they can do to prevent it.			
Middle Aged White Males	30.5	26.7	42.8
Overall	25.0	23.2	51.7
In the news, suicide is often sensationalized.			
Middle Aged White Males	26.9	25.8	47.3
Overall	27.9	26.6	45.6

Questions, cont.	Disagree	Neither Agree nor Disagree	Agree
Resources			
If a friend or family member is feeling suicidal, I know where I can seek help for him or her.			
Middle Aged White Males	26.9	16.6	56.5
Overall	22.9	13.0	64.1
I know of a suicide crisis line that I can call for help and support.			
Middle Aged White Males	45.9	12.4	41.6
Overall	43.0	10.0	47.0
If a friend was having thoughts about suicide, I would know where to find assistance.			
Middle Aged White Males	25.9	14.5	59.6
Overall	23.5	13.3	63.2
Action			
If a friend or family member was having thoughts of suicide I would express my concern to them.			
Middle Aged White Males	5.7	3.1	91.2
Overall	6.0	3.8	90.2
If a friend was having thoughts of suicide, I would do nothing; it is none of my business.			
Middle Aged White Males	90.7	3.1	6.2
Overall	83.8	3.4	12.9

Table 14. Middle-aged White men in comparison with overall responses for Other Action items.

Survey Item	Middle Aged White Males	Overall
Likely to visit a website for information.	87.6%	80.9%
	(169)	(1550)
Likely to call a crisis line or hotline.	85.6%	85.9%
	(166)	(1678)
Likely to provide them with a phone number or other resource.	94.8%	92.9%
	(184)	(1819)
Likely to express your concerns to them.	97.9%	91.6%
	(189)	(1796)
Likely to express your concerns to someone else.	93.3%	93.8%
	(180)	(1832)

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Appendix A: Survey

California Statewide Awareness of Suicide

Adapted from the Kentucky Statewide Awareness of Suicide survey with permission of

Julie Cerel, Ph.D. & Rosalie Aldrich, Ph.D.

INTRO1. Good morning/afternoon/evening. My name is _____. I am calling to ask for your participation in a survey about suicide and suicide prevention. The survey is funded by the California Mental Health Services Act. Your telephone number was chosen randomly. We are not selling anything. The interview will take about 10 minutes to complete.

FOR LANDLINE SAMPLE RECORDS READ INTRO2:

INTRO2. I need to randomly select one person in your household to be interviewed. May I please speak to the person in the house who is 18 or older and has had the most recent birthday?

FOR CELL PHONE SAMPLE RECORDS READ INTRO3 AND INTRO4:
INTRO3. This sounds like a cell phone. Are you in a place where you can safely talk on your cell phone? [IF NO, ASK FOR A BETTER TIME TO CALL BACK.]

INTRO4. When you are at home, do you get personal calls on a regular phone as well as this cell phone, do you get all your personal calls on this cell phone, or do you use this phone only for business calls?

1. GET CALLS ON REGULAR PHONE AND THIS CELL PHONE
2. GET CALLS ON THIS CELL PHONE ONLY
3. GET ONLY BUSINESS CALLS ON THIS CELL PHONE - **TERMINATE**
8. DON'T KNOW
9. REFUSED

INTRO5. Do you currently live in the State of California?

INTRO6. Thank you. We will not ask for your name or any other personal information that can identify you. The answers you give will be kept strictly confidential. You do not have to answer any questions you do not want to and you may stop the interview at any time.

Attitudes and Knowledge

To begin, I would like to read you some statements. Using a scale from one to five where one equals *strongly disagree* and five equals *strongly agree,* please tell me how much you agree with the following statements.

1	2	3	4	5	8	9
Strongly disagree				Strongly agree	DON'T KNOW	REF

1. Suicide is not something I can talk about in my family.
2. Suicide is preventable.
3. Asking someone whether they are thinking about ending their life would be too difficult to do.
4. People in my **family**, in general, would support my decision to talk to someone who I thought was suicidal.
5. I often see stories about suicide on TV.
6. Suicide is not a problem in California.
7. People who kill or attempt to kill themselves usually show some warning signs.
8. People in my **community,** in general, would support my decision to talk to someone who I thought was suicidal.
9. I often see stories about suicide in the newspaper or on the Internet.
ADD RESPONSE CATEGORY: DON'T READ NEWSPAPER
10. In California, more people die each year by suicide than by homicide.

Attitudes and Knowledge (Continued)

Again, I would like to read you some statements. Using the same one to five scale, please tell me how much you disagree or agree with the following statements**.**

11. If a friend or family member is feeling suicidal, I know where I can seek help for him or her.
12. I would be worried to bring up the topic of suicide with someone I was concerned about in case it gave them ideas.
13. Most people who end their lives do so without telling anyone.
14. I know of a suicide crisis line that I can call for help and support.
15. I am confident in my ability to discuss suicide with someone I care about.
16. When people talk about ending their life, they are probably serious about making an attempt.
17. If a friend was having thoughts about suicide, I would know where to find assistance.
18. If someone wants to kill themselves, there is nothing anyone can do to stop them.

19. If a friend or family member was having thoughts about suicide, I would express my concern to them.
20. News stories about suicide help people understand what they can do to prevent it.
21. In the news, suicide is often sensationalized.
22. If a friend was having thoughts about suicide, I would do nothing; it is none of my business.

Awareness and Knowledge

We are about halfway through the survey. Now I would like to ask you some questions about suicide prevention.

23. Have you heard of the National Suicide Prevention Lifeline, 1-800-273-TALK or 1-800-273-8255?

    1. YES
    2. NO

    8. DON'T KNOW
    9. REFUSED

24. Can you name three warning signs that someone might show, say, or do that indicate they are thinking of ending their life?

    [PROGRAM THREE SEPARATE TEXT BOXES]

    [OPEN-ENDED, RECORD RESPONSES VERBATIM]

    [PROMPT AFTER EACH RESPONSE: "Can you think of another warning sign?"]

[IF Q24=0, SKIP TO Q26]

25. Now I am going to ask you about what actions you are likely to take if someone you know is showing those warning signs.

    RANDOMIZE QUESTIONS IN THIS BLOCK (A-E)

    A. How likely would you be to visit a website for information?

        1. Very likely,
        2. Somewhat likely,
        3. Somewhat unlikely, or
        4. Very unlikely?

        8. DON'T KNOW
        9. REFUSED

    B. How likely would you be to call a crisis line or hotline for advice?

        1. Very likely,
        2. Somewhat likely,
        3. Somewhat unlikely, or
        4. Very unlikely?

8. DON’T KNOW
9. REFUSED

C. How likely would you be to provide them with resources such as a phone number?

1. Very likely,
2. Somewhat likely,
3. Somewhat unlikely, or
4. Very unlikely?

8. DON'T KNOW
9. REFUSED

D. How likely would you be to express your concerns to a person showing warning signs?

1. Very likely,
2. Somewhat likely,
3. Somewhat unlikely, or
4. Very unlikely?

8. DON'T KNOW
9. REFUSED

E. How likely would you be to express your concerns to someone else?

1. Very likely,
2. Somewhat likely,
3. Somewhat unlikely, or
4. Very unlikely?

8. DON'T KNOW
9. REFUSED

F. Is there something else you would do? [RECORD VERBATIM]

[ASK Q26 IF Q24=0, ELSE SKIP TO Q27]

26. If someone you knew did something to make you think he or she was suicidal, how likely would you be to take any of the following actions?

RANDOMIZE QUESTIONS IN THIS BLOCK (A-E)

A. How likely would you be to visit a website for information?

1. Very likely,
2. Somewhat likely,
3. Somewhat unlikely, or
4. Very unlikely?

8. DON'T KNOW
9. REFUSED

B. How likely would you be to call a crisis line or hotline for advice?

1. Very likely,
2. Somewhat likely,
3. Somewhat unlikely, or
4. Very unlikely?

8. DON’T KNOW
9. REFUSED

C. How likely would you be to provide them with resources, such as a phone number?

1. Very likely,
2. Somewhat likely,
3. Somewhat unlikely, or
4. Very unlikely?

8. DON'T KNOW
9. REFUSED

D. How likely would you be to express your concerns to them?

1. Very likely,
2. Somewhat likely,
3. Somewhat unlikely, or
4. Very unlikely?

8. DON'T KNOW
9. REFUSED

E. How likely would you be to express your concerns to someone else?

1. Very likely,
2. Somewhat likely,
3. Somewhat unlikely, or
4. Very unlikely?

8. DON'T KNOW
9. REFUSED

F. Is there something else you would do? [RECORD VERBATIM]

27. If someone feels suicidal, is there a phone number other than 9-1-1 in your community that can provide them with help?

1. YES
2. NO

8. DON'T KNOW
9. REFUSED

28. In the past several months, have you heard or seen any ads or messages related to suicide prevention?

1. YES
2. NO [SKIP TO TE]

8. DON'T KNOW [SKIP TO TE]
9. REFUSED [SKIP TO TE]

29. Can you describe what you remember from the messages that you saw or heard? Please be as specific as you can.

    [OPEN-ENDED, RECORD RESPONSES VERBATIM]

    [PROMPT AFTER EACH RESPONSE: "Can you think of anything else?"]

30. Where did you see or hear this ad or message?

    [READ ANSWER CHOICES, CHOOSE ALL THAT APPLY]

    1. TV
    2. Radio
    3. Magazine
    4. Website
    5. Billboard
    6. Brochure
    7. Newspaper
    8. Bus
    9. Movie Theater
    10. Is there any where else? _____ [SPECIFY]

    98. DON'T KNOW
    99. REFUSED

31. What do you think this ad or message was trying to tell people?

    [OPEN-ENDED, RECORD RESPONSES VERBATIM]

    [PROMPT AFTER EACH RESPONSE: "Can you think of anything else?"]

Experience

TE. Now I would like to ask you a few questions about your experience with people who have been suicidal. This information will allow us to better understand the problems that friends and family face, and it may help others in the future. This is a sensitive topic and some people may feel uncomfortable with these questions. Please keep in mind that you can ask me to skip any question you do not want to answer.

32. Do you know someone who has attempted or died by suicide?

    1. YES
    2. NO

    8. DON'T KNOW
    9. REFUSED

33. Are you aware of any support groups for persons grieving or coping with a suicide death?

    1. YES
    2. NO

    8. DON'T KNOW
    9. REFUSED

Demographics

TD. We are almost done. This last set of questions is for classification purposes only.

34. Do you live in an urban, suburban, or rural area?

    1. Urban
    2. Suburban
    3. Rural

    8. DON'T KNOW
    9. REFUSED

35. What is your postal zip code? _____

36. In what year were you born? _____

37. Are you a parent of any children ages 10-24?

    1. YES
    2. NO

    8. DON'T KNOW
    9. REFUSED

38. Are you a veteran, reservist, or currently in the military?

    1. Veteran
    2. Reserves
    3. Currently in the military
    4. Never in the military
    5. OTHER _____ [SPECIFY]

    8. DON'T KNOW
    9. REFUSED

39. Are you of Hispanic or Latino origin?

    1. YES
    2. NO

    8. DON'T KNOW
    9. REFUSED

40. What is your race?

[CHOOSE ALL THAT APPLY – IF RESPONDENT SAYS ANTHING OTHER THAN RESPONSES LISTED, PUT IN OTHER] [FOR EXAMPLE, “ITALIAN” OR “BLACK AND JAPANESE”]

1. AMERICAN INDIAN OR ALASKA NATIVE
2. ASIAN
3. BLACK OR AFRICAN AMERICAN
4. HISPANIC OR LATINO
5. NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
6. WHITE
7. OTHER [SPECIFY _____]
8. DON’T KNOW
9. REFUSED

41. In what county do you live?

Alameda County
Alpine County
Amador County
Butte County
Calaveras County
Colusa County
Contra Costa County
Del Norte County
El Dorado County
Fresno County
Glenn County
Humboldt County
Imperial County
Inyo County
Kern County
Kings County
Lake County
Lassen County
Los Angeles County
Madera County
Marin County
Mariposa County
Mendocino County
Merced County
Modoc County
Mono County
Monterey County

Napa County
Nevada County
Orange County
Placer County
Plumas County
Riverside County
Sacramento County
San Benito County
San Bernardino County
San Diego County
San Francisco County
San Joaquin County
San Luis Obispo County
San Mateo County
Santa Barbara County
Santa Clara County
Santa Cruz County
Shasta County
Sierra County
Siskiyou County
Solano County
Sonoma County
Stanislaus County
Sutter County
Tehama County
Trinity County
Tulare County
Tuolumne County
Ventura County
Yolo County
Yuba County

Thank you so much for your participation in this survey. Your input will help us to develop a public information campaign to raise awareness about suicide prevention.

Finally, I would like to let you know that if you are ever concerned about someone, or feel suicidal yourself, you can call 1-800-273-8255. This is a free call, available 24 hours a day, seven days a week.

PLACE ON THE BOTTOM OF EACH SCREEN:

[INTERVIEWERS, IF NEEDED PLEASE REFER THE RESPONDENT: If you are concerned about someone, or feel suicidal yourself, you can call 1-800-273-8255. This is a free call, available 24 hours a day, seven days a week.]

INTERVIEWER ONLY

IC1. INTERVIEWER: RECORD GENDER

1. MALE
2. FEMALE
8. DON'T KNOW

IC2. HOW WELL DID THE RESPONDENT UNDERSTAND THE QUESTIONS?

1. VERY WELL
2. SOMEWHAT WELL
3. NOT WELL

IC3. HOW ATTENTIVE WAS THE RESPONDENT?

1. VERY ATTENTIVE
2. SOMEWHAT ATTENTIVE
3. NOT AT ALL ATTENTIVE

IC4. HOW COOPERATIVE WAS THE RESPONDENT?

1. VERY COOPERATIVE
2. SOMEWHAT COOPERATIVE
3. NOT AT ALL COOPERATIVE

Appendix B: Urban vs. Rural Classifications by County

Note: Based on DHCS Classification, with San Bernardino, Kern, and Fresno Counties defined as Urban.

COUNTY	Population	Urban/Rural
Alpine County	1,041	R
Amador County	37,876	R
Butte County	220,577	R
Calaveras County	46,731	R
Colusa County	21,321	R
Del Norte County	29,114	R
El Dorado County	178,447	R
Glenn County	28,299	R
Humboldt County	129,623	R
Imperial County	166,874	R
Inyo County	17,293	R
Kings County	148,764	R
Lake County	65,279	R
Lassen County	34,473	R
Marin County	250,750	R
Mariposa County	17,792	R
Mendocino County	86,040	R
Merced County	245,321	R
Modoc County	9,107	R
Mono County	12,927	R
Monterey County	410,370	R
Napa County	134,650	R
Nevada County	97,751	R
Placer County	348,552	R
Plumas County	20,122	R
San Benito County	55,058	R
San Joaquin County	674,860	R
Santa Barbara County	407,057	R
San Luis Obispo County	266,971	R
Shasta County	181,099	R

Sierra County	3,174	R
Siskiyou County	44,634	R
Sonoma County	472,102	R
Stanislaus County	510,385	R
Sutter County	92,614	R
Tehama County	61,138	R
Trinity County	14,165	R
Tulare County	429,668	R
Tuolumne County	55,175	R
Yolo County	199,407	R
Yuba County	72,925	R
Alameda County	1,491,482	U
Contra Costa County	1,041,274	U
Los Angeles County	9,848,011	U
Madera County	148,632	U
Orange County	3,026,786	U
Riverside County	2,125,440	U
Sacramento County	1,400,949	U
San Diego County	3,053,793	U
San Francisco County	815,358	U
San Mateo County	718,989	U
Santa Clara County	1,784,642	U
Santa Cruz County	256,218	U
Solano County	407,234	U
Ventura County	802,983	U
Fresno County	915,267	U
San Bernardino County	2,017,673	U
Kern County	807,407	U
Total	36,961,664	

Appendix C: Regions by County

COUNTY	POP	REGION	Population Percent	Sample Percent	N
Alameda County	1,491,482	Bay Area	4.0352	3.7000	74
Contra Costa County	1,041,274	Bay Area	2.8172	2.7000	54
Marin County	250,750	Bay Area	0.6784	0.5000	10
Napa County	134,650	Bay Area	0.3643	0.5000	10
San Francisco County	815,358	Bay Area	2.2060	2.5000	50
San Mateo County	718,989	Bay Area	1.9452	1.2000	24
Santa Clara County	1,784,642	Bay Area	4.8284	3.1000	63
Santa Cruz County	256,218	Bay Area	0.6932	0.7000	15
Solano County	407,234	Bay Area	1.1018	1.4000	29
Sonoma County	472,102	Bay Area	1.2773	1.4000	28
Colusa County	21,321	Central Valley	0.0577	0.2000	4
El Dorado County	178,447	Central Valley	0.4828	0.5000	11
Placer County	348,552	Central Valley	0.9430	0.7000	14
Sacramento County	1,400,949	Central Valley	3.7903	3.1000	62
Sutter County	92,614	Central Valley	0.2506	0.1000	3
Yolo County	199,407	Central Valley	0.5395	0.4000	8
Yuba County	72,925	Central Valley	0.1973	0.5000	10
Los Angeles County	9,848,011	Los Angeles	26.6439	25.6000	512
Alpine County	1,041	North/Mountains	0.0028	0.0000	1
Amador County	37,876	North/Mountains	0.1025	0.1000	2
Butte County	220,577	North/Mountains	0.5968	0.6000	13
Calaveras County	46,731	North/Mountains	0.1264	0.1000	2
Del Norte County	29,114	North/Mountains	0.0788	0.1000	2
Glenn County	28,299	North/Mountains	0.0766	0.0000	1
Humboldt County	129,623	North/Mountains	0.3507	0.3000	7
Inyo County	17,293	North/Mountains	0.0468	0.1000	2
Lake County	65,279	North/Mountains	0.1766	0.3000	6
Lassen County	34,473	North/Mountains	0.0933	0.0000	1

Mariposa County	17,792	North/Mountains	0.0481	0.1000	2
Mendocino County	86,040	North/Mountains	0.2328	0.5000	10
Modoc County	9,107	North/Mountains	0.0246	0.0000	1
Mono County	12,927	North/Mountains	0.0350	0.0000	1
Nevada County	97,751	North/Mountains	0.2645	0.2000	5
Plumas County	20,122	North/Mountains	0.0544	0.0000	1
Shasta County	181,099	North/Mountains	0.4900	0.4000	8
Sierra County	3,174	North/Mountains	0.0086	0.0000	1
Siskiyou County	44,634	North/Mountains	0.1208	0.1000	2
Tehama County	61,138	North/Mountains	0.1654	0.3000	6
Trinity County	14,165	North/Mountains	0.0383	0.0000	1
Tuolumne County	55,175	North/Mountains	0.1493	0.2000	5
Orange County	3,026,786	Southern California	8.1890	6.6000	133
Riverside County	2,125,440	Southern California	5.7504	6.5000	130
San Bernardino County	2,017,673	Southern California	5.4588	4.8000	96
San Diego County	3,053,793	Southern California	8.2621	7.5000	151
Santa Barbara County	407,057	Southern California	1.1013	0.8000	17
Ventura County	802,983	Southern California	2.1725	2.3000	47
Fresno County	915,267	Southern Farm	2.4763	2.7000	54
Imperial County	166,874	Southern Farm	0.4515	0.4000	9
Kern County	807,407	Southern Farm	2.1844	1.9000	38
Kings County	148,764	Southern Farm	0.4025	0.4000	9
Madera County	148,632	Southern Farm	0.4021	0.3000	6
Merced County	245,321	Southern Farm	0.6637	0.7000	14
Monterey County	410,370	Southern Farm	1.1103	0.7000	15
San Benito County	55,058	Southern Farm	0.1490	0.0000	1
San Joaquin County	674,860	Southern Farm	1.8258	1.3000	27
San Luis Obispo County	266,971	Southern Farm	0.7223	0.4000	9
Stanislaus County	510,385	Southern Farm	1.3808	1.5000	30
Tulare County	429,668	Southern Farm	1.1625	1.0000	20

Appendix 1 Suicide in California: Basic Facts

Suicide in California: Basic Facts

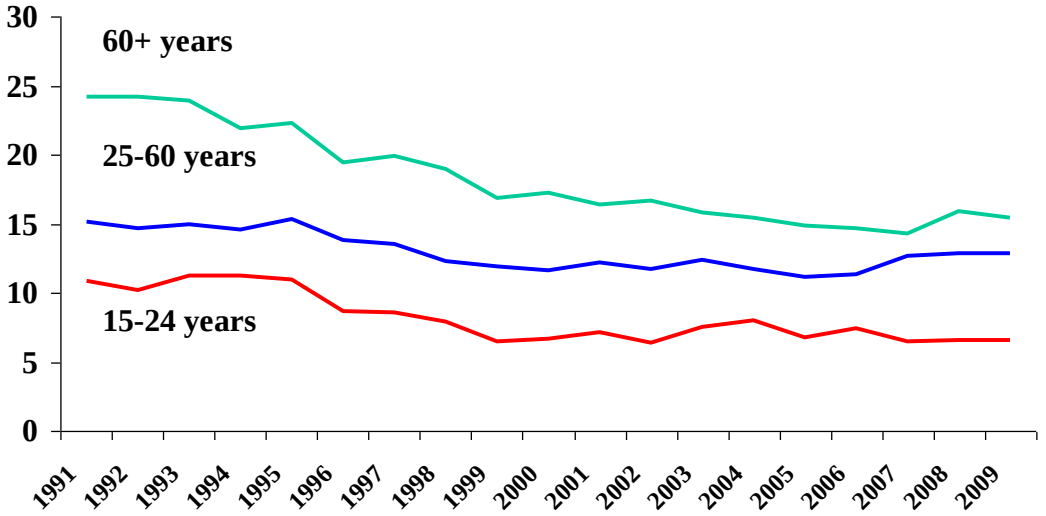
Prepared by Roger Trent, Ph.D.
Safe and Active Communities Branch
California Department of Public Health

Communities Taking Steps: Suicide Awareness and Prevention Conference
October 27-29, 2011
Sacramento, California

California suicide rates fell from 1991 to 2005 but recently have increased.

- California's overall suicide rates fell from 12.3 in 1991 to 8.6 in 2005.
- The decline occurred in older, middle aged, and young age groups.
- The suicide rate now stands at 9.7.
- Rates have recently risen among Californians over 24 years old.
- The U.S. suicide rate in 2007 (most recent available) was 11.8, compared to 9.3 for California in 2007.

Suicide trends by age group, rates per 100,000 population, California 1991-2009



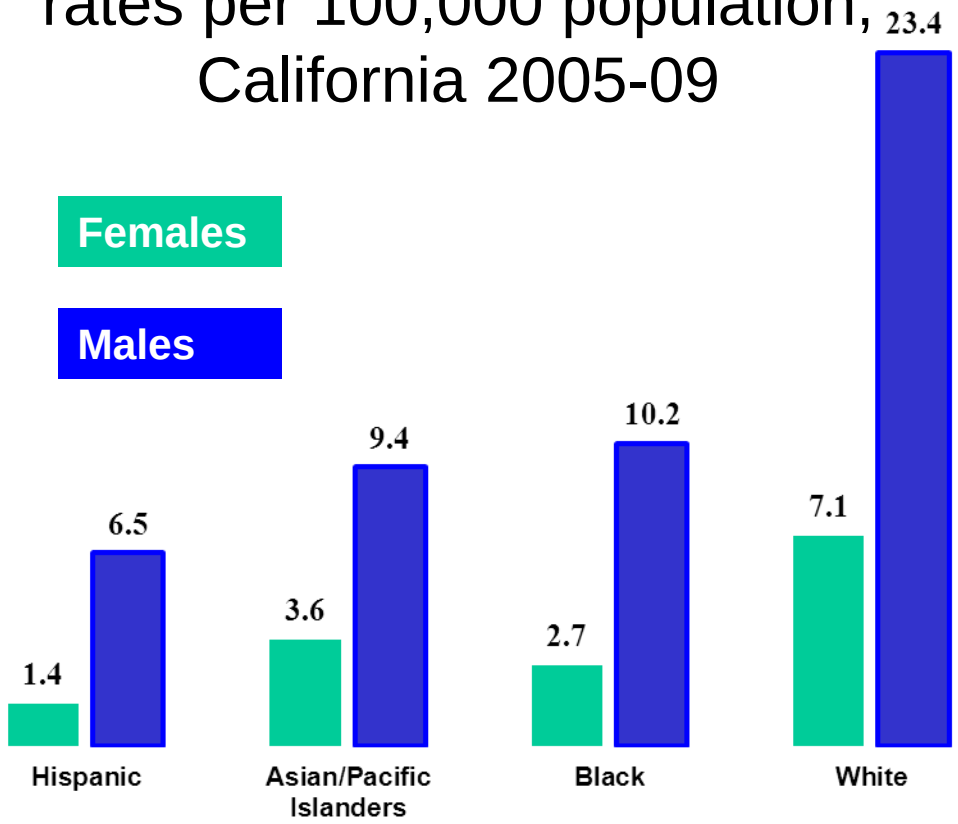
Source: Death statistical master files, California Department of Public Health.

http://EpiCenter.cdph.ca.gov

Suicide rates vary by sex and race/ethnicity.

- Overall, suicides rates for males are 3.3 times higher than rates for females.
- Whites have by far the highest rates, more than twice that of the next highest group, blacks.
- Hispanics have the lowest rates among major race/ethnic groups.
- Rates for white males are over 16 times higher than rates for Hispanic females.

Suicide by sex and race/ethnicity, rates per 100,000 population, California 2005-09



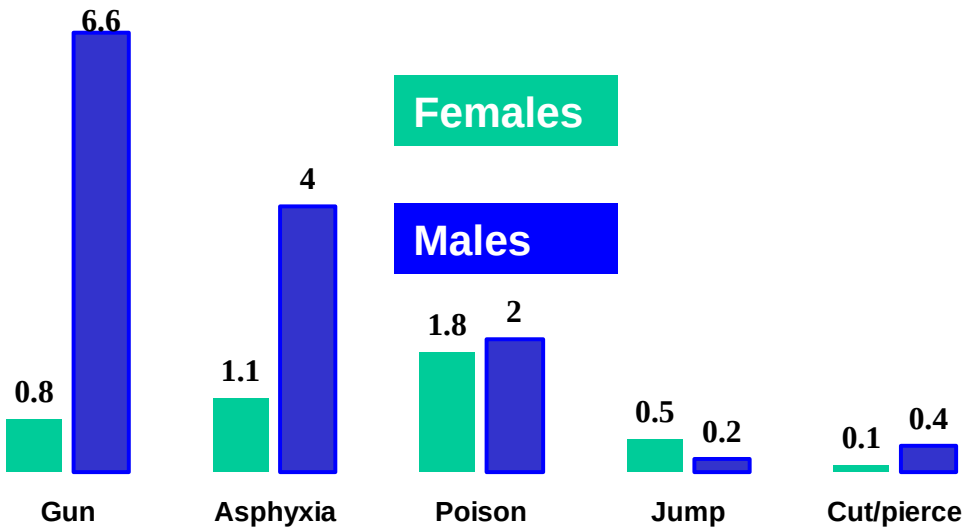
Source: Death statistical master files, California Department of Public Health.

http://EpiCenter.cdph.ca.gov

Males tend to use more lethal methods than do females.

- The most common methods are guns and asphyxia (hanging and suffocation), together accounting for 68 percent of all suicide deaths.
- Male suicides more often involve highly lethal methods, guns, and asphyxia.
- Female rates are nearly as high as male rates for poisoning, and they are higher for jumping.

Suicide by sex and method, rates per 100,000 population, California 2005-09



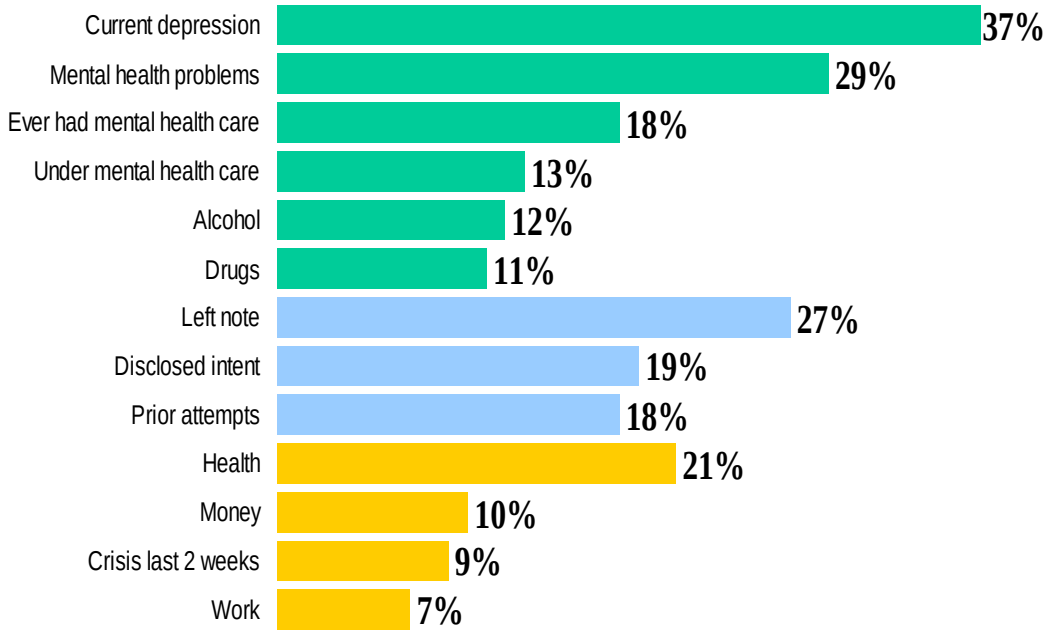
Source: Death statistical master files, California Department of Public Health.

http://EpiCenter.cdph.ca.gov

Some conditions that precede suicide.

- Suicide victims have depression and other mental and substance abuse issues.
- Many victims show “warning signs,” such as a note, stating an intention, or making a prior attempt.
- Problems of health, money, crises, and work are all documented in suicide victims.

Suicide precursors revealed in coroner investigations, California 2005-09



Percentages overlap and add up to more than 100 percent.

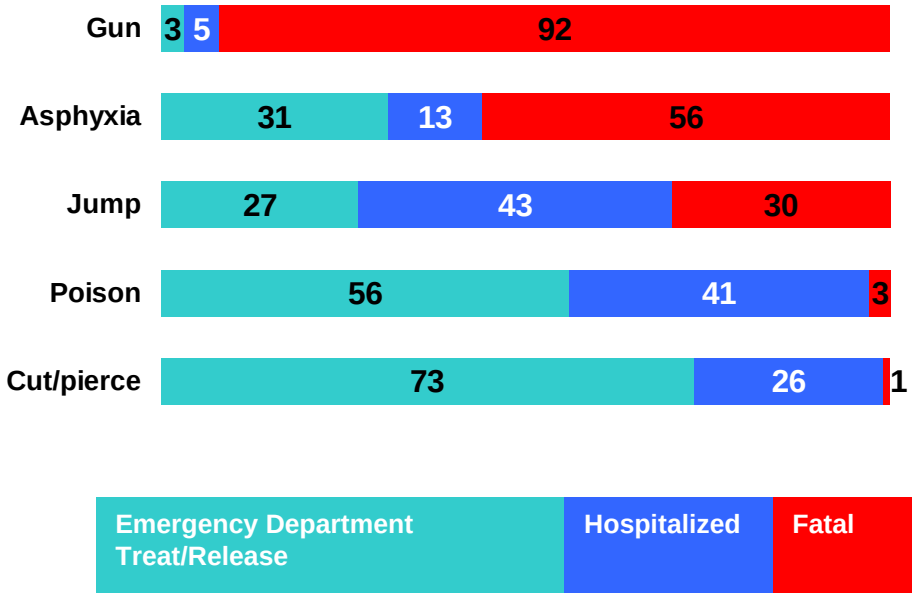
Source: California Electronic Violent Death Reporting System, California Department of Public Health.

http://EpiCenter.cdph.ca.gov

A grey area: self-inflicted injuries that may or may not have a suicidal intention.

- Most self-inflicted gunshots and asphyxia results in death.
- 30 percent of intentional jumping results in death.
- Low percentages of fatal injury are found among poisonings (three percent) and cut/piercing (one percent).
- Suicidal intent is often low or absent among the less lethal methods, especially cut/piercing.

Self-inflicted injuries, percent emergency department vs. hospitalized vs. fatal, by method, California 2009

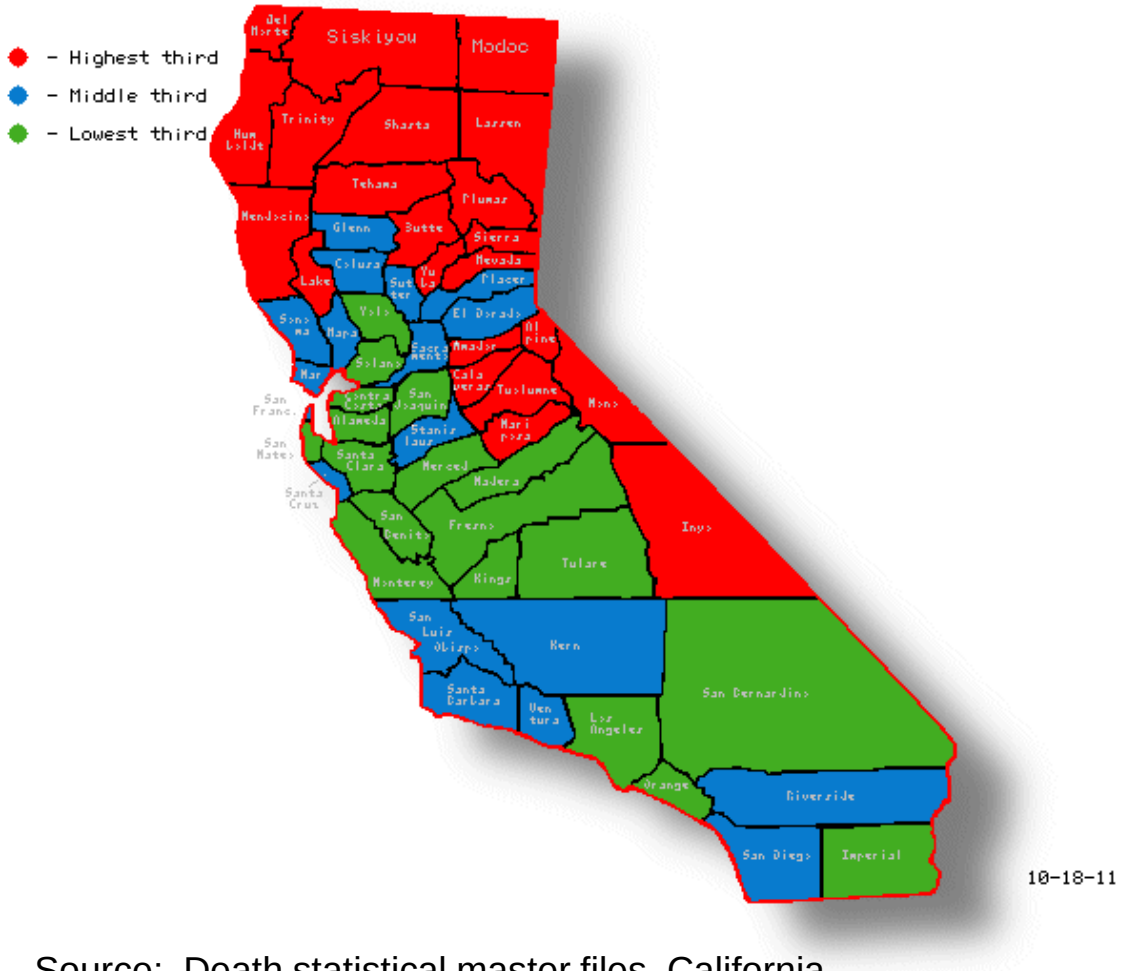


Source: Death statistical master files, California Department of Public Health; Inpatient and ED abstract files, California Office of Statewide Health Planning and Development

http://EpiCenter.cdph.ca.gov

California's northern counties have the highest suicide rates.

- Rates are based on the place where the person lived, not the place of occurrence.
- Counties with the highest percentages of white population tend to have the highest suicide rates.



Source: Death statistical master files, California Department of Public Health.

http://EpiCenter.cdph.ca.gov