

ASSESSING SUICIDE PREVENTION CAPACITY AND NEEDS:

An Analysis of 47 Counties



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INTRODUCTION

The California Mental Health Services Authority (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. The Mental Health Services Act (MHSA) Statewide Suicide Prevention initiative uses a full range of strategies from Prevention to Early Intervention to prevent suicide across ages and backgrounds. To ensure that counties had a voice in the design and implementation of the statewide suicide prevention campaign, the Program 3 Suicide Prevention Social Marketing team conducted an assessment of counties' communication capacity and needs. The instrument was developed collaboratively among several of the CalMHSA contractors with major components related to communications in order to consolidate questions into a single interview to learn about existing and needed marketing resources related to suicide prevention, stigma reduction and student mental health. The assessment, which was pilot tested with three counties to assure diversity and reliability (two in person and one online), sought to identify individual needs and circumstances for each county. Questions were also asked to obtain information on contacts for student mental health initiatives and about crisis and warmlines. All 58 counties¹ were invited, regardless of their CalMHSA membership, so that results would reflect existing assets and needed resources throughout the state.

Each county was provided the option of whether to participate by phone, online survey or in-person. (All formats used the same interview tool.) We were pleased that most counties selected in-person interviews, which generally yielded the best dialogue. Assessments were typically conducted by the MHSA or PEI Coordinator. In most cases, they invited additional participants as they wished; other participants ranged from the Mental Health Director to crisis center contractors to social service providers. Interviews were conducted by marketing and public health professionals from the AdEase team and their subcontractors; the interviews took place from October through February and are ongoing as requested.

This summary provides a synthesis as of Feb. 29, 2012 of the findings from 47 counties relative to suicide prevention only. An additional 5 interviews are scheduled to take place by March 3, 2012. Five counties were non-responsive or declined to participate. The findings represent a snapshot in time; many counties are actively engaged in building networks, launching trainings and other elements of CalMHSA and county-level programs. Therefore, their more recent activities may not be reflected in this report. All results drew upon the responses provided by the participants. Individual county reports are posted on the Your Voice Counts forum and can be viewed by counties who are registered on the forum.

¹ Sutter/Yuba is counted as one entity in this report. The total number of county entities therefore equals 57.

METHODS

Communication campaigns are best conducted in the context of an overall strategy. A media campaign by itself cannot substitute for a strategy, but can be a vital and visible component of a countywide plan. The California Strategic Plan on Suicide Prevention's Strategic Direction 3 is to educate communities to take action to prevent suicide. It calls for local communities to design and implement a strategy to engage local media, coordinate with other social marketing efforts, and to engage and educate local media. It also calls upon them to build grassroots outreach and engagement, design a community education plan, and foster development of peer support programs. Taking such a broad and comprehensive approach is required for success.

By mapping the assessment against the Strategic Plan, we identified the following assets as key for successful implementation of suicide prevention communications campaigns and assigned points. The highest possible score was 20.

- a) A countywide coalition, task force or workgroup dedicated to suicide prevention; (2 points) OR an agency-wide committee (1); and/or participation in regional suicide task force (1).
- b) Existing outreach efforts and champions (5 points total). One point each for: an active PIO or other person who does outreach to media sources; a recent past or existing suicide prevention campaign; recent past or existing stigma campaign that could serve as a foundation for an SP campaign; existing materials that are disseminated; strong relationships with local media.
- c) Community engagement as indicated by survivor, consumer and/or peer involvement (1 point); NAMI or AFSP chapter or survivor organization (1); gatekeeper trainings and/or other suicide prevention trainings such as QPR, ASIST, Mental Health First Aid, etc. (1); and current local suicide prevention events (1). *Note: the respondents' information may have overlooked the presence of such groups in their county. We coded only on the information provided. This score therefore may reflect the county respondents' awareness rather than actual presence of these resources, or that their presence isn't as strong as it could be.*
- d) Multiple channels through which a campaign can be conducted. These can include broadcast stations, newspapers, billboard locations, bus kiosks, existing websites, social media, etc. If respondents indicated that there were only a few channels, the score was 0, multiple channels were scored 1, and a multitude of channels were scored 2.

We assigned counties into one of three broad groupings based on the assets and gaps they identified. In some instances, missing data may have resulted in a lower total score than expected. These groupings reflect their **capacity to engage in suicide prevention marketing**, not the will, concern, or enthusiasm of the county behavioral health programs to engage in suicide prevention. All participants in the assessments were enthused and exhibited genuine concern for suicidal persons, their families and the providers who may serve them. All counties would do much more if they had the time, staff, budget, and technical assistance to do so. Finally, we mapped the counties geographically into regions.

High-capacity counties reported assets scored 13 or higher. The highest score was 17. N=13

Middle-capacity counties reported assets scoring from 9 to 12. N=11

Low-capacity counties reported assets scoring from 1 to 8. N=23

We then analyzed the communication needs² that they identified and mapped those against the three groupings.

² Respondents could indicate which of the following outreach materials they wanted: TV spots, radio spots, printed materials, print ads, billboard ads, bus ads, outreach materials, social media, website, technical assistances, how-to manuals.

RESULTS

High-capacity counties: [n=13] All high-capacity counties had existing networks (coalition, task force or workgroup) and/or suicide prevention campaigns.

The range of communication materials³ that these counties wanted was less expansive than mid-capacity counties. Many of them have already created materials for their existing campaigns, so their needs may be more focused. They also identified fewer specific populations⁴ than mid-capacity counties, perhaps because they had a greater understanding of who is at-risk or because they already have programs in place to serve some populations.

Five counties asked for materials in one language other than English, one for two languages, three asked for three languages, two for four languages, one for six languages, and one for seven languages. Two named specific dialects and one requested American Sign Language materials. All counties wanted materials in Spanish. Tagalog, Vietnamese and Hmong were also requested frequently.

These counties had specific requests for technical assistance and how-to materials. Most requests related to media: safe messaging (3), how to reach out and respond to media (3), help with social media (2), training for journalists, safe messaging guidelines, technical assistance with PR. Unlike low capacity counties, these counties wanted to know how to use social media *for suicide prevention*. At least two counties have already disseminated the media recommendations.

They also requested tools that would help them maximize the campaign: how to maximize support from advertising venues; how to work TV to get public service announcements aired, guides to use campaign materials effectively. One wanted assistance with how to evaluate the campaign.

They anticipated the statewide campaign eagerly and seemed ready to put it to use. One asked that local folks be involved in creating the materials. Two wanted materials that could be customized locally. One noted that materials should be developed for low literacy readers.

Notes on other issues: Two counties asked for trainings (Mental Health First Aid, QPR, ASIST) to be made available in Spanish. One also requested technical assistance or toolkits for primary care providers. Six of the counties mentioned that they refer to Lifeline as well as to their local crisis lines. One high capacity county had no suicide prevention crisis line.

Location: Many of the high capacity counties are located near the major media markets of Los Angeles, San Diego, and San Francisco. Otherwise, counties are geographically dispersed: four in the Southern region, two in the Superior region, three in the Greater Bay region, three in the Central region, and one in the LA region. No high-capacity counties are designated frontier counties.

³ Print materials and websites or a webpage were the most common requests. Six asked for outreach materials. There were two requests for radio, TV, cinema ads, billboards, print ads; three respondents wanted all eight options. Three wanted social media. There were also suggestions for bus kiosks, grocery bags, and banner ads.

⁴ Populations identified ranged from the standard responses of youth, TAY, LGBT, older adults, and Hispanics to more specific audiences which included: older gun owners, health care providers, blue collar workers, homeless youth, parents of TAY, traumatized youth in violent neighborhoods, monolingual Spanish speakers, individuals with dual diagnoses, individuals in psychiatric crisis, first responders, human resources, employers, geographically isolated, children, survivors, adult white men, and people across the lifespan.

Mid-capacity counties [n=11] Mid-capacity counties indicated that they have existing events and trainings, but fewer campaigns, materials or relationships with media. Most of them also had coalitions or participated in regional networks. [Note: some regions are just getting their networks off the ground now, which kept the scores lower for counties in those regions.]

These counties asked for a wide variety of communication materials⁵. Their requests were nuanced, showing the range of audiences that they hope to reach. This group identified a multitude of populations and audiences⁶ including a range of settings in which at-risk people might be found.

Four counties asked for materials in one language other than English, two asked for two languages, three wanted three languages, and two for five languages. One requested American Sign Language materials.

These counties had specific requests for technical assistance and how-to materials. Most requests related to processes and the media: Three wanted information on how to reach out to media and to promote safe messaging. One asked for case studies on the effectiveness of different advertising media to reach various audiences.

They also requested tools that would help them work with various segments of the community: faith providers, hospitals and ERs, schools. One wanted specific recommendations to help reach specific groups. Another asked how to develop materials appropriate to different cultures. Several wanted to be able to localize and customize materials provided to them.

One asked for toolkits on how to keep marketing going during and after staff transitions. Another wanted tools that would model how to have difficult conversations with someone who may be suicidal.

Notes on other issues: Half the counties (6) mentioned that they refer to Lifeline as well as to their local crisis lines. One noted that they may need assistance with storing and distributing hard copy resources.

Location: Mid-capacity counties are very evenly distributed: three in the Central region, three in the Greater Bay region, two are in Superior, and three in the Southern region. One mid-capacity county is a designated frontier county.

⁵ One-third of counties wanted all eight options. Five wanted print materials, three wanted a website or webpage, and two each wanted billboards, social media, radio ads and outreach materials. In addition, they asked for bus kiosk ads, narrowcasting methods, graphics, videos, fact sheets, video for teens, and personal story testimonials.

⁶ Populations identified ranged from the standard responses of youth, TAY, LGBT, older adults, and Hispanics to more specific audiences which included: general public or all ages, American Indians, deaf and hard-of-hearing, health care professionals, veterans, parents, survivors, white men, nursing homes, African Americans, students, adults, Mixteco, people who live in remote areas, Hmong, Oaxacan, Asians, mental health consumers, trauma survivors and firearm owners.

Low capacity counties [n=23] generally have no existing campaigns. They lack task forces, have few media channels and frequently have no one currently engaged in active outreach. They may have strong relationships with local media, but they lack community engagement as defined above. Although most of them do not yet participate in a full regional coalition, many of them collaborate with at least one nearby county.

These counties tended not to have created their own materials, so it isn't surprising that they asked for a wide range of communication materials⁷. They were also specific about which formats they could not use (primarily TV, billboards).

Costs were often on the minds of these county participants. Several made the point that they needed black-and-white or one color reproducible print materials. They wanted to be able to adapt the print resources locally, and were interested how they could share resources with surrounding counties.

These counties were less specific about what they needed in terms of technical assistance or how-to manuals. Their needs were more basic; for instance, five of them wanted to learn about how to use texting or social media in general. Seven counties want guidance on outreach to media, safe messaging and media recommendations. They also requested related tools such as press releases and talking points. Two counties wanted promotional items they could give away. There were also requests for how to conduct a campaign, assistance with evaluation, toolkits that community groups can use (recognizing the limitations of the county behavioral health agency), and for technical assistance to be offered face-to-face. Access to lethal means was named as an issue by several counties. The audiences⁸ identified by low-capacity counties tended to be broader than in the other two groupings of counties. Three counties requested materials that were designed for rural audiences.

These counties also had fewer multilingual needs. Eleven asked for materials in one language other than English, five asked for two languages, two for three languages. However, one asked for four languages and one named seven languages. Language information was not provided by two counties.

Notes on other issues: There was one request to train law enforcement, and two for technical assistance on how to deal with grief and loss. Although most counties have or promote some kind of crisis line, four counties have no suicide crisis hotline; one has an all volunteer hotline. Only three counties indicated that they promote the phone number of the National Suicide Prevention Lifeline.

Location: Ten counties are in the Superior region and eight in the Central region. Four are in the Greater Bay region and one in the Southern region. Ten of the low-capacity counties are designated frontier counties.

⁷ Most popular request was for print materials (8 counties), followed by outreach materials (7), radio (6), website or webpage (5) and all eight options (5). There were three requests each for TV, billboards, and bus ads. Four counties were interested in social media. Two counties requested DVDs or videos. There were also single requests for powerpoints, pens, road signs, cinema ads, newspaper ads, audio CDs in other languages.

⁸ Populations identified ranged from the standard responses of youth, TAY, LGBT, older adults, and Hispanics to more specific audiences which included: American Indians, all ages or general public, families or parents, veterans, children, correctional officers, AOD involved adults, older men, and deaf/hard of hearing. Two counties did not specify any populations.

FINDINGS

High-capacity counties are ready, able and willing to take campaign materials and put them to use. They may have staff with relevant experience, track records of media outreach, and good connections. They seem to have a clear sense of direction and are ready to move ahead. They identified fewer specific populations than mid-capacity counties.

Mid-capacity counties had the most diverse and extensive lists of populations and settings they want the materials to reach. They are holding events and trainings, but may need additional help with media outreach since they lack staff to do so.

Low-capacity counties may need assistance in identifying and prioritizing target populations, figuring out what is achievable, and in reaching out to new, untapped sectors in the community. They may need some initial assistance with strategic planning and might benefit from guidance about existing resources such as those listed in the Best Practices Registry and what will be listed on the Your Voice Counts (YVC) online forum (www.yourvoicecounts.org). Although their media markets may not be large or multi-faceted, the counties may not have experience in reaching out to them.

Overall observations: We recognize that tasks, key activities and deliverables from the suicide prevention social marketing program must be tailored to meet the counties where they are in terms of their needs, interests, capacity and resources. In addition, we observed:

- Spanish and Hmong were the two languages most frequently cited.
- Even among counties that do not promote Lifeline, some of them distribute SAMHSA materials which include the 800-273-8255 telephone number.
- Some respondents expressed concerns that successful marketing campaigns would lead to an increased demand on their over-stretched mental health services.
- Access to lethal means, in particular firearms, were identified as a risk factor more often in rural and frontier counties.
- Survivor involvement was notably absent from the reports of many rural and smaller counties.

Counties in all three groups requested technical assistance and manuals to help them reach out to local media, promote safe messaging, and maximize the effectiveness of the campaign. Counties across the three groups are interested in being able to localize materials with their own telephone numbers.

The wish list of formats, topics, settings and populations to be addressed by the campaign, presents an ambitious scope, reflective of the diversity of the state. It is clear that counties have a wide range of needs, not all of which can be met by social marketing campaigns.

PROPOSED FUTURE DIRECTIONS

To help further achieve Strategic Direction 3 of the California Strategic Plan on Suicide Prevention, the following next steps are proposed:

The Program 3 Suicide Prevention Social Marketing team should continue implementing the initial activities of the suicide prevention social marketing campaign. Continue engaging with the counties to gain increased understanding on what capacities can be strengthened to address the needs and gaps identified through this assessment.

The Program 3 Suicide Prevention Social Marketing team should collaborate with CalMHSAs program partners 1, 2 and 4 by sharing the findings of this assessment with them to inform them of the results and to explore how their programs might also be able to support county capacity building and address the identified needs.

Nearly every county would benefit from additional *technical assistance* on how to implement and plan campaigns based on best practices. As the California Strategic Plan points out, local communities should “build grassroots outreach and engagement efforts to tailor the suicide prevention campaign to meet community needs.” Low-capacity counties would benefit from assistance to build outreach and engagement so that they can launch a campaign. Mid-capacity counties need help in strategizing and leveraging their efforts, while high-capacity counties need help to expand and deepen their existing communications activities.

A determination should be made of how many *threshold languages* should or can be addressed through the suicide prevention and stigma campaigns and arrangements made for appropriate cultural adaptation and translation.

Posters and brochures that educate about suicide signs and symptoms, risk factors and resources in a variety of languages could be provided digitally to counties for *local dissemination*.

To assist in keeping *reproduction costs* low for counties, materials should be provided in both color and in black-and-white versions.

Many counties were grateful for the opportunity to express their needs and desires. *Annual check-ins* with the counties and reports on the topics covered in this assessment would help the overall program as well as the counties themselves learn the progress they make in implementing the campaign.