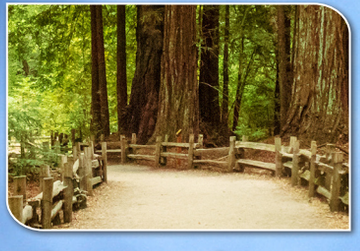
SANTA CRUZ COUNTY

Suicide Prevention Strategic Plan

Healthy People Living in Healthy Communities



The Path Forward

This strategic plan is envisioned to be a starting point for local efforts.

Contents

Introduction

Santa Cruz County Suicide Prevention Task Force Strategic Plan

Suicide is a delicate subject, riddled with taboo and shame, and a topic often avoided in discussion. As suicide rates continue to increase, community members often experience feelings of powerlessness and uncertainty as to the path forward toward effective intervention. In September 2018, Santa Cruz County Behavioral Health Services launched the Santa Cruz County Suicide Prevention Task Force with the overarching goal of preventing suicide deaths. The Task Force aimed to develop a strategic plan to identify action steps for our community.

Santa Cruz County currently experiences a suicide death rate that is higher than state and national averages. The state age-adjusted rate per 100,000 people is 10.7, while Santa Cruz County has a rate of 16.4. The goal of the Suicide Prevention Task Force is to focus our efforts on identification, research, and review of models within three specific realms of prevention, intervention, and postvention to affect change within the community.

The Task Force includes members of the community, health care organizations, local law enforcement, the faith-based community, contracted behavioral health agencies, community peer support services, local school personnel, hospice services, County Public Health, veteran advocates, and others. The Task Force is co-chaired by statewide suicide prevention expert Noah Whitaker, who brought a breadth of experience, having been directly responsible in the creation of highly regarded suicide prevention efforts in Tulare and Kings Counties and more recently in the great work accomplished with the Fresno County Suicide Prevention Collaborative.

The attached plan contains information based on in-depth monthly Task Force meetings, community key informant surveys, and stakeholder feedback to provide a strategic direction for our county to approach, prevent, respond, and understand the actions and behaviors that lead to suicidal thoughts and actions. The purpose of this document is to provide a framework for the county-wide suicide prevention plan and the future of those goals. In this plan we offer suggestions of clinical models that we, as a Task Force, have thoroughly discussed and reviewed in the understanding of commitment to sustainability for our community. Many of these models, for example the LOSS (Local Outreach to Suicide Survivors) team, will require long-term commitment to implementation and will happen over time and reiteration. Some of these models, such as community-based service supports, are focused initiatives that can be built upon existing community resources, including, for example, Suicide Prevention Services, the National Alliance on Mental Illness (NAMI), and Mental Health Client Action Network (MHCAN), thereby creating additional opportunities through existing resources for enhanced clinical understanding and response to suicide within the community.

We hope this plan becomes a starting point and an invitation for continued conversation and growth. We recognize the importance of suicide prevention in our community and take pride in our commitment to the health and well-being of our community.

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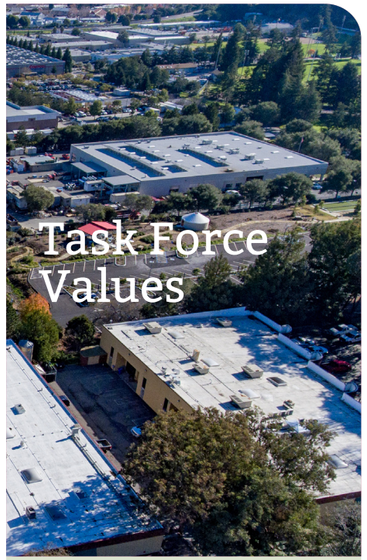


Task Force Values

In our initial meetings, the Task Force established a collective foundation of values to guide how we approached practices/ interventions and ensured they would be appropriate for inclusion in the Santa Cruz County suicide prevention plan:

COLLECTIVE VALUES

1. Culturally and linguistically appropriate services (CLAS); cultural sensitivity
2. Investigate and understand existing resource or similar resource in community
3. Fills a gap/need (general population vs. targeted services); prioritizing populations to serve
4. Accessibility; ease of linking to services
5. Cost-effective
6. Seek subsidies/leveraging other resources
7. Long-term sustainability or with understood launching strategy
8. Operationally effective and yield future data
9. Broad-based community representation
10. Broad-based community input
11. Supports infrastructure development; Senior management buy-in

A Framework For Action

Strategic Direction

The Santa Cruz County Suicide Prevention Task Force is composed of community members, representatives from behavioral health, public health, education, law enforcement, community-based organizations, mental health consumers and peers, suicide attempt and loss survivors, family members, and others.

The mission of the Santa Cruz County Suicide Prevention Task Force is to create an initial suicide prevention strategic plan to help coordinate and direct suicide prevention activities throughout the community.

Group objectives included:

• Adopt a framework to examine strategies relating to suicide prevention by November 16, 2018.

• Gain a basic understanding of the issue of suicide in Santa Cruz County by January 18, 2019.

• Review programs, training, interventions, and campaign's potential adoption by March 15, 2019.

• Generate a draft strategic plan for community review and input by April 19, 2019.

• Have the initial strategic plan adopted by the Santa Cruz Mental Health Advisory Board as well as the Santa Cruz Board of Supervisors before June 30, 2019.

During the planning process the task force examined the topic of suicide, adopted goals and objectives for action from the National Strategy for Suicide Prevention, explored data made available by the Santa Cruz County Sheriff's Department, conducted outreach to gather input and information about local attitudes and opinions on the subject, and worked to establish a unified vision for the future.

The intent of this document is to distill a wide array of complex information into a summary that can be useful for guiding initial implementation and action. The following information is a macro-overview of key concepts and information that helped guide our path toward the creation and adoption of this strategic plan as well as future endeavors.

Timeline

STRATEGIC PLANNING PROCESS

To help drive action toward the development of our strategic plan, the Task Force established a brief roadmap to chart our course, commencing in September of 2018.

September: The Task Force convened to create a shared vision, discussed functional parameters, and engaged in an initial discussion of information relating to suicide and suicide prevention.

October: The group affirmed our values, agreed to mirror the goals of the National Strategy for Suicide Prevention, and continued an informative discussion of information relating to suicide and prevention efforts.

November: Overview of suicide prevention programs by Prevention, Intervention, and Postvention. We identified a subset of select programs of interest and prioritized the programs that were desired for more depth in future meetings. Initial discussion of data and limitations.

December: Delved deeper into a handful of programs identified in the November meeting. Entertained brief discussions of these programs and/or local-level programs that are currently underway. Engaged in ongoing discussion of goals and objectives as well as data.

January: Examined in greater depth programs ranging prevention, intervention, and postvention from the November meeting. Discussed which programs fit our established values, goals, and resources, and might be leveraged with existing local-level programs. Began circulation of key informant interview survey.

February: Narrowed the focus of our examination of programs identified in the November meeting. Examined additional data available from local sources. Discussed making recommendations of the selected programs for implementation, tabling, or indefinite postponement. Expanded circulation of key informant interview survey.

March: Revisited the narrowed pool of identified programs. Voted on final recommendations from the Task Force as to programs and interventions that are desired for initial implementation to feed directly into the draft suicide prevention strategic plan for community discussion and feedback.

April: Initial draft of the strategic plan circulated for Task Force and stakeholder review and comment at the April 19 Task Force meeting; opened the 30-day public comment period.

May: Continue circulation of draft plan for 30-day public comment period to conclude at the May 16 Santa Cruz County Mental Health Advisory Board meeting. Discuss any emergent needs relating to the strategic plan and focus upon communication efforts. Incorporate any public comment/feedback.

June: Submit the draft plan for review and potential adoption by the Santa Cruz County Board of Supervisors. If adopted, encourage additional partners to review and adopt the strategic plan.

Strategic Areas

Our three strategic areas are:

To facilitate the selection of specific programs, trainings, communication, and actions, it was helpful to categorize programs into three programmatic areas, including prevention, intervention, and postvention. Across and underlying these three areas is promotion, which is communication about the availability of services, positive help-seeking behaviors, recognizing risk, positive factors, and instruction information on helping others and accessing care.

Prevention: a strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors

Intervention: a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition

Postvention: a response to and care for individuals affected in the aftermath of a suicide attempt or suicide death. These programs seek to respond to deaths to limit additional negative outcomes and can range from individual to community-wide.

Priority Populations

Suicide is a complex phenomenon. Some populations have an elevated risk compared to the general population. It is therefore important to keep these groups in mind when selecting strategies to ensure representation from these groups, sensitivity to their unique cultural needs, and that programs and interventions address their specific needs. In adherence with our CLAS values and existing research on suicide, the following priority populations were identified for consideration:

The Path Forward

This is an initial plan and is not foreseen to be comprehensive or to have fully examined every partnership, resource, opportunity, and obstacle in Santa Cruz County. This strategic plan is envisioned to be a starting point for local efforts. Preventing suicide is a continuous improvement process, as our environment is constantly changing and adapting.

The intent of this plan it to provide a set of guidelines for decision-making and cohesive action, encourage outreach in the community, leverage support from existing activities and partnerships, provide indicators for success, stimulate a vision of increased peer supports, motivate local experts and other community members to engage in action, and initiate the process of developing a suicide-safer community. It is the hope of the Task Force that many others will see a place for themselves as a partner in this movement.

The Santa Cruz County Suicide Prevention Task Force has identified immediate and ongoing priorites:

- Encourage dissemination and adoption of this strategic plan by local organizations and governing boards.
- Explore opportunities for collaboration and partnership on a regional level.
- Create subcommittees to implement the three recommended, initial programs.
  - ~ Community-based Supportive Services
  - ~ C-SSRS & Safety Planning
  - ~ LOSS Team
- Conduct system mapping around service delivery, capacity, and future growth to better understand strengths, needs, and gaps.
  - ~ Identify local experts who can be leveraged for a cost savings.
  - ~ Develop an inventory of all trainers currently in the area who are certified to offer training such as safeTALK, ASIST, QPR, MHFA, as well as additional training capacity and willingness to engage.
  - ~ Leverage established programs and opportunities for enhancement and integration associated with preventing suicide and supporting those who are struggling.
- Create a system for sharing information via existing committees to stimulate a local learning collaborative.
- Encourage the development of a coalition of peer-based service-delivery providers.
- Identify existing local data collection systems and methods for accessing and assessing data as key indicators for suicide prevention efforts.

The 2012 National Strategy for Suicide Prevention

The 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action establishes a baseline from which local goals and objectives can be established. The national strategy proposes four areas for strategic direction, each of which has goals and supporting objectives.

Local-level goals and objectives can directly mirror or be adapted from the National Strategy. This approach helps to bring local efforts into alignment with national priorities and to support those efforts. The strategic directions and associated goals are as follows:

1. Healthy and Empowered Individuals, Families, and Communities

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Goal 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Goal 3: Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illness in the entertainment industry, and the safety of online content related to suicide.

2. Clinical and Community Preventive Services

Goal 5: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Goal 6: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

Goal 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

3.Treatment and Support Services

Goal 8: Promote suicide prevention as a core component of health care services.

Goal 9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Goal 10: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

4.Surveillance, Research, and Evaluation

Goal 11: Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Goal 12: Promote and support research on suicide prevention.

Goal 13: Evaluate the impact and effectiveness of suicide prevention interventions and systems, and synthesize and disseminate findings.

RAND Corporation's Conceptual Model of Suicide Prevention Programs

In addition to the three strategic areas, it can be helpful to further categorize suicide prevention programs into nine broad areas identified by RAND Corporation in their Technical Report. This categorization is extremely helpful in planning and prioritizing activities and helps to more simplify a plethora of programs.

1. Training on Coping Skills and Self-referral
2. Marketing Campaigns
3. Gatekeeper Trainings
4. Crisis Hotlines
5. Postvention programs
6. Screening Programs
7. Provider training in suicide risk assessment and management
8. Mental Health Interventions
9. Social/Policy Interventions (such as access to care and means restriction)

NOTE

(1) https://www.rand.org/pubs/technical_reports/TR1317.html

The Social-Ecological Model

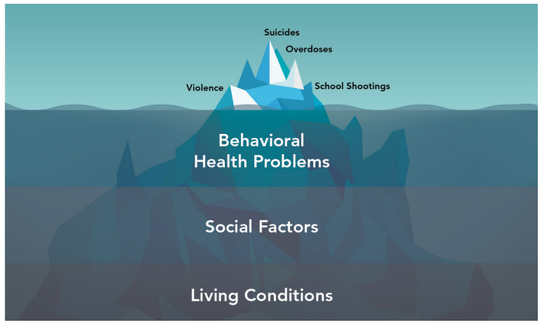
The prevention of suicide necessitates an understanding that suicide includes individual-level and population-level risk and protective factors. Interventions will be more successful when they span multiple layers (e.g., public policy, community, organizational, interpersonal, and individual) to address the determinants of health and outcomes such as the decision to die by suicide. It is therefore valuable to approach this issue through the lens of the Social-Ecological Model (SEM), which explores the relationship between an individual, his/her environment, and the social systems that influence everyday life.

We'll explore this model through the fictitious character Mateo, who in his mid-30s, white, male, identifies bi-sexual, is single, a high school graduate, has a history of childhood trauma, and was diagnosed with Bipolar II Disorder three years ago (individual). He has few close friends, as he is new to the area, and he often feels isolated and alone. He has been struggling since his last relative died six months ago. A trusted co-worker and his manager encouraged him to seek counseling services (interpersonal). Luckily, his work has an employee assistance program (EAP) that offers access to mental health counseling and provides paid time off for appointments (organizational). The EAP counselor was trained in modern practices for assessing and managing suicide risk and is helping Mateo process his grief as well as develop additional coping skills. It has been difficult for Mateo to consistently attend his therapy sessions, as his finances are tight due to the high cost of living in his area, and transportation is a challenge, as he lives in a rural area that doesn't have public transportation (community). Recent legislation provided funding for additional training for the EAP counselor and a new program that provides access with no share of cost (public policy).

This example illustrates that Mateo interacts with numerous environmental layers that influence his individual risk and protective factors. Each layer in his environment also influences other layers, such as the legislation providing for enhanced clinical training and providing easier access to services, both of which supported Mateo in receiving high-quality care and treatment. Even so, if Mateo's interpersonal relationships and work were not supportive of his engagement in services, he might not access them and therefore would receive no benefits from those systems.

An additional way to explore the Social-Ecological Model is to view negative outcomes such as suicide, overdoses, and violence as being highly visible, such as the tip of an iceberg. There are a host of contributing factors, often hidden beneath the surface, that contributed to those outcomes, including living conditions, social factors, and behavioral health problems. If the underlying contributing factors are not addressed, then the resulting problems will continue to break the surface and result in ongoing negative outcomes such as suicide.

The Social-Ecological Model in conjunction with our values, priority populations, strategic areas, RAND's conceptual model, and the goals and objectives of the National Strategy for Suicide Prevention created the foundation for the program selection criteria for the Santa Cruz Suicide Prevention Task Force. We examined dozens of programs and discussed the ways in which they could integrate into existing systems, address unique needs and gaps in the community, have the potential to function across multiple environmental layers, are sustainable, and have the potential to have the greatest impact with currently available resources.



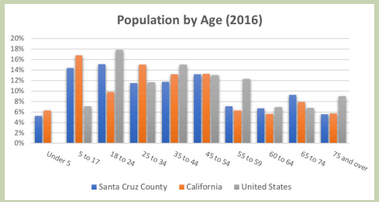
Suicide & Santa Cruz County

Suicide is a public health problem that has been growing in significance in the US. The impact of suicide is diverse and far-reaching, as it affects intimate relationships, families, coworkers, schools, and work environments, and can ripple across generations.

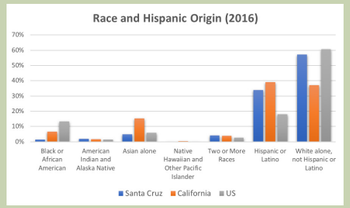
Santa Cruz County

The County of Santa Cruz is beautiful and diverse, with a varied landscape including the redwood-dotted Santa Cruz Mountains, golden flower-painted foothills, fertile agricultural fields and valleys, and vast stretches of sandy beaches. It is the epitome of the "sunshine state," with approximately 300 days of sunny skies per year. The community is located roughly 65 miles south of San Francisco and occupies the north point of Monterey Bay.

The county contains four incorporated cities, namely Santa Cruz, Watsonville, Scotts Valley, and Capitola, and additional, smaller unincorporated areas. The population is roughly 274,673 people (2016). The local economy is fueled primarily by technology, agriculture, and tourism. One of the greatest challenges in the community is a disparity between the cost of living and the prevailing wage as supported by the local job market. Although the economy has grown, the largest job growth came in low-wage, low-skill occupations. This creates a disparity between the average wage and the living wage, and places individuals and families under economic strain.



Examining the distribution of age in Santa Cruz County compared to the state and nation reveals some slight differences. Santa Cruz and California both have a dramatically higher proportion of youth aged 17 and younger as compared to the nation. Of note, Santa Cruz also differs from the state in young adults aged 18 to 24 but lags the US average in that age group. Santa Cruz is nearly identical to national averages for adults aged 25 to 34, 45 to 54, and those aged 60 to 64.



Data for Race and Hispanic Origin reveals that Santa Cruz has unique characteristics when compared to California and the nation. Santa Cruz is near national averages for White (not Hispanic or Latino) (57.2% and 60.7% respectively), but it is overrepresented in that population when compared to the state (37.2%). This difference is due primarily to Santa Cruz's having a slightly lower Hispanic or Latino population and large differences in Asian and Black populations. Santa Cruz and California have much higher Hispanic or Latino (33.9% and 39.1% respectively) representation than the national average (18.1%).

NOTE

For all graphs in this section, 2017 data is utilized, as it is the most recently available data from the Centers for Disease Control and Prevention's WISQARSTM database for national data. 2017 data is also the most recently available data from the California Department of Public Health's EpiCenter database for state- and county-level data. Due to population size, data from Santa Cruz County will have more year-by-year variance than state or national data, which have substantially larger population sizes and tend to have less year-by-year variation.

Age-Adujusted Suicide Rate by State, 2017

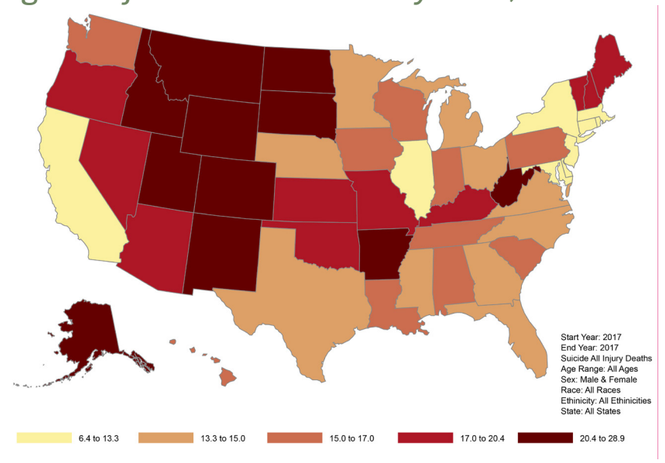


FIGURE 1

The age adjusted suicide rate for all states shows a pattern in which rural states tend to have higher rates of suicide when compared to more urban states.

NOTE

(2) McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) (1988). The social ecology of health promotion interventions. Health Education Quarterly, 15(4):351-377.

(3) Figure 1: created by mdlogix.com and used here with approval from Allen Y. Tien, MD, MHS

(4) https://www.census.gov/quickfacts/fact/dashboard/santacruzcountycalifornia/

(5) http://www.co.santa-cruz.ca.us

(6) http://www.co.santa-cruz.ca.us/portals/0/SCWDB%202018%20Report.pdf

(7) Source: Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2003). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available from: URL: www.cdc.gov/ncipc/wisqars. [2019 Feb. 9 Day]

(8) Source: California Office of Statewide Health Planning and Development, Emergency Department Data. Prepared by: California Department of Public Health, Safe and Active Communities Branch Report generated from http://epicenter.cdph.ca.gov on: February 9, 2019

NOTE

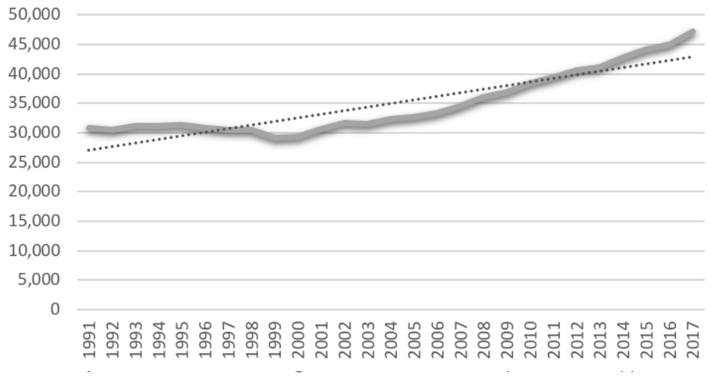
(9) https://www.cdc.gov/vitalsigns/suicide/

(10) Suicide Mortality Rate by State, Centers for Disease Control, 2019. https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

(11) Annual Crude Suicide Rates in States, 1990-2017, Washington, DC: American Association of Suicidology, 2019

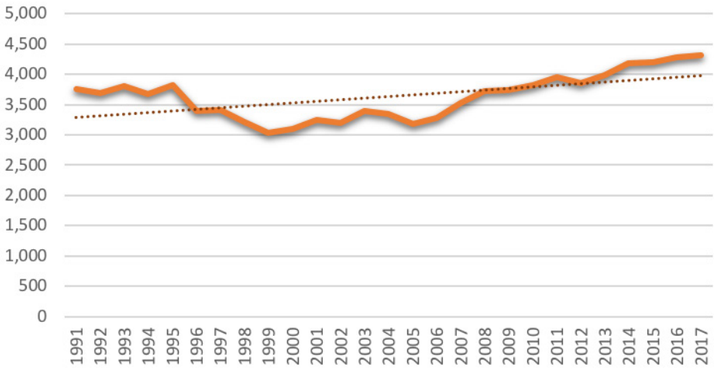
https://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2017/StateRates1990to2017TABLE.pdf

Suicide United States



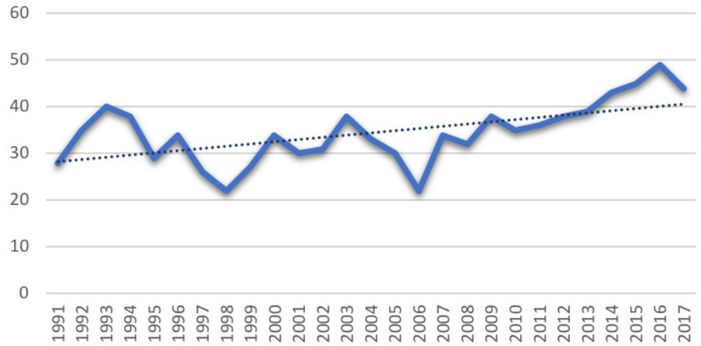
30% increase in rates in half of states from 1999 to 2016. This highlights a growing problem where more resources, research, and efforts are warranted to stem the rising tide of deaths. Suicide is often viewed as being the result of mental health conditions, but according to the CDC, less than half of the people who died by suicide had a known mental health condition at the time of their deaths.

Suicide California



In California, as with the national trend, suicide rates have been increasing since 1999. Despite this, California's suicide rates have been consistently lower than the national average since 1993. California's suicide rates continue to rank as one of the lower states. This effect might be moderated by an increased access to care, lower access to highly lethal means, and additional population-specific characteristics.

Suicides Santa Cruz

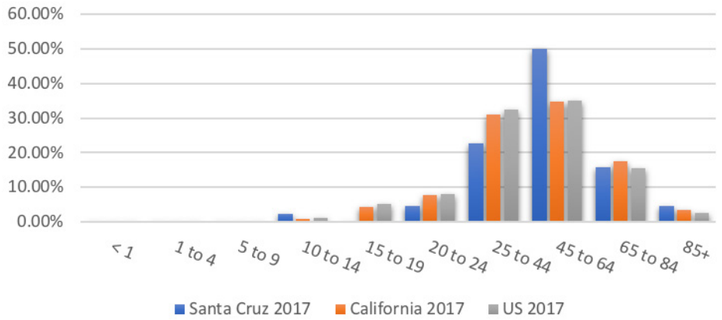


From 2014–2016, Santa Cruz averaged 45.7 suicide deaths per year, with a crude death rate of 16.6 per 100,000 and an age-adjusted death rate of 16.3. The suicide rate for the entire US was 13.9, with California having an age-adjusted death rate of 10.4. The suicide rate for Santa Cruz is above both state and national averages. By comparison, during the same time period, Santa Cruz averaged 7.7 homicides, with a crude death rate of 2.8 and an age-adjusted death rate of 2.7. This indicates that Santa Cruz experienced nearly six suicides per homicide, whereas in the United States there were 44,965 suicide deaths with a rate of 13.9 per 100,000 and 19,362 homicides with a rate of 6.0, with an age-adjusted rate of 6.1 or 2.3 suicides per homicide.

NOTE

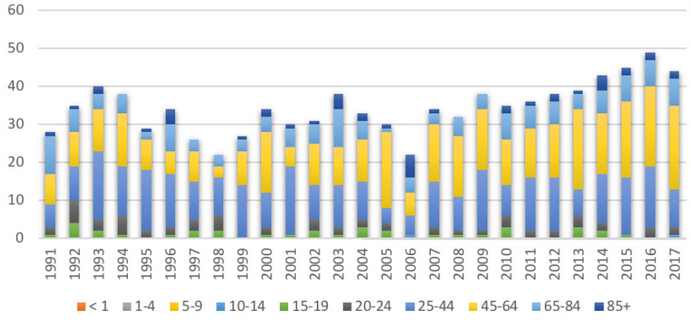
(12) California Department of Public Health, County Health Status Profiles 2018, www.cdph.ca.gov

Percent of Suicide Deaths by Age Group (2017)



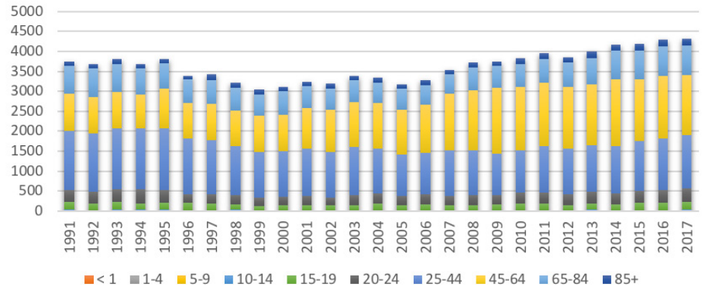
Comparing the distribution of suicides by age in 2017 across Santa Cruz, California, and the US shows slight differences. Santa Cruz experienced 50% of its suicide deaths among those aged 45 to 64, compared to 34.76% for California and 35.07% for the US. By contrast, Santa Cruz had a reduced volume of deaths among those aged 25 to 44, with 22.73% of deaths compared to California's 30.91% and the US's 32.40%.

Self-Inflicted/Suicide Death by Age/Year Santa Cruz



By examining the annual distribution of deaths by age, it helps to further reveal the year-by-year fluctuation that takes place within the community. This can make evaluation work challenging when targeting specific age groups.

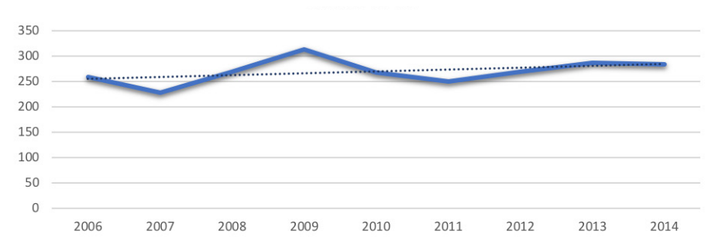
Self-Inflicted/Suicide Death by Age/Year California



California experiences fluctuations in suicides by age year-by-year but tends to have a more moderated fluctuation due to population size. Of note, both California and Santa Cruz experience the most deaths in the 45–64 age group.

Self-Inflicted/Suicides

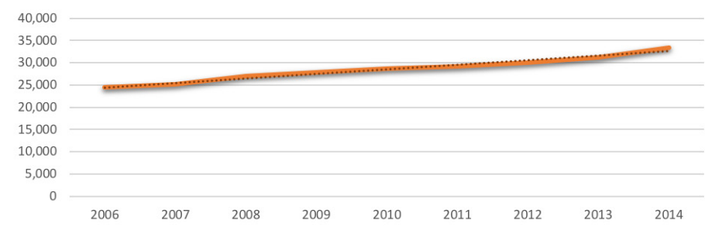
NON-FATAL EMERGENCY DEPARMENT TOTAL BY YEAR SANTA CRUZ



Another indicator of suicide risk in the community is emergency department visits for self-inflicted injuries with suicidal intent. It is interesting to note that suicide deaths had a higher rate of increase than did emergency department visits, which warrants further exploration. Unfortunately, data available via EpiCenter is only available for 2006 to 2014 and does not reveal more recent trends.

Self-Inflicted/Suicides

NON-FATAL EMERGENCY DEPARMENT TOTAL BY YEAR CALIFORNIA



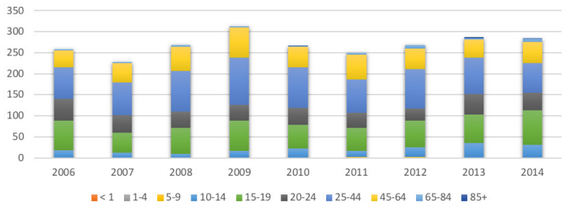
The number of emergency department visits for California saw a more pronounced elevation of visits during the same time period. It remains to be examined if there are differences in the lethality or severity of attempts leading to hospital visits in Santa Cruz County as compared to the state or what other variables might be influencing these differences. Additional investigation into these differences might better inform local efforts, such as through the Suicide Prevention Resource Center's Emergency Department Means Restriction Education program.

NOTE

(13) https://www.sprc.org/resources-programs/emergency-department-means-restriction-education

Self-Inflicted/Suicides

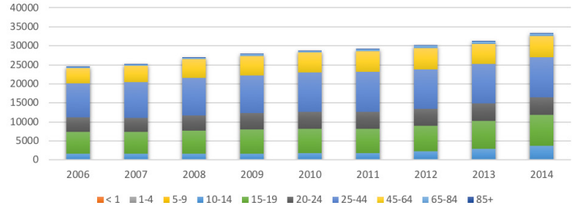
NON-FATAL EMERGENCY DEPARMENT VISITS BY AGE AND YEAR–SANTA CRUZ COUNTY



Viewing emergency department visits in Santa Cruz County by age and year helps to reveal underlying risk for suicide death via non-completions. This doesn't reveal any stark shifts on a year-by-year basis but tends to indicate changes in overall volume of visits across ages.

Self-Inflicted/Suicides

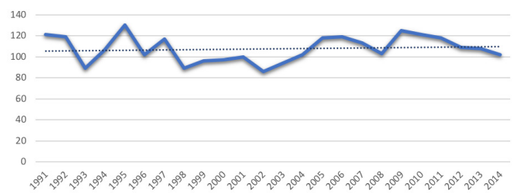
NON-FATAL EMERGENCY DEPARMENT VISITS BY AGE AND YEAR–CALIFORNIA



Looking at the change in emergency department visits for suicide attempts across California shows greater annual stability than at the local level and shows sustained annual growth in visits. It is unknown whether those who visited the emergency department for a suicide attempt had multiple visits or subsequently died by suicide.

Self-Inflicted/Suicides

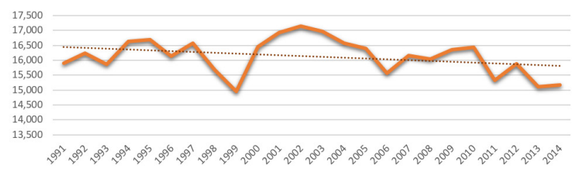
NON-FATAL HOSPITALIZATION TOTAL BY YEAR–SANTA CRUZ COUNTY



Hospitalizations show an elevated risk for death compared to emergency department visits, as indicated by a higher level of care. Santa Cruz had year-by-year fluctuation but overall had a slight sustained growth during this time period. Those requiring hospitalization are typically utilizing a more highly lethal means and might be at greater risk for subsequent death. Some communities have follow-up programs to reduce future risk.

Self-Inflicted/Suicides

NON-FATAL HOSPITALIZATION TOTAL BY YEAR–CALIFORNIA



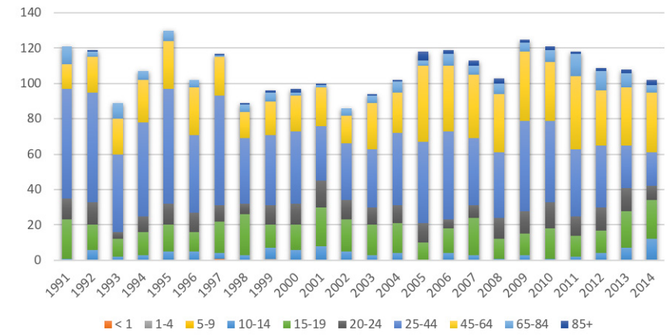
California non-fatal hospital visits had substantially larger annual fluctuation compared to Santa Cruz, as well as a sustained decrease in visits.

NOTE

(14) http://followupmatters.suicidepreventionlifeline.org/follow-up-starts-here/

Self-Inflicted/Suicide

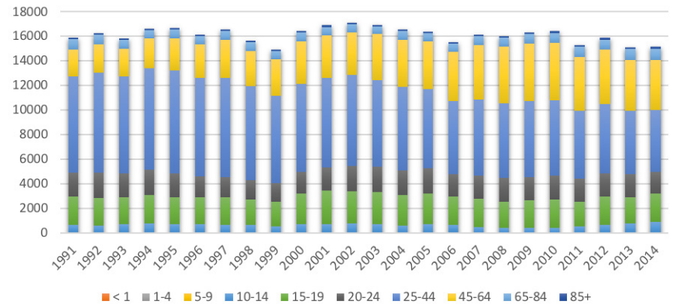
NON-FATAL HOSPITALIZATION TOTAL BY AGE–SANTA CRUZ COUNTY

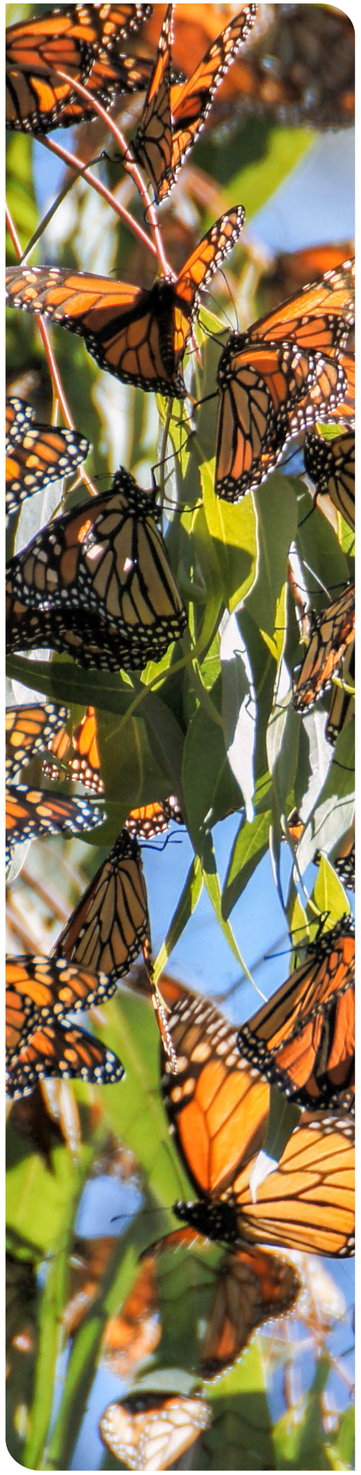


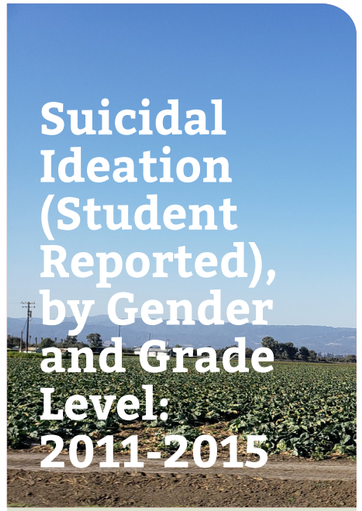
Non-fatal hospitalizations by age over time shows annual fluctuation in the age of those being hospitalized. The greatest changes are occurring in those aged 25–44, 45–64, and to a lesser extent those aged 15–19. In recent years, there were large declines in visits among those aged 25–44, while there have been increases among those aged 15–19 and 45–64. Similar changes appear to be occurring in state non-fatal suicide attempt hospitalizations.

Self-Inflicted/Suicide

NON-FATAL HOSPITALIZATION TOTAL BY YEAR–CALIFORNIA







Suicidal Ideation (Student Reported), by Gender and Grade Level: 2011-2015

(Grade Level: All; Gender: All; Student Response: Yes)

Definition: Estimated percentage of public school students in grades 9, 11, and non-traditional programs who seriously considered attempting suicide in the previous year, by gender and grade level (e.g., in 2013–2015, an estimated 26.5% of female 9th graders in California seriously considered attempting suicide in the previous year).

Data Source: WestEd, California Healthy Kids Survey. California Department of Education (Jul. 2017)

Footnote: Years presented comprise two school years (e.g., 2013–14 and 2014–15 school years are shown as 2013–2015). County- and state-level data are weighted estimates; school district-level data are unweighted. Students in non-traditional programs are those enrolled in community day schools or continuation education. The notation S refers to (a) data for school districts that have been suppressed because there were fewer than 10 respondents in that group, and (b) data for counties that have been suppressed because the sample was too small to be representative. N/A means that data are not available.

NOTE

(15) https://calschls.org

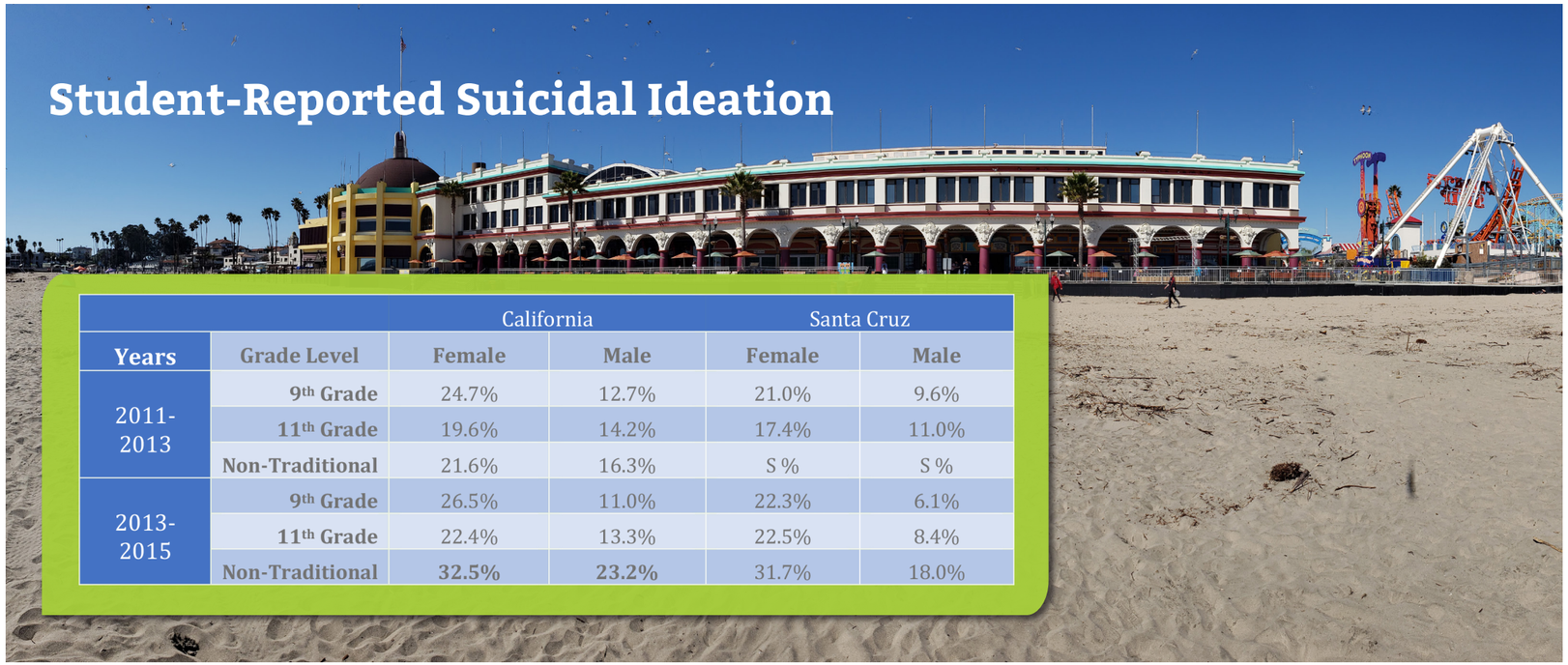
Youth Suicide

Suicide prevention efforts targeting youth are a critical component of community-based suicide prevention efforts. The teen and early adult years see a dramatic increase in suicide attempts and completions. Interventions targeted at youth can help reduce lifelong risk for suicide. Programs should not only seek to identify youth and intervene when indicated but can also help to train and empower youth to spot risk among their peers and become vital referral and support mechanisms.

During the formation of this initial strategic plan, youth suicide prevention efforts were not explored in-depth. This was due to the simultaneous efforts of the Santa Cruz County Office of Education working with local school districts to develop a school-based suicide prevention plan. It is the intent of the Santa Cruz Suicide Prevention Task Force to support these efforts of the Santa Cruz County Schools Suicide Prevention Plan and recommends adoption of that plan by all schools within Santa Cruz County.

At the time of the writing of this strategic plan, draft legislation SB331 Suicide Prevention: Strategic Plans came about, which if passed in its current form would require an emphasis on suicide prevention for children younger than 19. It is important to note that while youth suicide deaths in Santa Cruz are rare, youth are being seen in both emergency departments and hospitals for care following a self-injurious suicide attempt.

Another indicator of youth risk comes from the California Healthy Kids Survey. This survey reveals that suicidal ideation is prevalent among both females and males, but that females are nearly twice as likely to have serious thoughts of suicide as are males across years and grade levels surveyed.



Student-Reported Suicidal Ideation

		California		Santa Cruz	
Years	**Grade Level**	**Female**	**Male**	**Female**	**Male**
2011-2013	9th Grade	24.7%	12.7%	21.0%	9.6%
	11th Grade	19.6%	14.2%	17.4%	11.0%
	Non-Traditional	21.6%	16.3%	S %	S %
2013-2015	9th Grade	26.5%	11.0%	22.3%	6.1%
	11th Grade	22.4%	13.3%	22.5%	8.4%
	Non-Traditional	**32.5%**	**23.2%**	31.7%	18.0%

Key Informat Survey

The Santa Cruz County Suicide Prevention Task Force developed and distributed an electronic key informant survey from January to March 2019. This survey was first distributed to a targeted list of community stakeholders across law enforcement, education, health care, and mental health service providers and was expanded to include members of the distribution lists of NAMI Santa Cruz and Family Services Agency of the Central Coast for a total of 111 responses. As this was a targeted distribution, the demographics of the respondents are not fully representative of the population of Santa Cruz County. This survey was primarily utilized to gauge perceptions of the issue of suicide, inform the Task Force as to possible service-delivery mechanism, and highlight strengths and weaknesses within the existing system of care.

KEY FINDINGS

The survey included open-ended questions to help explore the thoughts and beliefs of respondents. Below are the questions that were asked and the most common responses.

In Santa Cruz County, what do you think is helping to protect people from attempting or dying by suicide?

Friends, family, crisis hotline, NAMI of Santa Cruz, MHCAN, support groups, peer support, public information campaigns increasing awareness, training, strong social networks, environment (sunshine and beauty), trained law enforcement officers, case managers, efforts in the schools, the mental health system, a tolerant and open community.

In Santa Cruz County, what do you think is placing people at risk for suicide?

Homelessness, substance abuse, mental illness (depression, anxiety, PTSD), financial stress (high cost of living), loneliness, and access to mental health services, incarceration, the foster care system, insurance (access to care), economic problems, isolation, lack of psychological services, lack of education about prevention, improper diagnosis, aging and loss of social connectedness, health problems, social media, psychological stress associated with "not making it," fear of institutionalization, inadequate support networks, sexual orientation, physical abuse and trauma.

What do you see as the barriers to suicide prevention in Santa Cruz County?

Lack of resources, homelessness, incarceration, substance abuse, mental health, shame/stigma, access to mental health, lack of a universal assessment, a lack of funding for programs, not enough services, not enough support groups, cost of services, tolerance, difficulty locating services (awareness), toxic expectations about masculinity (lack of help-seeking), culture of individualism, lack of mental health beds in local facilities, lack of coordinated services, bilingual or monolingual needs, lack of adequate aftercare.

What types of issues do you or other people face regularly in life that make you or them feel suicidal?

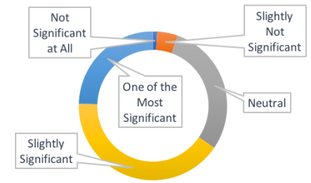
Finances, cost of living, disparity between living near wealth while living in poverty, mental illness (depression & anxiety), substance abuse, health problems, family problems, hopelessness, trauma/PTSD, lack of connectedness, isolation/loneliness, bullying, anger/frustration, divorce, loss.

Do you have any experiences you would like to share, either challenges or successes, regarding suicide prevention, intervention, post-intervention or postvention?

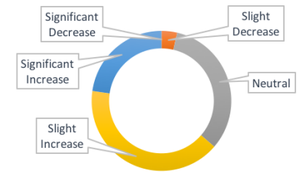
Successes: NAMI's Ending the Silence, phone-based therapeutic support, NAMI's peer support services, Mobile Emergency Response Team (MERT), Sheriff's Emergency Response Team (SERT), grief support following a suicide loss, successful treatment in talk therapy and medication, supportive others who show compassion, increased awareness in the medical community.

Challenges: Failure of medications to adequately treat a condition, limited hospital space and early discharge, communication (HIPAA) with and among providers (service coordination), fear of the experience of hospitalization, fragile access to care that is dependent upon public benefits, high perception of risk among youth, LGBT+, and people of color, insensitive comments from care providers, fear when someone communicates risk, people who are suicidal but do not meet criteria for hospitalization or 5150.

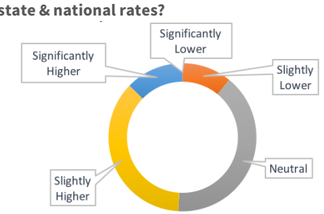
How significant of an issue is suicide in Santa Cruz County?



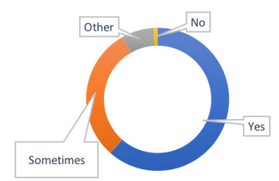
Has the rate of suicide deaths in Santa Cruz County changed over the last 10 years?



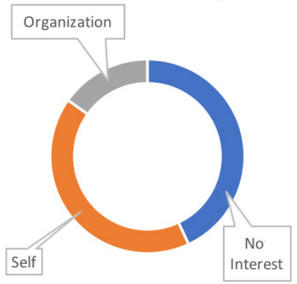
How does Santa Cruz's suicide rate compare to state & national rates?



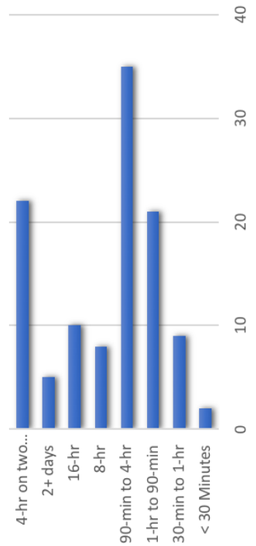
Do you agree with the statement "suicide is preventable"



Interest in Training



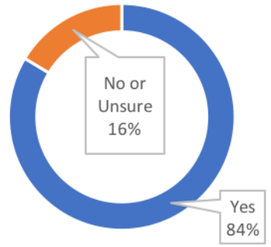
Length of time willing to spend in suicide prevention training



When asked about training, 43% of respondents were not interested in participating in training on suicide prevention. Among the 47% that were interested, the majority preferred shorter-duration training offerings of 90 minutes to 4 hours, or 4 hours of training on two separate days. Respondents also preferred training to take place in a community setting or at their organization, with a lower number desiring self-driven learning mechanisms such as self-study or podcasts. There was a sufficiently high desire for online training offers as well.

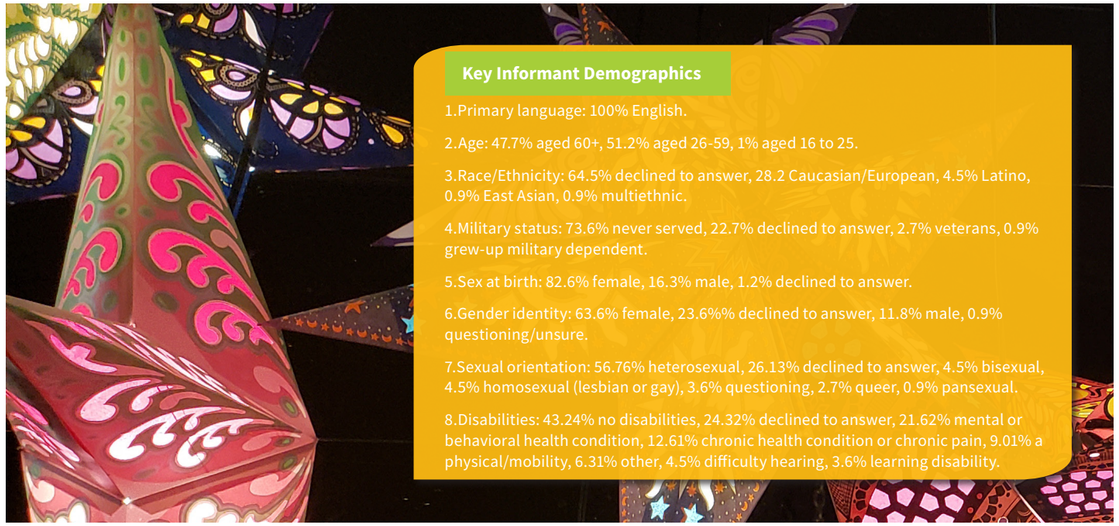
Feedback included a belief that suicide is most often preventable if the right systems and supports are in place. A common theme was the need for compassionate welcoming and interaction with representatives of the systems of care. There was an emphasis on learning the signs and symptoms of risk and having access to resources. The factors most often identified for suicide not being preventable were a fixed desire to die, that not all suicides are preventable, critical timing of interventions to assist those in crisis, a strong desire to die overcoming support systems, and that it is crucial to have access to both mental health and substance abuse services.

Are you aware of any services in our community that help prevent suicides?



Awareness of services currently available in Santa Cruz

The majority (84%) of respondents were knowledgeable of one or more resources currently available in Santa Cruz County, with most respondents being familiar with the National Suicide Prevention Lifeline. Some respondents shared that they either carry this hotline number in a wallet card or similar fashion or could easily locate it via search engine. Availability of licensed mental health clinicians tended to be high, as well as knowledge of support groups. It is interesting to note that while knowledge was high for this resource, respondents reported a preference for mental health counseling above the use of the hotline.



Key Informant Demographics

1.Primary language: 100% English.

2.Age: 47.7% aged 60+, 51.2% aged 26-59, 1% aged 16 to 25.

3.Race/Ethnicity: 64.5% declined to answer, 28.2 Caucasian/European, 4.5% Latino, 0.9% East Asian, 0.9% multiethnic.

4.Military status: 73.6% never served, 22.7% declined to answer, 2.7% veterans, 0.9% grew-up military dependent.

5.Sex at birth: 82.6% female, 16.3% male, 1.2% declined to answer.

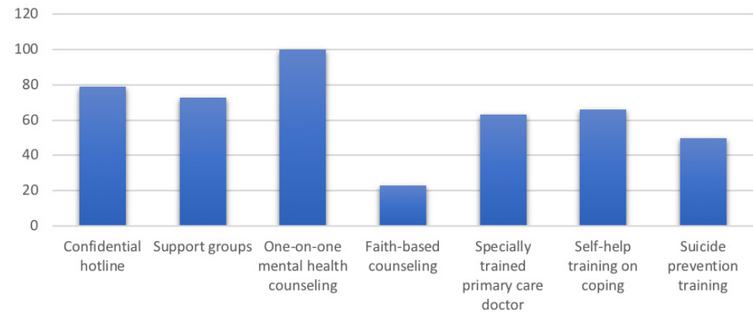
6.Gender identity: 63.6% female, 23.6%% declined to answer, 11.8% male, 0.9% questioning/unsure.

7.Sexual orientation: 56.76% heterosexual, 26.13% declined to answer, 4.5% bisexual, 4.5% homosexual (lesbian or gay), 3.6% questioning, 2.7% queer, 0.9% pansexual.

8.Disabilities: 43.24% no disabilities, 24.32% declined to answer, 21.62% mental or behavioral health condition, 12.61% chronic health condition or chronic pain, 9.01% a physical/mobility, 6.31% other, 4.5% difficulty hearing, 3.6% learning disability.

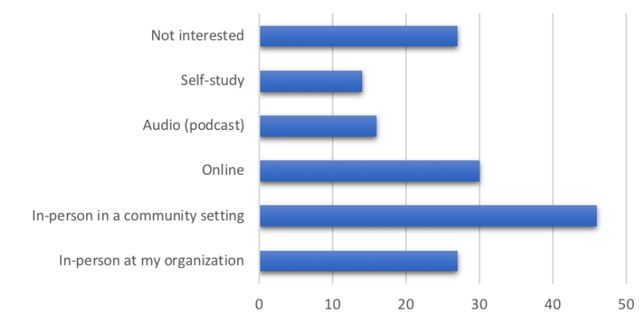
Personal preference for services if in need

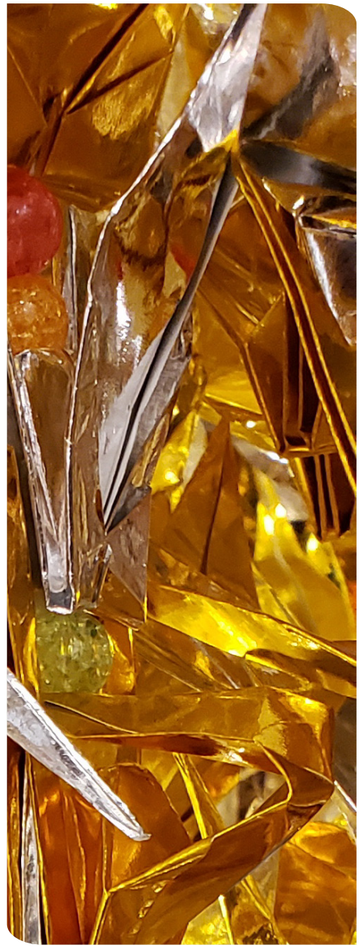
Respondents listed additional services, including: 24-hr. crisis hotline, Suicide Prevention Services through the Family Services Agency, the Crisis Text Line, Telecare, mental health liaisons (Sheriff's Dept), NAMI Santa Cruz, Community Connection, HOPE services, Santa Cruz County Behavioral Health, Dominican Hospital for assessment, Crisis Intervention Team, MHCAN, the Trevor Helpline, the Family Acceptance Project, the Access Team, UCSC's campus health services, Second Story through Encompass Community Services, Mobile Emergency Response Team (MERT), Wings grief support group at Suicide Prevention Services of the Central Coast, QPR training, churches, and Mental Health First Aid training.



Format of Training Delivery

Training is currently available in Santa Cruz County through existing programs funded through local Mental Health Services Act funding. This training can be delivered widely throughout the community by partnering with other organizations to host training at the organizations' sites as well as in natural community settings such as libraries, facilities owned by service clubs, meeting halls, and other public spaces.





General Considerations for Future Data Collection

Data is the major driver of sound decision-making and is a core function of ongoing strategic planning. Data places an issue such as suicide in an appropriate context and helps us to understand the extent of the local problem. It is essential to develop a consistent framework for data collection, review, and communication. Examining national, state, and local data sets will enable decision-makers to have a better understanding of the risk and protective factors prevalent or lacking in the community. This enables an approach that enriches the understanding of what drives local suicide attempts and completions.

Evaluation of efforts is another key consideration in the area of data. What are the goals of any programs and interventions selected for implementation? A reduction in suicide deaths and completions is the primary goal of suicide prevention efforts, but what are the intermediary goals? An understanding of the existing problem in the community facilitates the identification of desired outcomes for evaluation. However, it is important to recognize that: suicide is a complex phenomenon; a reduction in suicide completions might not take place immediately; and numbers can have significant annual fluctuations due to the size of the population in Santa Cruz.

Each program implemented through this plan should have clearly identified goals that are tied to data measures to gauge the success and impact of those initiatives. However, it is important to note that the rate of suicides in the community can still fluctuate significantly on a year-by-year basis, and the relatively small number of suicides in Santa Cruz County can make statistical analysis challenging. A longitudinal lens should be utilized rather than viewing the success or failure of these efforts on an annual basis. Over time, the rates of suicide can be reduced through consistent and integrated service delivery that spans the levels of the Social-Ecological Model.

Below is a brief listing of aspects of data collection that should be considered. In an ideal world we would have robust data systems that are easily accessible, highly valid, accurate, and actionable. In the real world, data can be difficult or impossible to obtain, time-consuming, and not helpful to the decision-making process. Before pursuing a data set, the value of that information should be weighed, as not all data will be necessary or beneficial. A few key considerations are:

- Who will request the data?
- Who will input it?
- Who will analyze it?
- Who will report it and how?
- How will the data be utilized?
- How do the costs of obtaining data compare to the benefits of having the data?

The tables below provide potential data sources. The identification, development, and utilization of local data is an essential step in local planning efforts. A strength of a diverse collaborative is the potential for the identification of and access to data sources that would be otherwise unknown or inaccessible. It is not necessary for individual-level data to be utilized if aggregate reporting is possible.

Ideation (Thoughts)

Data Source	Details	Issues to Consider
Suicide Prevention Lifeline	County-level call data should be available and can be divided by language of calls and veteran status. Data should include date and time of call, crisis center call was routed to, number of calls answered, not answered, busy, and abandoned.	Can have some underreporting due to cell use and blocked numbers. Data must be requested. Some calls might not be related to suicide but may reflect a broader crisis.
Crisis Response Team	Data including date and time of call, expression of suicidal ideation, and demographics.	Restricted data. Aggregate reports may be possible depending upon the records management system.
California Healthy Kids Survey	The California Healthy Kids Survey (CHKS) is an anonymous, confidential survey of school climate and safety, student wellness, and youth resiliency. Limited to grades 5, 7, 9, and 11.	Data limited to participating schools and districts. Includes “considered suicide” and “experienced chronic sadness/hopelessness.”

Attempts

Data Source	Details	Issues to Consider
Hospital (OSHPD)	Possible to obtain ED/ER visit diagnosis codes (ICD) and supplemental data (E-codes). Coding can indicate self-harm.	Local hospitals might not submit E-codes.
EMS (911) / Law Enforcement	Possible to obtain data reports for suicide attempt data.	Data may be restricted by state law or local command.
California Poison Control Center	Calls are received relating to suicide overdoses. Some calls received by individuals asking about lethal dosages.	Data is only accessible to County Health Officer or designee. Data may be duplicative through multiple sources reporting the same call. High time consumption to review and prepare data.
Crisis Response Team	Data including date and time of call, expression of suicidal ideation, and demographics.	Restricted data. Aggregate reports may be possible depending upon the records management system.

Completions

Data Source	Details	Issues to Consider
County Coroner	A Coroner can be the best source of suicide death data in real-time or on a regular basis. Access to data at the discretion of the S.O. Additional training such as Psychological Autopsy is possible.	Nationally it is estimated that suicide deaths are underreported by approx. 30%. Single-vehicle accidents, drug overdose, and difficulty determining between accidental/intentional contribute.
California EpiCenter	Record of recorded suicide deaths including age, sex, cause/mechanism, race/ethnicity.	Data can vary from Coroner’s data due to deaths occurring in other communities or reports circumventing the Coroner’s office. Known underreporting issues.

Postvention

Data Source	Details	Issues to Consider
LOSS Team	Data can include a variety of demographics relating to the decedent as well as identified loss survivors.	This data source is not currently available in Santa Cruz, as there is no established LOSS Team. Data is limited to what the local response team collects.

Selected Program Information

The Santa Cruz County Suicide Prevention Task Force examined more than 35 different programs, training options, communication campaigns, and resources. We utilized the elements set forth in our Strategic Direction to select a subset of 10 initiatives for greater discussion and examination. This process resulted in three program areas across prevention, intervention, and postvention to focus on three initial programmatic areas for community discussion and potential implementation. The tabled programs should be revisited in the future as public policy evolves and additional partners, funding streams, and resources become available.

Prevention

Community-Based Supportive Services

Overview: This is not a specific program but rather an approach to providing necessary services in the community to help increase supports, interventions, access to care, and to reduce risk for suicide. Community-Based Supportive Services are primarily provided by trained professionals and paraprofessionals such as behavioral health providers, educators, law enforcement, medical providers, community-based organizations, jails and prisons (including juvenile justice), inpatient services, and others. These services can and should include peer-based supports such as peer support specialist, peer support groups, and similar resources.

Services in this area can include individual and group counseling, medication, Assertive Community Treatment (ACT), Crisis Intervention Teams, school-based mental health supports, substance abuse support and recovery services, and similar support systems and models.

Purpose: To develop and provide services that address systemic gaps and meet local-level needs associated with increased risk for suicide.

Audience: At-risk groups identified in the community. Service population can be universal, selective, or indicated, depending upon the program being developed.

Training: Training is dependent upon the specific programs selected for development and implementation. Training should be strategically linked to other training provided in the community, such as Question, Persuade, Refer (QPR), Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), and similar training.

Cost: Program costs must be developed during strategic discussion and implementation and are dependent upon available allocations and resources. This can be facilitated through either sole-source agreement, through request for proposal (RFP), or similar processes.

Website: The document provided below outlines specific elements and strategies to develop successful community-based programs, which should also be applied to Community-based Peer Support programs.

Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention

https://theactionalliance.org/resource/transforming-communities-key-elements-implementation-comprehensive-community-based-suicide

Postvention

Local Outreach to Suicide Survivors (LOSS) Team

Overview: LOSS Teams follow the Active Postvention Model developed by Dr. Frank Campbell, in which trained loss survivors and other trained individuals respond in the aftermath of a suicide death to provide information, linkage, and referral to the newly bereaved. Each LOSS Team tends to have a unique structure that is dependent upon available resources, political will, and local help-providing systems. Some teams are grassroots, and some fall within community-based organizations such as crisis response centers or hospices, while others are housed within governmental entities. The center of LOSS Teams is the inclusion of suicide loss survivors who are often paired with clinicians or paraprofessionals on responses. LOSS Teams can engage in active postvention in which they immediately dispatch to an incident scene, or they can be delayed responses that take place days, weeks, months, or even years after a suicide death.

Purpose: Reduce the elapsed time between the experience of a suicide loss to engagement in supportive services, increase positive coping skills to aid in recovery rather than maladaptive coping skills, and provide a network of care and support for the newly bereaved. These teams link the newly bereaved with peer support groups, counseling services, and other coping supports.

Audience: Individuals who have experienced the loss of an individual to suicide.

Training: Initial training called Sudden & Traumatic Loss is available via Campbell & Associates as well as others. Additional training is developed by each team to cover local response protocol with law enforcement and trauma processing, and should include additional training supports such as Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid (MHFA), Question, Persuade, Refer (QPR), Critical Incident Stress Management (CISM), and other models.

Cost: Costs are fully dependent upon the structure of the LOSS Team. Each LOSS Team tends to be uniquely structured, depending upon the availability of resources. Consultation fees depend upon the depth and duration of consulting and training desired. Additional training costs should be considered, such as offering ASIST, MHFA, QPR, CISM, or other training identified as essential to the local team.

Website: http://www.lossteam.com

Intervention

Columbia Suicide Severity Rating Scale (C-SSRS)

Overview: A crucial first step in preventing suicide is to identify people who are most at risk for dying by suicide. In 2012, the FDA made the Columbia-Suicide Severity Rating Scale, also known as the Columbia Protocol, the "gold standard" for measuring suicidal ideation and behavior in clinical trials. It provides definitions and standardized questions to provide a uniform approach to understanding risk. The tool has several versions that are population adapted as well as "community cards" that can facilitate quick initial screening and can lead to interventions and more in-depth assessments by licensed mental/behavioral health care professionals.

The C-SSRS is structured into two sections: suicidal ideation and behavior. The tool examines the types of ideation of increasing severity and then explores the intensity of that ideation. Suicidal behaviors are assessed for actual attempts, interrupted attempts, aborted attempts, and preparatory behavior.

Purpose: Increase the detection of suicidal ideation and behavior across a wide array of individuals and sectors. This screening tool helps to more accurately assess for suicide risk.

Audience: This tool can assist anyone in asking questions about thoughts and behaviors to assess risk for suicide. This tool has been adapted for government health and social services agencies, health care, first responders, military, schools, correctional facilities, families, friends, and neighbors.

Training: Available for free online at The Columbia Lighthouse Project website. Training is possible through interactive training modules, pre-recorded webinars, online and downloadable videos, and other formats. In-person training can be offered by anyone competent in the tool. Training should include safety planning.

Cost: Use of the tool is free but costs include printing, staff time, training space, etc.

Website: http://cssrs.columbia.edu

Crisis & Safety Plan or Safety Plan Intervention

Overview: The Safety Plan Intervention was developed by Barbara Stanley, Ph.D., and Gregory K. Brown, Ph.D., to step beyond an assess and refer model to incorporate individuals in planning efforts to reduce and alleviate their own risk for suicide through the development of an individualized safety plan. The Stanley and Brown Safe Plan Intervention is utilized by the National Suicide Prevention Lifeline and supported by the Suicide Prevention Resource Center (SPRC) and the American Foundation for Suicide Prevention (AFSP).

Purpose: Reduce individual risk for suicide using a simple tool to develop a plan of action for current and future suicide risk.

Audience: This tool can be utilized by crisis hotlines, college counseling centers, emergency departments, mental/behavior health systems, veteran support systems, high school counselors, private practices, outpatient clinics, faith-based organizations, and others.

Training: In-person training can be developed or sought. Safety planning is an integral part of other training opportunities, such as Recognizing & Responding to Suicide Risk (RRSR), Assessing and Managing Suicide Risk (AMSR), and others. It is also a core component of Applied Suicide Intervention Skills Training (ASIST), though ASIST utilizes a slightly different model and process.

Training link – http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/sp/course.htm

Cost: Free, though in-person training may come with additional costs.

Website: The links provided below are to resources related to the Safety Plan Intervention.

1. http://suicidesafetyplan.com
2. https://www.sprc.org/sites/default/files/resource-program/Brown_StanleySafetyPlanTemplate.pdf
3. http://www.sprc.org/sites/default/files/SafetyPlanningGuide%20Quick%20Guide%20for%20Clinicians.p
4. http://suicidesafetyplan.com/uploads/Safety_Planning_-_Cog___Beh_Practice.pdf

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