WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

January 25, 2018
PowerPoint Presentations and Handouts

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News worth sharing online

Guest View: San Joaquin Task Force works to address homelessness

By Kathy Miller / San Joaquin County Supervisor

Posted Jan 6, 2018 at 6:00 AM
Updated Jan 6, 2018 at 6:14 PM

As chairwoman of the San Joaquin County Homelessness Task Force (HTF), I'm sometimes asked, "Why aren't we doing more about homelessness?" I respectfully offer that we're doing plenty and, as we enter the new year, I would like to share the progress made by the HTF in 2017 to help serve the estimated 1,500 homeless children and adults in San Joaquin County.

Guiding principles

In February, the Board of Supervisors adopted the HTF's recommended set of guiding principles which provided a blueprint to reduce homelessness in San Joaquin County.

Homeless Initiatives Program administrator

The Board also approved a full-time administrative position to coordinate task force efforts, convene an expanded continuum of care, and continue the momentum of the HTF. Under the guidance of the new administrator, we expect to see development of a county strategic plan to address homelessness, a community "report card" on outcomes, increased public communication on homelessness reduction efforts, identification of funding opportunities and examples of best practices.

Ready To Work program

This newly incorporated nonprofit has turned significant private donations into a partnership with the county and its Community Corrections Partnership to launch a residential treatment and jobs training program to prevent recently incarcerated individuals from becoming homeless and provide chronically homeless men with a path to stable housing and employment.

U.S. Department of Housing and Urban Development (HUD) assistance

San Joaquin County secured 200 hours of technical assistance from HUD to facilitate the transition from task force to an operational continuum of care. Working with HUD is important to ensure we're positioned to receive as much Federal funding as possible. Having HUD advise us on how best to structure and govern our continuum to conform to new Federal policies, is raising our profile within HUD and may make a big difference in our future success.

Whole Person Care pilot

SJ County has secured $18.3 million through 2020 to reduce reliance on emergency departments and to fund 15 recuperative care beds at the Gospel Center Rescue Mission, re-directing individuals after hospitalizations to prevent their return to homelessness. Savings realized by the medical system will be used to create a county housing pool.

Mental Health Services Act (MHSA) funding

Collaboration with the Housing Authority has resulted in the use of $3.5 million MHSA funding for additional housing units for homeless families and will include 14 units in Stockton, with additional housing units projected.

Housing First program

This County program serves homeless individuals with serious mental illnesses. Pending State approval, it will use $6.5 million in MHSA funding over five years to create rehabilitative housing. During the first three years, it's estimated that 12 to 18 publicly-funded houses will be developed throughout the County and will serve more than 70 individuals.

Homeward Bound Initiative. The County's partnership with Community Medical Centers secured $6 million in Proposition 47 grant funding for this Initiative which will serve 1,000 individuals with mental illness or substance use disorders annually. An additional $8.2 million of MHSA funding is pending approval, which will add an assessment and respite center component to the Initiative.

Public health services

A County partnership with HealthNet provided $100,000 of funding to enable Public Health Services to perform in-field syphilis and Hepatitis A testing and provide follow-up treatment at homeless encampments.

Community meetings

The Board held joint study sessions on homelessness with the Stockton and Lodi city councils. A third session is being planned with the City of Manteca. We are encouraged by the interest these communities have expressed in solving this shared crisis. We are hopeful that other San Joaquin County communities will see the value and become engaged in this effort.

It has taken decades for homelessness to reach the crisis proportions we are seeing across our country. The underlying causes of homelessness are complex, and addressing them requires multiple strategies. Real solutions won't be easy, quick or cheap. As the Homelessness Task Force prepares to become a long term, coordinated and sustained effort, the key elements for success are already at work: adaptation, partnership, compassion, and focus. For more information on past task force meetings, go to: **https://sjgov.app.box.com/v/HomelessnessTaskForce**.

County Supervisor Kathy Miller represents District 2 and has chaired the Homelessness Task Force since 2015.

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Greatness grows here.

MHSA Innovation Plans

A Presentation to:

Mental Health Services Oversight
and Accountability Commission

January 25, 2018

Tony Vartan, Director

Behavioral Health Services

INTRODUCTION

San Joaquin County: Strategic Priorities

County Priorities

- **Improve public safety and enhance the criminal justice system**
- **Adopt a "Housing First" model to reduce or eliminate barriers to housing**
- **Adopt a no wrong door approach to accessing services**
- **Foster public/private partnerships**

BHS Priorities

- **Increase access to treatment services**
- **Increase housing stability for consumers**
- **Integrate primary and behavioral health care services**
- **Decriminalize the mentally ill and reduce the incarceration of consumers**

Behavioral Health Services: 2017 MHSA Community Program Planning

Community Engagement

- **Community Surveys**
  - Over 600 returned!
  - 50% returned by consumers
  - 20% returned by family
- **Community Meetings**
  - Behavioral Health Board
  - Advisory Committee
  - General Public Forums
  - Consumer Focus Groups
  - Program Focus Groups

Key Findings

- **There are ongoing concerns regarding access to and usage of public mental health services among underserved populations.**
- **Affordable housing is very scarce for consumers.**
- **Consumers and stakeholders want more comprehensive and holistic behavioral health services.**

Introduction by:

Miguel Villapudua, District 1

San Joaquin County Board of Supervisors

ASSESSMENT AND RESPITE CENTER

Assessment and Respite Center: Justification of Need

Disparities in Access to Public Mental Health	Related Challenges to be Addressed
• Low penetration rates among Latinos	• Perceived stigma regarding "County Services"
• Overutilization of Crisis Services among African Americans	• "Service silos" increase the risk of falling through cracks
• Low retention of homeless individuals into public mental health services	• Behavioral health treatment and recovery is not the first priority for many homeless individuals

Assessment and Respite Center: Program Overview

ARC Clinic Services

- **Key Services:** Medical/psychosocial triage, assessment, and linkage to stabilization supports and behavioral health services.
- **Target Population:** homeless individuals and/or low-level offenders deemed likely to have a mental illness or co-occurring disorders.

ARC System Improvements

- CMC Clinic-wide capacity for coordinated behavioral health assessments
  - Joint assessment process with BHS
  - Uniform referral policies and procedures with BHS
  - Expanded primary care provider capacity in behavioral health treatment protocols and practices

Assessment and Respite Center: Proposed Solution

Major Objectives

- **Improve access to services for unserved and underserved populations.**
- **Reduce systemic challenges that cause individuals to fall through service system gaps.**

Service to be Delivered

- **Triage of Needs**
  - Clinical Needs
  - Daily Living Needs
- **Respite Services**
  - Peer Partner Engagement
  - Sobering and Brief Interventions
- **Referrals to Stabilization Services**
  - Housing Support Services
  - Withdrawal Management
- **Mental Health and Substance Use Assessment**
  - Validated and Bi-directional
- **Linkages to Ongoing Care**

Assessment and Respite Center Evaluation Components

Learning Questions

Will new processes result in more at-risk individuals completing assessments and linking to services?

Will new services result in greater utilization of mental health services by individuals from unserved/underserved communities?

Outcomes

Increase access to services among underserved populations.

- **Improve rates of completed assessments and referrals**
- **Increase planned service utilization and retention**

Reduce the negative consequences of untreated mental illnesses

- **Improve consumer well-being as measured though the *Adult Needs and Strengths Assessment* tool**
- **Reduce duration of hospitalizations, jail stays, or homelessness for participants**

Assessment and Respite Center: Innovation Budget

Community Medical Centers

- **Implementation Goals**
  - Co-located clinic offering assessment, respite, and linkages to stabilization services
  - Serving over 1,000 individuals annually
  - Target goal is to provide services 7-days a week, with non-standard operating hours

5 Yr. Program Budget

- **Total Budget: $11,216,688**
  - CMC Personnel: $ 8,433,388
  - Direct & Indirect : $ 2,288,300
  - Evaluation: $ 495,000

- **Projected Revenue: $ 3,044,084**
- **Total INN Costs: $ 8,172,604**

Clinical and medical personnel comprise the majority of the budget, including staff with lived experience.

Most CMC personnel are from underserved communities.

San Joaquin County Community Partners, Stakeholders, Family Members and Consumers:

- Miguel Villapudua, Supervisor District 1
- Kathy Miller, Supervisor District 2
- Tony Vartan, MSW,LCSW, Behavioral Health Services Director
- Frances Hutchins, Behavioral Health Services Assistant Director
- Kayce Garcia Rane, MHSA Planning Consultant
- Dr. Ruth Shim, UC Davis Behavioral Health Center for Excellence, Principal Investigator
- Christine Noguera, Community Medical Centers, Executive Director
- John Foley, Sacramento Self Help Housing, Executive Director
- Tasso Kandris, San Joaquin County Behavioral Health Board, NAMI
- Karen Ivy, Behavioral Health Board, Consumer Advisory Council
- Cary Martin, Behavioral Health Board,
- Gertie Kandris, NAMI San Joaquin
- Michael Fields, Peer Recovery Services, Executive Director
- Dr. Benjamin Morrison, Community Medical Centers, Medical Director
- Jaime Nunez, Behavioral Health Services, Chief Mental Health Clinician
- Kathleen Wilson Parish Behavioral Health Services, Chief Mental Health Clinician
- Carena Lane, Housing Authority of San Joaquin, Director of Housing Choice Voucher Program

Introduction by:

Katherine Miller, District 2

San Joaquin County Board of Supervisors

PROGRESSIVE HOUSING

Progressive Housing: Justification of Need

Lack of Recovery-oriented Housing

- **1500 homeless individuals, 30% with untreated mental illnesses**
- **30% reduction in Board and Care beds**
- **Housing costs increased 92% over the past 5 years**
- **Limited capacity for new construction**

Related Challenges to be Addressed

- **Housing insecurity inhibits treatment engagement.**
- **Lack of availability of affordable housing.**
- **Loss of beds results in longer utilization of more intensive interventions.**
- **Need for rapid solutions.**

Progressive Housing: Program Overview

Major Objectives

- **Develop new models of affordable, treatment-oriented housing that can be rapidly deployed to meet demand.**
- **Increase access to behavioral health services among underserved populations –** ***including those who are homeless, have co-occurring disorders, or have prior experiences with the criminal justice system.***

Services to be Delivered

Shared, Recovery-Oriented Homes

- Resident House Manager
- Consumer Choice Programming
- Volunteer &/or Vocational Opportunities
- Pre-contemplation (sobering & stabilization) house
- Clinical interventions by BHS

Target Population

- Individuals with severe and persistent mental illnesses who are homeless or are at risk of homelessness

Progressive Housing: Proposed Solutions

Major Challenges to Housing First Model	Innovative Adaptations to Model
• ***Housing First*** **does not require sobriety**	• **Modifies Housing First with a linear approach that moves consumers through levels of housing according to their recovery needs.**
• ***Housing First*** **typically relies on SROs or studios, increasing isolation**	• **Adapts peer supports into Housing First model through shared housing, use of peer partners, and consumer choice programming**
• ***Housing First*** **shows nominal outcomes associated with "recovery"**	

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Progressive Housing: Evaluation Components

Learning Questions	Outcomes
Does the adapted approach to *Housing First* more successfully engage homeless individuals with co-occurring disorders into treatment compared to outreach & engagement alone?	**Increase access to services among homeless individuals with serious mental illnesses** • **Increase behavioral health service utilization and retention**
Does the adapted approach to *Housing First* lead to comparable or better treatment outcomes for consumers compared to previous studies?	**Improve Recovery Outcomes for program participants** • **Increase matriculation to permanent housing; decreased substance use, increased community integration**

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Progressive Housing: Innovation Budget

Self-Help Housing

- **Implementation Goals**
  - Negotiate long-term leases for 12-18 houses within the project period.
  - Place 4-5 individuals in each house with a resident house manager
  - Provide transitional housing (18-24 months) for 70-90 individuals over the duration of the Innovation

5 Yr. Program Budget

- **$6,461,517**
  - BHS: $ 844,554
    - Housing liaison, 2 PT Peer Partners
  - BHCE: $ 445,500
  - SSHH: $5,171,463
    - Personnel: $1,891,262
    - Operations: $2,605,663

- **Rent and Housing Personnel comprise the majority of the budget.**
- **Treatment provided through routine mental health services.**

San Joaquin County Community Partners, Stakeholders, Family Members and Consumers:

- Miguel Villapudua, Supervisor District 1
- Kathy Miller, Supervisor District 2
- Tony Vartan, MSW,LCSW, Behavioral Health Services Director
- Frances Hutchins, Behavioral Health Services Assistant Director
- Kayce Garcia Rane, MHSA Planning Consultant
- Dr. Ruth Shim, UC Davis Behavioral Health Center for Excellence, Principal Investigator
- Christine Noguera, Community Medical Centers, Executive Director
- John Foley, Sacramento Self Help Housing, Executive Director
- Tasso Kandris, San Joaquin County Behavioral Health Board, NAMI
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- Cary Martin, Behavioral Health Board,
- Gertie Kandris, NAMI San Joaquin
- Michael Fields, Peer Recovery Services, Executive Director
- Dr. Benjamin Morrison, Community Medical Centers, Medical Director
- Jaime Nunez, Behavioral Health Services, Chief Mental Health Clinician
- Kathleen Wilson Parish Behavioral Health Services, Chief Mental Health Clinician
- Carena Lane, Housing Authority of San Joaquin, Director of Housing Choice Voucher Program

PROPOSED MOTION

MHSOAC approves San Joaquin County's two (2) Innovation Projects as follows:

1. **Assessment and Respite Center**
   Amount: $11,216,688
   Project Length: Five (5) Years

2. **Progressive Housing**
   Amount: $6,461,517
   Project Length: Five (5) Years

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Implementation of Assembly Bill 1315: Early Psychosis Intervention Plus (EPI Plus) Program

Norma Pate, Deputy Director

Tom Orrock, Chief of Commission Operations and Grants

January 25, 20108
Agenda Item 5

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EPI Plus

- Signed by the Governor in October 2017
- Requires Commission to implement a competitive selection process
- Establishes an advisory committee to assist with implementation of the grant program
- Contingent upon a $500,000 deposit of nonstate funds into the EPI Plus Fund, Commission must also adopt regulations

2

Advisory Committee Membership

- The Chair of the Commission, or his or her designee, appoints the members of the advisory Committee, as specified by the law

3

Advisory Committee Responsibilities

- Advise the Commission regarding:
  - Approaches to early psychosis and mood disorder detection and intervention
  - A competitive selection process
  - Guidelines or regulations
  - Recommendations to expand the state's capacity to provide high quality and evidence-based practices for early detection and intervention pf psychosis and mood disorders
  - Clinical research studies and clinical trials
  - Core set of standardized outcome measures to be collected from grantees

4

Funding

- The Legislature did not appropriate funding for the EPI Plus Program
- Cost $400,000 per year and three additional positions to fully implement program
  - Commission will need additional Mental Health Services Act Funds to be appropriated for these positions

5

Next Steps

- The Commission will need to:
  - Seek applications for the Advisory Committee
  - Seek additional resources to fully implement the EPI Plus Program
  - Develop regulations for the EPI Plus Program

6

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Adoption of Amendments to the Prevention and Early Intervention and Innovative Projects Regulations

January 25,2018
Filomena Yeroshek,
Chief Counsel

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Brief Background

- July 2017 the Commission adopted proposed amendments to the PEI and Innovation regulations
- Nov 2017 Commission modified the proposed amendments in response to public comments

2

Next Steps

- Commission adopts the amendments
- Office of Administrative Law (OAL) reviews the amendments for approval
- Upon OAL's approval the amendments would go into effect July 1, 2018

3

Proposed Motion

The Commission adopts the amendments to sections 3560, 3560.010, 3560.020, 3705, 3726, 3735, 3750, and 3755 of the PEI regulations and sections 3580 and 3580.010 of the Innovative project regulations as presented and authorizes the Executive Director to submit the rulemaking file to the Office of Administrative Law.

4

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Triage Grant Program Evaluation Contract

January 25, 2018

Norma Pate, Deputy Director
Tom Orrock, Chief of Commission Operations and Grants

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Evaluation Strategy Approved

- At the July 27, 2017 Commission meeting the Commission directed staff to include a state-wide evaluation strategy for the Triage program.

2

2014-2018 Triage Evaluation Constraints

- No unified evaluation approach
- Unable to aggregate data collected
- Limited ability to tell a state-wide story including a cost-benefit analysis

3

Triage Round 2 Evaluation Goals

- In coordination with an evaluation Contractor determine what to evaluate
- In coordination with counties the evaluation Contractor will determine consistent methods of evaluation based on individual level data.
- Create a strategy to share our findings with counties and other interested stakeholders
- Use the data to inform future programs

4

State-wide Evaluation Opportunities

- Enhance program to program comparison
- Strengthen the cost-benefit analysis
- Support in-depth case studies to determine best practices
- Provide Technical Assistance
- Increase potential for gap analysis

5

Proposed Motion

Proposed Motion: The Commission authorizes the Executive Director to enter into one or more contracts for a total amount not to exceed $10,000,000.00 to assist the Commission in conducting statewide evaluation of the second round of SB 82 Triage grant programs.

6

Donna Hardaker
Manager, Workplace Mental Health and Peer Engagement
Sutter Health

Donna Hardaker is an internationally recognized industry expert and visionary thought leader in the emerging fields of workplace mental health and psychological health and safety in the workplace. She is an award-winning curriculum developer, advocate, consultant, public speaker, writer and advisor. In her position as Manager, Workplace Mental Health and Peer Engagement at Sutter Health, Donna is supporting Sutter's commitment to being a socially responsible employer through developing, modeling and sharing best practices to comprehensively address workplace mental health.

Donna has leveraged her personal experience of mental health and addiction challenges, and their impact on her employment history, into a significant body of work. For fifteen years she has developed insightful education, resources and tools for employers and employees to transform the dialogue, deepen understanding and build capacity to address these complex issues more effectively.

Donna's background is in psychology, peer support, mental health policy, adult education, human resources management, and transformational coaching. She sits on the Workplace Taskforce for the National Action Alliance for Suicide Prevention and is a Stability Leader and Board Member with The Stability Network. Donna is from Toronto, Canada, and now lives in Sacramento, California.

DEVELOPING A STRATEGIC STATEWIDE SUICIDE PREVENTION PLAN

Project Framework

Suicide is one of the leading causes of death in California, for both youth and adults. More than 4,000 Californians die by suicide every year, and thousands more attempt suicide.[1] Suicide and suicide attempts affect every person and location in California, from north to south, both in human costs and economic loss.

Assembly Bill 114 (Chapter 38, Statutes of 2017) directs the MHSOAC to develop a statewide strategic plan for suicide prevention. The MHSOAC will develop this plan with stakeholders and will leverage previous efforts, including the plan drafted in 2008 by the former Department of Mental Health.[2]

This strategic plan will outline an action agenda for the State of California, the counties, the mental health community and other partners to reduce suicide, suicide attempts, suicidal thoughts, and related harm to people, families, loved ones, and communities. This action agenda will recommend immediate, short-term, and long-term strategies to prevent suicides and improve outcomes for people at-risk, families and communities.

In order to develop the action agenda, the Commission will:

- Explore what is understood and not understood about suicide and suicide attempts, including information on incidence and rates across California's diverse population, risk factors, and protective factors;
- Identify best practices for reducing suicide and risks for suicide, and for fortifying protective factors;
- Identify public, private, community, and other resources, strategies, and opportunities to support suicide prevention; and
- Engage with communities, stakeholders, thought leaders and experts across the State to develop a shared understanding of and commitment to the findings and recommendations of the project.

Background

Suicide and suicide attempts affect every demographic group in California. More than twice as many Californians die annually by suicide as from homicide.[3] Rates vary in significant ways, however. Some three-quarters of Californians who die by suicide each year are male.[4] Adults aged 20-59 account for more than 70 percent of suicides in the state, while the highest suicide death rates are among middle aged and older adults.[5] The largest numbers of suicides occur in southern California, with Los Angeles County accounting for about 20 percent of statewide suicide deaths annually. In contrast, suicide death rates are highest in rural northern California, with rates in the Superior region close to twice the national average. Additional at-risk populations include people involved with the criminal justice system, people experiencing homelessness, immigrants and refugees, veterans and military personnel, and LGBTQ – particularly transition aged youth.[6] As is true nationally, Californians are most likely to die by suicide using firearms (42 percent) compared to other means, such as suffocation (27 percent) and poisoning (19 percent).[7]

In addition to the devastating human impacts on survivors of suicide loss, suicides and suicide attempts also significantly affect the economy. The American Foundation for Suicide Prevention reports that in 2010 suicides cost California over $4 billion in combined medical expenses and lost productivity.[8] Another report suggest that suicide and suicide attempts nationally cost anywhere between $58 billion and $94 billion in 2013.[9]

Project Goal

Develop a statewide suicide prevention plan to reduce suicide, suicide attempts, and suicidal self-harm, including thoughts of suicide, and associated harm to families, loved ones, and communities, and to improve outcomes for survivors of suicide attempts and their families. The plan should include prevention, early intervention, and response strategies.

In order to develop that plan, the Commission will work with survivors of suicide attempts, mental health consumers and family members, State agencies, the counties, providers, community leaders, and other partners.

Project Structure and Activities

The Chair has appointed Commissioner and former Chair Tina Wooton to Chair a Suicide Prevention Subcommittee to lead this work. The Commission should consider a Subcommittee of three to five Commissioners to guide this project. The Subcommittee would lead the project, supported by a staff lead, and draft a proposed Suicide Prevention Strategic Plan for consideration by the Commission.

Recognizing that the Commission is an independent state agency, and that most state resources for suicide prevention fall under the authority of the California Health and Human Services Agency, the Commission should work closely with the Agency in the information gathering, development, and drafting of the statewide suicide prevention plan.

The Commission will engage with a broad array of stakeholders to gather information and build a common understanding of the challenges and opportunities to reducing suicide, suicide attempts, and associated harms. Below are proposed activities to support the development of this shared understanding and to facilitate public involvement through the state.

- Commission Meetings. Public hearings, including presentations by people with lived experience, subject matter experts, policy leaders, and members of the public, are tentatively scheduled during the May and August 2018 Commission Meetings.

- Subcommittee Meetings. A series of meetings to engage stakeholders and subject matter experts to explore topics in greater detail will be organized throughout the state. At least one meeting may be held prior to May 2018 in Northern California and one meeting prior to August 2018 in Southern California.

- Community Forums. One or more community forums may be organized to highlight challenges and opportunities for groups at increased risk of dying by suicide, including older men, LGBTQ transition-aged youth, and veterans and military personnel, and to broadly promote suicide prevention awareness. One community forum may be organized in September 2018 during Suicide Prevention Week.

- Site Visits. Site visits will be organized to support the development of foundational knowledge regarding challenges and solutions to preventing suicide, suicide attempts, and self-harm, and promoting suicide prevention awareness.

- Small Group Discussions. Small group discussions may be organized in partnership with community leaders and organizations to provide a safe, welcoming, and culturally sensitive environment for people from these communities to share their experiences and participate in a discussion with their peers.

These activities would be supported by background materials prepared by staff and subject matter experts to review and summarize relevant, available data and published materials, as well as a strong communications effort to ensure public awareness of project events and emerging findings.

ENDNOTES

[1] American Foundation for Suicide Prevention. *Suicide: California 2017 Facts & Figures*. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf. See also Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Jan 12, 2018.

[2] California Department of Mental Health. *California strategic plan on suicide prevention: Every Californian is part of the solution*. 2008. Accessed on January 12, 2018 at https://www.sprc.org/sites/default/files/California_CalSPSP_V92008.pdf.

[3] American Foundation for Suicide Prevention. Suicide: California 2017 Facts & Figures. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.

[4] Ramchand, Rajeev and Amariah Becker. *Suicide Rates in California: Trends and Implications for Prevention and Early Intervention Programs*. Santa Monica, CA: RAND Corporation, 2014. Accessed on January 12, 2018 at https://www.rand.org/pubs/research_briefs/RB9737.html.

[5] Ibid.

[6] U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. 2012. Accessed on January 11, 2018 at https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf.

[7] National Center for Injury Prevention and Control, CDC. Data Source: NCHS Vital Statistics System for numbers of deaths. *WISQARS: Web-based Injury Statistics Query and Reporting System*. (1999-2014). Accessed January 12, 2018 at https://webappa.cdc.gov.

[8] American Foundation for Suicide Prevention. *Suicide: California 2017 Facts & Figures*. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.

[9] Shepard, D. S., Gurewich, D., Lwin, A. K., Reed, G. A. and Silverman, M. M. (2016). *Suicide and Suicidal Attempts in the United States: Costs and Policy Implications. Suicide Life Threat Behav, 46*: 352–362. doi:10.1111/sltb.12225