INN-#17 Suicide Prevention Innovation Project
Operated by Stanislaus County Behavioral Health and Recovery Services
Final Report

ISSUE ADDRESSED

To understand the issue to be addressed, it is important to understand how the Innovation Project was developed. In 2015, the Stanislaus County Board of Supervisors, Stanislaus County Behavioral Health and Recovery Services (BHRS), and the local Mental Health Services Act (MHSA) Representative Stakeholder Committee (RSSC) identified concerns that statewide efforts to reduce suicide had not yielded the desired results in Stanislaus County.

During the time period 2013-2016, 207 Stanislaus County residents died by suicide, which equates to nearly one suicide death every week. For every one suicide, 115 people are directly and indirectly impacted.[1] Suicide takes an emotional toll on families, affects the well-being of the larger community and carries a heavy societal cost burden.

Discussions illuminated that although there were suicide prevention efforts within the county, work was often being done in silos. The following issues were recognized:

- There was little or no coordination of representative individuals and groups in Stanislaus County to collectively define the problem of suicides in Stanislaus County.
- There was a lack of shared understanding of local suicide data.
- Suicide awareness and prevention efforts, strategies, and interventions were delivered in silos in Stanislaus County.
- There was no centralized structure to bring diverse community perspectives and representation together to strategically address Stanislaus County suicides.
- The age-adjusted suicide rate for Stanislaus County was higher than California's rate and the National Objective.

DESCRIPTION OF PROJECT

The primary purpose of this Project was to increase the quality of mental health services, including better outcomes. The Project proposed to use the Collective Impact model as a framework to explore the issue of suicide through multiple perspectives by convening representatives from different agencies and interested parties across the community. The Collective Impact model would provide a structure for a focused, supported, and targeted approach to suicide prevention and intervention.

The Collective Impact model is a framework used to tackle deeply rooted and complex social problems. It is the commitment of a group of stakeholders from different sectors of the community with a shared vision

for solving a specific and complex social problem. The Suicide Prevention Innovation Project, also known as SPIP and referred to as the Project, was funded to use the Collective Impact model as the innovative approach because cross-sector perspectives and collaboration were needed to learn about and address the complex causes and multiple risk factors of suicide in Stanislaus County. The plan included the convening of an Advisory Board comprised of stakeholders from different sectors of the community to develop a county-wide strategic plan integrating suicide awareness and prevention efforts.

Local agencies, community-based organizations, non-profit foundations, and schools were among the many different groups addressing suicide prevention in different ways through "silos", and there was little or no coordination among these groups to review suicide data and collectively work together on strategies to combat the problem. No funding or centralized infrastructure existed to bring these diverse groups and individuals together to address this alarming community issue, and the community seemed ready to address this together.

The Advisory Board convened to review data, inventory existing efforts, brainstorm ideas, and develop a targeted strategic plan to address the problem. The strategy was to make a change to an existing mental health practice/approach, including an adaptation for a new setting or community. The Project utilized the concept of collective impact as a key strategy to achieving positive results and ultimately to decrease suicides in Stanislaus County. Stanislaus County's local community-wide prevention effort, Focus on Prevention, was also using a Collective Impact model, which this Project was able to draw upon. According to the Stanford Social Innovation Review, collective impact is the "commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem...Unlike most collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants."[2]

This suicide prevention and intervention community-wide effort mirrored activities similar to the Stanislaus County Focus on Prevention forums to address the issue of suicide. County agencies, community-based organizations, health providers, schools, the faith based community, neighborhoods, and families affected by suicide were all invited to be part of the collaborative SPIP Advisory Board.

This Innovation Project aimed to address the following learning questions:

1. Will a centralized infrastructure increase partnerships between individual sectors and their efforts to decrease suicides?

2. Through the use of collective impact principles, will the group develop a shared understanding of suicide data in our county? If so, how will the shared understanding impact suicide prevention planning?

3. Can a collaborative use data and combined information from multiple sources to develop a suicide prevention strategic plan that the community will support/embrace?

4. What methods are most effective in increasing suicide prevention awareness in Stanislaus County?

5. Will the collaborative's use of collective impact principles result in a decrease in the rate of suicide in Stanislaus County? Will specific demographic groups be impacted?

The Project began September 6, 2016 and ended September 14, 2019, and the evaluation timeframe was September 15, 2019 to March 15, 2020. However, multiple department and staffing issues prevented the completion of the evaluation and an extension was granted.

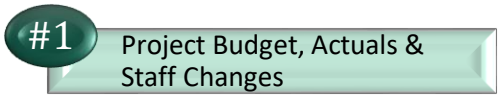
The Project was coordinated by Behavioral Health and Recovery Services through a dedicated Project Team. This program was located in existing departmental space at 800 Scenic Drive in Modesto; however, much of the work was conducted in the community. The Project Team provided the overall Project management support, in addition to providing facilitation and backbone support to the SPIP Advisory Board.

In the creation and planning of this Innovation Project, a 3-member staff team was originally assigned and budgeted as noted in the table below. As planning and implementation activities continued however, there was a need to rescope/reclassify and add additional positions to better fulfill the scope of work.

Changes to the staff composition and budget were made for the purpose of assigning a Project Manager as the lead to the Project where previously a Manager II was assigned. The role of the Staff Services Analyst was changed to a Data Analyst position to more properly align to the function of that position. Additionally, the Evaluator role was added.

An additional change was made that reclassified the Extra-Help, Admin Clerk III position to a Personal Services Contract, Event Planning Specialist. As the Project design and planning continued it was discovered that the scope of work required for the Admin Clerk to serve this Project was different than that of a traditional Admin Clerk and included several elements related to an Event Planner. Event Planner was not a position that existed within the County at the time, therefore the position was changed to Personal Services Contract, Event Planning Specialist to better reflect the duties covered in this scope of work.

For additional detail and to see the Estimated and Actual Project Budgets and the categories of spending for the Project, please see the budget tables below. Additionally, the table shows the changes and development to the staff budgets and hours assigned to each position within the Project.



	Budget					Actuals				
Expenditures	**Year One**	**Year Two**	**Year Three**	**Totals**		**16/17**	**17/18**	**18/19**	**19/20**	**Totals**
Salaries/Benefits	147,430	148,905	153,372	449,707		88,443.68	153,103.61	123,669.88	68,030.13	433,247.30
Marketing	55,000	55,000	55,000	165,000					696.18	696.18
Telecom/Supplies	1,220	1,220	1,220	3,660		10,067.47	9,383.39	10,455.56	6,517.00	36,423.42
Start-up costs	9,590	-	-	9,590		9,820.84	3,721.91			13,542.75
Meetings/Trainings/Conf/S-Word						6,533.98	16,307.91	36,557.98	242.00	59,641.87
Clear Impact								46,551.50	23,200.00	69,751.50
Outside Printing						100.89	3,599.80	9,960.06		13,660.75
Totals	**213,240**	**205,125**	**209,592**	**627,957**		**114,966.86**	**186,116.62**	**227,194.98**	**98,685.31**	**626,963.77**

First Budget
Manager II (PSC - 29 hours/wk)
Admin Clerk III (Extra Help 29 hours/wk)
Staff Services Analyst

Second Budget
Project Manager (PSC - 29 hrs/wk)-$50/hr
Admin Clerk III (Extra Help 29 hours/wk)-$20.36/hr
Data Analyst (PSC - 20 hrs/wk-$35/hr
Evaluations - 12.78 hrs/wk

Third Budget
Project Manager (PSC - 29 hrs/wk)-$50/hr
Event Planning Specialist (PSC 29 hours/wk)-$20/hr
Data Analyst (PSC - 20 hrs/wk-$35/hr
Evaluations - 12.78 hrs/wk

PLAN FOR AND ANALYSIS OF THE EFFECTIVENESS OF THE PROJECT

Defining and measuring success for this Innovation Project was based on the learning questions described above. Since the focus of the Project was to increase the quality of mental health services, including better outcomes, an emphasis was placed on the effectiveness of using the Collective Impact model to learn about and address suicides in Stanislaus County as well as the impact on the quality of services in the community arising from the Collective Impact model.

All of the methods and tools were designed to answer the Project's learning questions, but also to stay true to the evaluation of a collective impact initiative. The Collective Impact Forum's *Guide to Evaluating Collective Impact* offers a framework that encourages an initiative to use different types of evaluation and tools at different stages of development.[3] This Project falls within the "early years" stage (up to 3 years), and therefore focuses on "…understanding context and designing and implementing the initiative. This includes establishing the five core conditions of collective impact, as well as the coordinated implementation of multiple programs, activities, and campaigns…".[4] This type of evaluation is known as developmental evaluation and is focused on understanding both the context and development of the initiative. For example, evaluating ***how*** the Advisory Board was created, sustained, and operated was evaluated, as well as the outcomes of the Advisory Board's work. It is also important to note that providing participants with space for continuous learning and improvement is a critical component of collective impact principles, and therefore is also included in the evaluation of success. The developmental evaluation tools were used throughout the Project to revise and refine the processes used by the Project Team to strengthen the Advisory Board and collective impact activities. If the context and development are not understood, monitored, analyzed, and improved upon, the initiative is not likely to be successful.

Since the Collective Impact model is a means to ultimately achieve longer term outcomes (decreased suicides) in Stanislaus County, it is also critical to understand that for this Project to successfully show long-term outcomes, the 3-year term of the Project cannot be the end of the collective impact initiative.

Multiple methods of data collection, both qualitative and quantitative, were utilized to address the learning questions and help answer the overall success of the Project in utilizing the Collective Impact model. Data collection methods utilized are described below.

- Collection, compilation and analysis of data to measure the readiness and effectiveness of the Collective Impact model/Advisory Board
    - Collected, compiled and analyzed collaborative readiness information of the Advisory Board at three different intervals, including a final assessment. This information was then shared with the Board members for review, reflection, and development of interventions for improvement
    - Inventoried the collaboration factors of the Advisory Board at the end of the Project
    - Surveyed Advisory Board members after each meeting for data regarding members' dynamics including participation, cohesion, trust, preparedness, and accountability. This information was used to improve meetings and processes, as well as to measure readiness at the end of the Project
    - Tracked/documented the Problem Statement development process and completion of the Problem Statement
    - Source/Tools:
        - *Community Collaborative Assessment – A Diagnostic of Success Readiness*, adapted (See Attachment #1)
        - *Wilder Collaboration Factors Inventory* (See Attachment #2)

        - Advisory Board Meeting Survey (See Attachment #3)
        - Documentation of the "Problem Statement" development process
            - Group Root Cause Maps
            - Worksheets/Process Documents
            - Problem Statement
- Tracking of data to measure shared understanding of local suicide data
    - Surveyed Advisory Board members about their individual understanding of local suicide data at each meeting, as well as trust, cohesion, and participation at meetings
    - Tracked Advisory Board members' self-reported use of suicide and Project data outside of the Project at each meeting
    - Source/Tools:
        - Advisory Board Meeting Survey (See Attachment #3)
        - "Green Cards" to capture use of suicide/Project data outside of meetings (See Attachments #4a and 4b)

- Tracking of data to measure increased understanding of suicide awareness and prevention efforts, strategies, and interventions in Stanislaus County
    - Surveyed Advisory Board members about their understanding of suicide awareness and prevention efforts in Stanislaus County after each meeting
    - Tracked the participation of the Advisory Board members in
        - meetings
        - the creation of asset maps and gap analysis of efforts
        - the development of the shared measures for the Advisory Board
        - the development of the shared measures for the County-wide Suicide Prevention Plan
    - Collected and monitored data regarding the coordination and number of activities aligned towards achieving the common agenda and shared measures
    - Source/Tools:
        - Advisory Board Meeting Survey (See Attachment #3)
        - Regional and County-wide Asset Maps (See Attachment #5)
        - County-wide Gap Analysis (See Attachment #6)
        - Advisory Board Meeting Minutes
        - Collaboration Tracking Log

- Tracking and analysis of Advisory Board engagement and commitment
    - Tracked data elements to indicate engagement and commitment through surveys and qualitative observation and documentation of Advisory Board members'
        - Attendance
        - Shared responsibility and accountability
        - Sense of trust
        - Cohesiveness
        - Participation
        - Commitment to share data and develop shared measurements
    - Source/Tools:
        - Meeting Sign-in Sheets and Member Participation Log
        - Signed "Member Commitment" form (See Attachment #7)
        - Advisory Board Meeting Survey (See Attachment #3)
        - Advisory Board Meeting Minutes/Observations/Documentation
        - Collaboration Tracking Log

- Monitoring of shared measurements of suicide awareness and prevention efforts

    - Some shared measurements of the collective impact successes were developed and monitored
    - Most shared measurements were established at the end of the Project, so monitoring efforts were not completed during the Project. There are plans to collect and monitor this data
    - Source/Tools:
        - Clear Impact Scorecard

- Monitoring of age-adjusted suicide rate in Stanislaus County
    - The Project Team and Advisory Board monitored the rate annually
    - Source/Tools:
    - County VRBIS and California Department of Health Care EpiCenter Data
- Tracking of efforts for suicide awareness and prevention among specific demographic groups and target/high-risk populations
    - The Advisory Board identified demographic groups and high-risk populations through the needs assessment
    - Source/Tools:
        - Needs Assessment Data (See Attachment #8a)
        - Asset Map Data (See Attachment #5)

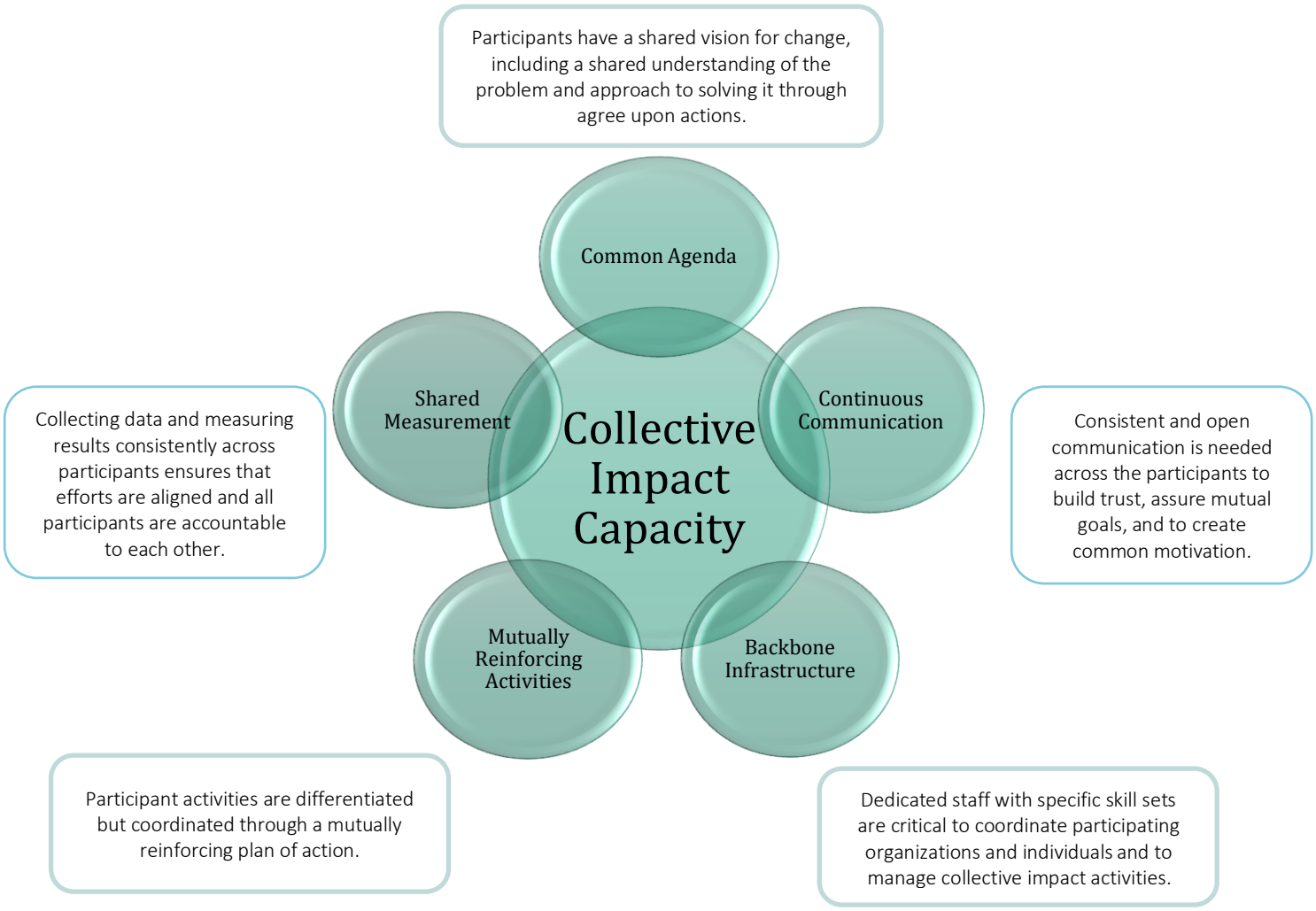
Unless otherwise specified, the information, data, and analysis presented below reflects the time period from the Project start date to the Project end date (as an Innovation Project), but only during the time in which the Advisory Board was meeting. This time period was February 7, 2017 to August 6, 2019.

COLLECTIVE IMPACT MODEL FOUNDATION

As previously stated, this Project is grounded in the Collective Impact model. Therefore, the evaluation of the Project must, in great part, evaluate the effectiveness of the design and implementation of the collective impact to do the work described. There are multiple sources for information about the Collective Impact model, and this final report for the Project will not go into great detail about the model. However, it is essential to discuss the basics of collective impact to assess how successful the Suicide Prevention Innovation Project was.

At the heart of collective impact is the idea that no individual organization can solve a large-scale social problem alone. It involves cross-sector collaboration and shared understanding of multiple elements to make an impact on a social issue. A successful collective impact initiative typically has five conditions: 1. Common agenda; 2. Shared measurement system; 3. Mutually reinforcing activities; 4. Continuous communication; and 5. Backbone support organization. The funder of the initiative (in this case BHRS) must also be willing to invest sufficient resources in the facilitation, coordination, and measurement of the initiative.[5] The Project Team based the Project's operational framework and trajectory on those five key conditions. Below is a visual of the model, adapted from *Guide to Evaluating Collective Impact* to illustrate the framework from which the Suicide Prevention Advisory Board, Project Team, and the initiative was designed, developed, and evaluated.[6]

#2 Collective Impact Key Conditions



These conditions will be separately explored, analyzed, and evaluated. The collective impact capacity will be measured as a whole based on the five key conditions for a successful initiative.

BACKBONE INFRASTRUCTURE

As previously mentioned, BHRS served as the Backbone Organization since MHSA Innovation funding was utilized for the Project. Although the Project began in September 2016, the initial hiring of staff and setting up the Project Team took some time, and was not fully staffed until March 2017. It was not easy to recruit well qualified staff on a part-time and short-term basis. The team consisted of a Program Manager, a Data Analyst, an Event Planning Specialist, and a Project Evaluator. The Project Manager was hired as a Personal

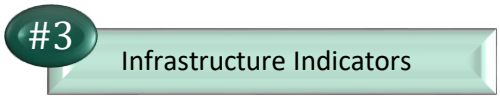
Services Contractor (PSC) at a Manager II level; the Data Analyst was a PSC at a Staff Services Analyst level; and the Event Planning Specialist was originally slated to be hired as an "Extra Help" Administrative Clerk III, but was changed to a PSC to be consistent and also to be able to hire the appropriately skilled staff. The Project Evaluator was an internal BHRS staff at a Manager III level. The Program Manager was hired in September 2016, the Data Analyst in February 2017, and the Event Planning Specialist in March 2017. The Program Manager was under the supervision of the MHSA Manager and also consistently reported to two BHRS Senior Leaders for Project updates. The Program Manager supervised the two other PSC positions.

Once established, the team started immediately working on building community interest and establishing the SPIP Advisory Board. The Program Manager completed part of the recruiting process of the Advisory Board members even prior to the hiring of the remaining staff, and once the entire team was on board they built rapport quickly to move the Project forward.

The staffing of this Project proved to be challenging in some respects. Previously mentioned, hiring was difficult as the County's position structure and process is not necessarily conducive to a Project like this. Additionally, given the short-term, part-time, non-benefitted nature of the positions, there was always the risk of staff attrition. This is an important aspect to consider since the team represents the "backbone" of the Collective Impact model, one that represents stability and support. Approximately 18 months into the Project the Data Analyst left the team, followed by the Project Manager about 6 months after that, both for permanent full-time positions. It would be approximately three months later before the Project Manager could be refilled and four months later before the Data Analyst position could be filled for the remaining 8 months of the Project. It is also worthy of noting that the Data Analyst position was changed to a higher level of Staff Services Coordinator to reflect the skill needed and type of work the staff would focus on. Although the MHSA Manager continued meeting with the Advisory Board during the time while those staff positions were vacant, there was some lag in moving the Project forward as the staff hours could not be completely filled.

In addition, the Evaluator was an internal staff member. Although there are seeming benefits to having an internal Evaluator (cost savings, availability, and interest), there were challenges with this position as well. Urgent departmental issues and responsibilities often eroded the consistent time needed for the full evaluation. Instead of steady weekly or monthly hours, the team had to adjust to less frequent but concentrated time for evaluation.

Given all of the turnover and challenges, the Project Team fulfilled much of the functions of the ***Backbone Infrastructure*** with the support and high-level oversight of BHRS leadership. Below is a table showing the extent to which the Project Team provided the infrastructure for the Suicide Prevention Innovation Project, with details following the table.



INFRASTRUCTURE RESPONSIBILITY	
Supports the Advisory Board to ensure it includes diverse perspectives from multiple sectors	• Established Advisory Board by using broad informational outreach and follow up • Continuously worked to improve representation
Project Team are respected by partners and stakeholders	• Partners and stakeholders indicated satisfaction with the Project Team
Project Team provides Project management support, monitors progress towards goals, and connects	• Scheduled and operationalized the "Kick Off" meeting, all 14 Advisory Board meetings, and additional work group meetings

partners to share opportunities, challenges, gaps, and redundancies	• Monitored, summarized, and reviewed progress towards goals • Provided multiple opportunities to share opportunities and challenges • Hosted a forum for gap analysis
Partners look to the Project Team for support, strategic and vision guidance, and leadership	• Created environment and space for learning, communication, and development of shared vision and strategy • Provided exercises to develop the Project vision and strategies, summarizing the outcomes and offering opportunities for reflection
Pursues new opportunities and ensures alignment of existing opportunities by convening partners and external stakeholders	• Continuously outreached to community, soliciting new ideas and sharing Project vision • Established partnerships for Project activities • Hosted guest speakers at Advisory Board meetings and other venues
Supports the collection and use of data to promote accountability, learning, and improvement	• Developed surveys and tools to collect data to share and review collective impact progress • Facilitated discussions about collective impact successes and challenges based on data • Made recommendation for improvements based on discussions
Supports the reviewing and use of shared measurement system data to monitor progress towards goals and to inform decision making	• Facilitated the decision to use Clear Impact as a shared measurement system, a system grounded in Results Based Accountability (RBA) • Provided structured learning about RBA and the shared measurement system so all Advisory Board members had shared understanding of the system • Offered advanced RBA certification to champions of the system

These indicators measure the success of the Project Team in fulfilling the key responsibilities of support for the Suicide Prevention Innovation Project.

Supports the Advisory Board

At the core of the Collective Impact model was the creation of the Suicide Prevention Innovation Project (SPIP) Advisory Board. As soon as the Project Manager was hired, the Advisory Board planning began. Representation from Stanislaus County Departments, community-based organizations, education, health care, law enforcement, faith-based community, cultural collaboratives, and community members at large were sought to build the Advisory Board. The Project Team reached out to these multiple sectors and also presented information to organizations to develop interest and excitement about the Project. Invitations went out to attend the *Suicide Prevention Advisory Board Kick-off Convening Meeting.*

The first SPIP Advisory Board Convening Meeting took place on February 7, 2017. There were 62 people invited to the first meeting and 56 attended. Additional information about the 3-year Innovation Project was shared and discussed, including the expectations, commitment, and goals for the Project. Many of the attendees shared the reasons behind their interest in participating in the Project, and many were very

personal. The passion and support for suicide prevention in Stanislaus County was apparent through those responses and were essential for the success of the collective impact.

The first meeting's key sharing points:

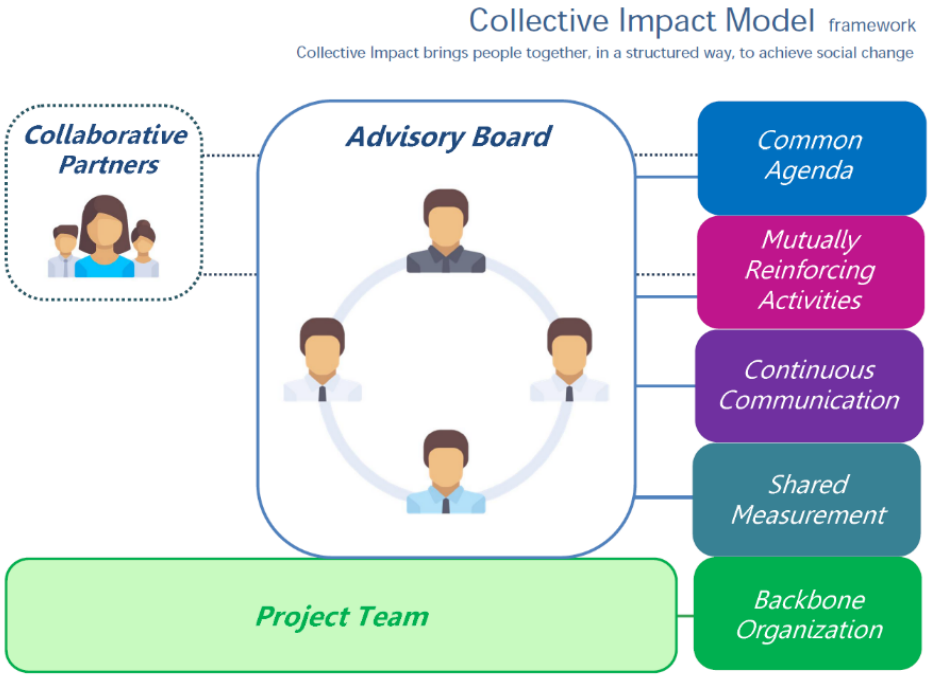
- The Project is funded by Mental Health Service Act Innovation with the primary purpose of increasing the quality of mental health services, including measurable outcomes.
- Innovation Projects are intended to contribute to learning about and addressing an unmet need, by testing a new approach in the mental health setting, rather than providing direct service.
- The Suicide Prevention Innovation Project will use and evaluate the Collective Impact model to learn about and address the suicide rate in Stanislaus County.
- The Collective Impact model will be used to form and convene an Advisory Board over the 3-year Project period.
- The Advisory Board will collectively review data to define the problem, make data-driven decisions and develop a county-wide strategic plan that integrates suicide awareness and prevention efforts.

The Collective Impact model was also explained to the group and the attendees were asked to review the information provided and decide whether they (or somebody else) could commit to the group - to be at the meetings and to be fully present and participatory on the Advisory Board. A total of 44 individuals submitted a signed "Suicide Prevention Advisory Board Commitment" (See Attachment # 7), indicating that they were committed to the practices towards successful collective impact.

From the April 2017 meeting forward, the Advisory Board was challenged to create a common agenda, participate in mutually reinforcing activities, maintain continuous communication, and commit to develop and monitor shared measurement with the support of the Project Team.

The diagram below, found in the *Stanislaus County Suicide Prevention Innovation Project 2017 Annual Report* depicts what the model looked like for the Suicide Prevention Innovation Project.

#4 Project Collective Impact Model



The Project Team also continued to monitor and recruit for broad and relevant representation; when a member left an organization or could no longer attend, the Project Team tried to fill that void in membership. Although members may have changed, the organizations and agencies remained fairly stable. The Advisory Board and partner representation included the entities listed here.

#5 Advisory Board

Suicide Prevention
Advisory Board Organizations and Agencies

American Foundation for Suicide Prevention (AFSP) - Central Valley Chapter
Aspiranet
The Bridge
Center for Human Services
Central Valley Suicide Prevention Line
Community Hospice
Doctor's Behavioral Health Center
El Concillio
Family Resource Centers
Golden Valley Health Centers
Jessica's House
LGBTQA Collaborative for Greater Well-Being
Livingston Community Health
MHSA Steering Committee Stakeholders
Modesto Junior College
National Alliance on Mental Illness (NAMI)
Patterson Family Resource Center
Private Practice - Child Psychotherapist
Sierra Vista Child & Family Services
Stanislaus County Behavioral Health and Recovery Services
- *Outcomes & Evaluation*
- *Josie's Place*
- *MHSA Administration*
- *Prevention & Early Intervention*
- *Workforce, Education & Training*

Stanislaus County Chief Executive Office -Focus on Prevention
Stanislaus County Community Services Agency
Stanislaus County Health Services Agency -Public Health
Stanislaus County Probation
Sutter Health/Sutter Gould Medical Foundation
Turlock Family Resource Center
Turning Point Community Programs
West Modesto Community Collaborative
Westside Health Care Task-Force

Collaborative Partner Organizations and Agencies

California Forensics Medical Group
Del Puerto Health Care District
Health Plan of San Joaquin
Kaiser Permanente
Protecting Soldier's Rights
Stanislaus County Coroner's Office
Stanislaus County Office of Education
Stanislaus County Medical Society
Stanislaus County Veteran Services Office
Turlock Community Collaborative

Below is a table indicating the number of active Advisory Board members throughout the Project.

#6 Advisory Board Active Participation

	Year 1	*Year 2*	*Year 3*
# Active Board Members **(participated at least once during time period)**	**56**	**38**	**24**

The table indicates that there was a fairly significant drop in Advisory Board active membership after the first year of the Project. There was still attrition during the second year, but slightly less even though there was fairly consistent attendance. This means that although members continued to attend, the particular members attending each meeting changed. It is recommended that continuous efforts be made to ensure that representation is strong, especially in the areas that may be marginalized and not easily engaged.

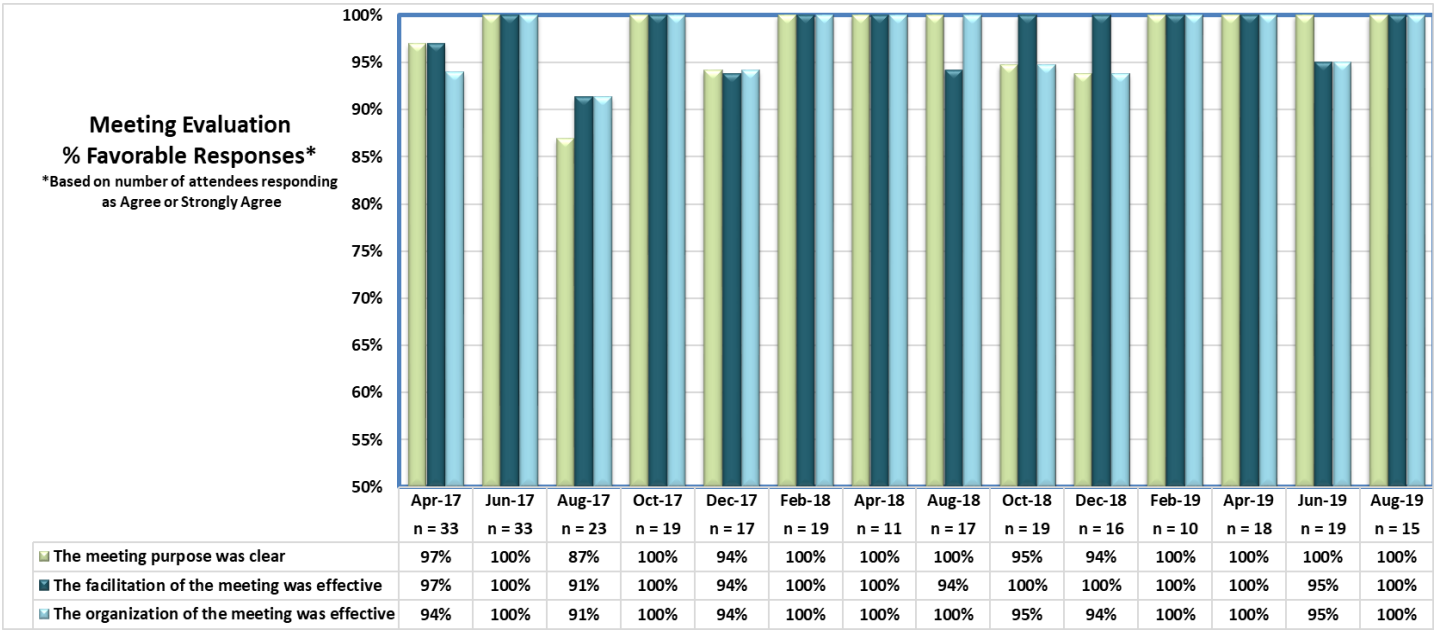
Project Management, Support, Guidance, Leadership, and Respect

Meeting Management and Facilitation

The Project Team scheduled and facilitated the Kick Off meeting and the 14 Advisory Board meetings throughout the 3-year Project. Only one scheduled meeting did not take place due to the staff turnover. Additional special workgroup meetings were scheduled and convened by the Project Team to facilitate common agenda development, shared measurement conversations, and RBA "Champions" trainings. Each meeting included an agenda sent out beforehand, a presentation by the Project Team and/or others on the Advisory Board or guests, and most included activities or exercises.

During every meeting, the participants were asked to complete a meeting survey. One section of the survey concentrated on the meeting support, organization, and accomplishments. Below is a chart indicating that throughout the Project, Advisory Board members felt very positive about the purpose, facilitation, and organization of the meetings.

#7 Meeting Survey Results



	Apr-17 n = 33	Jun-17 n = 33	Aug-17 n = 23	Oct-17 n = 19	Dec-17 n = 17	Feb-18 n = 19	Apr-18 n = 11	Aug-18 n = 17	Oct-18 n = 19	Dec-18 n = 16	Feb-19 n = 10	Apr-19 n = 18	Jun-19 n = 19	Aug-19 n = 15
The meeting purpose was clear	97%	100%	87%	100%	94%	100%	100%	100%	95%	94%	100%	100%	100%	100%
The facilitation of the meeting was effective	97%	100%	91%	100%	94%	100%	100%	94%	100%	100%	100%	100%	95%	100%
The organization of the meeting was effective	94%	100%	91%	100%	94%	100%	100%	100%	95%	94%	100%	100%	95%	100%

This chart shows that none of the 14 meetings throughout the three years resulted in less than 87% positive responses in these areas, and very few meetings had less than 94% positive responses. The Advisory Board highly indicated that the purpose, facilitation, and organization of the meetings were effective.

Progress Towards Goals

Each agenda included time for the Project Team to provide an update regarding progress towards goals. Depending on the stage of the Project, that update included progress towards completion of the Common Agenda/Problem Statement, Gap Analysis, Annual Report, or Needs Assessment. It also included results of the meeting surveys and how improvements could be made regarding the meetings or dynamics of the Advisory Board, as well as the results of the assessments of collaborative success readiness and factor inventory. Each of these areas will be discussed in the shared measurement/use of data section.

Opportunities for Sharing, Learning, and Development

The Project Team built in multiple spaces and times to share opportunities and challenges both within meetings and outside of meetings. Each member had contact information for the entire Advisory Board, and there was time during every meeting for them to share activities and feedback amongst each other. During each meeting, the participants also were asked to share new activities, partnerships, and events on "Green Cards" (See Attachments #4a and 4b). Summaries of this information were provided to the Advisory Board at the following meeting. Even the table arrangements were carefully thought out in order to provide space and opportunity for sharing and participation.

Shared vision and strategy were developed thoughtfully through several exercises and activities. Thoughts and ideas were solicited, discussed, and then summarized and presented. Small group activities were developed to encourage active participation and then time was given for reflection and feedback. Ultimately, the common agenda and shared vision and strategies were created through the participation of the Advisory Board with the Project Team support in guiding and providing a structure for the work.

Pursuit of New and Alignment of Existing Opportunities

The Project Team facilitated the pursuit of new opportunities and ensured that existing opportunities were in alignment with the Project's vision and strategies. Continuously outreaching to the community and sharing the vision while soliciting new ideas, the Project Team took the lead on the following activities. Even though the Project Team led the effort, all of the events/activities were in partnership with multiple agencies and community organizations.

May 2018 - *The 'S' Word* Documentary film screening and forum was presented in the community at four locations to reach multiple regions and populations of the county

- 05.14.18 – Opening Night at the State Theater – Modesto
  - Co-sponsored by Stanislaus County Office of Education, Prevention Programs, Foster Youth Services Coordinating Program)
- 05.15.18 - Hanline Elementary School – Ceres
  - Co-sponsored by Ceres Promotores
- 05.15.18 - Patterson Joint Unified School District – Patterson
  - Co-sponsored by Catholic Charities
- 05.16.18 – West Modesto Collaborative Community Center – West Modesto
  - Co-sponsored by West Modesto Community Collaborative and NAMI

September 2018 - Out of the Darkness Community Walk

- 09.15.18 – Walking teams and donation to American Foundation for Suicide Prevention (AFSP) of $1,000

October 2018 - Suicide Prevention Symposium – Base Education

- 10.05.18 – Stanislaus County Student Mental Wellness Partnership
  - Provided information and support for educators throughout the County
  - Hosted the event with Stanislaus County Office Education, in partnership with California State University Stanislaus Peer Project

- Suicide Prevention Technical Assistance Provider Panel with AFSP and National Alliance for Mental Illness (NAMI) Stanislaus
- Multiple exhibitors
- Suicide Prevention Toolkits were distributed to 43 sites following the Symposium; included *The 'S' Word* Documentary DVD and *The 'S' Word Screening Guide Education Edition* booklets in both English and Spanish and on USB

April 2019 - Send Silence Packing – Active Minds Exhibit
- 04.03.19 – Stanislaus State Event
- 04.04.19 – Modesto Junior College Event

September 2019 - Out of the Darkness Community Walk
- 09.14.19 – Participated in the planning; provided support and walking teams for AFSP

Participation and Additional Support Provided
- 06.15.18 – AFSP Stronger Communities LGBTQ & Suicide Prevention Conference
- 09.17.18 – Bridges Out of Poverty Workshop (Stanislaus County Health Services Agency)
- 11.30.18 – QRP Training held at Paradise Medical Office (Stanislaus County Office of Education)
- Participation in AFSP "Strike Out Suicide" bowling fundraiser
- Presented the Project, Collective Impact model, and suicide data and prevention information to community organizations, BHRS staff, and other groups

Supports the Collection and Use of Data

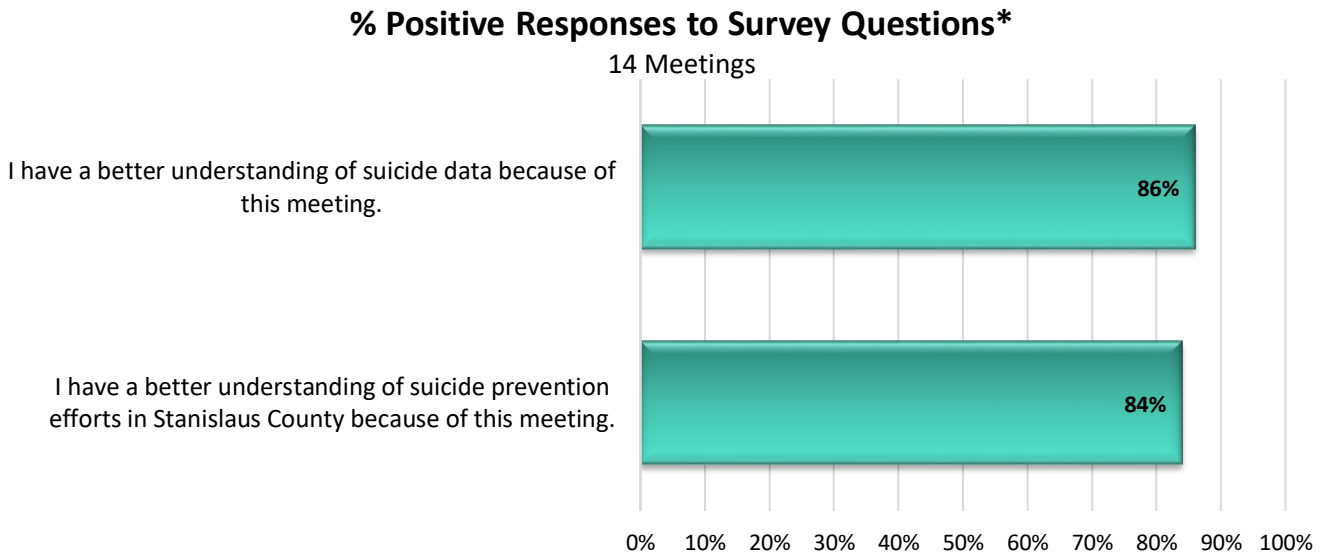
Even before the Project formally began and the Advisory Board convened, the Project Team started developing surveys and tools to collect data to promote accountability, learning, and improvement. Once the Advisory Board was formed, data was collected, compiled and analyzed, then results shared with the members to discuss and make some recommendations for improvement. The Project Team spent time between meetings discussing ways that the data could be used to refine learning opportunities for both the staff and the Advisory Board, and the members were asked to reflect on the information and provide feedback. Numerous decisions were then made based on the data collected.

The Project Team also researched and presented suicide data to the Advisory Board, provided data to be used in the needs assessment, and continuously explored data that could support or inform the Advisory Board. Attachment # 9 is an example of the data presented, discussed and used to help make decisions, including which indicators to track and recommended strategies for the strategic plan.

As stated previously, Advisory Board meeting surveys were administered at the end of every meeting. The data was used to measure and monitor several essential aspects of a successful collective impact Advisory Board as well as the effectiveness of the Project Team, already discussed. Survey results will be shared throughout this report.

There was also opportunity on the survey for Advisory Board members to indicate whether they had a better understanding about suicide prevention efforts in Stanislaus County and better understanding of suicide data. Most members continued to learn about efforts and understand the data better throughout the three years of the Project. The Project Team continued to place data in the forefront of most meetings.

#8 Meeting Survey Results - Increased Understanding



*Positive responses = Strongly Agree or Agree; Based on an average of 19 surveys completed each meeting

Supports and Promotes a Shared Measurement System

Shared measurement was discussed from the initial meeting forward. The Project Team built the topic into each meeting, and it was clearly a staple of the Collective Impact model. Shared measurement was presented to the Advisory Board on two levels: 1. How well the Collective Impact model was working throughout the Project; and 2. Impact on the problem of suicide.

Although measurement and evaluation of the Collective Impact model was designed before the Project began, there was still ample room for Advisory Board participation. A workgroup was initiated, and facilitated by the Project Team, the group developed performance measures to continuously collect data and monitor the Advisory Board's effectiveness and likelihood of being successful. This was known as the "Collective Success Performance Measures". Much of that work was based on the Community Collaborative Assessment results and the Advisory Board Meeting Survey.

In addition, the Project Team researched and supported the effort to procure, train, and implement a Shared Measurement System for long-term impact measurement of suicides and suicide prevention in Stanislaus County. Additional information about this topic will be discussed in the section specifically about the Shared Measurement System.

CONTINUOUS COMMUNICATION

The second essential condition of collective impact success is ***Continuous Communication.*** This area involves the need for regularly scheduled meetings during which members actively participate. It also includes members coordinating and communicating both with Project Team support and independently.

For this condition to be met, it is also important for the Advisory Board members to trust each other, feel group cohesion, and have a sense of accomplishment when they meet.

#9 Continuous Communication Indicators

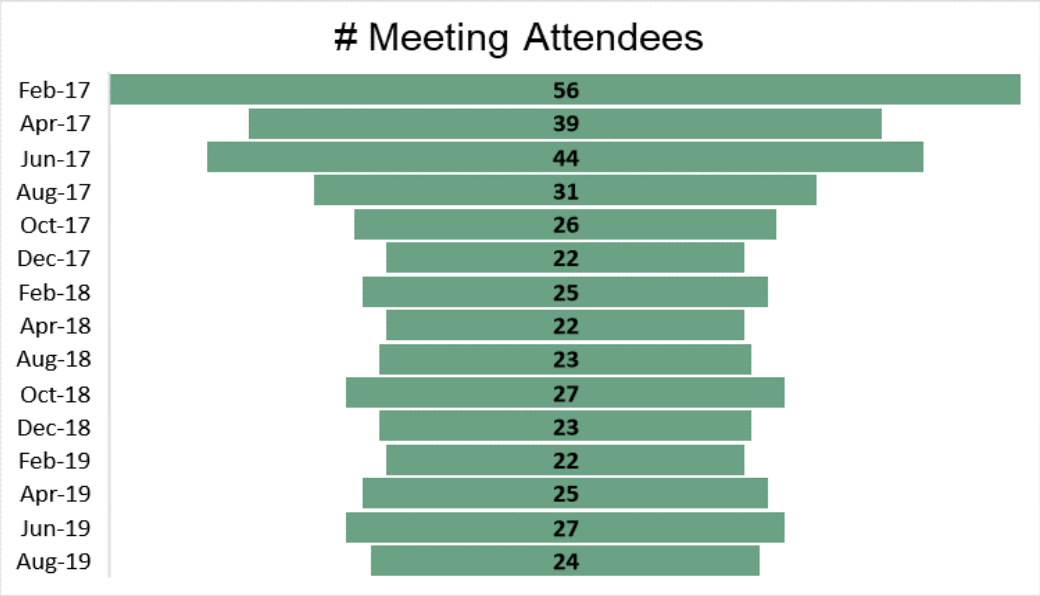
Continuous Communication	
The Advisory Board and working groups have regularly scheduled meetings	• Advisory Board members met regularly every other month from April 2017 through August 2019 • Only one meeting, June 2018 was missed due to staffing issues
Members attend and participate actively in meetings	• There was some membership attrition due to multiple factors • Of those who attended, an average of 74%* indicated that they participated actively
Members trust each other, feel group cohesion, and shared responsibility and accountability for the success of each meeting	• An average of 89%* of the members attending meetings indicated that they trusted other on the Advisory Board • An average of 88%* indicated that they felt the group was cohesive • An average of 91%* indicated that members were prepared and shared responsibility and accountability each meeting
Members communicate and coordinate efforts regularly, both with the Project Team and independently	• Advisory Board members communicated and coordinated both within structured settings (meetings/events) and outside the structured settings

*aggregate of all meetings

Regularly Scheduled Meetings, Attendance, and Active Participation

In order to achieve continuous communication, it was imperative to have strong attendance at each Advisory Board meeting throughout the life of the Project. The kick-off meeting served as an introduction to the Project and collective impact, so the organizational representation was strong. The number attending subsequent to the initial kick-off dropped by 30%, which was the expectation. The goal was to secure a solid membership that was sustainable. After the subsequent two meetings, the average attendance fell by another 40% and then remained quite stable through the rest of the duration of the Project at an average of 25 attendees per meeting. This positive stability allowed members to establish trust and cohesion.

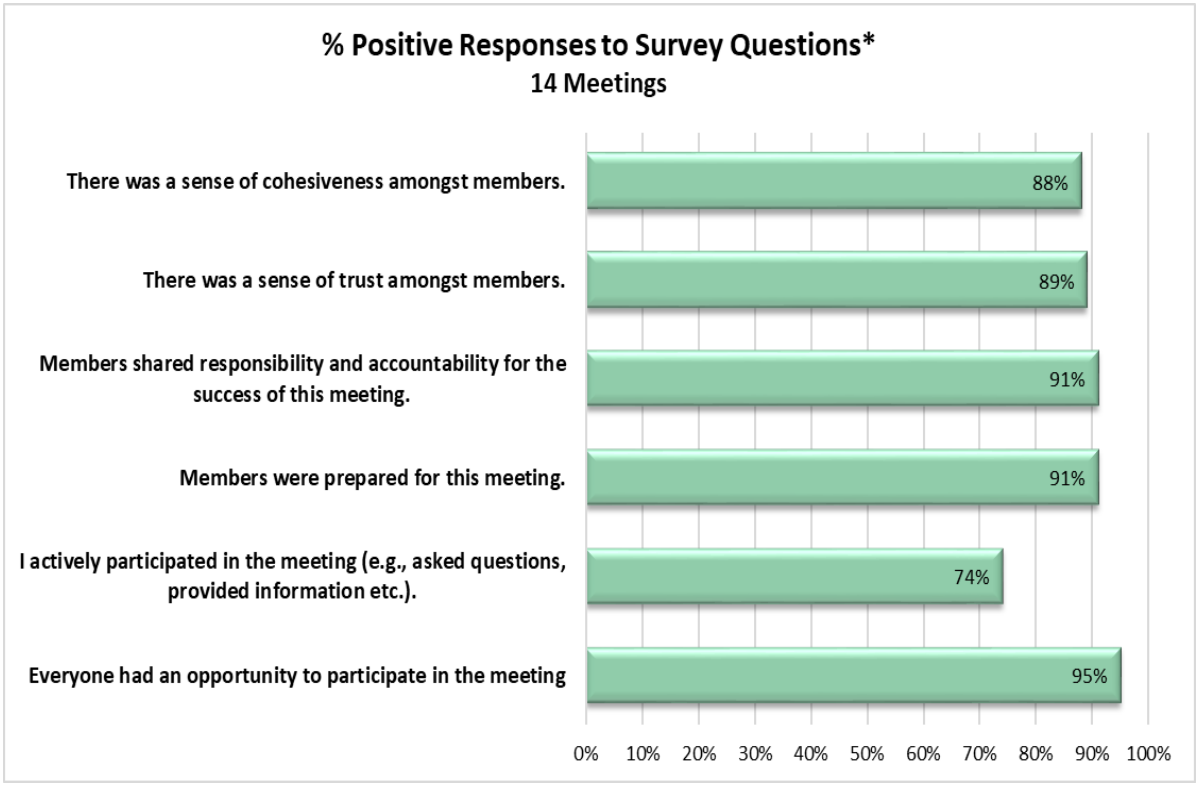
#10 Meeting Attendance



Trust, Cohesion, and Accomplishment

Member dynamics was a critical component to the success of the Advisory Board, and ultimately to the collective impact initiative. As stated previously, Advisory Board meeting surveys were administered at the end of every meeting. The data was used to measure and monitor several essential aspects of a successful collective impact advisory board.

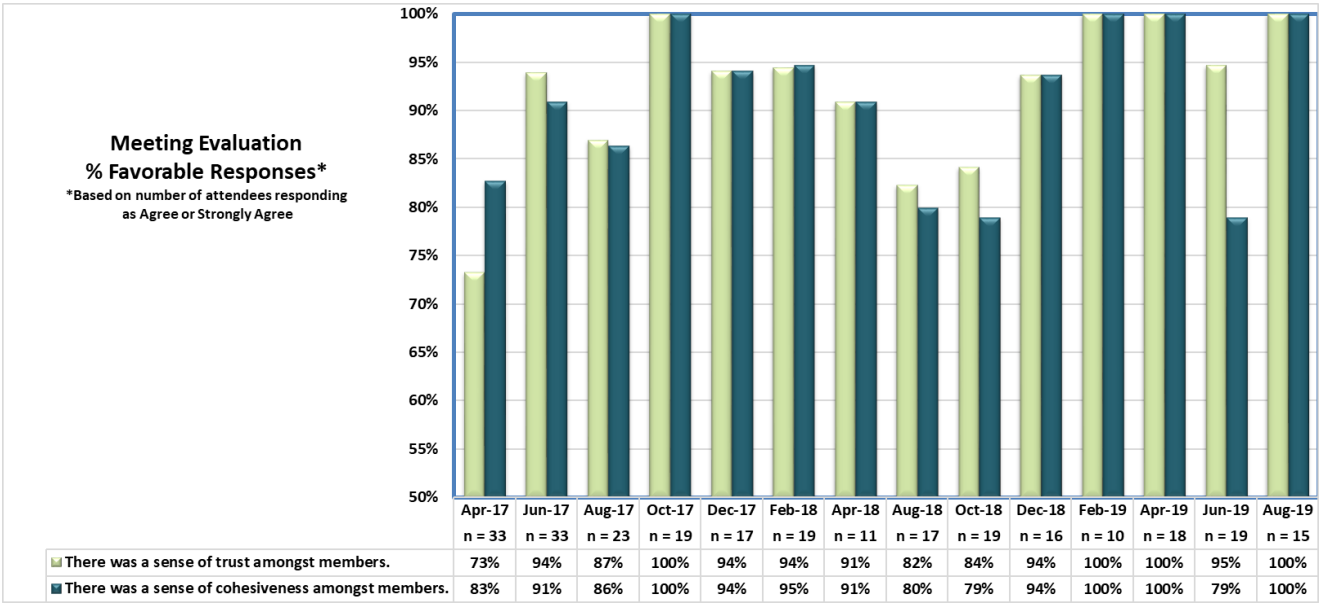
#11 Meeting Survey Results - Member Dynamics



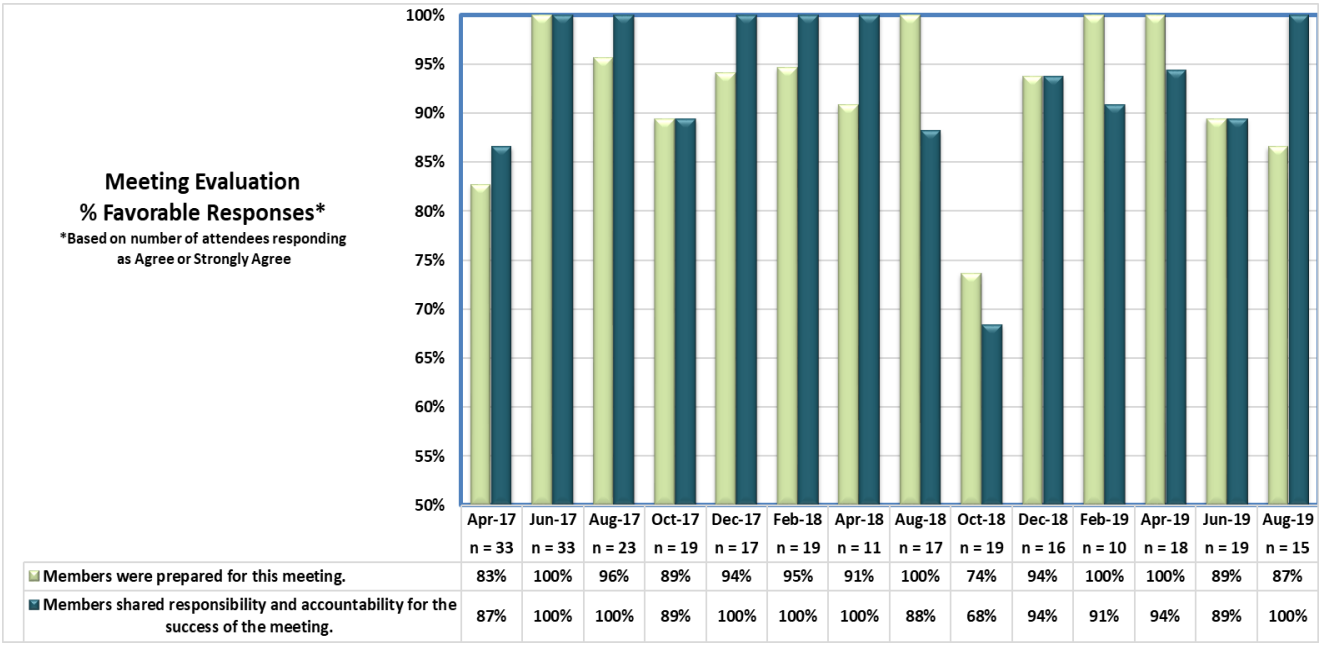
The surveys asked about accountability, preparation, participation, trust, and cohesiveness. As the group was refined during the first several meetings, the members began to trust each other and form relationships. The responses to the questions offer insight into the member dynamics. The Advisory Board members clearly indicated they felt shared responsibility and accountability and were prepared. The members also felt strongly that there was cohesiveness and trust amongst themselves. While they felt strongly that everyone had ***opportunity*** to participate, members didn't always feel that they had ***actually*** participated.

The Advisory Board members' responses were fairly consistent throughout the 14 meeting span as illustrated in the above charts. However, there were several times when the percentage dipped slightly.

#12 Meeting Survey Results - Dynamics Across Time



	Apr-17 n = 33	Jun-17 n = 33	Aug-17 n = 23	Oct-17 n = 19	Dec-17 n = 17	Feb-18 n = 19	Apr-18 n = 11	Aug-18 n = 17	Oct-18 n = 19	Dec-18 n = 16	Feb-19 n = 10	Apr-19 n = 18	Jun-19 n = 19	Aug-19 n = 15
There was a sense of trust amongst members.	73%	94%	87%	100%	94%	94%	91%	82%	84%	94%	100%	100%	95%	100%
There was a sense of cohesiveness amongst members.	83%	91%	86%	100%	94%	95%	91%	80%	79%	94%	100%	100%	79%	100%



	Apr-17 n = 33	Jun-17 n = 33	Aug-17 n = 23	Oct-17 n = 19	Dec-17 n = 17	Feb-18 n = 19	Apr-18 n = 11	Aug-18 n = 17	Oct-18 n = 19	Dec-18 n = 16	Feb-19 n = 10	Apr-19 n = 18	Jun-19 n = 19	Aug-19 n = 15
Members were prepared for this meeting.	83%	100%	96%	89%	94%	95%	91%	100%	74%	94%	100%	100%	89%	87%
Members shared responsibility and accountability for the success of the meeting.	87%	100%	100%	89%	100%	100%	100%	88%	68%	94%	91%	94%	89%	100%

The change corresponded to the time when the second Project Team member was leaving the Project, slightly over midway through the Project timeline. Otherwise, the Advisory Board members strongly supported each other and were accountable and prepared for the meetings.

Member responsibility, accountability, trust, and the sense of cohesiveness especially dipped in October 2018, with trust and cohesion also dropping in August and cohesion again in June 2019. The Project Team recognized this data as being a possible indication that the members were not feeling fully engaged or moving forward. One comment stated, "I think we need to begin some action planning or action steps. We need to re-engage organizations that are no longer attending." The Project Team discussed the issue and decided to help facilitate more small group discussions and try to move the Project along by developing activities to progress with the strategic planning.

Communication and Coordination

Communication and coordination of efforts were strongly encouraged both during the Advisory Board meetings as well as independently. Different methods of communication were used to apprise members of news, updates, events, and activities that were occurring in the community and with fellow Board members and partners.

- During the beginning of each meeting, time was allocated for announcements and sharing. Members also documented new partnerships, new activities, and data sharing efforts on "green cards", which will be discussed in the next section. Results of this documentation were shared during the next meeting.
- Email communication was used for updates and news in between meetings.
- Advisory Board members received a list of contact information for the entire Advisory Board, which was requested by participants during the first meeting.

Every Advisory Board meeting provided an opportunity to network, communicate, and coordinate. The Project Team became aware of how important the meeting environment was for being effective in this area. Early meetings yielded survey comments such as, "May need a larger venue" and "Table set-up was key to participation." Details such as providing lunch before the meeting and coffee throughout also can be conducive to impromptu conversations and communication about partnerships and coordination.

Activities during meetings also served as a conduit to communication and coordination. Small group discussions fostered discussions leading to new ideas for collaborative efforts. One member shared, "Appreciate agencies that participate in this meeting - increased networking and partnerships." Other members stated that they appreciated the opportunities for communicating with other agencies through the Advisory Board.

MUTUALLY REINFORCING ACTIVITIES

The third essential condition of collective impact success is ***Mutually Reinforcing Activities.*** This condition is characterized by Advisory Board members understanding their own role and others' role in aligning with, supporting, and contributing to the common agenda and mutually agreed upon plan of action. Throughout the Project, the Advisory Board members were given opportunities to network, share, and coordinate mutually reinforcing activities. Many members participated in these actions. However, a recommended action plan with strategies was not formally introduced until the end of the Project, so a full analysis of the mutually reinforcing activities is limited to those occurring during the Project period.

#13 Mutually Reinforcing Activities Indicators

Mutually Reinforcing Activities	
Advisory Board members have committed to implementing an action plan	• The action plan for the Project period was to understand and use data to formulate a common agenda and engage in continuous communication • Recommended strategies for an ongoing action plan were adopted by the Advisory Board at the end of the Project.
Members coordinate activities in alignment with the common agenda and plan of action	• Members took the opportunity to coordinate activities both within and outside of the structure of the Advisory Board.
Members understand the roles of others and how each support the common agenda	• Continuous sharing and learning about other members supported the understanding of how each support the common agenda.
Members have clear approaches for their own contribution to the working group and change to better align with the common agenda and plan of action	• As members learned about the data and problem of suicide in Stanislaus County, they began to formulate approaches for their own contribution.

Commitment of Advisory Board to Action Plan Implementation

As previously discussed, Advisory Board members committed to the work of the Project early in its development. The Commitment Form was signed by 44 individuals, and an average of 27 (25 if not including the first several meetings) attended the Board meetings due to various reasons such as individuals leaving an organization and changes in duties, as well as very early attrition.

The Commitment Form clearly stated what the member was agreeing to, and served as the pledge to be accountable to the Project and collective impact conditions of success, including mutually reinforcing activities. The commitment included implementing differentiated approaches, contributing to the strategic plan, and building trust and relationships among fellow members and stakeholders. Additionally, the Advisory Board members contributed to the development of recommended strategies for an ongoing action plan at the end of the Project.

Aligned Coordinated Activities

"Green Cards" were set out and completed by Advisory Board members before or during each meeting. These cards served several purposes – to give members the opportunity to share and learn from each other's activities, discuss and learn about new and ongoing existing partnerships, and to allow for possible new connections. A summary of this data is provided below.

#14 Green Card Summary

# of Times Suicide Data was Shared or Used Outside Advisory Board	# of Suicide Awareness or Prevention Efforts Outside Advisory Board	# of New Partners or Partnerships	# of New Activities or Interventions
86	83	19	32

The table illustrates how new opportunities for partnerships, activities, and interventions were provided and developed. At the same time, existing efforts were also aligned with the vision of the Project. Data was often shared outside the Advisory Board to help begin conversations about suicide awareness and prevention efforts and to establish new partnerships. The amount of data sharing, efforts, activities, and partnerships remained fairly consistent across the 3-year Project period, and an average of 57% of meeting attendees reported that they shared data, worked on a suicide awareness or prevention effort, and/or formed new partnerships or started new activities/interventions.

Sharing data was an instrument used to spark interest and conversations. It also served as an instigator to develop some of the efforts, partnerships and activities. The following are just some of the people, organizations, and groups that were involved with data conversations, and suicide awareness and prevention efforts and activities.

#15 Mutually Reinforcing Activities

Mutually Reinforcing Activities	
Shared Data	➢ Own staff/organization ➢ Clinicians/Mental health providers ➢ Community members/groups/leaders ➢ Community partner agencies ➢ Clients ➢ Support groups ➢ Community presentations/trainings ➢ University Health Center ➢ University faculty ➢ Grief counselors ➢ Community events ➢ Parents ➢ Students ➢ Healthcare Task Force ➢ Promotores Meeting (in Spanish) ➢ Mental Health First Aid Training ➢ American Foundation Suicide Prevention Advocacy Day – State Legislators ➢ LGBTQ Groups; Transgender Advisory Council ➢ Fresno Suicide Prevention Collaborative ➢ Organizations' Boards ➢ Staff and Community working with Homeless ➢ Clergy/Faith leaders ➢ Stanislaus New Leadership Network

Suicide Awareness and Prevention Efforts

***Indicates a new partnership**
^Indicates a new activity or intervention

- Community Trainings*^
- Staff Trainings*^
- High School Trainings*^
- Community Presentations*^
- Suicide Awareness Walk (Out of the Darkness)
- NAMI Walk
- Contract Agencies
- Health Center*^
- PEER Project*^
- Raising Our Wellness*^
- Working with clients^
- Stigma reduction efforts^
- Presentations to LGBT groups, including transgender population*^
- Local Suicide Loss Group^
- Training for Suicide Loss Group Facilitators^
- QPR (Question, Persuade, Refer) Suicide Prevention trainings at University^
- Grief Support and Sudden Loss groups
- "Friends for Survival" support group (suicide loss peer group)*^
- TAPS Group (military suicides)^
- Faith Based Stigma Reduction block party^
- Changes in clinical screening tool related to suicide^
- Send Silence Packing events*^
- Social media posting by private practitioner^
- Social Worker trainings^

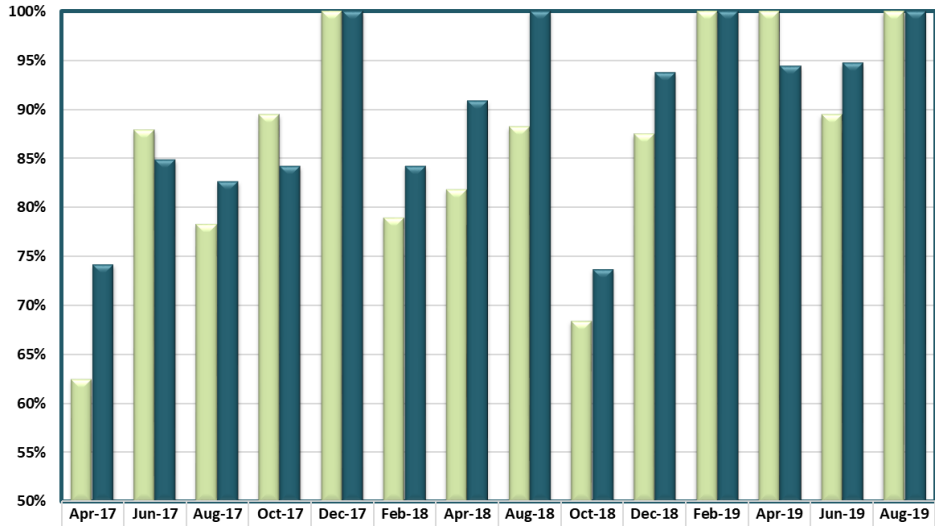
Understanding of Roles and Contributions

The Advisory Board members continued to learn about their own roles and contributions to the collective impact, as well as the roles and contributions of other. As the Project progressed, the multiple channels of communication, sharing, exploration and reflection allowed Advisory Board members to develop a better understanding of what other organizations, agencies, collaboratives, communities, and even individuals were doing to contribute to solving the problem of suicide.

The green card summaries and announcements shared at the beginning of each meeting allowed members to hear about events and activities, and often led to additional questions and possible collaboration opportunities. The meeting survey results illustrated that most members continued to learn and have a better understanding of the suicide prevention and suicide awareness activities across Stanislaus County throughout the three years of the Project.

This chart depicts how most meetings resulted in a better understanding of suicide prevention and awareness efforts in Stanislaus County. The percentage of members who had a better understanding ranged from 63% to 100%, with the majority of meetings resulting in over 80% of the attendees having increased understanding.

#16 Meeting Survey Results - Understanding of Efforts



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I have a better understanding of suicide prevention efforts in Stanislaus County because of this meeting	63%	88%	78%	89%	100%	79%	82%	88%	68%	88%	100%	100%	89%	100%
I have a better understanding of suicide awareness efforts in Stanislaus County because of this meeting	74%	85%	83%	84%	100%	84%	91%	100%	74%	94%	100%	94%	95%	100%

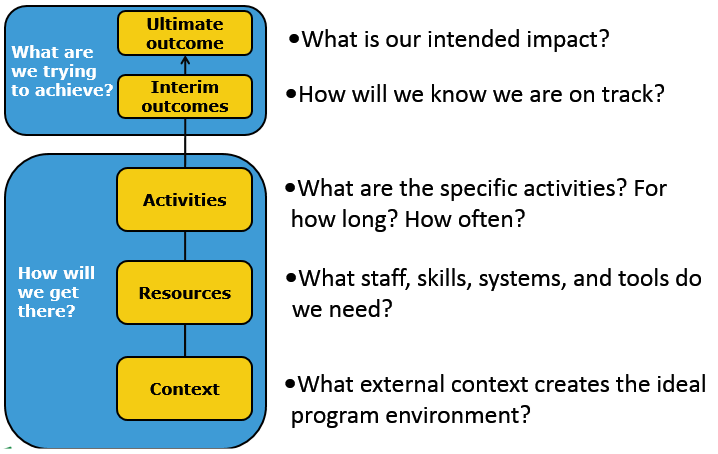
In addition, all of the activities that led to the formation of the common agenda created shared understanding of the current assets and gaps, along with the need to design activities that would align with the needs of the Stanislaus County community. As the recommendations from the root cause analysis and needs assessments were established, the members began to think about how their own and others' contributions could be better aligned. The recommendations included:

- Align local interventions and prevention strategies to reach subpopulations identified in State and National data
- Strengthen prevention programs and interventions that focus on building positive relationships and coping strategies
- Strengthen the identification and support of people at risk through crisis intervention services and post-attempt treatment
- Increase communication about suicide and suicide risk factors
- Strengthen and increase suicide prevention through gatekeeper training
- Strengthen access and delivery of resources and services related to suicide through policy and training of service providers
- Create policies that promote protective environments and demonstrate that mental health is valued

Then, as the shared measurement system was being developed, members also had an opportunity to think about how their activities could be aligned with the recommended strategies and performance measures. This process is ongoing and will require additional attention and work.

This graphic describes the process of designing mutually reinforcing activities.[7]

Although the language is slightly different, it is very similar to the Results Based Accountability framework that the Advisory Board adopted towards the end of the Project. The process starts with the ends (what are we trying to achieve?) and works backwards to the means (how will we get there?). As discussed, the Advisory Board developed strategic recommendations which are in alignment with the process of designing mutually reinforcing activities that contribute to solving the problem of suicide in Stanislaus County.



COMMON AGENDA

The fourth essential condition of collective impact success is ***Common Agenda.*** This condition is critical in that the Advisory Board has mutual understanding of the problem, has a shared vision and mission, and a collective plan to move the needle on the problem.

#17 Common Agenda Indicators

Common Agenda	
The Project's Advisory Board includes voices from all relevant sectors and constituencies	• The Advisory Board was comprised of multiple sectors of the community • All Advisory Board members were invited to participate in the process of asset mapping, gap analysis, root cause analysis, and the development of the common agenda • Advisory Board members were asked to elicit feedback from the community and their constituents to inform the process
Members of the target population help shape the common agenda	• There was representation from target populations and feedback to help shape the common agenda • This was an area with room for improvement
Members use data to inform selection of strategies and actions	• The Project Team and multiple guest speakers presented data to the Advisory Board; the data was discussed, and shared understanding confirmed • The entire process of asset mapping, gap analysis, root cause analysis, needs assessment, and the development of the problem statement and common agenda all utilized data

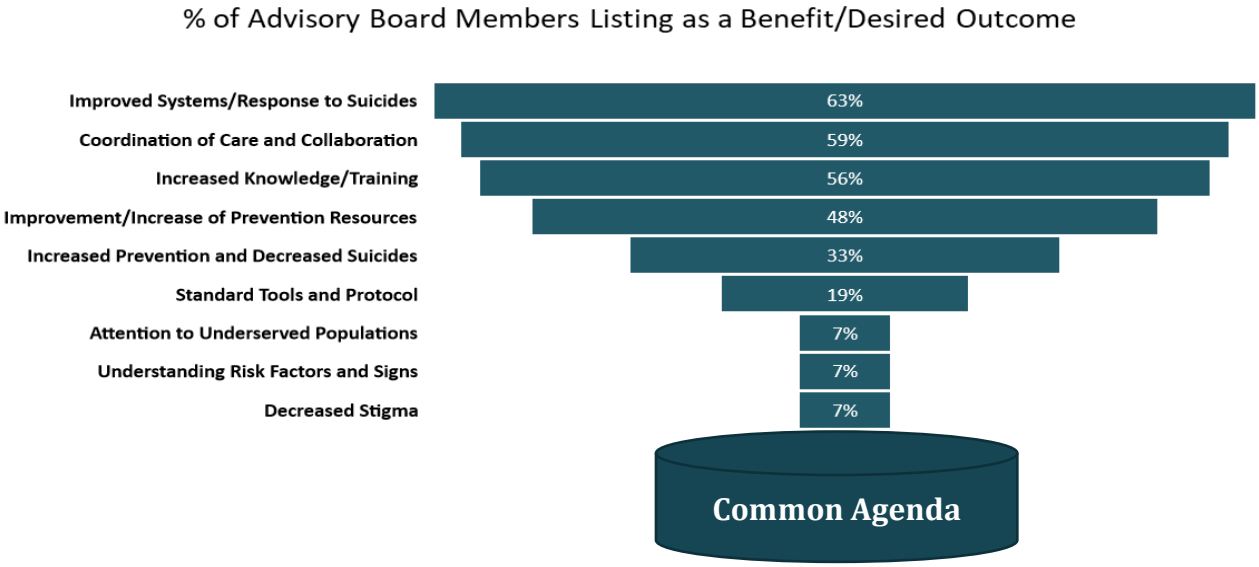
Members and the broader community understand and can articulate the problem	• Advisory Board members and the Project Team shared the problem statement and root cause analysis with the broader community • A *Suicide Prevention Needs Assessment* was created and distributed • A *Suicide Prevention Needs Assessment Executive Summary* was developed and distributed to help the community articulate the problem

The Common Agenda was developed over time through multiple methods. An asset mapping activity, gap analysis, and root cause analysis were conducted to lay a foundation for the common agenda work. The context of the Stanislaus County environment was critical for the Advisory Board and community to understand for the collective impact initiative to be successful. This work spanned approximately 6 months before a problem statement that the Advisory Board could stand behind was created.

Voices from Advisory Board and Targeted Populations are Heard

During the first meeting of the Advisory Board, members were asked to share up to three benefits or desired outcomes they wanted to gain for their organization or community by participating in this particular Project as a collective impact initiative. There were 27 Advisory Board members who responded with the following categories of benefits or desired outcomes.

#18 Categorized Benefits/Outcomes



The percentage reflects the percent of respondents who listed a benefit or desired outcome in the category. Because each of the 27 respondents may have responses that are in multiple categories, the total percentage does not equal 100%.

This figure illustrates how participants in this collective impact initiative already came to the Project with agenda ideas, much of which were consistent amongst the other participants. Working through a process of reviewing data, asset mapping, gap analysis, needs assessment, and developing a problem statement led to refining a common agenda. It should be noted that these processes and results represent the ideas, work, and expertise of only the Stanislaus County Suicide Prevention Advisory Board members.

Asset Mapping and Gap Analysis

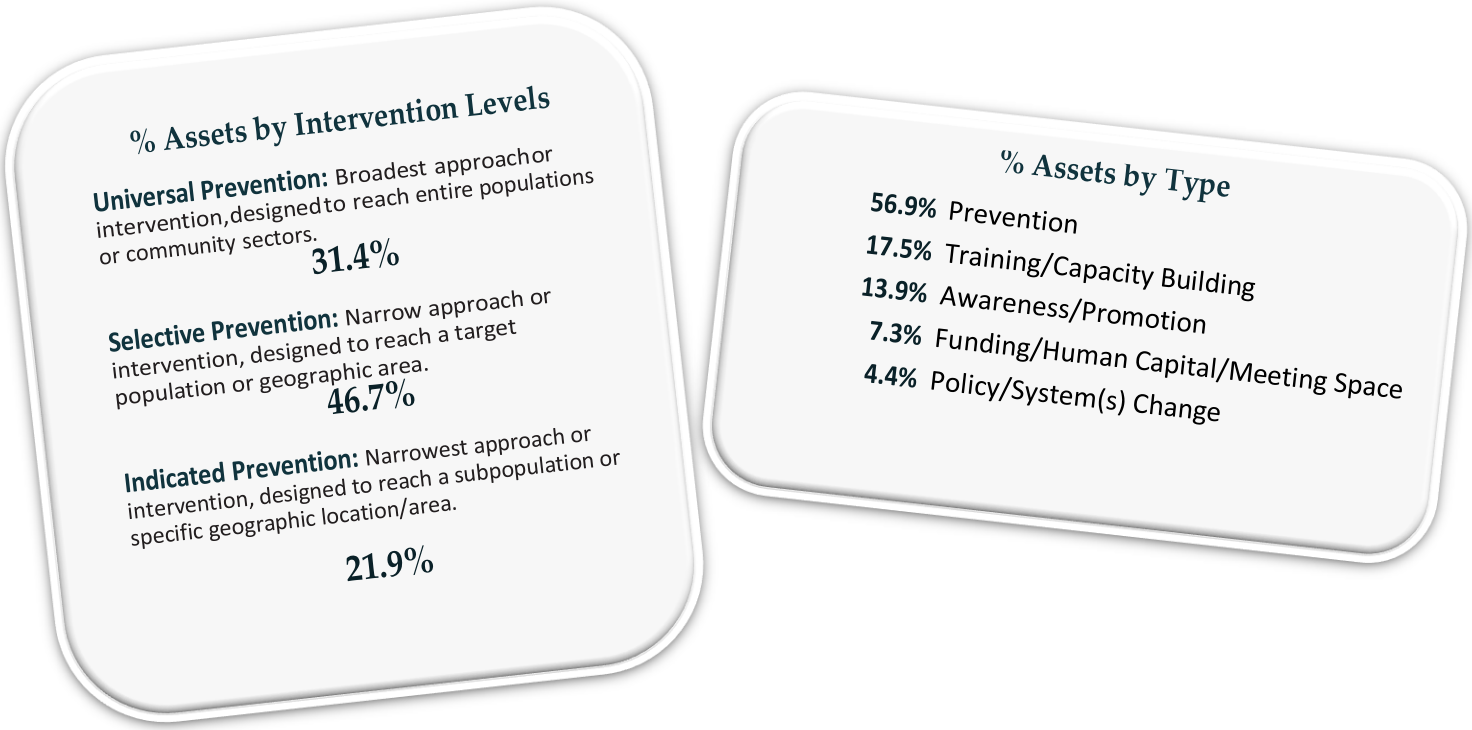
Early in the collective impact process, the Project Team guided an asset mapping and gap analysis process to move the Advisory Board forward towards a needs assessment, common agenda, and ultimately strategic recommendations towards a strategic plan. The process provided information about the strengths and resources (assets) of Stanislaus County to address the issue of suicide, helped determine if there were gaps or unmet needs, as well as redundancy of efforts. In addition, when assets are inventoried and displayed in a map, it is often easier to determine how to use and leverage the assets to make improvements and uncover other possible effective solutions.[8] This activity would prove useful during the needs assessment and strategic planning processes.

Advisory Board members were asked to inventory all of the assets their organization, agency, and/or community provided, used, or were aware of in relation to addressing suicide within Stanislaus County. The results were aggregated and summarized (See Attachment # 5). They were also encouraged to include other individuals within their community to assist with the inventory. The results were included in the *Stanislaus County Suicide Prevention Needs Assessment* as a critical component of the assessment.

The County was divided into nine regions and a total of **78** assets were mapped, for an average of **8** suicide prevention and awareness assets per region. Prevention assets accounted for 77% of the total, followed by Training/Capacity Building and Awareness/Promotion with 11.5% each.

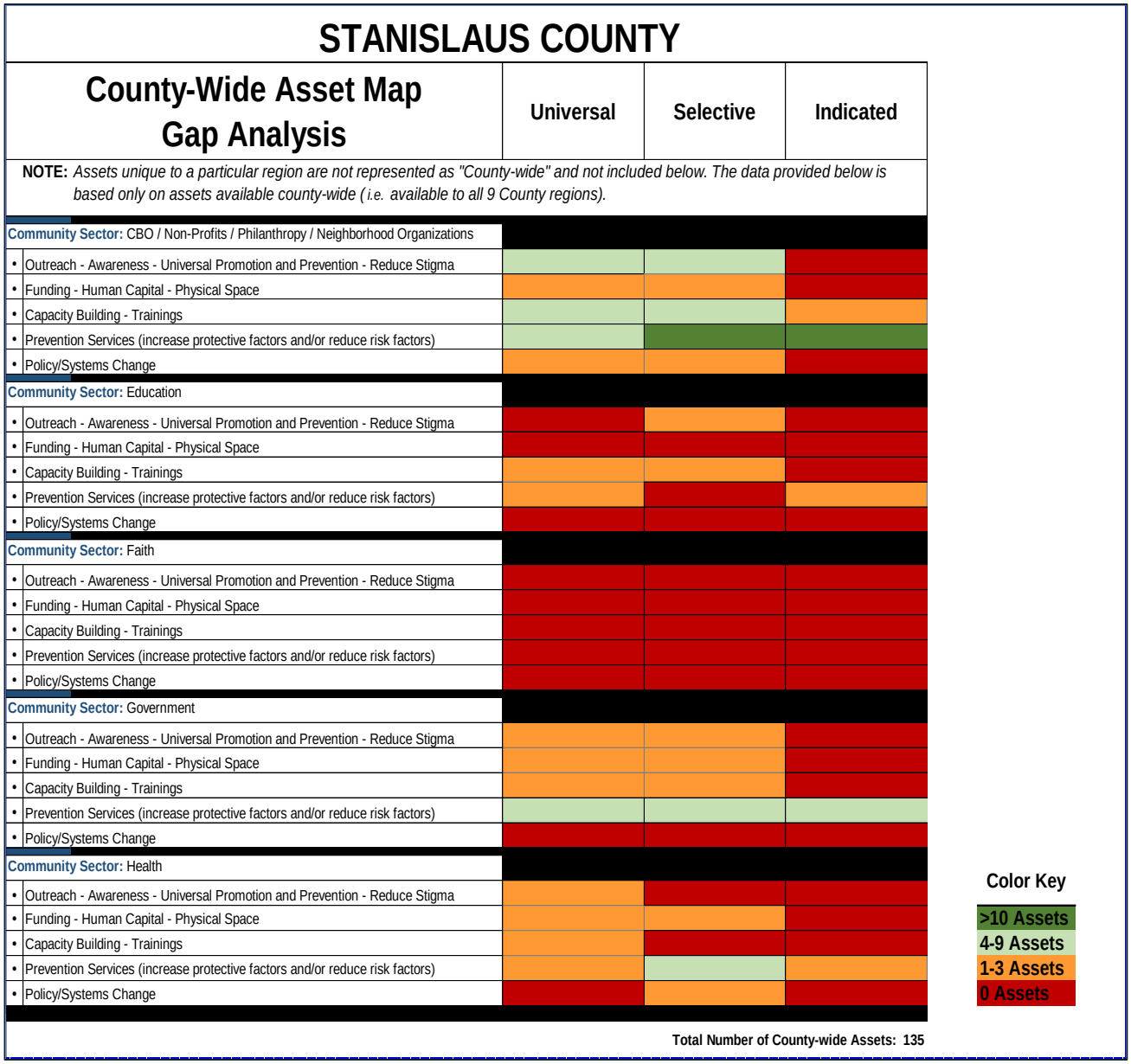
A total of **137** County-wide assets (not unique to a region) were inventoried, and then categorized into three intervention levels and five asset types. As illustrated below, county-wide assets are comprised of higher percentages of training/capacity building and awareness/promotion than the regional assets.

#19 Assets by Level and Type



The gap analysis that ensued after the asset mapping uncovered areas that were not as strong within the County. The county-wide Asset Map Gap Analysis below illustrates the sectors, types, and intervention levels for which the county has strong assets and those for which there are gaps. It is worthy to note that there is a complete gap within the Faith Sector due to the lack of representation from this area. Although Stanislaus County has many strengths and assets, it is also clear that the collective impact initiative is warranted and there is work to be done. The analysis provided important information for the common agenda and the strategic plan.

#20 Asset Map Gap Analysis



Root Cause Analysis

Shortly after the asset mapping and gap analysis were completed, a root cause mapping and analysis was conducted. A consultant organization was contracted to help conduct the exercise, and a half-day workshop was dedicated to the process. Root cause mapping is a structured approach that helps identify contributing factors and secondary causes of a complex social problem. In this case, it helped isolate the primary sources of suicide and the scope of the problem. Great care was taken to ensure a high level of participation and interaction so that multiple perspectives could be leveraged, documented, and used for strategic planning. Highlighted in the *Stanislaus County Suicide Prevention Needs Assessment,* the root causes ultimately defined the problem of suicide in Stanislaus County. The root causes and associated contributing factors, compound causes, and first level cause can be explored in much greater detail in the needs assessment. The Advisory Board was able to define the problem of suicide after gaining a shared understanding of Stanislaus County suicide data, assets, gaps, and root causes.

Use of Data to Inform Strategies

Needs Assessment and Problem Statement

The asset mapping, gap analysis, and root cause mapping and analysis culminated in the *Stanislaus County Suicide Prevention Needs Assessment.* This comprehensive document incorporated much of the suicide data, and asset/gap data to better understand and capture the essence of the problem of suicide in Stanislaus County. Armed with this knowledge, the Advisory Board was able to establish the problem statement and work towards the common agenda. The purpose of the problem statement was to determine the focus and direction of the attention and efforts of the Advisory Board, as well as to communicate clearly the issue of suicide in Stanislaus County. Advisory Board meetings were used to discuss the asset/gap and root cause data, using the data as a springboard for developing the problem statement. The members worked both individually and in small groups to draft possible problem statements using tools/handouts as guides (See Attachments #10a, 10b, and 10c). The members could see the importance of the problem statement in the chain of steps contributing and leading to the Suicide Prevention Strategic Plan. The problem statement was incorporated into the *Stanislaus County Suicide Prevention Needs Assessment* along with all of the supporting data that led the Advisory Board to a strong statement of the Stanislaus County suicide problem as seen below.

Root Causes: Scope of the Problem

The multiple contributing factors of suicide and suicidal behaviors are complex and often attributed to the interaction of several factors. To identify the root causes of suicide and suicide attempts in Stanislaus County, the Advisory Board used the root cause mapping process. The process produced ***eight compound causes*** (various contributing factors or a combination of causes) and ***11 contributing factors*** (do not directly cause the problem, cause-and-effect relationship that ultimately create a problem), which were then further broken down into ***four root causes***:

- Mental Health Stigma
- Decline in Connectedness
- Challenges of Sharing Information Across Sectors
- Lack of Shared Best Practices or Standards

PROBLEM STATEMENT

During the last four years (2013 - 2016) 207 Stanislaus County residents died by suicide, which equates to nearly one suicide death every week. The number of deaths from suicide reflects only a portion of the problem. Non-fatal suicidal behavior is a serious challenge and strongly associated with the suicide rate. Suicide has no single cause. The multiple contributing factors of suicide and suicidal behaviors are complex and can be attributed to the interaction of the following root causes:

- *Mental health stigma and misconceptions around suicide*
- *Decline in connectedness, interpersonal relationships, institutions, and other social assets of a society*
- *(social capital)*
- *Challenges of sharing information across public and private systems, impacting the quality of care*
- *Lack of shared best practices or standard practices of care for suicidal behaviors and prevention*

Although suicide is a complex problem, it is preventable. A collaborative of cross-sector partners are needed on an ongoing basis to support, contribute and provide multidisciplinary perspectives to implement effective suicide prevention strategies.

As discussed previously, the problem statement was included in the needs assessment, and the contents of the needs assessment was thoroughly reviewed by the Advisory Board. Questions and clarifications came through small workgroups, and the data presentation was made stronger with the feedback. Ultimately, the problem statement and the common agenda were created by reviewing and understanding the data supporting the issue of suicide.

Common Agenda Components and Development

A common agenda is formed when stakeholders collectively define a problem and create a shared vision to solve the problem. There are four components of a common agenda:

1. Problem Statement – provides the "why" for the goals that are chosen to work on
2. Vision Statement – desired end result that will be achieved together; easily communicated and inspiring
3. Mission Statement – summary statement of "what" and "how" will be worked on; translates the vision into something measurable
4. Strategic Plan – roadmap of strategies to achieve the end result

A Common Agenda Subcommittee of 8 Advisory Board members (4 Project Team members) was formed, and this group utilized the problem statement and relevant supporting data to draft the second and third components of the Suicide Prevention Advisory Board Common Agenda. The full Advisory Board reviewed and approved this work, resulting in the following statements.

Who We Are

Stanislaus County Suicide Prevention Advisory Board is a partnership of thirty-five organizations and agencies dedicated to collectively addressing the problem of suicide through leadership, a structured approach and sustainable prevention programs.

Our Vision

Stanislaus County is a community free from stigma and suicide.

Our Mission

To facilitate knowledge, attitude and behavior change among individuals, communities and environments that reduce stigma and prevent suicide in Stanislaus County.

The final component of the common agenda is the strategic plan. This component is not complete; however, foundational work has been done. The Advisory Board participated in multiple strategic planning sessions/activities that leveraged the learning gained and the groundwork laid during the first two years of the Project. In addition, during the last four months of the Project, a presentation of Fresno County's Suicide Prevention Strategic Plan was made to the Advisory Board; members liked aspects of the plan and it can be used as a guide for Stanislaus. Results Based Accountability and Clear Impact Scorecard software were also introduced and used to develop strategic recommendations with the goal of completing a formal strategic plan at a later date. This process will be described further in the next section.

Members and Community Understand and Articulate the Problem

The Advisory Board was embedded in the work of the asset mapping, gap analysis, root cause analysis, needs assessment and common agenda. Each step of the way, information was brought to meetings and small groups reviewed, reflected, and provided input through activities and worksheets, documenting the feedback. While working through these processes, the Project Team encouraged the Advisory Board to include their community constituents. For example, other organizations and community members were enlisted to help inventory assets in their own community.

As the needs assessment was developed, the Advisory Board spent time through large and small group activities brainstorming ways to share the information, data, and problem of suicide with Stanislaus County residents. The recommendation was to create three different formats of the needs assessment to support information sharing for the different targeted populations. Three documents were created: the *Stanislaus County Suicide Prevention Needs Assessment*, the *Stanislaus County Suicide Prevention Needs Assessment Executive Summary,* and the *Stanislaus County Suicide Data Fact Sheet* (two-page communication brief – See Attachments #8a and 8b for the full document and Executive Summary and #11a for the Fact Sheet). The executive summary and communication brief were also translated and published in Spanish (See Attachments #8c and #11b). Advisory Board members used these documents to share the problem of suicide in Stanislaus County and the work being done to address it. When presenting this information, the members were provided with a structure to help guide discussions about the data and the problem, and help elicit possible solutions and strategies from multiple perspectives.

SHARED MEASUREMENT

The last essential condition of collective impact success is ***Shared Measurement.*** This condition involved establishing a shared measurement system for the Advisory Board collective approach and Collective Impact model progress. It also included establishing a shared measurement system (SMS) for the impact on suicide in Stanislaus County. Developing indicators, performance measures, data collection, tracking, and reporting are also essential for collective impact success.

#21 Shared Measurement System (SMS)

Shared Measurement System (SMS)	
Members understand the value of the shared measurement system and how they will participate in it	• Members learned about the plan to establish and participate in an SMS before committing to participate on the Advisory Board. • The importance of providing data and participating in the collection of data was consistently discussed.
Members commit to collecting the data as defined in the plan	• The Advisory Board Commitment Form lists "Shared Measurement" as one of the responsibilities of the Advisory Board. • Each Board member signed the Commitment Form indicating the pledge to collect data
A participatory process is used to determine a set of indicators and data collection methods	• A workgroup designed a draft set of indicators and method of collecting the data for the Advisory Board progress SMS • Results Based Accountability (RBA) was explored and presented to the Advisory Board as a framework for shared measurement • Clear Impact was researched and presented to the Advisory Board as an electronic SMS tool
The system includes a common set of indicators and data collection methods that can provide timely evidence of (or lack of) progress toward the Project's outcomes	• A common set of indicators and data collection methods were established that enabled the Project Team and Advisory Board to review evidence of Advisory Board progress • A common set of indicators was recommended to the Advisory Board to provide evidence of progress towards suicide prevention
Members know how to use the SMS	• A workgroup of "champions" have learned how to use the Clear Impact SMS • Some "champions" have received professional RBA certification • There is work to be done to train others to use the Clear Impact SMS

Members agree to a data sharing agreement that supports ongoing collaboration	• The Clear Impact SMS provides a forum for shared data and some members began sharing their organization's data • There is work to be done to further the objective of shared data
Members contribute data on indicators in a timely and consistent manner	• Members contributed data towards the Advisory Board progress every meeting through surveys and index cards • Members contributed data towards the Advisory Board progress through the *Community Collaborative Assessment* • Some members have contributed data through the Clear Impact SMS

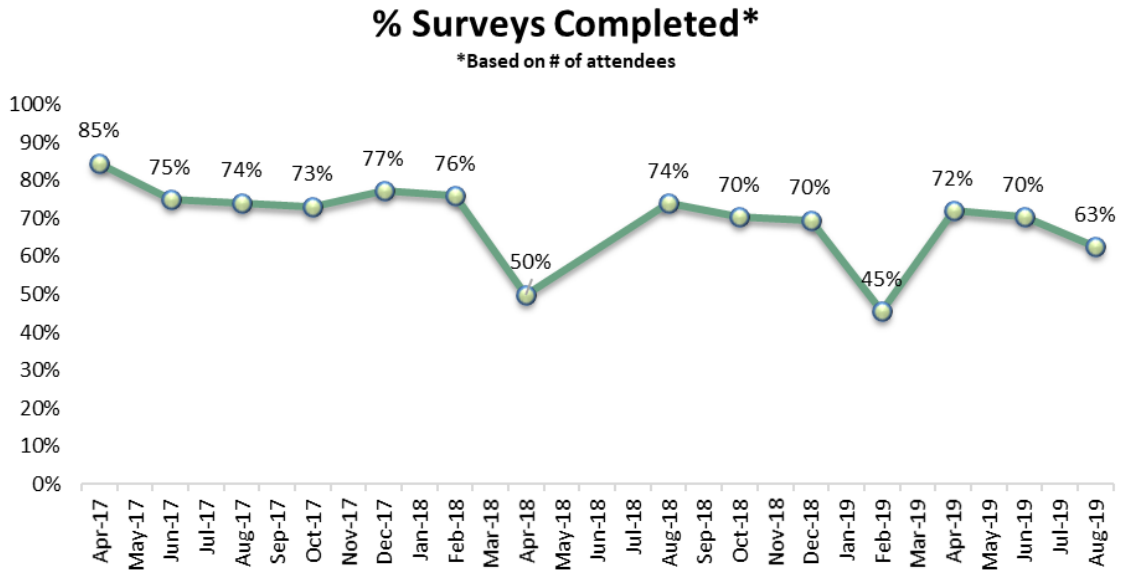
Value, Commitment, and Participation

As discussed in sections earlier, Advisory Board members learned about the Collective Impact model, and the five conditions for success. The value of a shared measurement system was shared in the first kick-off meeting and continued to be discussed and emphasized throughout the 3-year Project. The commitment members made was to:

- *Collect data and track progress in a consistent way*
- *Share in accountability among fellow members and stakeholders*
- *Allow for continuous improvement and learning*

One aspect of the SMS was to collect data to monitor performance, track progress and learn what is and is not working in the Advisory Board's collective approach to collective impact. Members attending the Advisory Board meetings had the opportunity to contribute data and information each time through surveys and "green cards". The chart below shows that not all members provided data each time through the survey method.

#22 Completed Meeting Surveys



Response rates ranged from 85% at the first meeting to a low of 45% early in 2019. The majority of meetings achieved a 70% response rate or above with an average of 71%.

There were also other opportunities to contribute data to the SMS through the two assessments administered. The *Community Collaborative Assessment* and the *Wilder Collaboration Factors Inventory* were two tools used during the Project period to capture data regarding the Advisory Board's readiness and progress towards successful collective impact work.

Community Collaborative Assessment

The Advisory Board members were asked to complete the *Community Collaborative Assessment – A Diagnostic of Success Readiness* at three different times during the 3-year Project period. The first was in October 2017, serving as a baseline measurement, the second was a year later in October 2018, and the final administration was during the last meeting in August 2019. The purpose of the assessment was to "improve the likelihood of creating significant impact against social problems that by definition have long been intractable."[9]

The results of each of the first two assessments were shared with the Advisory Board. The strengths (higher scores) as well as the areas for improvement (lower scores) were discussed. The strengths indicated that the Advisory Board could use those areas to build upon, and possible strategies for improvement in the other areas were discussed.

The assessment is divided into two major categories and sections within those categories. The full results for each administration can be found in Attachments #12a, 12b, and 12c, but below is a side-by-side comparison of the major categories and sections from the three time periods. It should be noted that there were fewer participants in the last assessment compared to the baseline and intermediary assessments.

Community Collaborative Assessment Summary of Readiness	October 2017 Baseline n=16	October 2018 Intermediary n=21	August 2019 Final n=14
How ready is my community for collaborative work?	75%	80%	83%
Do we have the core principles in place for a successful collaboration?	70%	78%	82%
PART A: Develop the Idea	**73%**	**79%**	**82%**
How aligned and organized is our community?	73%	78%	83%
Do we have the capacity and resources in place to be successful?	75%	79%	78%
PART B: Plan and Align Resources	**74%**	**78%**	**81%**
OVERALL READINESS	**74%**	**79%**	**82%**

This chart illustrates that the "overall readiness" of the SPIP Advisory Board to be successful increased by 8 percentage points from the baseline to the final assessment. Part A, the measurement for developing the

idea for the collaborative work increased the most, and in particular, "Do we have the core principles in place for a successful collaboration?" increased 12 percentage points. It is important to note that the increase occurred incrementally throughout the three years in all areas except "Do we have the capacity and resources in place to be successful?". It is a possibility that during the final assessment the Advisory Board knew that the Project was ending and therefore the Backbone Organization would no longer be supporting the Advisory Board's work. There remains questions about what will happen during the next phase of the collective impact initiative without the Suicide Prevention Innovation Project's funding and support, and this uncertainty may have affected the responses in this area.

Wilder Collaboration Factors Inventory

The Advisory Board also completed the *Wilder Collaboration Factors Inventory – Edition 3*. Similar in many respects to the *Community Collaborative Assessment - A Diagnostic of Success Readiness* tool, it "…is a tool for assessing how a collaboration is doing on the "…22 research-tested factors that influence success."[10] This tool was administered only at the end of the Project and served to look at the readiness and success indicators of the Suicide Prevention Advisory Board from a slightly different angle, either corroborating or negating the findings of the *Community Collaborative Assessment*. A total of 21 Advisory Board members completed the inventory and the complete results can be found in Attachment #13. The average scores for each of the 22 success factors are shown below.

#24 Summary of Success Factors

Average score for each of the 22 success factors (scale of 1-5, 5 being the highest)
n=21

Factor	Factor Average
History of collaboration or cooperation in the community	**3.6**
Collaborative group seen as a legitimate leader in the community	**3.7**
Favorable political and social climate	**4.5**
Mutual respect, understanding, and trust	**4.4**
Appropriate cross section of members	**3.5**
Members see collaboration as being in their self-interest	**4.4**
Ability to compromise	**4.0**
Members share a stake in both process and outcome	**4.1**
Multiple layers of participation	**3.9**
Flexibility	**4.2**
Development of clear roles and policy guidelines	**3.8**
Adaptability to changing conditions	**3.9**
Appropriate pace of development	**3.8**
Evaluation and continuous learning	**4.0**
Open and frequent communication	**4.3**
Established informal relationships and communication links	**3.8**
Concrete, attainable goals and objectives	**4.2**
Shared vision	**4.1**
Unique purpose	**4.5**
Sufficient funds, staff, materials, and time	**3.4**
Skilled leadership	**4.3**
Engaged stakeholders	**3.6**

As a general rule...
Scores of 4.0 to 5.0 - strengths, don't need special attention
Scores of 3.0 to 3.9 - borderline, deserve discussion
Scores of 1.0 to 2.9 - concerns that should be addressed

As illustrated, the lowest scored factor was "Sufficient funds, staff, materials, and time", which is consistent with the *Community Collaborative Assessment.* It is followed closely by "Appropriate cross section of members" as Advisory Board members have shared that there are missing representatives from this Project. The highest scored factors are "Unique purpose" and "Favorable political and social climate", followed closely by "Mutual respect, understanding, and trust". These results are also consistent with other data in this evaluation – members' connection to the problem of suicide in Stanislaus County, the interest of the community and County Board of Supervisors, and the trust and cohesion the members indicated.

Results Based Accountability and Clear Impact Scorecard

Another component of the SMS was collecting data to monitor and track progress, learning what was and was not working towards achieving the Population Result of ***Stanislaus County is a community free from stigma and suicide***. The members' commitment was also to work towards this result, sharing data that would help understand what works in achieving the Population Result. The framework chosen to do this was Results Based Accountability (RBA) and the aligned SMS Clear Impact Scorecard software.

Results Based Accountability was selected as a framework due to its alignment with collective impact fundamentals. RBA is "…a disciplined way of thinking and taking action used by communities to improve the lives of children, families and the community as a whole…" and can also be "…used by agencies to improve the performance of their programs."[11] When using RBA, one starts with the ends (what do you want to see as a result?) and works backwards to the means (what will it take to get there?). This clearly can be related to collective impact's common agenda, mutually reinforcing activities, and shared measurement systems. The vision of the Advisory Board, ***Stanislaus County is a community free from stigma and suicide*** becomes the Population Result (or condition of wellbeing) in the RBA framework. The measurement of the work of the organizations, agencies, and other programs become performance measures that ***contribute*** to the Population Indicators that measure progress towards the Population Result. A "Turn the Curve" approach is also used in RBA, which involves viewing the problem form different perspectives, taking the context and causes into effect, and monitoring data to ensure that it is headed in the right direction for making progress towards the intended result. For additional information about RBA, please see Attachment #14.

Clear Impact Scorecard software is used in conjunction with RBA and is a shared measurement system that allows the Advisory Board members (as well as other stakeholders) to review the data through the indicators, and also includes the strategies, partners, and actions that work to "Turn the Curve". The organizations or agencies can also create a scorecard to track their own performance measures that ***contribute*** to turning the curve towards the Population Result.

Although RBA and Clear Impact Scorecard were adopted as the shared measurement system, they also served as a critical tool to advance strategic planning. RBA is ideal in providing a framework for thinking about and developing strategies and actions to solve problems and improve lives. Clear Impact Scorecard software is valuable in providing the structure and venue for documenting this process, and then monitoring progress. The strategic planning workgroup, in conjunction with the Clear Impact consultant, used the activity/brainstorming ideas from the Advisory Board to undergo an RBA process to develop draft strategic recommendations by sectors for suicide prevention in Stanislaus County. These recommendations, along with identified potential partners, were then presented during the Advisory Board meeting and shared electronically for additional review and feedback. The Project Team subsequently finalized and entered the sector strategy recommendations, providing a live link for the Advisory Board to access and review them in Clear Impact format (See Attachments #15a and 15b).

Participatory Process for Indicators and Data Collection

A workgroup was formed to develop the indicators, performance measures, and data collection tools for shared measurement. Specifically, a group of 7 was tasked with drafting a common set of measures to

monitor performance, track progress, and learn about the group's collective approach (Advisory Board progress). Another workgroup of 12 convened to draft a set of indicators to measure collective progress towards the Population Result of ***Stanislaus County is a community free from stigma and suicide***.

For the first set of measures, the workgroup decided to use the *Community Collaborative Assessment* items (See Attachment # 1) as well as the meeting survey questions to formulate a set of measures since the Advisory Board members had already been using both as tools and baselines were established. These performance measures were presented to the full Advisory Board, discussed, and approved.

As previously mentioned, the Project Team explored Results Based Accountability as a framework and Clear Impact as an electronic SMS software tool to monitor progress towards solving the complex problem of suicide in Stanislaus County. The framework and tool were presented and adopted by the Advisory Board.

Timely Indicators Providing Evidence of Progress

The common set of performance measures and data collection methods that were established by the first workgroup and approved by the Advisory Board enabled the Project Team and Advisory Board to review evidence of the Advisory Board progress. Since the tools were already being utilized, they provided the foundation for the measurements. Below are the adopted measures and the evidence of Advisory Board progress towards conditions for a successful collective approach.

#25 Shared Measurement - Collective Approach (1)

Shared Measurements: *Collective Success Performance Measures*

Shared Measurement Type (1) of Collaborative Shared Measurements

Purpose: Establish a common set of measures to monitor performance, track progress and learn what is and is not working in the group's collective approach

Progress Overtime View →

Data Source: *Meeting Evaluation Forms*

	Apr-2017	Jun-2017	Aug-2017	Oct-2017	Dec-2017	Feb-2018	Apr-2018	Jun-2018	Aug-2018	Oct-2018	Dec-2018	Feb-2019	Apr-2019	Jun-2019	Aug-2019
	n = 34	n = 32	n = 23	n = 19	n = 17	n = 19	n = 11	n = 0	n = 17	n = 19	n = 18	n = 11	n = 18	n = 20	n = 15
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
The meeting purpose was achieved.	97%	97%	87%	95%	94%	100%	100%	N/A	100%	89%	100%	100%	94%	95%	100%
The meeting was a good investment of time.	94%	100%	96%	95%	94%	100%	100%	N/A	100%	89%	94%	100%	100%	100%	100%
Everyone had an opportunity to participate in the meeting.	84%	97%	96%	95%	94%	100%	100%	N/A	100%	95%	100%	100%	100%	90%	100%
Members shared responsibility and accountability for the success of this meeting.	86%	100%	100%	89%	100%	100%	100%	N/A	88%	68%	94%	91%	94%	85%	100%
There was a sense of trust amongst members.	73%	95%	87%	100%	94%	94%	91%	N/A	82%	84%	94%	100%	100%	90%	100%
There was a sense of cohesiveness amongst members.	83%	92%	87%	100%	94%	95%	91%	N/A	80%	79%	94%	100%	100%	75%	100%

Meeting Specific View ↓

Target 85% or Higher

Scale:

Green 100% - 91%

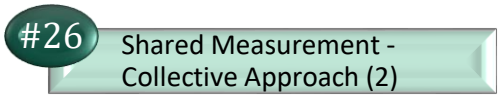
Yellow 90% - 85%

Red 84% or below

Note: Percentages represent "Agree" or "Strongly Agree" responses

The performance measures in this chart were derived from the meeting evaluation surveys. The target was to reach 85% of the members responding positively in the areas chosen. Although the majority of the measures indicated successful outcomes, there were some that indicated opportunity for improvement or development. These were the areas and meetings that the Project Team reviewed closely, conversed with the Advisory Board, and attempted to make improvements. There seemed to be a dip in the measures mid-Project, but then turned around. These measures allowed the Advisory Board to monitor the important aspects of purpose, good use of time, participation, responsibility/accountability, trust, and cohesion. When any of these percentages were (and continue to be) in red, it was time to consider what could be causing the issues and address them before they manifest further.

The next set of measurements were derived from the *Community Collaborative Assessment.* As this tool was only administered three times during the three years of the Project, there is less fluctuation and more apparent progress. Although there are only two performance measures that reached the target, these were during the most recent administration, indicating progress. Further, most measures show improvement, even if still red. All improved from baseline to last, and only two fell slightly since mid-year. Again, these are areas to monitor and consider making changes.



Shared Measurements: *Collective Success Performance Measures*

Shared Measurement Type (1) of Collaborative Shared Measurements

Purpose: Establish a common set of measures to monitor performance, track progress and learn what is and is not working in the group's collective appro

Data Source: *Community Collaborative Assessment*

	Initial/Baseline: Year 1 n = 16 %	Mid-Project: Year 2 n = 21 %	End-of-Project: Year 3 n = 14 %
Providers in my community use evidence-based practices to address the issue (suicide).	62%	77%	81%
The Advisory Board aspires to needle-moving change.	67%	75%	85%
The Advisory Board has a clear sense of what the collaborative uniquely can add to our community and how we can partner with existing work.	67%	81%	79%
The Advisory Board is focused on moving the entire community (county) forward.	71%	83%	93%
Key stakeholders (Advisory Board Members and Collaborative Partners) are committed to this work for the long-term.	77%	83%	81%
The Advisory Board has identified sustainable funding and/or in-kind resources.	52%	67%	69%
The Advisory Board is aligned with other suicide prevention and awareness efforts (national, state and local).	Not measured yet		
The Advisory Board collectively uses effective strategies.			
The Advisory Board uses interventions that effect change and align with our goals.			
The Advisory Board has the necessary people, structure and processes to sustain the work.	74%	80%	81%

Specific Point-in-Time View

Target 85% or Higher

Scale:

Green 100% - 91%

Yellow 90% - 85%

Red 84% or below

Regarding the population indicators to measure progress towards solving the complex problem of suicide, a common set of indicators was recommended to the Advisory Board to provide evidence of progress towards the Population Result of ***Stanislaus County is a community free from stigma and suicide.*** These indicators have been entered into the Clear Impact Scorecard SMS and are listed below.

1) # of Total Suicide Deaths
2) # of Total Suicide Deaths - Disaggregated by Age
3) # of Suicide Deaths -Disaggregated by Race/Ethnicity
4) # of Total Suicide Attempts (Non-Fatal ER and Hospitalizations) - Disaggregated by Gender
5) # of Total Suicide Deaths - Disaggregated by Gender
6) # of Total Suicide Attempts (Non-Fatal ER and Hospitalizations)
7) # of Total Suicide Attempts (Non-Fatal ER and Hospitalizations) - Disaggregated by Age

All indicators are for Stanislaus County, and details about the sources and methodology will be located in the Clear Impact tool.

Use of the Shared Measurement System and Data Sharing Agreements

The Project Team assembled a group of 12 Advisory Board members and staff who were excited about RBA and the Clear Impact Scorecard tool. Although participation varied during the three months of meetings, these were the "champions" who met regularly to receive training on the tool with a Clear Impact consultant, as well as advanced training in RBA. Some of them also participated in a rigorous professional RBA course, passed examinations and delivered final projects. They are now certified RBA professionals and are equipped to train others. Those who could not complete the time-consuming training at that time still have that opportunity.

This workgroup facilitated training and demonstrations for the full Advisory Board with the assistance of the Clear Impact consultant. The members learned what RBA is and about how the Clear Impact Scorecard's software would provide a structure and venue for the collection and sharing of data, tracking progress towards the Population Result of ***Stanislaus County is a community free from stigma and suicide.*** The goal of the training and demonstrations was to empower the members to use the SMS to track progress as well as use the RBA framework to continue working on the strategic plan in a deliberate and structured manner.

The Clear Impact Scorecard SMS provides a forum for shared data on a program level as well as population level. Some members have begun to create their program scorecards that will show how what they are doing ***contributes*** to the Population Result, the overall impact on suicide. Recalling that the foundational concept behind collective impact is that no one individual, organization, or agency can solve a complex social problem alone, this framework is perfectly suited for the Suicide Prevention Advisory Board's use. Very few have begun using the SMS, and there is work to be done to further the objective of shared data, including shared data agreements.

WHAT WAS LEARNED

Will a centralized infrastructure increase partnerships between individual sectors and their efforts to decrease suicides?

The data and information shared in the previous sections demonstrate that a centralized infrastructure, provided through the Collective Impact model, did increase partnerships between individual sectors and their efforts to decrease suicides. The Backbone Organization (BHRS) funded and supported the Project Team staff as well as the activities necessary to build a collective impact initiative for the Suicide Prevention Innovation Project. The Project Team provided the necessary infrastructure that undergirded the collective efforts of individual sectors. Outreach to the community to establish an Advisory Board, organizing and facilitating meetings, providing opportunities to network and share information, and assisting with communication methods for the Advisory Board members all led to increased partnerships between individual sectors.

Representatives from County agencies, community based organizations, community collaboratives, the education system, law enforcement, healthcare organizations, and community members at large assembled, shared information and perspectives, participated in activities and creating documents, and joined in continuous learning about multiple efforts to decrease suicides. These activities led to networking and essential conversations; silos were broken down and partnerships established.

- Figure #5 depicts the number and type of organizations, agencies, and individuals that Advisory Board members could partner with and learn from.
- Page 13 explains the opportunities for sharing, learning, and development, which led to increased partnerships and efforts to decrease suicide.
- Pages 13-14 illustrate the multiple new activities or events that Advisory Board members could partner with others to participate in or support; no activity or event was planned or hosted in silos.
- Page 18, including Chart #12, shows how Advisory Board members increased participation, trust, and cohesiveness to form a strong basis for partnerships.
- Pages 20-22 describe how Advisory Board members shared events, activities, and announcements with others, fostering partnerships.
- Chart # 14 shows the data regarding new partnerships and activities developed; 19 new partners/partnerships and 32 new interventions or activities were developed.

Through the use of collective impact principles, will the group develop a shared understanding of suicide data in our county? If so, how will the shared understanding impact suicide prevention planning?

The Project Team and other organizations shared a large amount of suicide and suicide attempt data with the Advisory Board. There was ample time for questions, exploration, and discussion about the data. The needs assessment also included an abundance of data, bringing forth more questioning and conversation. Small group exploration and reviews led to additional shared understanding in the context of the county environment.

- Chart # 16 illustrates how most Advisory Board meetings resulted in a better understanding of suicide prevention and awareness efforts in Stanislaus County; by the last meeting in August

2019, 100% of the respondents agreed that they had a better understanding of both suicide prevention and awareness efforts.

The shared and increased understanding of suicide related data affected how Advisory Board members viewed suicide in Stanislaus County. This led to deeper investigation into the root causes of suicide, as well as an asset mapping and gap analysis of suicide related resources for the county. Prevention strategy recommendations were directly derived from the review of the data and led the Advisory Board to the data supported recommendations (also found and discussed on page 23):

- Align local interventions and prevention strategies to reach subpopulations identified in State and National data
- Strengthen prevention programs and interventions that focus on building positive relationships and coping strategies
- Strengthen the identification and support of people at risk through crisis intervention services and post-attempt treatment
- Increase communication about suicide and suicide risk factors
- Strengthen and increase suicide prevention through gatekeeper training
- Strengthen access and delivery of resources and services related to suicide through policy and training of service providers
- Create policies that promote protective environments and demonstrate that mental health is valued

Can a collaborative use data and combined information from multiple sources to develop a suicide prevention strategic plan that the community will support/embrace?

As stated previously, data was obtained and shared from multiple sources. The problem statement, vision, and mission were developed from the use of combined information. These elements coupled with the recommendations from the needs assessment, which were also based on data and information from multiple sources, ultimately led to the strategic plan strategy recommendations. Although the Advisory Board members adopted the strategic recommendations, it was during the last meeting and the strategic plan has not been formally completed. However, the needs assessment strategic recommendations were presented throughout the county in a variety of platforms and community members have shared their enthusiasm with the work done. Feedback was collected during these sessions/presentations and were very positive.

As discussed in the Common Agenda and Shared Measurements System sections, RBA and Clear Impact Scorecard served as catalysts in transforming ideas into strategies that can be utilized to form a strategic plan. This effort resulted in strategic recommendations and can be viewed by accessing this live embedded link to the Scorecard: ***Stanislaus County Suicide Prevention Scorecard*** (Also see Attachments #15a and 15b). Although the Scorecard is not fully updated with data, the link will eventually also allow community members and potential partners to review the work of the Suicide Prevention Advisory Board and suicide data, as well as monitor the County "Turning the Curve". Now that the Advisory Board membership has RBA capacity and champions, it is expected that the Scorecard can continue to be used for suicide prevention strategic planning and cross sector collaboration. It is highly recommended that additional stakeholders across multiple sectors be engaged to further the effort to utilize the Collective Impact model, RBA, and the Clear Impact Scorecard shared measurement system to develop the *Stanislaus County Suicide Prevention Strategic Plan*.

What methods are most effective in increasing suicide prevention awareness in Stanislaus County?

A variety of methods and strategies were shared, explored and researched throughout the Suicide Prevention Innovation Project. Throughout the asset mapping, gap analysis, and needs assessment process, it was clear that Stanislaus County has many assets, as well as areas of gaps. Because not all sectors were represented in the process, it is difficult to fully assess what is working and what is not, and it is evident that those sectors need to be at the table to help determine effective solutions. It also became clear that in order to determine what methods are most effective, exploring root causes is critical to effectively increase suicide prevention and awareness, not just addressing the symptoms. The contributing factors and secondary causes inform which populations can and should be targeted to increase suicide prevention awareness in Stanislaus County.

Several methods and activities were used to increase suicide prevention awareness during the Suicide Prevention Innovation Project:

- Suicide data sharing in the community through the Advisory Board members and publications
- *The 'S' Word* Documentary film screening and forum presented in the community at four locations to reach multiple regions and populations of the County
- Out of the Darkness Community Walk
- Suicide Prevention Symposium – Base Education
- Send Silence Packing – Active Minds Exhibit
- QRP Training held at Paradise Medical Office (Stanislaus County Office of Education)
- Participation in AFSP "Strike Out Suicide" bowling fundraiser
- Presentations of the Project, Collective Impact model, and suicide data and prevention information to community organizations, BHRS staff, and other agencies

All methods proved effective in different ways. As described in the Asset Mapping, there are three intervention levels – Universal (broad population), Selective (narrower targeted population), and Indicated (narrowest subpopulation that indicate signs). When attempting to increase suicide prevention awareness to the largest number of people, universal interventions and methods are most effective. This includes activities like "Out of the Darkness Community Walk", which was broadly advertised, open to anyone in Stanislaus County (and beyond), and highly attended. In 2019, the Walk attracted 109 walking teams and over 960 individuals. Since the event was covered by the media and all focused on suicide and suicide prevention, including stories, exhibits, and support, it was very effective in raising awareness to a large number of individuals.

The 'S' Word documentary film screening and forum represents a Selective Prevention intervention, which is intended to reach more targeted populations. Although open to the public, the screenings and forums were strategically presented in four different communities in Stanislaus County and co-sponsored by multiple entities. Two locations were reserved through a local school/district and were sponsored by Ceres Promotores and Catholic Charities. Both serve Hispanic/Latinos and Spanish speaking populations, which would attract cultural populations and those in the regions. Another was located at the West Modesto Collaborative Community Center in an area of high poverty, and sponsored by West Modesto Community Collaborative and NAMI. Communities in that neighborhood would be drawn to that event. The final location was the State Theater in Modesto, a large venue conducive to drawing populations near downtown and connected to education, prevention, and social services programs given that sponsorship was through Stanislaus County Office of Education, Prevention Programs, and Foster Youth Services Coordinating Program. With 440 attendees across the 4 sites, this event effectively raised awareness; although just 55 attendees completed a survey about the event, 97% felt that it did raise awareness about suicide prevention and available resources. Some comments included, "Suicide continues to be a taboo topic and if trainings

continue it will be a great benefit to our community" and "Thank you for bringing this valuable resource to Stanislaus County."

The Suicide Prevention Symposium was another Selective Prevention intervention. The event was targeted to adults working with youth (K - College), school personnel, youth support service providers, and program staff who engage or serve youth. Sponsored by Stanislaus County Student Mental Wellness Partnership/Stanislaus County Office of Education, the symposium offered training on identifying opportunities to engage youth and use of assessment and intervention tools by BASE Education (social/emotional learning); a suicide prevention panel with AFSP and NAMI; and resource information. Of the 31 attendees responding to a survey, 90% definitely learned more about suicide awareness efforts by attending the symposium. One attendee commented, "WOW...what a great presentation. It has offered insight and perspective about the challenges, complexity, and possibilities for intervention of suicide" and another, "I enjoyed the symposium. It truly was a great investment of the time. Thank you for organizing it. The speaker and the two testimonials added a lot more to the topic and understanding it better." The Project Team also distributed Suicide Prevention Toolkits to 43 sites following the Symposium; they included The 'S' Word Documentary DVD and The 'S' Word Screening Guide Education Edition booklets in both English and Spanish and on a USB drive. A total of 89 individuals learned about suicide prevention, the symposium effectively raising awareness.

Send Silence Packing was another example of a Selective Prevention intervention. Brought to the Modesto Junior College and California State University Stanislaus campuses through Active Minds, this awareness campaign raised awareness, connected attendees to mental health resources, and inspired action for suicide prevention. Co-sponsored by Stanislaus County Office of Education, it targeted college students, faculty, and staff, but was open to the public. Backpacks representing college students who have died by suicide were displayed all day on each of the two campuses, and resource booths were present. Volunteers for the events commented, "The visual display was very impactful. The pictures and stories on the backpacks were perfect and many students read many" and "I was glad I helped in this event because it raised more awareness." Foot traffic was moderate to high, depending on the time, but because it was an all-day event, there was plenty of opportunity to walk by and become aware of suicide prevention.

Other forms of effective suicide awareness include:

- Presentations of the Suicide Prevention Innovation Project to organizations and community groups
- Advisory Board members sharing data with their organizations/colleagues/group members
- Advisory Board members sharing the needs assessment documents:
    - *Stanislaus County Suicide Prevention Needs Assessment Executive Summary*
    - *Stanislaus County Suicide Prevention Needs Assessment*
    - *Stanislaus County Suicide Data Fact Sheet*

Throughout the Project period, an average of 57% of the Advisory Board members reported that they shared data, worked on a suicide awareness or prevention effort, and/or formed new partnerships or started new activities/interventions. They shared suicide data 86 times and worked on suicide awareness or prevention efforts 83 times. The *Stanislaus County Suicide Data Fact Sheet* in particular often sparked conversations, and all of these activities ultimately raised awareness.

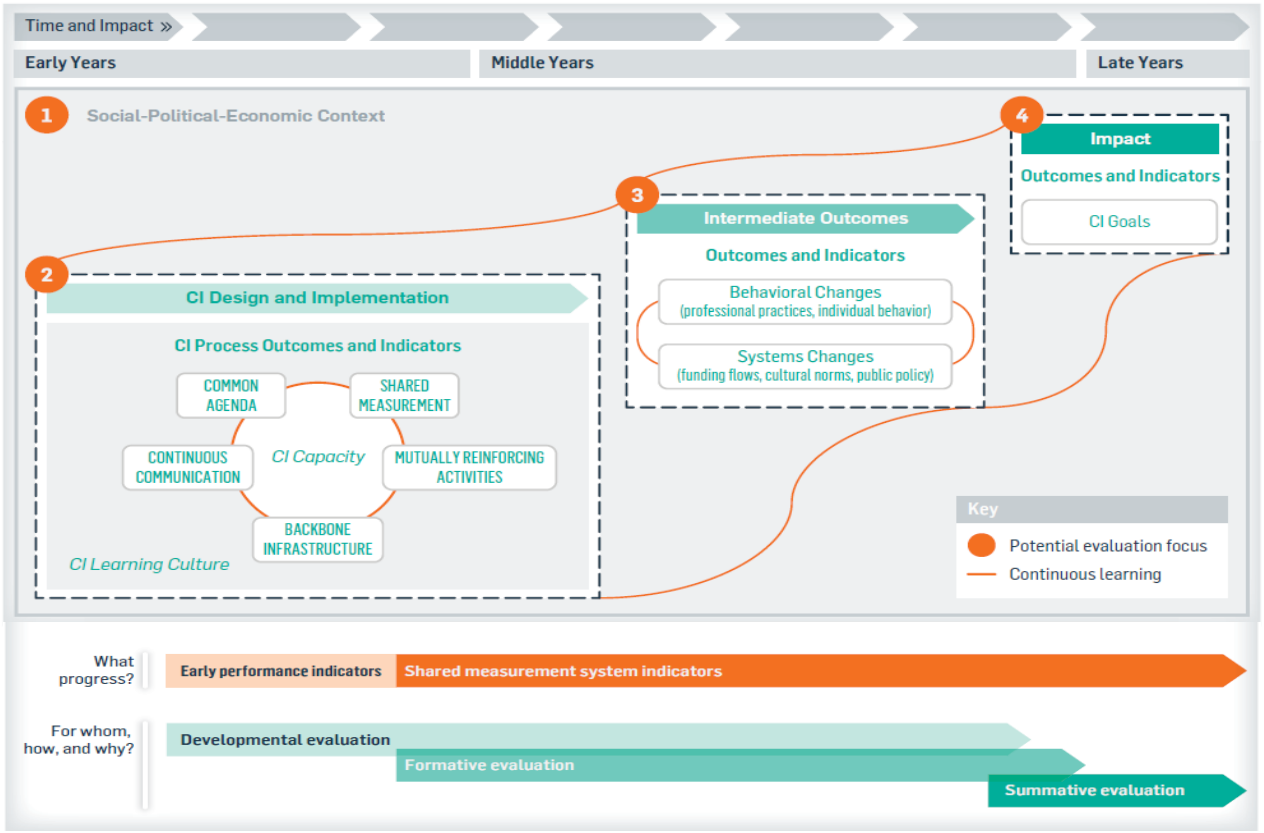
Once the Project participants begin to use the shared measurement system widely, there will be a stronger ability to show effective impact regarding suicide awareness and prevention efforts and the contribution they may make on the problem of suicide in Stanislaus County.

Will the collaborative's use of collective impact principles result in a decrease in the rate of suicide in Stanislaus County? Will specific demographic groups be impacted?

If the Advisory Board continues to use collective impact principles, it is expected that the collaborative work will ultimately result in a decrease in the rate of suicide in Stanislaus County. It is very important to recognize that this Suicide Prevention Innovation Project was a 3-year Project using the Collective Impact model as a framework to explore the issue of suicide through multiple perspectives, convening representatives from different agencies and interested parties across the community. Since collective impact work is intended to be used for deeply rooted and complex social problems, as illustrated in the needs assessment, the problem of suicide in Stanislaus County is not simple nor are the solutions. Below is a diagram of the phases of collective impact.[12] It is not a short-term effort and involves continuous learning and refinement. According to the model, the early years are usually years 1-3. As shared throughout this report, this Project is finishing the early years, and therefore the focus is on a developmental evaluation of the collective impact; it is about exploring and developing. The collective impact efforts are currently at a critical juncture crossing into the evolving and refinement stage of the "middle years", warranting formative evaluation. It is not until the "late years" that summative evaluation of Population Results are expected.

#27 Evaluation Framework for Collective Impact Efforts

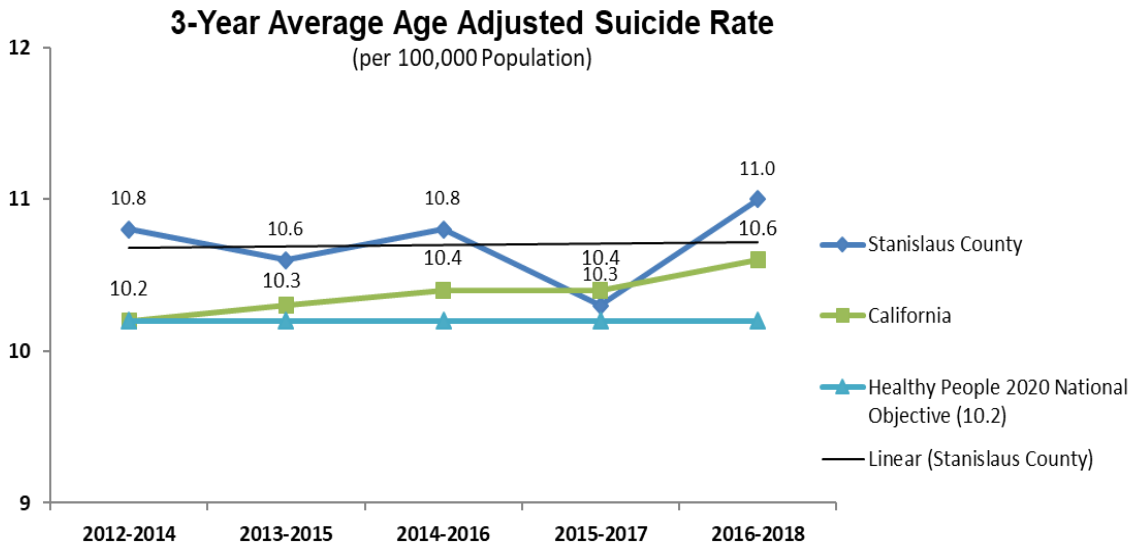
A Framework for Performance Measurement and Evaluation of Collective Impact Efforts



That being stated, the following charts present some updated population level data. It is fully expected that the late years of the collective impact efforts, should they continue to develop, will have a positive impact on decreasing the suicide rate in Stanislaus County. As described, it takes the work and multiple perspectives of organizations, agencies, groups, and communities to impact a complex social problem. If the work that this Suicide Prevention Innovation Project started continues, the expectation is that the suicide rate will decrease.

Below is a chart of the Age Adjusted Suicide Rate using a 3-year average. Note that these rates are rolling averages and are derived from the California Department of Public Health (CDPH) in order to have a consistent source for both Stanislaus County and California (a different source than the needs assessment). Stanislaus County's rate is higher than California's rate except for the 3-year period of 2015-2017. Although the rate looks substantially higher in the most recent time period, the trend line shows that it is trending upward just slightly. According to the CDPH data, Stanislaus County has also been consistently above the Healthy People 2020 target of 10.2. The Healthy People leading health indicator of "Reduce the suicide rate" is a subset of the National Objectives and selected to communicate high-priority health issues.[13]

#28 3-Yr Average Age Adjusted Suicide Rate

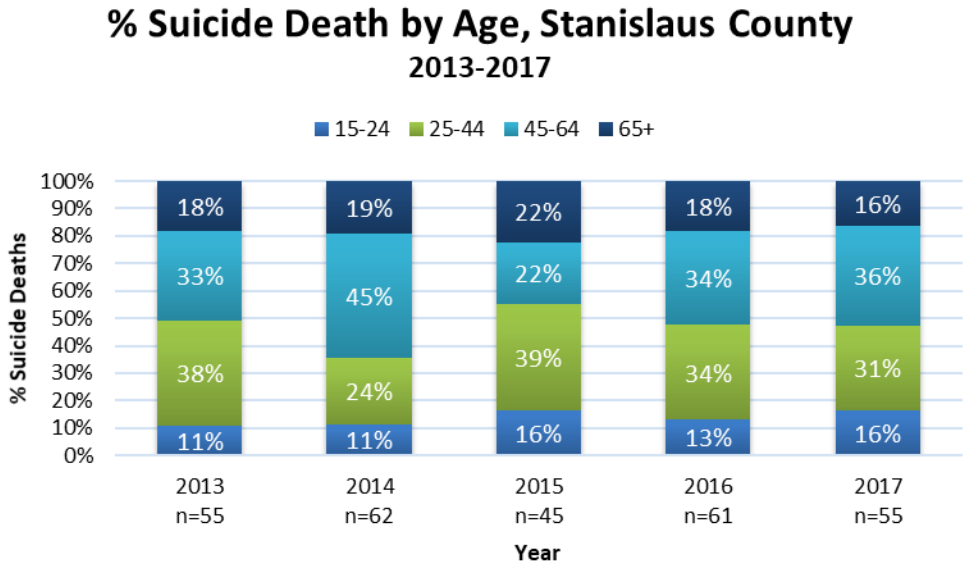


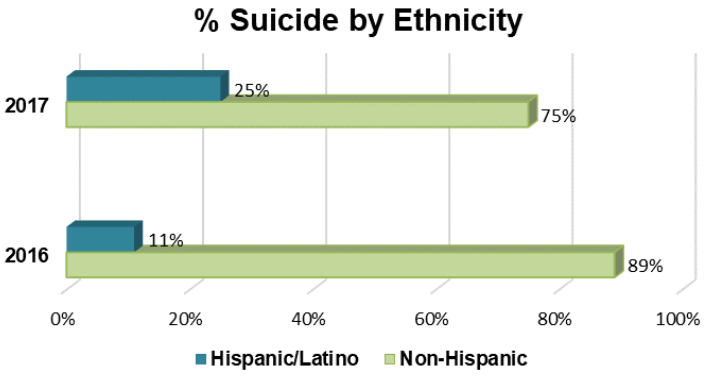
California Department of Public Health, *County Health Status Profiles,* 2016, 2017, 2018, 2019, 2020.

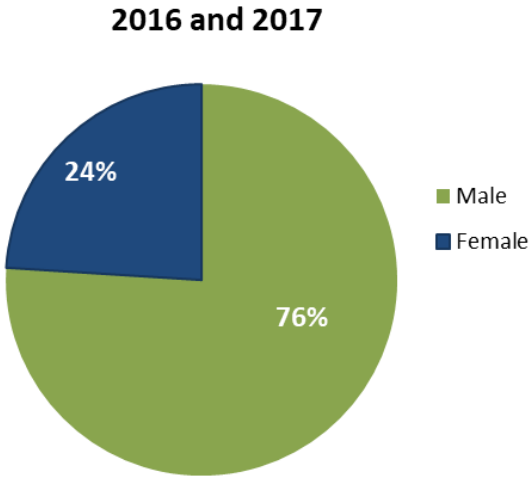
The next several charts illustrate some demographic information about suicides in the county.
When reviewing the percentage of suicides by age each year, it has been fairly consistent with a few exceptions in the earlier years. Likewise, the percentage of suicides by gender remained the same from 2016 to 2017. There was an increase in the percentage of Hispanic/Latino suicides from 2016 to 2017. When there are substantial changes in the total or when demographic group's percentage changes, indicated interventions for those demographics may be warranted.

In addition, the *Stanislaus County Suicide Prevention Needs Assessment 2018* identified subpopulations that are at high risk for suicide: individuals living in poverty or low socio-economic status; living with a mental illness or mental health problem; incarcerated; with previous suicide attempts; Veterans; who are homeless; and of sexual minority status. It will be important to track and monitor the intervention efforts of the collective impact group and any subsequent changes in suicide data. This is difficult to do on a local level since the data is not readily available, and is usually underreported or not reported at all.

#29 Suicide Demographic Charts







CDPH Vital Statistics Death Statistical Master Files
Prepared by: California Department of Public Health, Safe and Active Communities Branch

It will be important to use the Clear Impact Scorecard software to continue to track and monitor Stanislaus County suicide data and to also track the efforts of the multiple partners to recognize the differentiated but mutually reinforcing activities and how they are contributing to any changes in the suicide rate or changes in suicides of demographic groups.

EVALUATION RECOMMENDATIONS

One of the key factors in the multiple successful efforts of the Suicide Prevention Innovation Project was the use of the Collective Impact model, and especially dedicating a Backbone Organization and Project Team to the collective impact work. Throughout this report, many unique activities, events, and efforts were recognized. The Backbone Infrastructure of the collective impact efforts was critical to bringing the work all together in a structured and focused, yet flexible way.

The following are recommendations for this Project, but are also intended to be informative for other counties desiring to do this type of work to tackle a complex social problem.

- It is recommended that the collective impact initiative recruit and engage additional community members representative of other sectors and community groups (especially those often marginalized). In particular, the faith-based community, those with lived experience, and additional cultural representation are critical participants. Although some sectors and groups were initially invited, additional efforts must be made to ***engage*** and ***sustain*** participation from a broader slice of the community.

- Efforts should be made to welcome individuals, especially those personally affected by the issue, rather than just organization/agency representatives. Power imbalances must be recognized and space created for community members to "come to the table" and share their passion for being part of the solution to the problem. Ultimately, "It's the intersection of the collective actions of funders, participating organizations, and the people we serve that is the locus for true effective collective impact."[14]

- When starting work of this type, RBA and a system at least similar to Clear Impact Scorecard software should be utilized earlier in the process. The full and early benefits of a framework and structure are only realized if used early in the Project and may have saved time. The "Turning the Curve" questions and process could also assist in developing a strategic plan in a more efficiently structured and comprehensive way. For this particular Project, it will be critical to continue using RBA and the Scorecard to move forward.

- Tracking interventions intended to reach/serve each demographic group and high-risk population identified in the needs assessment (e.g., veterans, individuals living in poverty, individuals of sexual minority status) is recommended.

- It is recommended to be cautious when using local data for tracking and reporting subpopulation suicides. Percentages (decreases and increases) can be misleading when working with relatively small numbers (e.g., an increase of 50% could mean one individual in a subpopulation).

- It is important that a consistent source of data be used to track and report indicators. If using a threshold or target such as Healthy People 2020 National Objectives, it is critical that the

methodology used by the data source is the same as the target measurement. For example, Healthy People 2020 uses the per 100,000 age-adjusted rate (ICD-10 codes U03, X60-X84, Y87.0) from the National Vital Statistics System and the Bridged-race Population Estimates. The source that the collective impact initiative uses should be the same or the source should use the same methodology. If comparing to California data, it is recommended that the source be the same.

- Data sharing agreements are recommended to allow for cross-sector data use and analysis.
- It is critical that a stable Backbone Organization and Project Team/Infrastructure is sustained in some form. This is one of the essential components of collective impact success.
- Funding should be specifically allocated to the evaluation of the collective impact work on an ongoing basis. Although utilizing an internal evaluator can be beneficial (cost savings, availability, and interest), the challenges should be considered as well.
- As ongoing data collection, tracking, and monitoring is critical to the success of this Project and collective impact, dedicated resources are recommended to ensure this is occurring on a regular basis.
- If possible, a clear and sustainable funding source for all essential components of collective impact should be secured and shared with stakeholder to sustain interest and dedication.
- It is recommended that work continue to develop a formal *Stanislaus County Suicide Prevention Strategic Plan,* utilizing all of the previous work and documents developed, the Scorecard/strategic recommendations, as well as additional stakeholders as stated earlier.

CONTINUE THIS PROJECT UNDER A DIFFERENT FUNDING SOURCE?

While the Suicide Prevention Innovation Project as a learning Project will not continue, BHRS through its Prevention and Early Intervention (PEI) Program will continue implementing suicide prevention strategies. Strategies were identified in the strategic recommendations proposed in the Advisory Board's strategic planning process, which occurred May through August 2019.

Prior to completion of the Project, the Advisory Board was surveyed to gain buy in towards continuation of the board outside of BHRS taking the lead as was done during the Innovation Project. Member organizations were informed that the need for this would require whoever wished to take the lead to be the organizational support and/or backbone of suicide prevention efforts moving forward.

While no members or organizations that served as part of the Advisory Board were willing to make a commitment to convene, or provide backbone support to the same Advisory Board going forward, there was interest among the Advisory Board members to be informed about future planning efforts and opportunities to collaborate around specific suicide prevention strategy development initiatives that aligned to their organizational missions and activities.

The sentiment expressed from the Advisory Board members overall was gratitude for what the Project was able to accomplish in its Project time frame, but a recommendation that future planning efforts or what was referred to as a potential 'Phase 2' suicide prevention strategic planning effort for Stanislaus County, would be re-examined in the future after the Project concluded. Additionally, there was an expressed sentiment

that the Advisory Board members individually did not have the capacity at that time to take on a leadership role that could facilitate or convene a 'Phase 2' collaboration. It was also expressed that stakeholder composition of a future collaboration should consider adding other members and strategic partners for engagement from other sectors within the community that were not as active or present in the SPIP Advisory Board active membership.

BHRS plans to continue to explore and evaluate the need to establish a suicide prevention strategic planning coalition going forward as part of its Department strategic planning and 3-year planning initiatives. BHRS also plans to consider how to leverage the learning and recommendations from this Project and what additional support BHRS and other community partners can provide in a larger suicide prevention community planning effort.

MATERIALS DEVELOPED TO COMMUNICATE LESSONS LEARNED AND PROJECT RESULTS

This report and the other materials developed to communicate the Project results will be posted at www.stanislausmhsa.com. The following are the materials that can be viewed at that location:

- *Stanislaus County Suicide Prevention Needs Assessment 2018*
- *Stanislaus County Suicide Prevention Needs Assessment Executive Summary 2018*
- *Stanislaus County Suicide Prevention Needs Assessment Executive Summary 2018 – Spanish Version*
- *Stanislaus County Suicide Data Fact Sheet*
- *Stanislaus County Suicide Data Fact Sheet – Spanish Version*

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8. UCLA Center for Health Policy Research Health DATA Section 1: Asset Mapping. *Program,* https://healthpolicy.ucla.edu/programs/health-data/trainings/Documents/tw_cba20.pdf.

9. *Community Collaborative Assessment-A Diagnostic of Success Readiness.* https://www.serve.gov/new-images/council/pdf/community_collaborative_assessment.pdf, 2017.

10. Mattessich, Paul W. and Johnson, Kirsten M. *Collaboration: What Makes it Work 3rd Edition*, Fieldstone Alliance, 2018.

11. Clear Impact, *Results Based Accountability Guide.* 2016.

12. Preskill, Parkhurst, Marcie Parkhurst, and Jennifer Splansky Juster.

13. Office of Disease Prevention and Health Promotion, Healthy People 2020. https://www.healthypeople.gov/node/4804/data_details.

14. Duncan, Dan. "The Components of Effective Collective Impact." *Clear Impact*, 2016.

ATTACHMENTS

1. *Community Collaborative Assessment – A Diagnostic of Success Readiness*
2. *Wilder Collaboration Factors Inventory – Third Edition*
3. Advisory Board Meeting Survey
4.
    a. "Green Card"
    b. Tracking Matrix
5. Regional Asset Maps
6. County-wide Gap Analysis
7. Suicide Prevention Advisory Board Commitment form
8.
    a. *Stanislaus County Suicide Prevention Needs Assessment 2018*
    b. *Stanislaus County Suicide Prevention Needs Assessment 2018 Executive Summary-English version*
    c. *Stanislaus County Suicide Prevention Needs Assessment 2018 Executive Summary-Spanish version*
9. Sample Suicide Data presented to Advisory Board
10. Problem Statement Tools
    a. Meeting Activities Overview – Problem Statement and Common Agenda
    b. Small Group Problem Statement Worksheet
    c. Problem Statement Activity – Cards (Blank)
11.
    a. *Stanislaus County Suicide Data Fact Sheet/Communication Brief-English version*
    b. *Stanislaus County Suicide Data Fact Sheet/Communication Brief-Spanish*
12.
    a. *Community Collaborative Assessment-A Diagnostic of Success Readiness* – Administration #1
    b. *Community Collaborative Assessment-A Diagnostic of Success Readiness* – Administration #2
    c. *Community Collaborative Assessment-A Diagnostic of Success Readiness* – Administration #3
13. *Wilder Collaboration Factors Inventory* Results Summary
14. *The Results-Based Accountability Guide*
15.
    a. Stanislaus County Suicide Prevention Scorecard – Strategy Recommendations
    b. Stanislaus County Suicide Prevention Scorecard – Turn the Curve Details

Other Attachments – Advisory Board Annual Reports:

A. 2017 Suicide Prevention Advisory Board Annual Report
B. *2018 Suicide Prevention Advisory Board Annual Report*

Community Collaborative Assessment – A Diagnostic of Success Readiness

It looks like the countdown has begun. You have identified your community's most pressing issue, gathered a group eager to attack it, and now you are all ready to go. Or are you? This assessment will help you know whether your community fully understands the requirements and implications of forming a collaborative – *before* you start down a long and hard road.

Indeed, the essential purpose of this assessment is to improve the likelihood of creating significant impact against social problems that by definition have long been intractable. Though no community is ever completely ready to take on large-scale change, this checklist will assist you in identifying areas where you may need to do extra work, or just think some more. Ideally suited for organizations less than three years old, this assessment should nevertheless assist any collaborative that: 1) has just begun planning, or is in the early stages of rolling out its operations; 2) may be facing some challenges; or 3) is willing to revisit basic principles to ensure that it is maximizing its chances for success.

Who should use this assessment?

This readiness aid is for collaboratives that say "yes" to the following questions:

- Do we aim to effect "**needle-moving"** change (i.e., 10% or more) on a community-wide metric?
- Do we believe that **a long-term investment** (i.e., three to five-plus years) by stakeholders is necessary to achieve success?
- Do we believe that **cross-sector engagement** is essential for community-wide change?
- Are we committed to **using measurable data** to set the agenda and improve over time?
- Are we committed to **having community members as partners and producers** of impact?

For more information on any of these five components, please refer to the <Framework for Community Collaborative Introduction - Core Principles>.

How does it work?

This assessment contains two parts.

Part A: Develop the Idea < Building or Improving a Community Collaborative - Develop the Idea> will help you start out (or get refocused) by having you review your community's past experience with collaboratives, and by getting you to determine whether your answers to the questions above are truly affirmative. To do this, Part A poses a pair of critical questions:

- *Section* 1: How will our community's history with collaboratives influence our new collaborative work?
- *Section 2*: Do we have the core principles in place for a successful collaboration?

Part B: Plan & Align Resources < Building or Improving a Community Collaborative – Plan> and < Building or Improving a Community Collaborative – Align Resources> will support your collaboration's work after it has started. It helps you gauge how well you align with some common characteristics of successful collaborations. Again, this self-rating exercise entails answering two key questions:

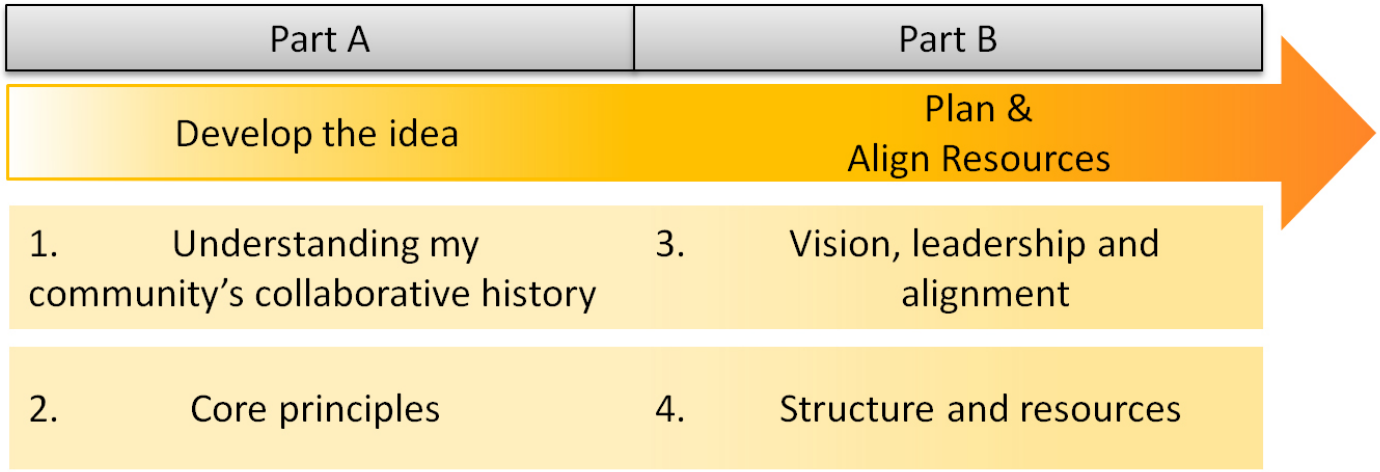
- *Section 3:* How well aligned and organized is our community?
- *Section 4:* Do we have the capacity and resources in place to be successful?

Though based on a continuum, both parts should be useful to virtually any collaborative, regardless of how long in operation.

Here's how the assessment works: Each section leads users through a series of key topics that are linked to statements. These statements reveal variations in readiness. Based on the selection of which statement you identify with, you will receive a score. That score, in turn, will give you a sense of your strengths and weaknesses on each topic. More than simply revealing areas of need, though, the assessment also provides related links to the Building or Improving a

Community Collaborative document, which offers guidance, checklists, case studies, best practices, resources and effective tools that can help you improve in each area and stage of development. Please refer to <Building or Improving a Community Collaborative > for this information.

The figure below illustrates the breakdown of this Assessment:



We have discovered that successful collaboratives share common characteristics. Yet, varying widely in approach and design, each is unique. This assessment acknowledges those differences while raising universal questions about how much forethought your team has put into mapping your collaborative's future. Here are some preliminary questions to ask yourself as you either start down that path or change direction:

- What is our collaborative's vision for the impact we want to achieve in five to 10 years?
- Is there anything we can or should do to strengthen our position before launching?
- How do the approaches and questions in this assessment resonate with our intentions and how do they not?

Part A: Develop the Idea

Section 1: How ready is my community for collaborative work?

Overview of Section 1: This section will allow you to evaluate your community's experiences with collaboration, its successes and challenges, now and in the past. It should also enable you to gain a deeper understanding of the community context within which you will be working (including how to assess the need for a new collaborative) and how to think about partnerships for change. For more information concerning this phase in the development of your collaborative, please refer to <Building or Improving a Community Collaborative - Develop the Idea>.

*Pick the statement in the rows marked A, B or C that best describes your community **over the past five years.** Each topic may require more than one row to cover adequately.*

Topic area	Statement A	Statement B	Statement C
History of collaboratives	My community has demonstrated interest in the issue we are trying to address (e.g., crime, dropouts) over the past five years through the mayor's office, community initiatives and in other ways.	Ideas have been generated for collaborative efforts on this issue, along with some early attempts, but no sustained collaborative efforts.	My community has not demonstrated interest in this type of work.
	My community has collaborated across sectors when necessary over the past five years (e.g., among nonprofit, government, business).	We have had conversations across sectors, but have not formally collaborated.	While we needed to collaborate across sectors, we were not able to do so (due to lack of either interest or capacity).
History of community engagement	My community has a strong history of citizen engagement (parents, small businesses, etc.) in community affairs.	My community has had some successes and some failures in engaging citizens.	We have not tried to engage.
	My community has a strong history of youth engagement in community affairs involving them.	My community has had some successes and some failures in engaging youth.	We have failed to engage youth.
Ecosystem of providers and collaboratives	Historically, a strong provider network (i.e. network of organizations) has focused on our issue.	We have a moderately strong provider community, but it is not very aligned.	We do not have a strong provider network focused on this issue.
	We have a clear need for our collaborative; no other effective collaboratives exist addressing this or related issues.	Similar collaborative efforts exist that we could join; but those collaboratives are only partially effective or only partially aligned on the issue.	We are not sure what else is happening in our community on this issue.
	The providers in my community are using evidence-based practices to address this issue.	Some providers use evidence-based practices; some do not.	Most providers do not use evidence-based practices, or are not familiar with evidence-based practices for this issue.
	Providers or funders have acted successfully as leaders in my community by convening peers and facilitating	Prior efforts have produced leadership that has gained mixed results.	No one has done work in this area, or the leaders of that work were unsuccessful.

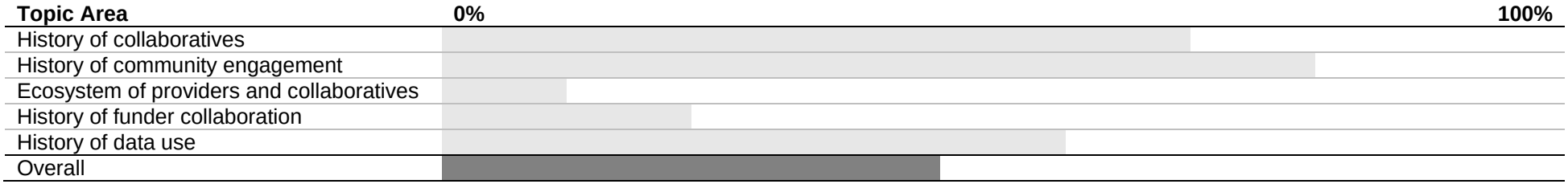
	collaborative conversations.		
	We have providers or funders that are respected and maintain a relatively neutral stance on the issue.	The providers or funders have won the respect of some, but not all.	We are not sure about the agendas of our providers or funders.
History of funder collaboration	Over the past five years, my local funder community has worked well together, collaborating many times.	We have seen some funder collaboration and organization.	Our funder community is not organized and has not collaborated in the past.
	Over the past five years, my community's funders have been aligned around a common set of goals about what to fund in my community.	Some funder alignment has occurred on what to fund.	There has been no funder alignment on what to fund.
History of data use	Over the past five years, our community has used data to examine, assess and create shared understanding of our challenges.	We have sometimes used data to create shared understanding of our challenges.	We have not used data to create shared understanding of our challenges.
	My community has tracked a set of indicators or outcomes related to the goals of my collaborative.	Some tracking is happening in my community, but it is in very early stages.	No data tracking is taking place.
	My community has used data to create actionable plans for the future and set the current agenda.	We sometime use the data we collect to influence our plans for the future.	Our plans are not determined by data.

Scoring Assessment

The following graph helps you to see how ready you are in each category. Where you have the least shading are areas that may make beginning your collaborative more challenging. It is important to take time to create plans to address these areas. Please refer to resources in <Building or Improving a Community Collaborative> and please consult the full list of resources at the end of this document for further information on any of the above topics.

ILLUSTRATIVE SCORING:

[Note on scoring methodology: For each Statement A you select, you will receive 3 points, for each Statement B you select, you will receive 2 points, for each Statement C, you will receive 1 point. The shading represents the percentage of points you have, out of the total potential number of points. The overall readiness for this area is a simple average of the above percentages.]



Section 2: Do we have the core principles in place for a successful collaboration?

Overview of Section 2: This section measures something that equates to a collaborative's ambition, resolve and realistic expectations. The last – expectations – involves a hardheaded understanding about who needs to be on board, how progress is to be measured in unarguable ways, and whether or not the community is genuinely ready and mobilized. We call these the core principles of success for collaboratives. To increase your odds, go back through the questions copied below.

- Do we aim to effect "**needle-moving"** change (i.e., 10% or more) on a community-wide metric?
- Do we believe that **a long-term investment** (i.e., three to five-plus years) by stakeholders is necessary to achieve success?
- Do we believe that **cross-sector engagement** is essential for community-wide change?
- Are we committed to **using measurable data** to set the agenda and improve over time?
- Are we committed to **having community members as partners and producers** of impact?

Is your collaborative adequately prepared, based on these principles? Answering the queries below will help you determine if you are. Pick the statement in the rows marked A, B and C that best describes your collaborative's perspectives on the core precepts. Again, the topics may require several rows of statements to cover.

Core principle	Statement A	Statement B	Statement C
Aspires to "needle-moving" change	Our collaborative aspires to needle-moving change: 10%-plus change from the baseline on our outcomes.	Some potential participants are committed to 10%-plus change from the baseline on our outcomes.	The issue is not on key leaders' radar screens; we do not have consensus yet.
	We have a clear sense of what the collaborative uniquely can add to our community and how we can partner with existing work.	We know what else is happening related to our issue and are figuring out how our work fits in.	We have not looked deeply at related work happening in our community.
	Our collaborative is focused on moving the entire community, city or region forward (i.e., graduation rates across the city).	We have only somewhat defined our boundaries. Or, our boundaries represent a subset of the community.	We have not defined our boundaries at all.
Long-term investment in success	Key stakeholders are committed to this work for the long-term (three to five-plus years).	Key stakeholders are committed to this work for at least the early phase of the work (i.e., one to two years); we are still building commitment for the long-term.	Key stakeholders have not defined how long they will remain committed.
	We have identified a key funder that has expressed interest in a long-term commitment (of three to five-plus years).	We have held exploratory conversations, but no funder has expressed an interest in long-term commitment.	We are still identifying potential funders.
Cross-sector engagement	We have multiple participants ready to support the collaborative from the sectors that are relevant to our issue area, (i.e., government, philanthropy, nonprofit, business and the like).	We have some, but not all, of the appropriate participants.	We are missing many of the relevant participants.

Data and continuous learning	We are committed to regularly using data that others or we collect in order to determine our direction and priorities.	Data will be a part of our work, but secondary to some other aspects of the collaborative's work	We do not plan to collect data as a part of our collaborative.
	We have a plan, now underway, for capturing and analyzing relevant data, considering the data as a group, and adjusting course based on the data.	We have a plan for how to capture relevant data, but we have not determined how to regularly incorporate it into our work.	We are in the process of developing a plan.
Community engagement	We have identified individuals from the community who should be involved in our collaborative process and have decided how they should be involved.	We are thinking about the engagement of key individuals, but don't know who to engage or how.	We have not thought about engagement beyond the institutional participants in our collaborative.
	Our leadership has established a process for gaining buy-in from relevant community members in our community (e.g., parents and youth).	We are developing a process to establish buy-in.	We are not going to develop a buy-in process.

Scoring Assessment

The following graph helps you to see how ready you are in each category. Where you have the least shading are areas where you are least ready. Please refer to resources in <Building or Improving a Community Collaborative> for general help with this section, <Community Collaboratives Learning Examples> for data and continuous learning help and <The Next Generation of Community Participation> for help with community engagement, and please consult the full list of resources at the end of this document for further information on any of the above topics.

ILLUSTRATIVE SCORING:

[Note on scoring methodology: For each Statement A you select, you will receive 3 points, for each Statement B you select, you will receive 2 points, for each Statement C, you will receive 1 point. The shading represents the percentage of points you have, out of the total potential number of points. The overall readiness for this area is a simple average of the above percentages.]

Core Principle	**0%**	**100%**
Aspires to "needle moving" change		
Long-term investment in success		
Cross-sector engagement		
Data and continuous learning		
Community engagement		
Overall		

Part B: Plan & Align Resources

Successful collaboratives share common characteristics:

The next two sections rate your adoption of and adherence to some proven success traits shared among collaboratives demonstrating best practices. How do you line up along these five characteristics of success?

1. **Shared vision and agenda:** Does our entire collaborative community have a shared vision, with milestones that will demonstrate our progress?
2. **Effective leadership and governance:** Do we have a clear leadership structure, with accountability systems built into place?
3. **Deliberate alignment of resources, programs and advocacy toward what works:** Have we identified programs and strategies with demonstrated effectiveness and aligned our resources to them?
4. **Dedicated capacity and appropriate structure:** Do we have the people (including a lead convener) to facilitate this work? Do we have the right staffing? How will we build the capacity of our collaborative in the future?
5. **Sufficient resources:** Do we have a long-term (three to five-plus year) plan for funding? Have we thought about how this can become sustainable?

As you complete these sections, ask yourself:

"For our collaborative, which of these characteristics are most important to have in our collaborative? Which are less important and why?"

***Section 3:* How aligned and organized is our community?**

Overview of Section 3: This section will help you assess your collaborative's alignment, organization and approach as you start to implement your work. This section will help you understand how ready you are to do that work. For more information concerning this phase in the development of your collaborative, please refer to <Building or Improving a Community Collaborative - Plan> and <Building or Improving a Community Collaborative - Align Resources>.

Pick the statement in each row A, B or C that best describes your collaborative's work on each of the common characteristics of success. Each characteristic may require several rows of statements to cover.

Characteristics of success	Statement A	Statement B	Statement C
Shared vision and agenda	The collaborative participants and broader community share a common vision for the future about the issue.	Parties have somewhat distinct visions about this issue in our community.	No one has clearly articulated vision statements for the community; the issue is not on people's minds.
	We have agreed upon a road map to guide how we will achieve community-wide change.	We do have a road map, but it is under development. Or, we have only reached partial agreement on our path.	We tried to create a road map, but there is no agreement.
	We have data metrics that match up with our goals and action plan.	We are not sure how to measure metrics to assess progress against the road map.	We do not plan to use data.
Effective leadership and governance	We have achieved buy-in from engaged community leaders around the collaborative's vision, road map and defined goals.	Some community leaders are engaged and have bought in.	We have gained very little engagement and little buy-in from community leaders.
	We currently have a respected, neutral leader at the head of our collaborative, who is able to convene and maintain a diverse collaborative.	Our leadership lacks some characteristics and skills required to convene and maintain the collaborative.	Our leadership lacks most of the necessary characteristics and skills to convene and maintain the collaborative.
Deliberate alignment of resources, programs and advocacy toward what works	We have engaged the full set of organizations and leaders that must be aligned to reach our goals.	We are missing some of the necessary organizations and leaders in our collaborative.	We are not sure if we have the right organizations and leaders at the table.
	We have researched similar efforts outside our community to identify effective strategies that we can adapt.	We have researched some effective strategies, but are unsure how to adapt them to our model.	We have not researched other similar efforts.
	Our roadmap specifies a complete set of interventions that logically lead to the changes we want to see.	Our roadmap includes only some of the interventions we believe are necessary for change; our roadmap is partially complete	We have not thought about how our interventions lead to the change we want to see; our roadmap is not completed at all.

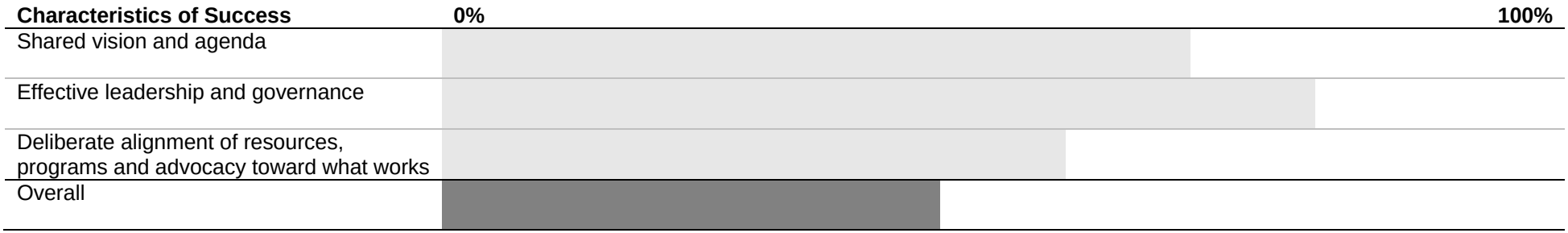
	Where applicable, we have advocacy efforts focused on changing the policies, funding and systems in our community to better address the issue.	We have a plan for how to create advocacy effectively.	We need advocacy in our community, but we have not thought about how to create it.

Scoring Assessment

The following graph helps you to see how ready you are in each category. Where you have the least shading are areas where you are least ready. Please refer to resources in <Building or Improving a Community Collaborative> to help with this section and please consult the full list of resources at the end of this document for further information on any of the above topics.

ILLUSTRATIVE SCORING:

[Note on scoring methodology: For each Statement A you select, you will receive 3 points, for each Statement B you select, you will receive 2 points, for each Statement C, you will receive 1 point. The shading represents the percentage of points you have, out of the total potential number of points. The overall readiness for this area is a simple average of the above percentages.]



***Section 4:* Do we have the capacity and resources in place to be successful?**

Overview of Section 4: This section will assist you in making an assessment of your collaborative's infrastructure and resources as you start your work.

Pick the statement in each row A, B or C that best describes your collaborative's work on these core characteristics. Several statement rows may be required to cover each.

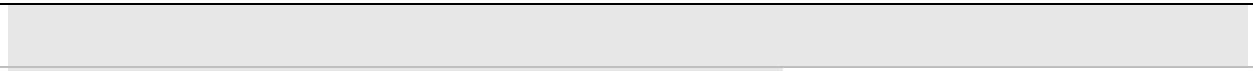
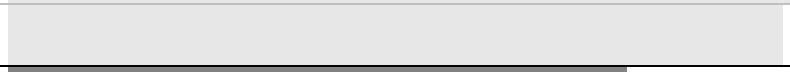
Characteristics of success	Statement A	Statement B	Statement C
Dedicated capacity and appropriate structure	We have a clear sense of the time and talent needed to run the collaborative itself (separate from participating organizations' capacity).	We have not considered what capacity is needed, but will in the future.	We do not plan to have dedicated capacity for the collaborative.
	We have identified paid staff who can help coordinate or facilitate the collaborative process.	We are not sure how to get paid staff.	We do not plan to have paid staff.
	We have clearly defined roles within the collaborative (such as a facilitator, data measurement specialist and so on).	We have some roles, but they are not explicitly defined.	We do not have clear roles.
	We have the necessary structure, processes and systems to support our work (committees, systems to analyze data and so on).	We have some of this in place.	We do not have any structures, processes or systems in place.
	Providers in my community have the capacity to come together and collaborate or partner.	Providers have some capacity, but not enough for our collaborative.	Providers have minimal capacity to come together and collaborate.
Sufficient resources	We have a clear sense of what it will take to fund our collaborative, including dedicated capacity, over the next five years.	We have estimates, but are not sure how to figure out what resources are required.	We do not have estimates yet.
	We have long-term financial commitments from funders to cover the dedicated capacity and collaborative work.	We have short-term commitments from funders.	We don't have any financial commitments.

Scoring Assessment

Please refer to resources in <Building or Improving a Community Collaborative> and <Community Collaboratives Learning Examples > to help with this section and please consult the full list of resources at the end of this document for further information on any of the above topics.

ILLUSTRATIVE SCORING:

[Note on scoring methodology: For each Statement A you select, you will receive 3 points, for each Statement B you select, you will receive 2 points, for each Statement C, you will receive 1 point. The shading represents the percentage of points you have, out of the total potential number of points. The overall readiness for this area is a simple average of the above percentages.]

Characteristics of Success	**0%**	**100%**
Dedicated capacity and appropriate structure		
Sufficient resources		
Overall		

Overall Score

ILLUSTRATIVE SCORING:

Your score on this assessment is intended to give you a sense of where you are in the collaborative life stages (please refer to <Community Collaboratives Learning Examples - Life Stage Map>). Armed with an understanding of what stage your collaborative is in, you can determine what is next for your collaborative and its partners. In addition, the individual sections of the assessment are intended to show you where your investments have paid off and you are making progress, and where you need to concentrate going forward. Your score on the assessment can be used to jump start conversations with collaborative partners and to "align resources" your efforts as you continue the hard work of collaboration.

[Note on scoring methodology: For each Statement A you select, you will receive 3 points, for each Statement B you select, you will receive 2 points, for each Statement C, you will receive 1 point. The shading represents the percentage of points you have, out of the total potential number of points. The overall readiness for this area is a simple average of the above percentages.]

Section of Assessment	**0%**	**100%**
Part A: Develop the Idea		
Part B: Plan & Align Resources		
Overall		

Overall, you have a [high, medium, low] level of readiness.

How to understand your score:

- If your score is high: Nice work!
  You are likely ready to successfully implement your plan. Use this assessment to understand your relative strengths and weaknesses, continuing to build your strengths and looking for ways to improve your weaknesses.
- If your score is medium: You have made significant progress!
  While you may be ready to begin implementing, it is important that you carefully consider the areas where you scored the lowest and address those by referencing relevant resources.
- If your score is low: You are on your way, but consider addressing the weaker areas before beginning!
  By now, you are likely well aware that needle-moving collaboratives require a significant investment of time and energy. Though you likely still have significant work to do before implementing, completing this assessment has put you on a path to understanding where to focus your efforts. Please consult the full set of resources below.

Regardless of how you scored on the assessment, the full list of resources below, organized by assessment section, will be helpful in continuing to strengthen your collaborative and extend its impact in your community.

Resources

Topic	Tool
Develop the Idea	
Ecosystem of providers and collaborative	<Source 55, Find Youth Community Assessment>
	<Source 54, NFVP Community Map>
	<Source 53, NFVP Plan>
	<Source 27, Ready by 21 Stakeholders Wheel>
	<Source 12, NLC Stakeholder Engagement>
Core Principles	
	<Source 7, NLC Youth Action Kit>
	<Source 42, McKinsey Public-Private Partnerships>
	<Source 78, Adaptive Problems>
Long-term investment in success	<Source 42, McKinsey Public-Private Partnerships>
	<Source 78, Adaptive Problems>
	<Source 6, NLC Gang Violence Prevention>
	<Source 13, NLC Vital Partners>
	<Source 14, NLC Violence Reduction Strategy>
	<Source 28, Ready by 21 Existing Efforts>
	<Source 42, McKinsey Public-Private Partnerships>
	<Source 53, NFVP Plan>
	<Source 85, Case Studies of Effective Collaboratives: Herkimer County Narrative>
	<Source 87, Case Studies of Effective Collaboratives: Boston Narrative>
	<Source 90, Case Studies of Effective Collaboratives: Chicago Narrative>
	<Source 92, Case Studies of Effective Collaboratives: Philadelphia Narrative>
	<Source 95, Case Studies of Effective Collaboratives: San Jose Narrative>
	<Source 8, NLC Evaluation Recommendations>
	<Source 9, NLC Municipal Action Guide>
	<Source 43, Charting Impact>
	<Source 84, Memphis C - Use of Data>
	<Source 86, Case Studies of Effective Collaboratives: Cincinnati, Covington, Newport Narrative - Use of Data>
	<Source 87, Case Studies of Effective Collaboratives: Boston Narrative - Use of Data>
	<Source 88, Case Studies of Effective Collaboratives: Parramore Narrative - Use of Data>
	<Source 90, Case Studies of Effective Collaboratives: Chicago Narrative - Use of Data>
	<Source 92, Case Studies of Effective Collaboratives: Philadelphia Narrative - Use of Data>
Community Engagement	<Source 2, Mobile Blueprint>
	<Source 53, NFVP Plan>
	<Source 55, Find Youth Community Assessment>

	<Source 72, America Speaks Voices and Choices>
	<Source 73, America Speaks Unified New Orleans>
	<Source 74, Keystone Feedback App>
	<Source 76, Civic Engagement Measure>
	<Source 79, Keystone Prospectus>
	<Source 80, 21st Century Constituency Voice>
	<Source 83, Keystone Constituency Voice Overview>
	<Source 84, Case Studies of Effective Collaboratives: Memphis Narrative - Community Engagement>
	<Source 88, Case Studies of Effective Collaboratives: Parramore Narrative - Community Engagement>
	<Source 89, Case Studies of Effective Collaboratives : Nashville Narrative - Community Engagement>
	<Source 91, Case Studies of Effective Collaboratives: Milwaukee Narrative - Community Engagement>
	<Source 92, Case Studies of Effective Collaboratives: Philadelphia Narrative - Community Engagement>
	<Source 93, Case Studies of Effective Collaboratives: San Joaquin County Narrative - Community Engagement>
	<Source 94, Case Studies of Effective Collaboratives: Atlanta Narrative - Community Engagement>
Plan	**Align Resources**
Vision, leadership, and alignment	
Shared vision and agenda	<Source 2, Mobile Blueprint>
	<Source 6, NLC Gang Violence Prevention>
	<Source 7, NLC Youth Action Kit>
	<Source 11, NLC Comprehensive Youth Strategies>
	<Source 13, NLC Vital Partners>
	<Source 14, NLC Violence Reduction Strategy>
	<Source 43, Charting Impact>
	<Source 53, NFVP Plan>
	<Source 77, Intended Impact / Theory of Change Tool>
	<Source 84, Case Studies of Effective Collaboratives: Memphis Narrative - Shared Vision>
	<Source 86, Case Studies of Effective Collaboratives: Cincinnati, Covington, Newport Narrative - Shared Vision>
	<Source 89, Case Studies of Effective Collaboratives: Nashville Narrative - Shared Vision>
	<Source 95, Case Studies of Effective Collaboratives: San Jose Narrative - Shared Vision>

Effective leadership and governance	<Source 7, NLC Youth Action Kit>
	<Source 13, NLC Vital Partners>
	<Source 14, NLC Violence Reduction Strategy>
	<Source 16, NLC City Leadership>
	<Source 46, Ready by 21 Leadership Audit>
	<Source 88, Case Studies of Effective Collaboratives: Parramore Narrative - Effective Leadership & Governance>
	<Source 89, Case Studies of Effective Collaboratives: Nashville Narrative - Effective Leadership & Governance>
	<Source 91, Case Studies of Effective Collaboratives: Milwaukee Narrative - Effective Leadership & Governance>
	<Source 95, Case Studies of Effective Collaboratives: San Jose Narrative - Effective Leadership & Governance>
Deliberate alignment of resources, programs and advocacy	<Source 2, Mobile Blueprint>
	<Source 11, NLC Comprehensive Youth Strategies>
	<Source 16, NLC City Leadership>
	<Source 25, Ready by 21 Leadership Update>
	<Source 26, Ready by 21 Leadership Capacity>
	<Source 43, Charting Impact>
	<Source 84, Case Studies of Effective Collaboratives: Memphis Narrative - Deliberate Alignment>
	<Source 87, Case Studies of Effective Collaboratives: Boston Narrative - Deliberate Alignment>
	<Source 88, Case Studies of Effective Collaboratives: Parramore Narrative - Deliberate Alignment>
	<Source 90, Case Studies of Effective Collaboratives: Chicago Narrative - Deliberate Alignment>
Structure and resources	
Dedicated capacity and appropriate structure	<Source 2, Mobile Blueprint>
	<Source 6, NLC Gang Violence Prevention>
	<Source 13, NLC Vital Partners>
	<Source 16, NLC City Leadership>
	<Source 27, Ready by 21 Stakeholders Wheel>
	<Source 28, Ready by 21 Existing Efforts>
	<Source 43, Charting Impact>
	<Source 46, Ready by 21 Leadership Audit>
	<Source 84, Case Studies of Effective Collaboratives: Memphis Narrative - Dedicated Capacity & Appropriate Structure>
	<Source 86, Case Studies of Effective Collaboratives: Cincinnati, Covington, Newport Narrative - Dedicated Capacity & Appropriate Structure>

	<Source 89, Case Studies of Effective Collaboratives: Nashville Narrative - Dedicated Capacity & Appropriate Structure>
	<Source 90, Case Studies of Effective Collaboratives: Chicago Narrative - Dedicated Capacity & Appropriate Structure>
	<Source 91, Case Studies of Effective Collaboratives: Milwaukee Narrative - Dedicated Capacity & Appropriate Structure>
	<Source 92, Case Studies of Effective Collaboratives: Philadelphia Narrative - Dedicated Capacity & Appropriate Structure>
	<Source 94, Case Studies of Effective Collaboratives: Atlanta Narrative - Dedicated Capacity & Appropriate Structure>
	<Source 95, Case Studies of Effective Collaboratives: San Jose Narrative - Dedicated Capacity & Appropriate Structure>
Sufficient resources	<Source 16, NLC City Leadership>
	<Source 85, Case Studies of Effective Collaboratives: Herkimer County Narrative - Sufficient Resources>
	<Source 86, Case Studies of Effective Collaboratives : Cincinnati, Covington, Newport Narrative - Sufficient Resources>
	<Source 89, Case Studies of Effective Collaboratives : Nashville Narrative - Sufficient Resources>
	<Source 94, Case Studies of Effective Collaboratives: Atlanta Narrative - Sufficient Resources>
	<Source 95, Case Studies of Effective Collaboratives: San Jose Narrative - Sufficient Resources>

The Wilder Collaboration Factors Inventory

Name of Collaboration Project _____ Date _____

Statements about Your Collaborative Group:

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
History of collaboration or cooperation in the community	1. Agencies in our community have a history of working together.	1	2	3	4	5
	2. Trying to solve problems through collaboration has been common in this community. It has been done a lot before.	1	2	3	4	5
Collaborative group seen as a legitimate leader in the community	3. Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	1	2	3	4	5
	4. Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	1	2	3	4	5
Favorable political and social climate	5. The political and social climate seems to be "right" for starting a collaborative project like this one.	1	2	3	4	5
	6. The time is right for this collaborative project.	1	2	3	4	5
Mutual respect, understanding, and trust	7. People involved in our collaboration trust one another.	1	2	3	4	5
	8. I have a lot of respect for the other people involved in this collaboration.	1	2	3	4	5
Appropriate cross section of members	9. The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	1	2	3	4	5
	10. All the organizations that we need to be members of this collaborative group have become members of the group.	1	2	3	4	5
Members see collaboration as being in their self-interest	11. My organization will benefit from being involved in this collaboration.	1	2	3	4	5
Ability to compromise	12. People involved in our collaboration are willing to compromise on important aspects of our project.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Members share a stake in both process and outcome	13. The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	1	2	3	4	5
	14. Everyone who is a member of our collaborative group wants this project to succeed.	1	2	3	4	5
	15. The level of commitment among the collaboration participants is high.	1	2	3	4	5
Multiple layers of participation	16. When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	1	2	3	4	5
	17. Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	1	2	3	4	5
Flexibility	18. There is a lot of flexibility when decisions are made; people are open to discussing different options.	1	2	3	4	5
	19. People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	1	2	3	4	5
Development of clear roles and policy guidelines	20. People in this collaborative group have a clear sense of their roles and responsibilities.	1	2	3	4	5
	21. There is a clear process for making decisions among the partners in this collaboration.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Adaptability to changing conditions	22. This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership.	1	2	3	4	5
	23. This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	1	2	3	4	5
Appropriate pace of development	24. This collaborative group has been careful to take on the right amount of work at the right pace.	1	2	3	4	5
	25. This group is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	1	2	3	4	5
Evaluation and continuous learning	26. A system exists to monitor and report the activities and/or services of our collaboration.	1	2	3	4	5
	27. We measure and report the outcomes of our collaboration.	1	2	3	4	5
	28. Information about our activities, services, and outcomes is used by members of the collaborative group to improve our joint work.	1	2	3	4	5
Open and frequent communication	29. People in this collaboration communicate openly with one another.	1	2	3	4	5
	30. I am informed as often as I should be about what is going on in the collaboration.	1	2	3	4	5
	31. The people who lead this collaborative group communicate well with the members.	1	2	3	4	5
Established informal relationships and communication links	32. Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	1	2	3	4	5
	33. I personally have informal conversations about the project with others who are involved in this collaborative group.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Concrete, attainable goals and objectives	34. I have a clear understanding of what our collaboration is trying to accomplish.	1	2	3	4	5
	35. People in our collaborative group know and understand our goals.	1	2	3	4	5
	36. People in our collaborative group have established reasonable goals.	1	2	3	4	5
Shared vision	37. The people in this collaborative group are dedicated to the idea that we can make this project work.	1	2	3	4	5
	38. My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	1	2	3	4	5
Unique purpose	39. What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	1	2	3	4	5
	40. No other organization in the community is trying to do exactly what we are trying to do.	1	2	3	4	5
Sufficient funds, staff, materials, and time	41. Our collaborative group has adequate funds to do what it wants to accomplish.	1	2	3	4	5
	42. Our collaborative group has adequate “people power” to do what it wants to accomplish.	1	2	3	4	5
Skilled leadership	43. The people in leadership positions for this collaboration have good skills for working with other people and organizations.	1	2	3	4	5
Engaged stakeholders	44. Our collaborative group engages other stakeholders, outside of the group, as much as we should.	1	2	3	4	5

SUICIDE PREVENTION INNOVATION PROJECT ADVISORY BOARD

The Advisory Board is an essential part of the Suicide Prevention Innovation Project. It is very important for the project's success to evaluate the effectiveness of the Advisory Board's regularly scheduled meetings. This survey will take approximately 5-10 minutes to complete, and we would appreciate your feedback. We encourage you to be candid – your responses will be completely confidential.

1. I am attending this meeting as the:
   - ◯ Primary representative of my organization
   - ◯ Alternate representative of my organization
   - ◯ Other (please specify): _____

2. My current ***primary*** role in the organization I am representing is (choose only one):
   - ◯ Direct Service Staff / Provider
   - ◯ Supervisor / Manager / Coordinator
   - ◯ Consumer
   - ◯ Director / CEO
   - ◯ Volunteer
   - ◯ I am not representing an organization
   - ◯ Other (please specify): _____

3. Please rate your agreement with the following statements regarding ***this meeting***.

	Strongly **Disagree**	Disagree	Neither Agree nor Disagree	Agree	Strongly **Agree**
The meeting purpose was ***clear*****.**	◯	◯	◯	◯	◯
The meeting purpose was ***achieved*****.**	◯	◯	◯	◯	◯
The meeting was a ***good investment*** of time.	◯	◯	◯	◯	◯
Everyone had an opportunity to ***participate*** in the meeting.	◯	◯	◯	◯	◯
The ***facilitation*** of the meeting was effective**.**	◯	◯	◯	◯	◯
The ***organization*** of the meeting was effective.	◯	◯	◯	◯	◯

4. Please rate your agreement with the following statements regarding your experience during ***this meeting***.

	Strongly **Disagree**	Disagree	Neither Agree nor Disagree	Agree	Strongly **Agree**
I ***actively participated*** in the meeting (e.g., asked questions, provided information, etc.)**.**	◯	◯	◯	◯	◯
I have a better understanding of suicide ***prevention*** efforts in Stanislaus County because of this meeting.	◯	◯	◯	◯	◯
I have a better understanding of suicide ***awareness*** efforts in Stanislaus County because of this meeting.	◯	◯	◯	◯	◯
I have a better understanding of suicide ***data*** because of this meeting.	◯	◯	◯	◯	◯

Please continue on back

5. Please rate your agreement with the following statements regarding aspects of collaboration during ***this meeting***.

	Strongly **Disagree**	Disagree	Neither Agree nor Disagree	Agree	Strongly **Agree**
Members were ***prepared*** for this meeting.	◯	◯	◯	◯	◯
Members shared ***responsibility and accountability*** for the success of this meeting.	◯	◯	◯	◯	◯
There was a sense of ***trust*** amongst members.	◯	◯	◯	◯	◯
There was a sense of ***cohesiveness*** amongst members.	◯	◯	◯	◯	◯

6. Please indicate your satisfaction with the accomplishments achieved during ***this meeting***.

◯Very Dissatisfied ◯Dissatisfied ◯Neither Dissatisfied nor Satisfied ◯Satisfied ◯Very Satisfied

Please feel free to provide additional feedback as it relates to the Advisory Board meetings.

Positive Feedback:

Opportunities for Improvement:

Please feel free to provide additional feedback as it relates to the Suicide Prevention Innovation Project.

Positive Feedback:

Opportunities for Improvement:

Thank you very much for your participation!

Suicide Prevention Innovation Project Tracking Matrix

Attachment 4A

Data Sharing and Collaboration Evaluation

Suicide Prevention Advisory Board Responses Collected in April 2018

Organization / Community	Outside of the Advisory Board, have you shared or used any suicide data?	Outside of the Advisory Board, have you worked with others regarding suicide awareness and/or prevention?	Is this a new partner/partnership?	Is this a new activity/intervention?
Total of **YES** Response				

Meeting Attendance: ##

Total Number of Responses: #

Total Number of No Response Submitted: ##

* Response Submissions

In Meeting Responses: #

Outside of Meeting Responses: 0

Organization / Community: _____

Outside of the Advisory Board meetings, have you shared or used any suicide data? No ☐ Yes ☐

Please describe (e.g., when, with whom, context):

_____

_____

_____

_____

Organization / Community: _____

Outside of the Advisory Board meetings, have you shared or used any suicide data? No ☐ Yes ☐

Please describe (e.g., when, with whom, context):

_____

_____

_____

_____

Organization / Community: _____

Outside of the Advisory Board meetings, have you shared or used any suicide data? No ☐ Yes ☐

Please describe (e.g., when, with whom, context):

_____

_____

_____

_____

Organization / Community: _____

Outside of the Advisory Board meetings, have you shared or used any suicide data? No ☐ Yes ☐

Please describe (e.g., when, with whom, context):

_____

_____

_____

_____

Outside of the Advisory Board meetings, have you worked with others regarding suicide awareness and/or prevention?

No ☐ Yes ☐

Please describe (e.g., when, with whom, context):

Is this a new partner/partnership? No ☐ Yes ☐

Is this a new activity/intervention? No ☐ Yes ☐

Outside of the Advisory Board meetings, have you worked with others regarding suicide awareness and/or prevention?

No ☐ Yes ☐

Please describe (e.g., when, with whom, context):

Is this a new partner/partnership? No ☐ Yes ☐

Is this a new activity/intervention? No ☐ Yes ☐

Outside of the Advisory Board meetings, have you worked with others regarding suicide awareness and/or prevention?

No ☐ Yes ☐

Please describe (e.g., when, with whom, context):

Is this a new partner/partnership? No ☐ Yes ☐

Is this a new activity/intervention? No ☐ Yes ☐

Outside of the Advisory Board meetings, have you worked with others regarding suicide awareness and/or prevention?

No ☐ Yes ☐

Please describe (e.g., when, with whom, context):

Is this a new partner/partnership? No ☐ Yes ☐

Is this a new activity/intervention? No ☐ Yes ☐

Stanislaus County Suicide Prevention Asset Map

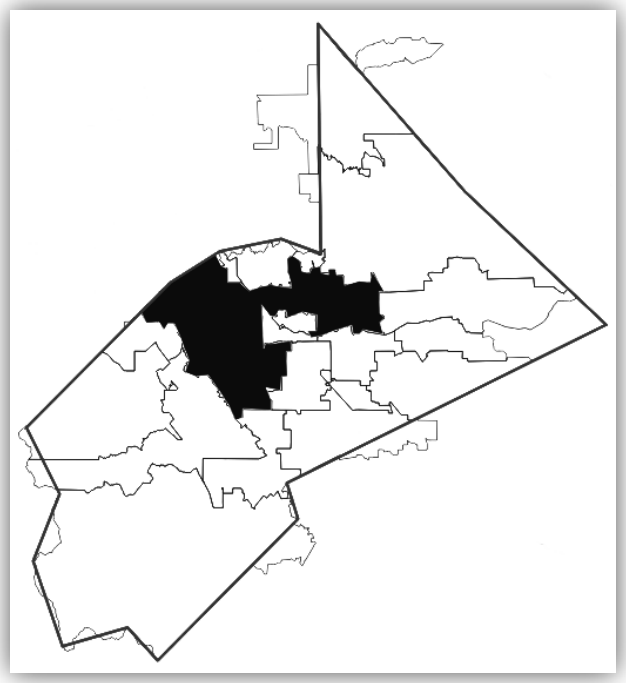
Region 1: Central

Prevention Spectrum	Asset Name	Asset	Sector
Universal	None		
Selective	*Congregation Beth Shalom, The Center for Jewish Life in Stanislaus County: Counseling/Referrals*	Prevention *(+Protective/-Risk)*	Faith-Based
Selective	*Golden Valley Health Centers: Family Medicine Services*	Prevention *(+Protective/-Risk)*	Health
Selective	*Golden Valley Health Centers: Health Education Services*	Prevention *(+Protective/-Risk)*	Health
Selective	*Golden Valley Health Centers: Women's Health Services*	Prevention *(+Protective/-Risk)*	Health
Selective	*Modesto Junior College: Health Education and Health Counseling*	Training/Capacity Building	Education
Selective	*Stanislaus County Health Services Agency: McHenry Medical Office*	Prevention *(+Protective/-Risk)*	Government
Indicated	*Modesto Junior College: Medical Services*	Prevention *(+Protective/-Risk)*	Education
Indicated	*Modesto Junior College: Mental Health Referrals*	Prevention *(+Protective/-Risk)*	Education
		Total Assets	**8**

Note: *County-wide assets are also available in this region; refer to the* ***County-wide Suicide Prevention Asset Map*** *for details.*

Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016).*
Total suicide deaths are an average of 2013-2015 data.

The asset map is a tool to assist in the strategic planning process.



Region 1 Demographics

Central: Modesto (portions), Outlying Areas

Zip Code(s): 95350, 95355, 95357, 95358

Region deaths by suicide are **proportionate** to the region population, as evident by the data below.

Percentage of Total County Population: 29.4%

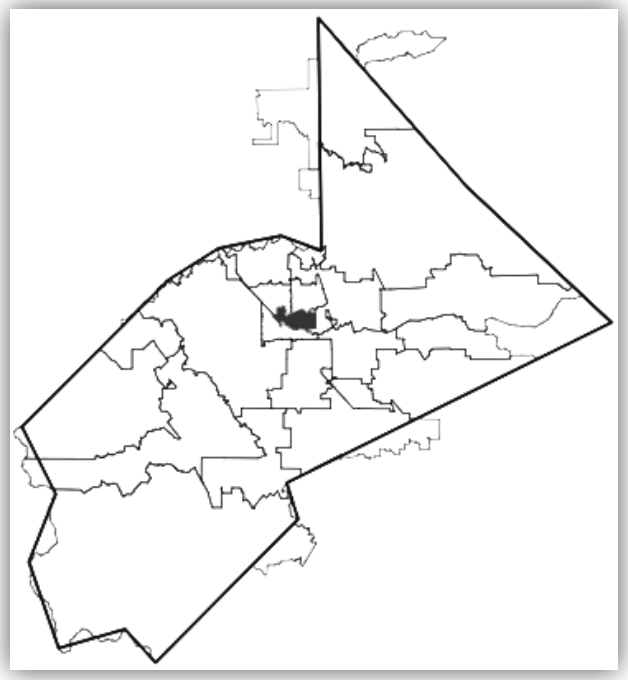
Percentage of Total Deaths by Suicide: 30.5% (n=15)

Stanislaus County Suicide Prevention Asset Map

Region 2: East Central

Prevention Spectrum

	Asset Name	Asset	Sector
Universal	None		
Selective	*Congregation Beth Shalom, The Center for Jewish Life in Stanislaus County: Counseling/Referrals*	Prevention *(+Protective/-Risk)*	Faith-Based
	Golden Valley Health Center: Behavioral Health Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Family Medicine Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Health Education Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Women's Health Services	Prevention *(+Protective/-Risk)*	Health
Indicated	None		
		Total Assets	**5**



Region 2 Demographics

East Central: Airport Neighborhood, East Modesto (portions)

Zip Code(s): 95354

Region deaths by suicide are **disproportionately high** relative to the region population, as evident by the data below.

Percentage of Total County Population: 4.7%

Percentage of Total Deaths by Suicide: 8.6% (n=4)

Note: *County-wide assets are also available in this region; refer to the* ***County-wide Suicide Prevention Asset Map*** *for details.*

Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016). Total suicide deaths are an average of 2013-2015 data.*

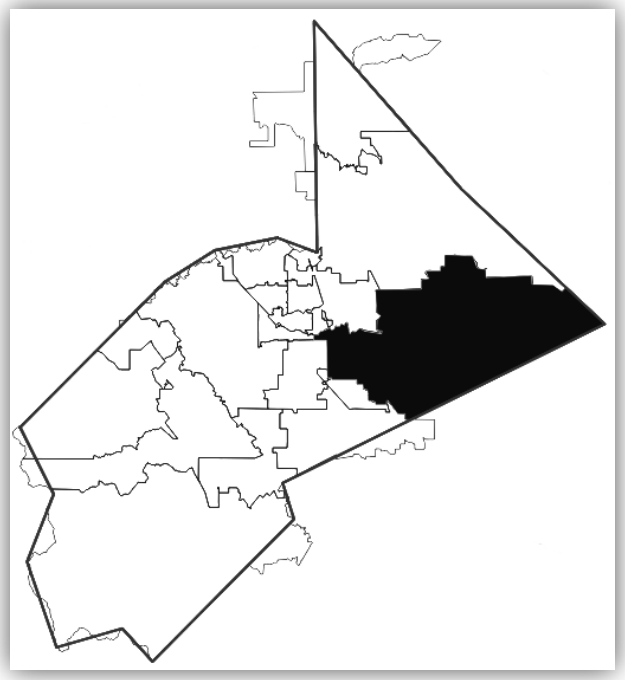
The asset map is a tool to assist in the strategic planning process.

Stanislaus County Suicide Prevention Asset Map

Region 3: Southeast Side

Prevention Spectrum

	Asset Name	Asset	Sector
Universal	None		
Selective	*Livingston Community Health: Behavioral Health*	Prevention *(+Protective/-Risk)*	Health
	Livingston Community Health: Urgent Needs/Chronic Disease	Prevention *(+Protective/-Risk)*	Health
	Sierra Vista Family & Children Services: Hughson Family Resource Center	Prevention *(+Protective/-Risk)*	Community Based Organization
	Stanislaus County Health Services Agency: Hughson Medical Office	Prevention *(+Protective/-Risk)*	Government
Indicated	*Livingston Community Health: Women's Health SUPER MAMA Program*	Prevention *(+Protective/-Risk)*	Health
		Total Assets	**5**



Region 3 Demographics

Southeast Side: Denair, Empire, Hughson, Hickman, La Grange, Waterford

Zip Code(s): 95316, 95319, 95326, 95323, 95329, 95386

Region deaths by suicide are **proportionate** relative to the region population, as evident by the data below.

Percentage of Total County Population: 6.2%

Percentage of Total Deaths by Suicide: 6.0% (n=3)

Note: *County-wide assets are also available in this region; refer to the* ***County-wide Suicide Prevention Asset Map*** *for details.*

Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016).*
Total suicide deaths are an average of 2013-2015 data.

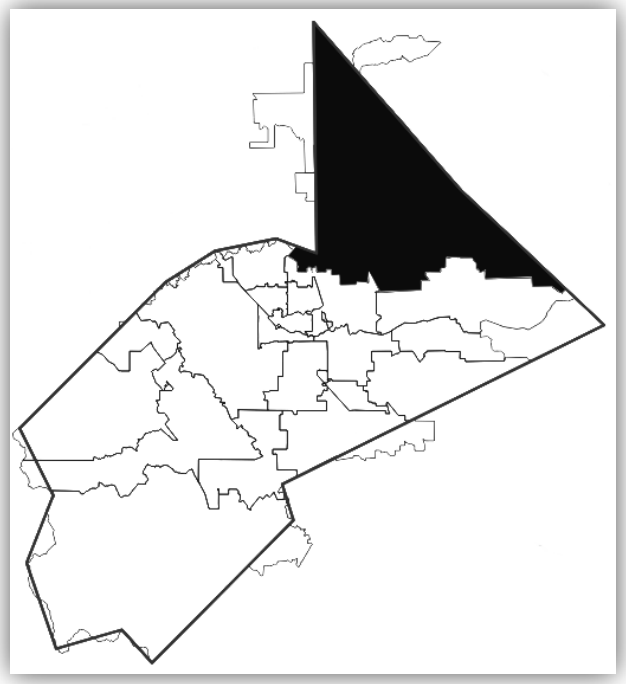
The asset map is a tool to assist in the strategic planning process.

Stanislaus County Suicide Prevention Asset Map

Region 4: Northeast Side

Prevention Spectrum

	Asset Name	Asset	Sector
Universal	None		
Selective	*Center for Human Services: Promotores/Community Health Outreach Workers*	Awareness/Promotion Training/Capacity Building Prevention *(+Protective/-Risk)*	Community Based Organization
	Dry Creek Community Church	Prevention *(+Protective/-Risk)*	Faith-Based
	Golden Valley Health Center: Family Medicine Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Health Education Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Women's Health Services	Prevention *(+Protective/-Risk)*	Health
	Oakdale Rescue Mission	Prevention *(+Protective/-Risk)*	Faith-Based
Indicated	*None*		
		Total Assets	**8**



Region 4 Demographics

Northeast Side: Knights Ferry, Valley Home, Oakdale, Riverbank

Zip Code(s): 95230, 95361, 95367

Region deaths by suicide are **disproportionately low** relative to the region population, as evident by the data below.

Percentage of Total County Population: 11.0%

Percentage of Total Deaths by Suicide: 6.0% (n=3)

Note: *County-wide assets are also available in this region; refer to the* ***County-wide Suicide Prevention Asset Map*** *for details.*

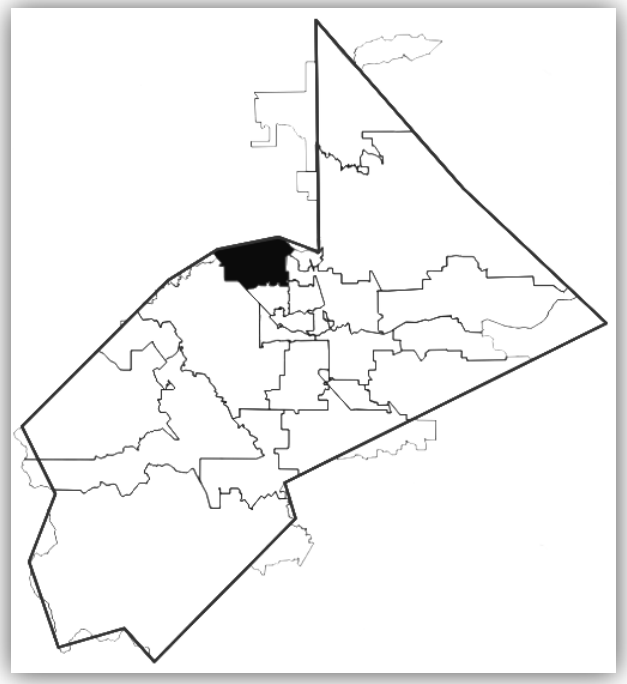
Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016).*
Total suicide deaths are an average of 2013-2015 data.

The asset map is a tool to assist in the strategic planning process.

Stanislaus County Suicide Prevention Asset Map

Region 5: North Side

Prevention Spectrum	Asset Name	Asset	Sector
Universal	None		
Selective	*Congregation Beth Shalom, The Center for Jewish Life in Stanislaus County: Counseling/Referrals*	Prevention *(+Protective/-Risk)*	Faith-Based
Selective	*Sierra Vista Children & Family Services: North Modesto Family Resource Center; Services/Support*	Prevention *(+Protective/-Risk)*	Community Based Organization
Indicated	*None*		
		Total Assets	**2**



Region 5 Demographics

North Side: Del Rio, Salida, Modesto (portions)

Zip Code(s): 95356, 95368

Region deaths by suicide are **disproportionately high** relative to the region population, as evident by the data below.

Percentage of Total County Population: 8.9%

Percentage of Total Deaths by Suicide: 11.9% (n=6)

Note: *County-wide assets are also available in this region; refer to the* ***County-wide Suicide Prevention Asset Map*** *for details.*

Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016).*
Total suicide deaths are an average of 2013-2015 data.

The asset map is a tool to assist in the strategic planning process.

Stanislaus County Suicide Prevention Asset Map

Region 6: Southwest Central

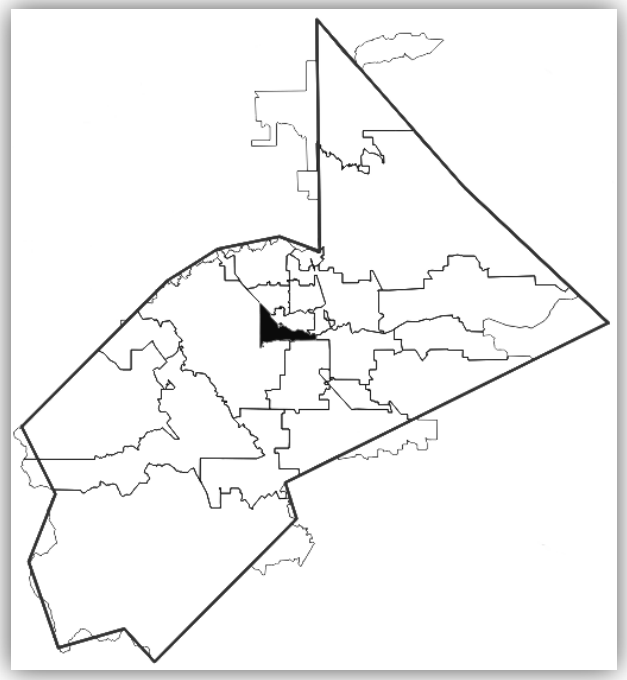
Prevention Spectrum

	Asset Name	Asset	Sector
Universal	None		
Selective	*Congregation Beth Shalom, The Center for Jewish Life in Stanislaus County: Counseling/Referrals*	Prevention *(+Protective/-Risk)*	Faith-Based
	Golden Valley Health Center: Behavioral Health Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Internal Medicine Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Pediatric Services	Prevention *(+Protective/-Risk)*	Health
	West Modesto Community Collaborative (WMCC)	Awareness/Promotion Prevention *(+Protective/-Risk)*	Community Based Organization
	WMCC: Community Capacity Building	Training/Capacity Building	Community Based Organization
	WMCC: WMCC Junior High Wellness Project	Training/Capacity Building Prevention *(+Protective/-Risk)*	Community Based Organization
	WMCC: Neighborhood Outreach and Engagement	Awareness/Promotion Prevention *(+Protective/-Risk)*	Community Based Organization
	WMCC: Promotores Neighborhood Outreach Workers	Awareness/Promotion Training/Capacity Building Prevention *(+Protective/-Risk)*	Community Based Organization
Indicated	*West Modesto Community Collaborative: Zephyr Clarke Wellness Center*	Prevention *(+Protective/-Risk)*	Community Based Organization
		Total Assets	**15**

Note: *County-wide assets are also available in this region; refer to the* ***County-wide Suicide Prevention Asset Map*** *for details.*

Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016).*
Total suicide deaths are an average of 2013-2015 data.

The asset map is a tool to assist in the strategic planning process.



Region 6 Demographics

Southwest Central: West Modesto, South Modesto

Zip Code(s): 95351

Region deaths by suicide are **disproportionately high** relative to the region population, as evident by the data below.

Percentage of Total County Population: 9.3%

Percentage of Total Deaths by Suicide: 10.6% (n=5)

Stanislaus County Suicide Prevention Asset Map

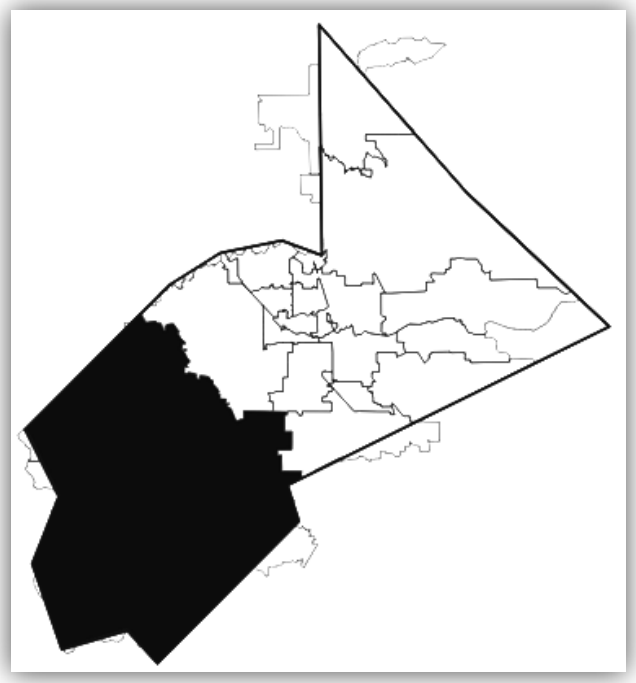
Region 7: West Side

Prevention Spectrum	Asset Name	Asset	Sector
Universal	None		
Selective	*Center for Human Services: Promotores/Community Health Outreach Workers*	Awareness/Promotion Training/Capacity Building Prevention *(+Protective/-Risk)*	Community Based Organization
	Golden Valley Health Center: Behavioral Health Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Family Medicine Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Health Education Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Pediatric Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Women's Health Services	Prevention *(+Protective/-Risk)*	Health
	Livingston Community Health: Behavioral Health	Prevention *(+Protective/-Risk)*	Health
	Livingston Community Health: Urgent Needs/Chronic Disease	Prevention *(+Protective/-Risk)*	Health
Indicated	*Livingston Community Health: Women's Health SUPER MAMA Program*	Prevention *(+Protective/-Risk)*	Health
		Total Assets	**11**

Note: *County-wide assets are also available in this region; refer to the* ***County-wide Suicide Prevention Asset Map*** *for details.*

Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016).*
Total suicide deaths are an average of 2013-2015 data.

The asset map is a tool to assist in the strategic planning process.



Region 7 Demographics

West Side: Crows Landing, Grayson, Newman, Patterson

Zip Code(s): 95313, 95360, 95363, 95385, 95387

Region deaths by suicide are **disproportionately low** relative to the region population, as evident by the data below.

Percentage of Total County Population: 7.6%

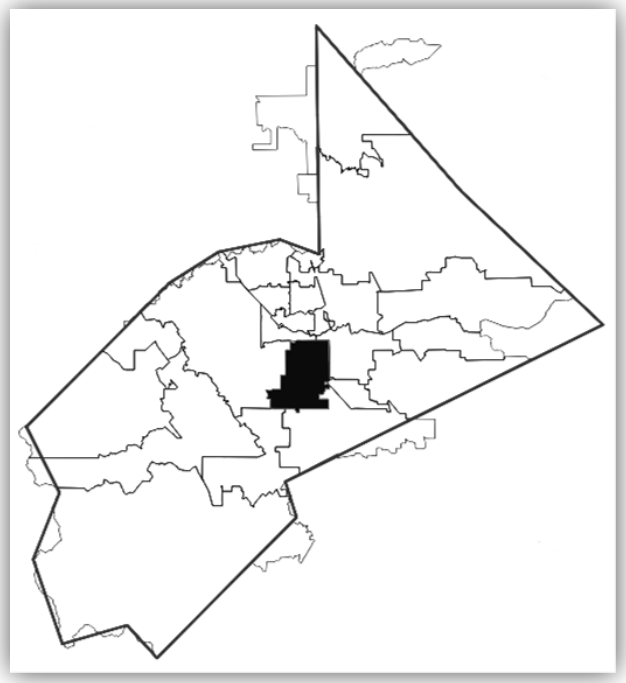
Percentage of Total Deaths by Suicide: 5.3% (n=3)

Stanislaus County Suicide Prevention Asset Map

Region 8: South Central

Prevention Spectrum

	Asset Name	Asset	Sector
Universal	None		
Selective	*Center for Human Services: Promotores/Community Health Outreach Workers*	Awareness/Promotion Training/Capacity Building Prevention *(+Protective/-Risk)*	Community Based Organization
	Golden Valley Health Center: Family Medicine Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Health Education Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Women's Health Services	Prevention *(+Protective/-Risk)*	Health
	Stanislaus County Health Services Agency: Ceres Medical Office	Prevention *(+Protective/-Risk)*	Government
Indicated	None		
		Total Assets	**7**



Region 8 Demographics

South Central: Ceres, Keyes

Zip Code(s): 95307, 95328

Region deaths by suicide are **disproportionately high** relative to the region population, as evident by the data below.

Percentage of Total County Population: 9.0%

Percentage of Total Deaths by Suicide: 8.6% (n=4)

Note: *County-wide assets are also available in this region; refer to the* ***County-wide Suicide Prevention Asset Map*** *for details.*

Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016).*
Total suicide deaths are an average of 2013-2015 data.

The asset map is a tool to assist in the strategic planning process.

Stanislaus County Suicide Prevention Asset Map

Region 9: South Side

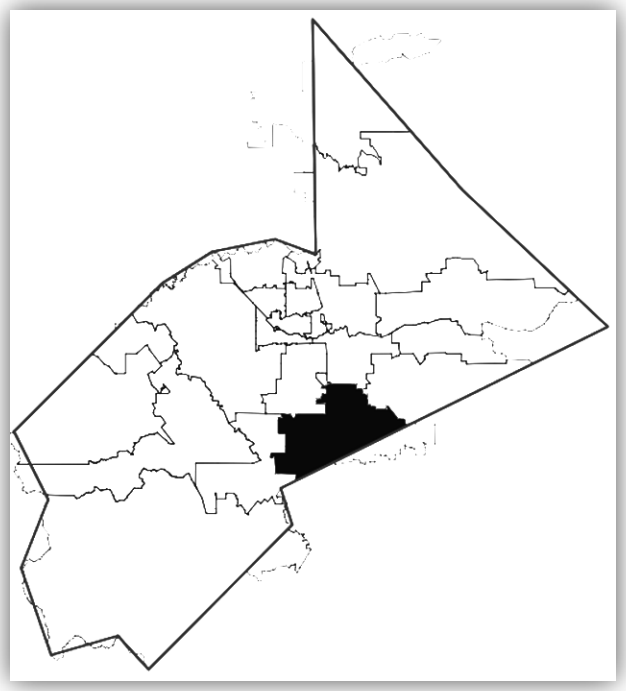
Prevention Spectrum

	Asset Name	Asset	Sector
Universal	None		
Selective	*ASPIRAnet: Turlock Family Resource Center; Services/Support*	Prevention *(+Protective/-Risk)*	Community Based Organization
	*California State University Stanislaus(**CSUS**): Behavioral Intervention Team*	Awareness/Promotion Prevention *(+Protective/-Risk)* Training/Capacity Building	Education
	Center for Human Services: Promotores/Community Health Outreach Workers	Awareness/Promotion Training/Capacity Building Prevention *(+Protective/-Risk)*	Community Based Organization
	Golden Valley Health Center: Family Medicine Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Health Education Services	Prevention *(+Protective/-Risk)*	Health
	Golden Valley Health Center: Women's Health Services	Prevention *(+Protective/-Risk)*	Health
	Livingston Community Health: Behavioral Health	Prevention *(+Protective/-Risk)*	Health
	Livingston Community Health: Urgent Needs/Chronic Disease	Prevention *(+Protective/-Risk)*	Health
	Stanislaus County Health Services Agency: Turlock Medical Office	Prevention *(+Protective/-Risk)*	Government
Indicated	***CSUS:** PEER Project of Stanislaus State*	Awareness/Promotion Prevention *(+Protective/-Risk)*	Education
	***CSUS:** Psychological Counseling Services* (PCS)	Prevention *(+Protective/-Risk)*	Education
	Livingston Community Health: Women's Health SUPER MAMA Program	Prevention *(+Protective/-Risk)*	Health
		Total Assets	**17**

Note: *County-wide assets are also available in this region; refer to the **County-wide Suicide Prevention Asset Map** for details.*

Data Source: *EpiCenter Population Data (2015); SCHSA Suicide Death Data (2016).*
Total suicide deaths are an average of 2013-2015 data.

The asset map is a tool to assist in the strategic planning process.



Region 9 Demographics

South Side: Turlock

Zip Code(s): 95380, 95382

Region deaths by suicide are **disproportionately low** to the region population, as evident by the data below.

Percentage of Total County Population: 14.9%

Percentage of Total Deaths by Suicide: 12.6% (n=6)

STANISLAUS COUNTY

Attachment 6

County-Wide Asset Map Gap Analysis	Universal	Selective	Indicated
NOTE: *Assets unique to a particular region are not represented as "County-wide" and not included below. The data provided below is based only on assets available county-wide (i.e. available to all 9 County regions).*			
Community Sector: CBO / Non-Profits / Philanthropy / Neighborhood Organizations			
• Outreach - Awareness - Universal Promotion and Prevention - Reduce Stigma			
• Funding - Human Capital - Physical Space			
• Capacity Building - Trainings			
• Prevention Services (increase protective factors and/or reduce risk factors)			
• Policy/Systems Change			
Community Sector: Education			
• Outreach - Awareness - Universal Promotion and Prevention - Reduce Stigma			
• Funding - Human Capital - Physical Space			
• Capacity Building - Trainings			
• Prevention Services (increase protective factors and/or reduce risk factors)			
• Policy/Systems Change			
Community Sector: Faith			
• Outreach - Awareness - Universal Promotion and Prevention - Reduce Stigma			
• Funding - Human Capital - Physical Space			
• Capacity Building - Trainings			
• Prevention Services (increase protective factors and/or reduce risk factors)			
• Policy/Systems Change			
Community Sector: Government			
• Outreach - Awareness - Universal Promotion and Prevention - Reduce Stigma			
• Funding - Human Capital - Physical Space			
• Capacity Building - Trainings			
• Prevention Services (increase protective factors and/or reduce risk factors)			
• Policy/Systems Change			
Community Sector: Health			
• Outreach - Awareness - Universal Promotion and Prevention - Reduce Stigma			
• Funding - Human Capital - Physical Space			
• Capacity Building - Trainings			
• Prevention Services (increase protective factors and/or reduce risk factors)			
• Policy/Systems Change			

Color Key

>10 Assets
4-9 Assets
1-3 Assets
0 Assets

Total Number of County-wide Assets: 137

Note: *The County-wide Gap Analysis is a tool to assist in the strategic planning process. The outcome of the strategic planning process will be a County-wide Suicide Awareness and Prevention Plan.*

DRAFT

Created 08.01.2017

Stanislaus County Suicide Prevention Advisory Board Member Commitment

I, _____, as a member of the Stanislaus County Suicide Prevention Advisory Board commit to:

Common Agenda:

- Collectively define the problem
- Create a shared vision of change to solve the problem

Shared Measurement

- Collect data and track progress in a consistent way
- Share in accountability among fellow members and stakeholders
- Allow for continuous improvement and learning

Mutually Reinforcing Activities

- Implement differentiated approaches
- Contribute to the *Stanislaus County Suicide Prevention Strategic Plan*
- Build trust and relationships among fellow members and stakeholders

Continuous Communication

- Share updates, data and progress on approaches and strategies being implemented within my organization, agency or community
- Regularly contribute to meaningful participation at Board meetings
- Make every effort to attend meetings
- If unable to attend, the designated alternate will attend
- Regularly provide project updates to the designated alternate

_____ _____

Signature Date

_____

Print Name

_____

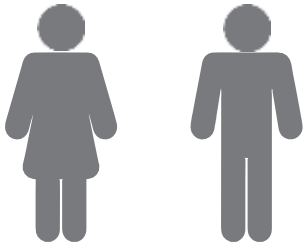
Agency/Organization/Community

Collective impact brings people together, in a structured way, to achieve social change.

Stanislaus County At A Glance

Attachment 8A

Total Population: **530,561**



51% Female

49% Male

Population by Ethnicity
56% Non-Hispanic and 44% Hispanic

Median Household Income
$51,591

Unemployment Rate
13.8%

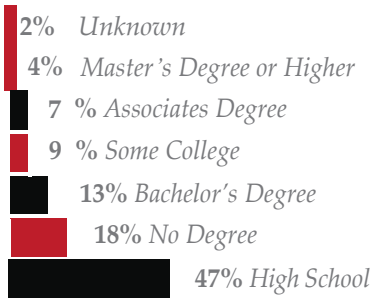
Veteran Population
6.1% of residents 18 years or older

Homeless Population
1,661**

American Community Survey, Stanislaus County 5yr Estimate 2012 - 2016 **Point-In-Time County Survey Stanislaus County, 2017

2016 Suicide Death Data

Education Attainment of 2016 Suicide Deaths

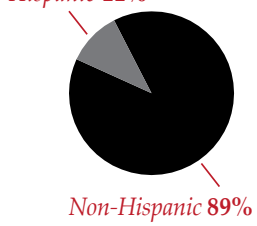


Gender:

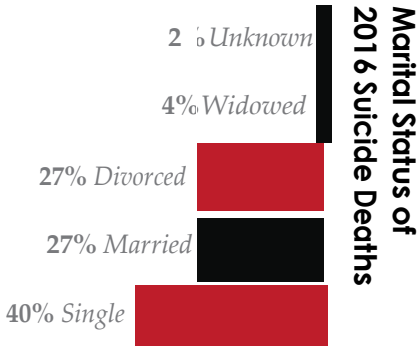
24% Female

76% Male

Ethnicity:



Marital Status of 2016 Suicide Deaths



Suicide Data

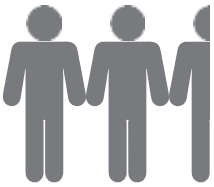
Suicide death demographic data describes suicide deaths by gender, age group, race, county region, educational attainment, marital status, veteran status and cause in Stanislaus County. These data points represent the years of 2013 through 2015. The age-adjusted rate of suicide death is also given and compared against the State rate and the National Healthy People 2020 objective.

Suicide Data Limitations

Limited access to protected health information can make determining the intent (intentional or unintentional) of an overdose / poisoning death difficult. California Assembly Bill 2119 which began January 1, 2017, allows for the Coroner / Medical Examiner to have full access to a decedent's health record, including mental health records in order to more accurately determine the manner of death. This policy change could have an impact on the number of overdose/poisoning deaths being ruled by intentional (suicide).

More Stanislaus County residents die by suicide than by homicide

55 Total Suicide Deaths 2016



25 Total Homicide Deaths 2016

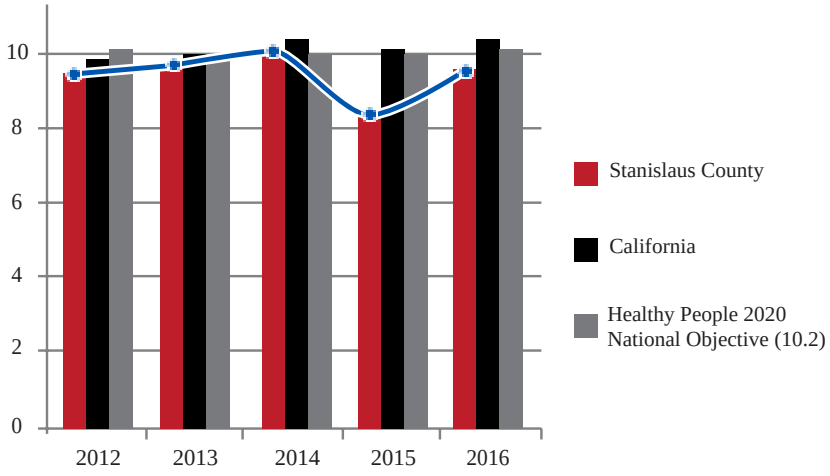
Vital Records Business Intelligence System (2016). Stanislaus County death data retrieval: January 1, 2016 through December 31, 2016.

Suicide Death Data Trends

Suicide Data

Age Adjusted Suicide Rate 2012-2016

Per 100,000 Population

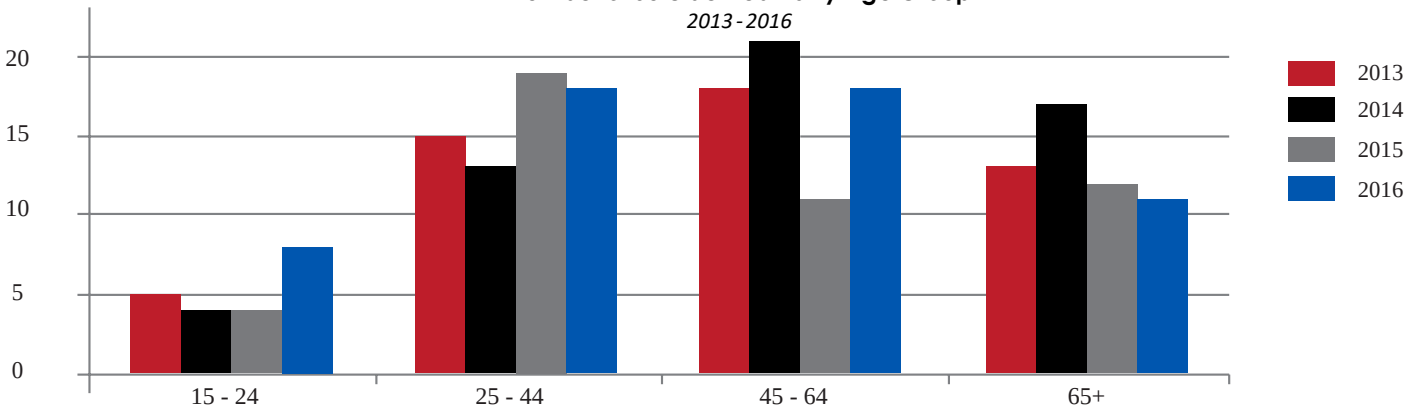


- Age adjusted rate calculations accounts for differences in a population's age distribution.
- The decrease in suicide rate for 2015 can be attributed to a slight decrease in the total number of deaths. Although it appears to show a dramatic decrease, it reflects a **difference of 9 fewer suicide deaths during 2015 than in 2014 and 2016.**
- While the total number of suicide deaths in 2014 and 2015 are the same (55), the age adjusted rate fluctuates because of the change in county population.

Suicide Data

Number of Suicide Deaths By Age Group

2013 - 2016



Vital Records Business Intelligence System (2016). Stanislaus County death data retrieval: January 1, 2016 through December 31, 2016.

Suicide Related Data

California State University Stanislaus (CSUS) Students Reported

1 in 14	Seriously Considered Suicide
1 in 23	Intentionally Injured Themselves
1 in 110	Attempted Suicide

(American College Health Association, National College Health Assessment II; Stanislaus State University Executive Summary, Spring 2016; Spring 2016 Reference Group Executive Summary)

Stanislaus County Youth Reported

1 in 3	Felt Chronic Sadness & Hopelessness.
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(West Ed., California Healthy Kids Survey, Stanislaus County Secondary 2014-2015 Main report; 7th [n=5,273], 9th [n=3,939], 11th [n=3,324], Non-traditional [n=684])

Suicide Related Data

Suicide Attempt Data

Suicide attempt data represents the total number of emergency department visits or hospitalizations that occur as the result of a non-fatal self-inflicted injury. Gender, age group, race and cause are also included in this data. The age-adjusted rate of suicide attempts in Stanislaus County is compared against state and national rates. The total number of suicide attempts is calculated as a sum of emergency department visits and hospitalizations resulting from a non-fatal self-inflicted injury (suicide attempt).

Suicide Attempt Data Limitations

Suicide attempt data only captures non-fatal self-inflicted injuries that resulted in an emergency department visit or hospitalization. The actual number of suicide attempts may be greater than reported.

Suicide Attempt Data 2014

Non-Fatal Emergency Department Visits: **725**

Non-Fatal Hospitalizations: **234**

AGE

33% Age 25-44	**35%** Age 45-65
23% Age 45-64	**32%** Age 25-44
20% Age 15-19	**12%** Age 15-19

Race / Ethnicity

64% White	**67%** White
25% Hispanic	**20%** Hispanic

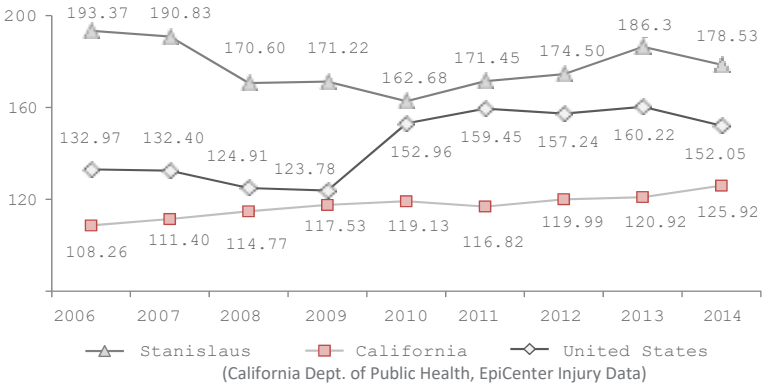
Type of Injury

57% Poisoning	**79%** Poisoning
29% Cut/Pierce	**15%** Cut/Pierce

62% Female **38%** Male **61%** Female **39%** Male

California Department of Public Health (2018). EpiCenter: Stanislaus County self-inflicted non-fatal injuries, 2014. Retrieved from http://epicenter.cdph.ca.gov/Default.aspx

Age Adjusted Rate per 100,000 Population
Non-Fatal Self-Inflicted Injuries Resulting in a Hospitalization or Emergency Dept. Visit, 2014



(California Dept. of Public Health, EpiCenter Injury Data)

An observational retrospective-prospective cohort study published August 2016, was used to gain more accurate estimates of suicide prevalence among suicide attempters.

The study found that **scheduling a follow-up psychiatric appointment** upon discharge from an emergency department or hospital after an initial suicide attempt, appeared to be **highly protective and reduced the risk of a subsequent completed suicide.** The scheduled follow-up appointment was still found to be highly protective **even if the individual did not keep or show for the appointment.**
(Bostwick et.al, 2016).

The Cost of Suicide in California
$4,784,903,000
Combined medical and work loss cost, 2013

NCHS Vital Statistics System for number of deaths; NEISS All Injury Program operated by the U.S. Consumer Product Safety, 2018)

Suicide attempts **cost Stanislaus County an estimated $11,368,000** in combined medical and work loss costs during 2014. However, costs are calculated on known suicide attempts and **may actually be much higher.**

(n=959)
NCHS Vital Statistics System for number of deaths; NEISS All Injury Program operated by the U.S. Consumer Product Safety, 2018.

Attachment 8B

2018

Stanislaus County
Suicide Prevention
Needs Assessment
Executive Summary

Teamwork is the secret that makes common
people achieve uncommon results.
- Ifeanyi Onuoha -

Introduction

During the last four years (2013 - 2016) **207 Stanislaus County residents** have died by suicide, which equates to nearly **one suicide death every week.**

Suicide takes an emotional toll on families, affects the well-being of the larger community and carries a heavy societal cost burden. The number of deaths from suicide reflects only a portion of the problem. Non-fatal suicidal behaviors and attempts pose a serious challenge and are strongly associated with suicide rates. The multiple contributing factors of suicide and suicidal behaviors are complex and often are attributed to the interaction of several factors. Suicide has no single cause.

For every **one suicide, 115 people** are directly and indirectly impacted.

-Hines, 2015

Project Overview

Stanislaus County Suicide Prevention Innovation Project

In 2015, the Stanislaus County Board of Supervisors and the local Mental Health Services Act (MHSA) Representative Stakeholder Steering Committee (RSSC) identified concerns that statewide efforts to reduce suicides had not yielded the desired results in Stanislaus County. A funding recommendation and project proposal for the Suicide Prevention Innovation Project was submitted and subsequently approved by the MHSA Oversight and Accountability Commission.

The Suicide Prevention Innovation Project was funded to use the Collective Impact Model to learn about and address suicides in Stanislaus County. The plan included the convening of an Advisory Board comprised of stakeholders from different sectors of the community to develop a countywide strategic plan integrating suicide awareness and prevention efforts.

The Collective Impact Model is a framework used to tackle deeply rooted and complex social problems. It is the commitment of a group of stakeholders from different sectors of the community, with a shared vision for solving a specific and complex social problem. The Collective Impact Model was selected as the innovative approach because cross-sector perspectives and collaboration are needed to address the complex causes and multiple risk factors of suicide.

Purpose

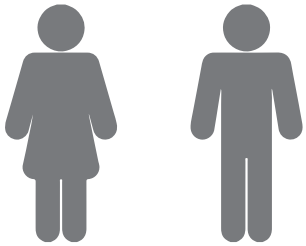
The purpose of the Needs Assessment is to gather and analyze local, state and national data and information about suicide. This information will be used by the Stanislaus County Suicide Prevention Advisory Board members to:

- Establish a shared understanding of the problem
- Catalog local suicide prevention and awareness assets and resources
- Identify any gaps in local suicide prevention and awareness efforts
- Communicate the extent of the problem with the community
- Set baselines and benchmarks to track progress over time
- Make recommendations for a county-wide coordinated suicide prevention strategic plan

The overall purpose of the Needs Assessment is to provide the Advisory Board members the information needed to make data-driven decisions, share consistent and clear information with the community and to determine specific local suicide prevention and awareness strategies.

Stanislaus County At A Glance

Total Population: **530,561**



51% Female

49% Male

Population by Ethnicity
56% Non-Hispanic and 44% Hispanic

Median Household Income
$51,591

Unemployment Rate
13.8%

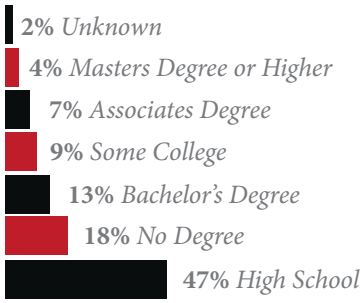
Veteran Population
6.1% of residents 18 years or older

Homeless Population
1,661**

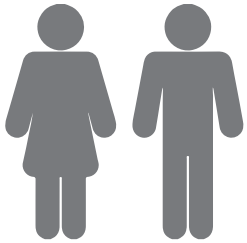
American Community Survey, Stanislus County 5yr Estimate 2012 - 2016 **Point-In-Time County Survey Stanislaus County, 2017

2016 Suicide Death Data

Education Attainment of 2016 Suicide Deaths



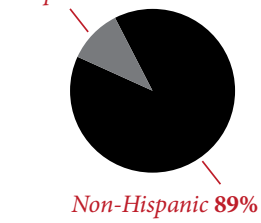
Gender:



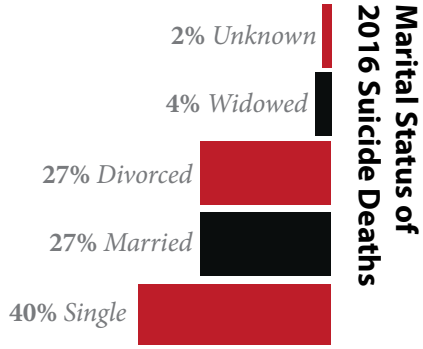
24% Female

76% Male

Ethnicity:



Marital Status of 2016 Suicide Deaths



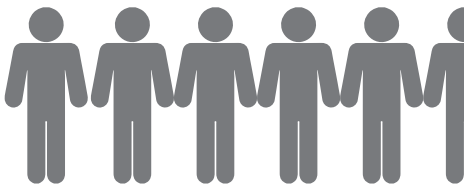
Suicide Data:

Suicide death demographic data describes suicide deaths by gender, age group, race, county region, educational attainment, marital status, veteran status and cause in Stanislaus County. These data points represent the years of 2013 through 2015. The age-adjusted rate of suicide death is also given and compared against the State rate and the National Healthy People 2020 objective.

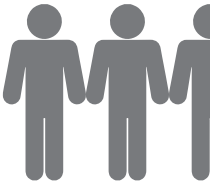
Suicide Data Limitations:

Limited access to protected health information can make determining the intent (intentional or unintentional) of an overdose / poisoning death difficult. California Assembly Bill 2119 which began January 1, 2017, allows for the Coroner / Medical Examiner to have full acess to a decedent's health record, including mental health records in order to more accurately determine the manner of death. This policy change could have an impact on the number of overdose/poisoning deaths being ruled by intentional (suicide).

More Stanislaus County residents die by suicide than by homicide



55 Total Suicide Deaths 2016



25 Total Homicide Deaths 2016

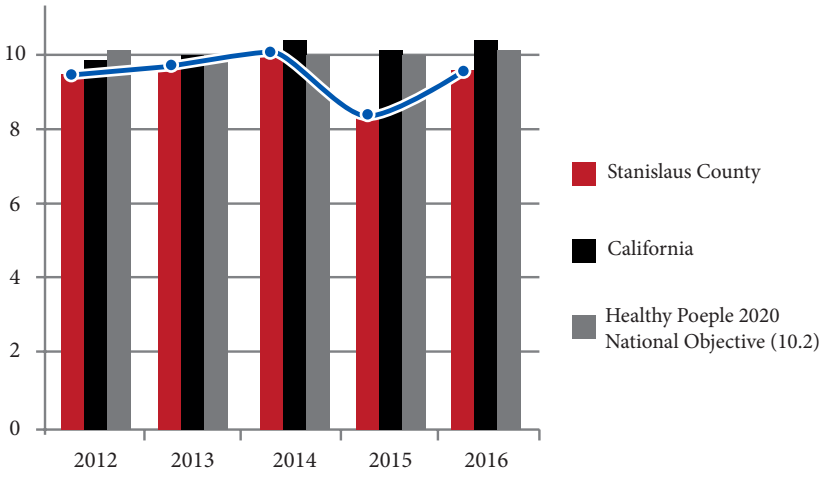
Vital Records Business Intelligence System (2016). Stanislaus County death data retrieval: January 1, 2016 through December 31, 2016.

Suicide Death Data Trends

Suicide Data

Age Adjusted Suicide Rate 2012-2016

Per 100,000 Population

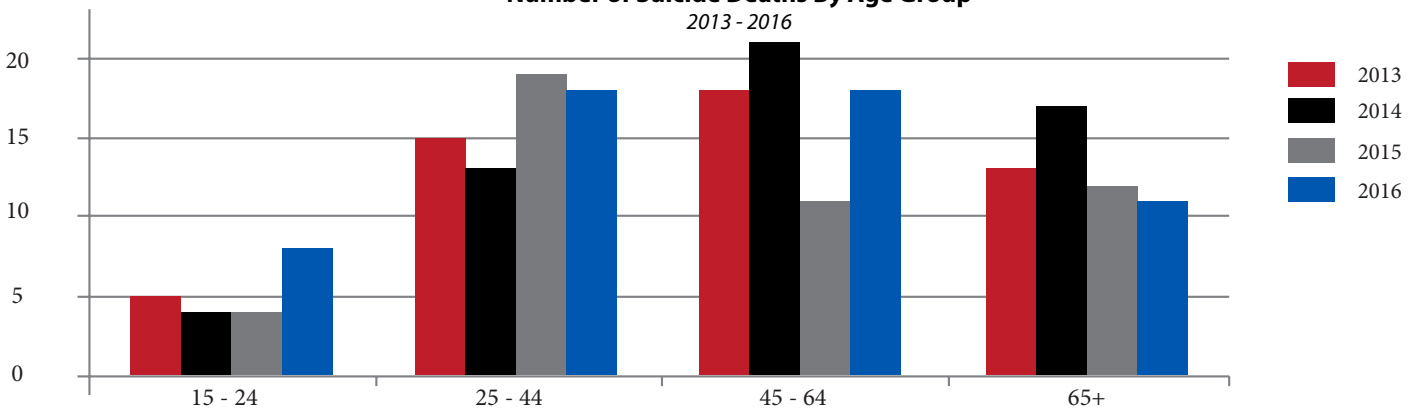


- Age adjusted rate calculations accounts for differences in a population's age distribution.
- The decrease in suicide rate for 2015 can be attributed to a slight decrease in the total number of deaths. Although it appears to show a dramatic decrease, it reflects a **difference of 9 fewer suicide deaths during 2015 than in 2014 and 2016.**
- While the total number of suicide deaths in 2014 and 2015 are the same (55), the age adjusted rate fluctuates because of the change in county population.

Suicide Data

Number of Suicide Deaths By Age Group

2013 - 2016



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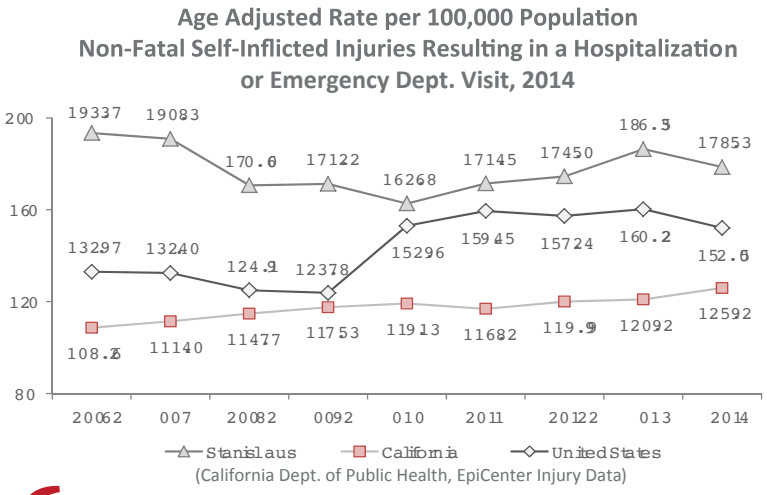

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Asset Mapping Data Highlights

Asset Mapping and Gap Analysis

Asset mapping provided information about the strengths and resources (assets) in each of the nine geographic county regions and the County as a whole. Mapping each region, as well as county-wide assets, allowed for an analysis to be conducted on gaps and duplication of service. The gap analysis also illustrated concentration of services and/or unmet needs in the regions of the County.

Asset Mapping and Gap Analysis Limitations

The assets provided in the asset map assessment may not represent all suicide prevention and awareness assets in Stanislaus County, as they represent those known by the Advisory Board.

Assets were categorized within three intervention levels: Universal, Selective, Indicated.

Five Community Sectors: Community Based Organization, Education, Faith Based, Government, Health.

Five Asset Types: Awareness/Promotion, Funding/Human Capital/Meeting Space, Training/Capacity Building, Prevention (increasing protective factors or decreasing risk factors) and Policy/System(s) Change.

Asset mapping was conducted at a county-wide level and regional level.

On average, each region contains **8** suicide prevention and awareness assets.

78 Assets among the **nine** regions.

Prevention assets accounted for **77%**

Training/Capacity Building and Awareness/ Promotion each represented **11.5%** of assets.

Country-wide, assets are country wide assets not unique to a region and available to all residents.

Total County Wide Assets

137

Intervention Level

46.7% **Selective**

31.4% **Universal**

21.9% **Indicated**

Asset Type

56.9% **Prevention**

17.5% **Training/Capacity Building**

13.9% **Awareness/Promotion**

7.3% **Funding/Human, Capital/Meeting Space**

4.4% **Policy/System(s)Change**

Universal Prevention:
Broadest approach or intervention, designed to reach entire populations or community sectors.

Selective Prevention:
Narrow approach or intervention, designed to reach a target population or geographic area.

Indicated Prevention:
Narrowest approach or intervention, designed to reach a subpopulation or specific geographic location/area.

Root Cause Mapping

The Advisory Board used root cause mapping, a structured approach, to identify beyond symptoms, contributing factors and secondary causes, the root causes of suicide death in Stanislaus County. Root cause mapping isolates the primary sources of suicide and scope of the problem.

Root Cause Mapping Limitations

The root causes emerged from a mapping exercise completed by the Advisory Board. The root causes represent the ideas and expertise of only the Stanislaus County Suicide Prevention Advisory Board members.

Problem Statement

The problem statement was created collectively to concisely describe and outline the root causes that must be addressed. The purpose of the problem statement is to establish a focus and direct the attention and efforts of the Advisory Board.

Problem Statement Limitations

The problem statement is a collective writing that only represents the ideas and expertise of the Stanislaus County Suicide Prevention Advisory Board.

Root Causes: Scope of the Problem

The multiple contributing factors of suicide and suicidal behaviors are complex and often attributed to the interaction of several factors. To identify the root causes of suicide and suicide attempts in Stanislaus County, the Advisory Board used the root cause mapping process. The process produced eight compound causes (various contributing factors or a combination of causes) and 11 contributing factors (do not directly cause the problem, cause-and-effect relationship that ultimately create a problem), which were then further broken down into four root causes: Mental Health Stigma, Decline in Connectedness, Challenges of Sharing Information Across Sectors and Lack of Shared Best Practices or Standards. Throughout the next few pages of this Needs Assessment, the compound and second level causes associated with each root cause will be discussed in more detail. With a shared understanding of Stanislaus County suicide data, assets and root causes, the Advisory Board was able to clearly define the problem of suicide.

Root Causes

Mental Health Stigma

Mental health stigma is negative, harmful or prejudice attitudes, values or beliefs about mental illness including those related with suicide. Mental health stigma can be seen at the societal and individual level. Stigma is correlated with isolation, low self-esteem, low social support and poor quality of life. Perceived or self-stigma is when an individual internalizes negative attitudes and perceptions of discrimination (Graham, 2013). Stigmatizing beliefs about suicide are held by a broad range of individuals within society in the form of unwarranted assumptions, avoidance, friendship-loss and social rejection. The low value placed on mental health by mainstream society nurtures attitudes and discriminatory behaviors that foster the stigma associated with suicide. Stigma and other contributing factors create barriers to preventative services and diminish self-help seeking behaviors, which can significantly impact treatment outcomes. At both the societal and individual level, there is a lack of mental health awareness and education. Media regularly plays a role in perpetuating stereotypes and stigma associated with suicide. Mental health stigma is also wide spread in the medical profession, in part because it is given low priority during the training of doctors and providers (Graham, 2013).

Decline in Connectedness

Connectedness is defined by the amount of social closeness among individuals or groups of people and can refer to Connectedness among individuals, families, community sectors or society. It can also be measured by the amount of community assets shared with one another. Related to connectedness, social capital refers to the level of trust a person has in his/her "community." Social capital denotes the level of social integration and availability of social organizations or community activities. A decline in connectedness is among the root causes of suicide in Stanislaus County. Overall, studies show that connectedness is an important attribute for suicide prevention and is a protective factor. Connectedness protects against suicidal behaviors by decreasing isolation and increasing coping, problem-solving and self-help seeking skills. If risk factors or life stresses, whether acute or chronic, outweigh protective factors or coping skills the risk of suicide increases. For example, economic hardship or financial strain, such as unemployment, earning a non-livable wage, difficulty covering medical, food and housing costs may increase the risk of suicide (Stone, et al., 2017). Additionally, without living wages, people must meet basic needs by working longer hours,sometimes at multiple workplaces, which leaves little time forfamily, faith, civic or community activities (Konigsburg, 2017). Earning a livable wage and escaping poverty then sustainslivelihoods, restores human dignity and builds connectedness.With financial security, individuals can participate in family and community activities, therefore increasing the amount of connectedness as a protective factor (Konigsburg, 2017).

Mental Health Stigma

Contributing Factors

- Substance Use and Abuse
- Uninformed/Inexperienced Providers
- Uninformed/Uneducated Clients
- Untreated/Undiagnosed Mental Illness

Compound Causes

- Barriers to Access
- Cultural and Religious Values
- Isolation
- Lack of Mental Health Awareness and or Education
- Social Norm to Place Low Value on Mental Health

First Level Cause

- Insufficient Protective Factors

Decline in Connectedness

Contributing Factors

- Domestic Violence
- Fatherlessness
- Lack of Affordable Housing
- Limited Livable Wage
- Non-Nuclear Family Environment
- Substance Use and Abuse

Compound Causes

- Breakdown of Family and Community
- Cultural and Religious Values
- Economic Hardship, Poverty, Impoverishment
- Isolation
- Social Norm to Place Low Value on Mental Health

First Level Cause

- Insufficient Protective Factors

Root Causes

Challenges of Sharing Information Across Sectors

Contributing Factors

- Complex Service Systems
- Federal and State Policy Impacts on Local Services Delivery
- Uninformed/Inexperienced Providers
- Untreated/Undiagnosed Mental Illness

Compound Causes

- Barriers to Access
- Service Capacity Limitations

First Level Cause

- Underutilized Preventative Services

Lack of Shared Best Practices and Standards

Contributing Factors

- Complex Service Systems
- Federal and State Policy Impacts on Local Services Delivery
- Service Eligibility Requirements
- Uninformed/Inexperienced Providers
- Untreated/Undiagnosed Mental Illness

Compound Causes

- Cultural and Religious Values
- Barriers to Access
- Lack of Mental Health Awareness and or Education

First Level Cause

- Underutilized Preventative Services

Challenges of Sharing Information

Research suggests services are maximized when care systems and providers are set up to effectively and efficiently share information. Access to preventative services is a contributing factor related to the underuse of preventative services and can lead to untreated suicidal behaviors. Improved access to timely, affordable and quality services is critical to suicide prevention (Stone, et.al, 2017).

Strong formal relationships among agencies, community organizations, service providers and systems of care can increase the access and delivery of services, as well as promote the value of mental health and wellness (CDC Connectedness ASAP, 2011). Formal relationships also establish a pathway for information to be shared across agencies, organization and providers.

The ability to provide coordinated care is rooted in the ability to share vital information in a timely and ethical manner.(SPRC, 2013) Information sharing and coordination of care across all types of providers is paramount to effective suicide prevention. However, agencies, service providers and systems of care face many challenges and barriers in their ability to share vital care information. Service delivery systems are often complex and have limited ability to share information due to federal, state and/or other policies. Additionally, there is a lack of resources available to address the complex challenges and barriers that impede the ability to share information across public and private sectors.

Lack of Shared Best Practices and Standards

A best practice or standard of care is defined as a level and type of care that a reasonably competent and skilled professional, with a similar background and education would have provided. The continuity of care focuses on quality of care and ongoing cooperative care-management with a shared goal of high quality, cost-effective care. The lack of a shared best practice or approach, as well as the lack of a standard or continuity of care for suicide prevention, intervention and after-attempt care is a root cause of suicide in Stanislaus County. Shared best practices and standards of care have been found to substantially reduce the number of suicide deaths and attempts (Suicide Prevention Resource Center, 2013).

Key Findings and Recommendations

Local Level Data on Subpopulations and At Risk Populations

Root Causes:

- Mental Health Stigma
- Lack of Shared Best Practices and Standards

Key Finding:

- While the current data indicates the majority of Stanislaus County suicide deaths mirror closely those of State and National Demographics, Consistent local level data for indicated or subpopulations populations are not available.
- In order to decrease suicides among specific subpopulations in Stanislaus County, Valid and reliable local data collection of these populations is needed.

Recommendation:

- Align Local Interventions and prevention strategies to reach subpopulation identified in State and National data, such as individuals living in poverty or low socio-economic status; Living with a mental illness or mental health problem; incarcerated; with previous suicide attempts; Veterans; who are homeless, and of sexual minority status.

Access and Use of Preventative Services

Root Causes:

- Decline in Connectedness
- Challenges of Sharing Information

Key Finding:

- Improving or expanding services alone does not guarantee increased use by individual most need, nor will it necessarily increse compliace with recommended service referrals, follow up care or treatment.

Recommendation:

- Strengthen prevention programs and interventions that focus on building positive relationships and coping strategies.
- Strength the identification and support of people at risk through crisis intervention services and post-attempt treatment.

Awareness and Education

Root Causes:

- Mental Health Stigma
- Lack of Shared Best Practices and Standards

Key Finding:

- A lack of suicide prevention awareness and education among both providers and clients is associated with untreated / undiagnosed suicidal behaviors, barriers to access and underused preventative services.

Recommendation:

- Increase communication about suicide and suicide risk factors.
- Strengthen and increase suicide prevention through gatekeeper training.
- Strengthen access and delivery of resources and services related to suicide through policy and training of service providers.
- Create polices that promote protective environments and demonstrate that mental health is valued.

Conclusion

During the last four years (2013 - 2016) 207 Stanislaus County residents died by suicide, which equates to nearly one suicide death every week. The number of deaths from suicide reflect only a portion of the problem. Non-fatal suicidal behavior is a serious challenge and strongly associated with the suicide rate. Suicide has no single cause. The multiple contributing factors of suicide and suicidal behaviors are complex and can be attributed to the interaction of the following root causes:

- Mental health stigma and misconceptions around suicide
- Decline in connectedness, interpersonal relationships, institutions, and other social assets of a society (social capital)
- Challenges of sharing information across public and private systems, impacting the quality of care
- Lack of shared best practices or standard practices of care for suicidal behaviors and prevention

Although suicide is a complex problem, it is preventable. A collaborative of cross-sector partners are needed on an ongoing basis to support, contribute and provide multidisciplinary perspectives to implement effective suicide prevention strategies. Therefore, the final recommendation of this Needs Assessment is to develop specific strategies and interventions, and set measurable outcomes to address the root causes and key findings outlined within this document.

Working Together to Make an Impact

Advisory Board

Representatives From:

American Foundation for Suicide Prevention
Aspiranet
California State University Stanislaus
Catholic Charities
Center for Human Services
Central Valley Suicide Prevention Hotline
Community Hospice
Doctors Behavioral Health Center
El Concilio
Golden Valley Health Center
Jessica's House
LGBTQA Collaborative for Greater Well-Being
Livingston Community Health
Modesto Junior College
National Alliance on Mental Illness
Private Practice - Child Psychotherapist
Sierra Vista Child and Family Services
Stanislaus County Behavioral Health and Recovery Services
Stanislaus County Chief Executive Office - Focus on Prevention
Stanislaus County Community Services Agency
Stanislaus County Health Services Agency - Public Health
Stanislaus County Probation
Sutter Health / Sutter Gould Medical Foundation
Turning Point Community Programs
West Modesto Community Collaborative
Westside Health Care Task Force

Collaborative Partners

California Forensics Medical Group
Del Puerto Health Care District
Health Plan of San Joaquin
Kaiser Permanente
Protecting Soldier's Rights
Stanislaus County Coroner's Office
Stanislaus County Office of Education
Stanislaus County Medical Society
Stanislaus County Veteran Services Office
Turlock Community Collaborative

Acknowledgements

The Stanislaus County Suicide Prevention Innovation Project, operated by Stanislaus County Behavioral Health and Recovery Services, would like to thank the many organizations, agencies and individuals who assisted in the development of this Needs Assessment.

The sucess of the Needs Assessment was dependent on the dedication and collaborative participation of the Stanislaus County Suicide Prevention Advisory Board, collaborative partners, service providers, county staff, and community members.

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Red Nacional de Prevenvión del Suicidio
1-888-628-9454
prevenviondelsuicidio.org

Asian LifeNet Lifeline
1-877-990-8585
(Cantonese, Mandarin, Japanese, Korean, Fujianese)

Trans Lifeline
1-877-565-8860
www.translifeline.org

Central Valley Suicide Prevention Hotline
1-888-506-5991
www.centralvalleysuicidepreventionhotline.org

Stanislaus County Warm Line
209-558-4600

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Stanislaus County
Suicide Prevention Advisory Board
Suicide Prevention Innovation Project
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209.525.6208

WELLNESS • RECOVERY • RESILIENCE

The Suicide Prevention Innovation Project is funded by the Mental Health Services Act.

Attachment 8C

2018

Informe Comunitario

de Evaluación de Necesidades de

Prevención del Suicidio

del Condado Stanislaus

El trabajo en equipo es el secreto que hace que la gente común obtenga resultados poco comunes.

- Ifeanyi Onuoha -

Introducción

Durante los últimos cuatro años (2013 - 2016) **207 residentes del condado Stanislaus** murieron por causa de suicidio, lo cual equivale a casi **un suicidio cada semana**.

El suicidio tiene un impacto emocional en las familias, afecta el bienestar de la comunidad en general y conlleva una gran carga de costos sociales. El número de muertes por suicidio refleja solamente una porción del problema. Los comportamientos e intentos de suicidio no fatales poseen un serio desafío y están fuertemente asociados con los porcentajes de suicidio. Los múltiples factores que contribuyen al suicidio y los comportamientos suicidas son complejos y pueden atribuirse a la interacción de varios factores. El suicidio no tiene una sola causa.

Por **cada suicidio, 115 personas** son impactadas directa o indirectamente.

-Hines, 2015

Descripción del Proyecto

Proyecto de Innovación de Prevención del Suicidio del Condado Stanislaus

En el año 2015, el Consejo de Supervisores del Condado Stanislaus y el Comité Representativo de Partes Interesadas (RSSC, por sus siglas en inglés) de la Ley local de Servicios de Salud Mental (MHSA, por sus siglas en inglés) identificaron preocupaciones de que los esfuerzos estatales para reducir los suicidios no hayan producido los resultados deseados en el condado Stanislaus. Una recomendación de financiamiento y una propuesta de proyecto fueron presentadas al Proyecto de Innovación de Prevención del Suicidio y posteriormente ambas aprobadas por la comisión de supervisión y responsabilidad de MHSA.

El Proyecto de Innovación de Prevención del Suicidio fue fundado para utilizar el modelo de impacto colectivo para conocer y abordar los suicidios en el condado Stanislaus. El plan incluyó la convocatoria de un Consejo Asesor compuesto por partes interesadas de diferentes sectores de la comunidad para desarrollar un plan estratégico a nivel condado que integre los esfuerzos de prevención y conciencia del suicidio.

El modelo de impacto colectivo es un marco utilizado para abordar problemas sociales profundamente arraigados y complejos. Es el compromiso de un grupo de partes interesadas de diferentes sectores de la comunidad, con una visión compartida para resolver un problema social específico y complejo. El modelo de impacto colectivo fue seleccionado como el enfoque innovador porque se necesitan perspectivas y colaboración intersectoriales para abordar las causas complejas y los múltiples factores del riesgo de suicidio.

Propósito

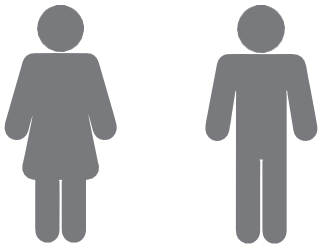
El propósito de la Evaluación de Necesidades es para recopilar y analizar datos e información local, estatal y nacional sobre el suicidio. Esta información será utilizada por los miembros del Consejo Asesor de Prevención de Suicidio del Condado Stanislaus para:

- Establecer una comprensión compartida del problema
- Catalogar los recursos locales y conocimientos de la prevención del suicidio
- Identificar cualquier brecha en los esfuerzos locales de prevención y conciencia del suicidio
- Comunicar a la comunidad el grado del problema
- Establecer líneas de base y puntos de referencia para seguir el progreso con el tiempo
- Hacer recomendaciones para un plan estratégico coordinado de prevención del suicidio para todo el condado

El objetivo general de la Evaluación de Necesidades es proporcionar a los miembros del Consejo Asesor la información necesaria para tomar decisiones basadas en datos, compartir información clara y consistente con la comunidad y determinar estrategias locales específicas de prevención y conocimientos del suicidio.

Un Vistazo al Condado Stanislaus

Población Total: **530,561**



51% Femenina

49% Masculina

Población por Etnicidad
56% No Hispana y 44% Hispana

Ingreso Familiar Mediano
$51,591

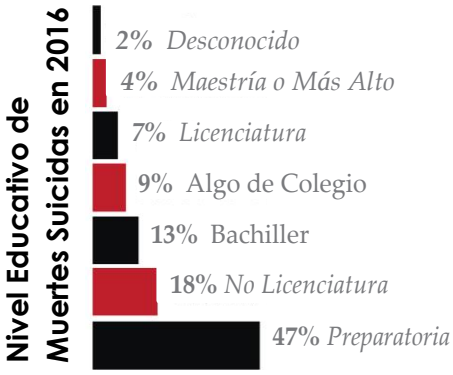
Tasa de Desempleo
13.8%

Población de Veteranos
6.1% de residentes de 18 años o mayores

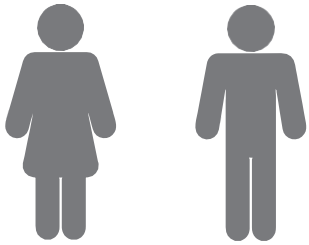
Población Sin Hogar
1,661**

Encuesta de la Comunidad Estadounidense, Calculación de 5 años del Condado Stanislaus 2012 - 2016 **En el Momento de la Encuesta en el Condado, 2017

Datos de Muerte Suicida – 2016



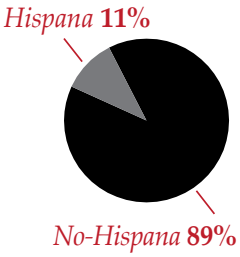
Género:

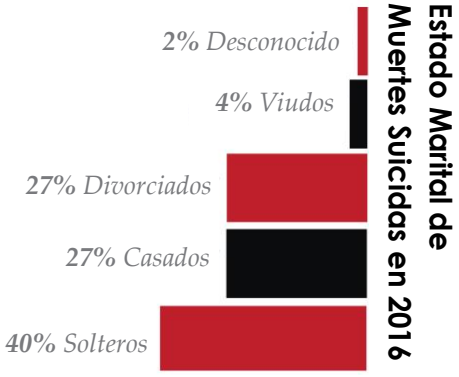


24% Femenino

76% Masculino

Etnicidad:





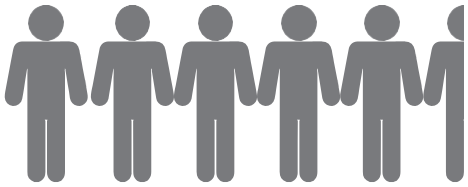
Datos de Suicidio

Los datos demográficos sobre la muerte suicida describen los suicidios por género, grupo de edad, raza, región del condado, nivel educativo, estado marital, estado veterano y causa en el condado Stanislaus. Estos puntos de datos representan los años 2013 al 2015. La tasa de suicidio ajustada por edad también es presentada y comparada con la tasa estatal y el objetivo nacional Healthy People 2020 (Gente Sana 2020).

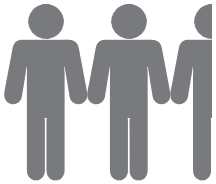
Limitaciones de Datos Suicidas

El acceso limitado a la información de salud protegida puede dificultar la determinación de la intención (intencional o no) de una muerte por sobredosis/envenenamiento. El proyecto de ley 2119 de la asamblea de California que comenzó el 1º de enero, 2017, permite que el forense/médico forense tenga acceso completo al registro de salud de un difunto, incluyendo los registros de salud mental con el fin de determinar con mayor precisión la causa de muerte. Este cambio de política podría tener un impacto en el número de muertos por sobredosis/envenenamiento que se registran por suicidio intencional.

Más residentes del condado Stanislaus mueren por suicidioque por homicidio.



55 muertes en total
por suicidio en 2016



25 muertes en total
por homicidio en 2016

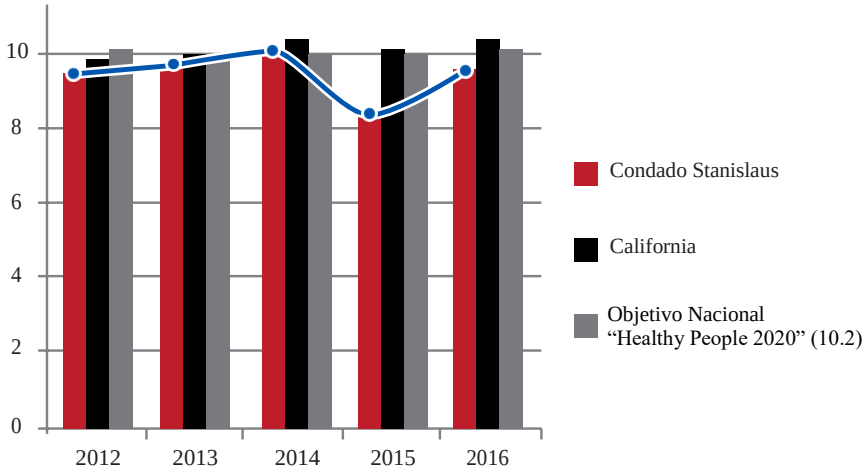
Sistema de Inteligencia de Negocios de Registros Vitales (2016). Obtenido de datos de muertes del Condado Stanislaus: 1º de enero, 2016 hasta el 31 de diciembre, 2016.

Tendencias de los Datos por Muerte

Datos de Suicidio

Tasa de Suicidio Ajustada por Edad 2012 – 2016

Por una Población de 100,000

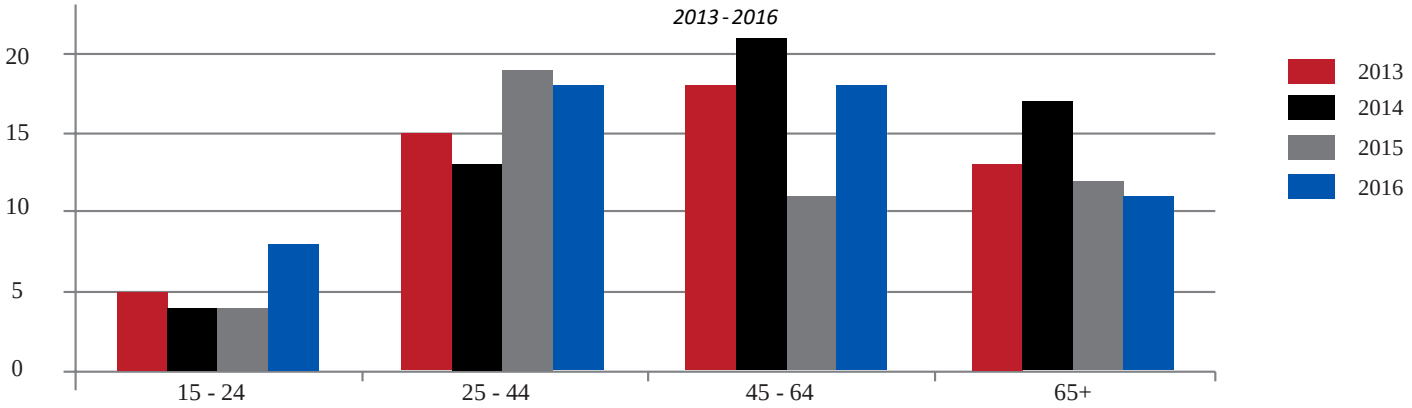


- Los cálculos de la tasa ajustada por edad representan las diferencias en la distribución por edad de una población.
- La disminución en la tasa de suicidios en el 2015 se puede atribuir a una leve disminución en el número total de muertes; aunque parece mostrar una disminución dramática, refleja una **diferencia de 9 muertes menos por suicidio durante el 2015, que en el 2014 y 2016**.
- Si bien el número total de muertes por suicidio en el 2014 y 2015 es el mismo (55), la tasa ajustada por edad fluctúa debido al cambio en la población del condado.

Datos de Suicidio

Número de Muertes Suicidas por Grupo de Edad

2013 - 2016



Sistema de Inteligencia de Negocios de Registros Vitales (2016). Obtenido de datos de muertes del Condado Stanislaus: 1º de enero, 2016 hasta el 31 de diciembre, 2016.

Datos Relacionados con el Suicidio

Universidad Estatal Stanislaus
(CSUS, por sus siglas en inglés)
Estudiantes Reportados

1 de cada 14	Seriamente Consideraron el Suicidio
1 de cada 23	Se Auto-dañaron Intencionalmente
1 de cada 110	Intentaron Suicidarse

Jóvenes del Condado Stanislaus Reportados

1 de cada 3	Sintieron Tristeza Crónica o Desesperanza
1 de cada 5	Consideraron Suicidarse

American College Health Association, National College Health Assessment II (Asociación de Salud del Colegio Americano, Evaluación de Salud II del Colegio Nacional); Resumen Ejecutivo de la Universidad Estatal Stanislaus; Primavera del 2016; Resumen Ejecutivo del Grupo de Referencia de Primavera

West Ed., California Healthy Kids Survey, (Educación Oeste., Encuesta de Niños Saludables de California) Reporte Principal Secundario del Condado Stanislaus 2014-2015; 7º [n=5,273], 9º [n=3,939], 11º [n=3,324], No Tradicional [n=684])

Datos Relacionados con el Suicidio

Datos de Intento de Suicidio

Los datos de intento de suicidio representan el número total de visitas al departamento de emergencias u hospitalizaciones que ocurren como resultado de una lesión auto-infligida no mortal. Género, grupo de edad, raza y causa también se incluyen en estos datos. La tasa de intentos de suicidio ajustada por la edad en el condado Stanislaus se compara con las tasas estatales y nacionales. El número total de intentos de suicidio se calcula como la suma de las visitas al departamento de emergencia y las hospitalizaciones resultantes de una lesión auto-infligida no mortal (intento de suicidio).

Limitaciones de los Datos de Intentos de Suicidio

Los datos de intento de suicidio solo capturan lesiones auto-infligidas no fatales que resultaron en una visita al departamento de emergencia u hospitalización. El número real de intentos de suicidio puede ser mayor que el reportado.

Datos de Intento de Suicidio

2014

Visitas No Fatal al Departamento de Emergencias	Hospitalizaciones No Fatal
725	234

Edad

33% Edad 25-44	**35%** Edad 45-65
23% Edad 45-64	**32%** Edad 25-44
20% Edad 15-19	**12%** Edad 15-19

Raza/Etnicidad

64% Anglosajona	**67%** Anglosajona
25% Hispana	**20%** Hispana

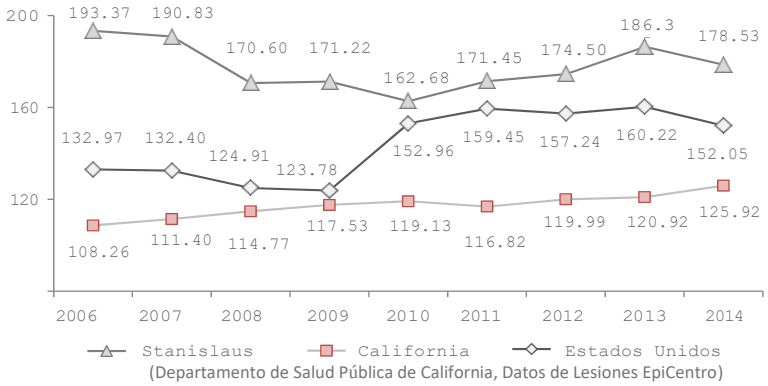
Tipo de Lesión

57% Envenenamiento	**57%** Envenenamiento
29% Corte/Perforación	**15%** Corte/Perforación

62% Femenino **38%** Masculino **61%** Femenino **39%** Masculino

Departamento de Salud Pública de California (2018). EpiCentro: Lesiones no fatales auto-infligidas en el condado Stanislaus, 2014. Obtenido de http://epicenter.cdph.ca.gov/Default.aspx

Tasa Ajustada por Edad en Población de 100,000
Lesiones No Fatales, Auto-Infligidas Resultantes en una Hospitalización o Visita al Departamento de Emergencia, 2014



(Departamento de Salud Pública de California, Datos de Lesiones EpiCentro)

Un estudio de observación retro-prospectivo de casos publicado en agosto, 2016, se utilizó para obtener cálculos más precisos de la prevalencia de suicidios entre quienes intentan suicidarse.

El estudio encontró que **programar una cita psiquiátrica de seguimiento** al momento de ser dado de alta del departamento de emergencia u hospital después de un intento inicial de suicidio, parecía proporcionar una **alta protección y reducía el riesgo de completar un suicidio subsecuente**. La cita de seguimiento programada seguía proporcionando una alta protección, **incluso si la persona no conservaba o no se presentaba a la cita** (Bostwick et.al, 2016).

El costo por suicidios en California en combinación con pérdidas médicas y laborales en el año 2013 fue de

$ 4,784,903,000

Sistema de Estadísticas Vitales de NCHS para el número de muertes; El Programa de Lesiones NEISS, operado por la seguridad de productos de consumo de los E. U., 2018

El costo por intento de suicidio en el **condado Stanislaus** en combinación con pérdidas médicas y laborales se **estimó ser $11,368,000** durante el 2014. Sin embargo, los costos se calculan en intentos de suicidio conocidos y **pueden ser mucho más altos**.

Sistema de Estadísticas Vitales de NCHS para el número de muertes; El Programa de Lesiones NEISS, operado por la seguridad de productos de consumo de los E. U., 2018

Datos Destacados de Áreas Activas

Áreas Activas y Análisis de Diferencias

Las áreas activas proporcionaron información acerca de las fortalezas y recursos (activos) en cada una de las nueve regiones geográficas del condado y del condado en sí. Representando cada región, al igual que cada área activa, permitió que un análisis fuera llevado a cabo sobre áreas de diferencias y duplicación de servicios. El análisis de diferencias además ilustró una concentración de servicios y/o necesidades no satisfechas en las regiones del condado.

Limitaciones de Áreas Activas y Análisis de Diferencias

Las áreas activas proporcionadas en la evaluación del mapa de áreas activas, pueden no representar todo lo activo en prevención y concientización del suicidio en el condado Stanislaus, ya que representan aquellos conocidos por el Consejo Asesor.

Las áreas activas fueron categorizadas dentro de tres niveles de intervención: Universal, Selectiva e Indicada

Cinco Sectores Comunitarios: Organización Basada en la Comunidad, Nivel Educativo, En Base a Religión, Gobierno, Salud

Cinco Tipos de Activos: Concientización/Promoción, Financiación/Humanitario Capital/Espacio para Reuniones, Entrenamiento/Desarrollo de Capacidad, Prevención (incrementando factores de protección o disminuyendo factores de riesgo) y Política/Cambio de Sistema(s)

Las áreas activas se llevaron a cabo a nivel del condado entero y a nivel regional.

En promedio, cada región contiene **9** áreas activas de prevención y concientización del suicidio.

78 áreas activas entre **9** regiones.

Las áreas de prevención representaron un **77%**

Entrenamiento/Desarrollo de Capacidad y Concientización/Promoción, cada uno representó el **11.5%** de las áreas activas.

En el condado entero, las áreas activas son activas en todo el condado y no únicas a una región y están disponibles para todos los residentes.

Nivel de Intervención

- 46.7% **Selectiva**
- 31.4% **Universal**
- 21.9% **Indicada**

Áreas Activas en Todo el Condado son 137

Tipos de Activos

- 56.9% **Prevención**
- 17.5% **Entrenamiento/Desarrollo de Capacidad**
- 13.9% **Concientización/Promoción**
- 7.3% **Financiación/Humanitario Capital/Espacio para Reuniones**
- 4.4% **Política/Cambio de Sistema(s)**

Prevención Universal:
El enfoque o intervención más amplio, diseñado para llegar a poblaciones enteras o sectores comunitarios.

Prevención Selectiva:
El enfoque o intervención reducida, diseñada para llegar a una población objetivo o área geográfica.

Prevención Indicada:
El enfoque o intervención más reducida, diseñada a llegar a la subpoblación o área/locación geográfica específica.

Causa Principal en Áreas Activas

El Consejo Asesor utilizó la causa principal de áreas activas, un enfoque estructurado, para identificar más allá de los síntomas, los factores contribuyentes y las causas secundarias; las causas principales de la muerte por suicidio en el condado Stanislaus. La causa principal en áreas activas aísla las fuentes principales de suicidio y la amplitud del problema.

Limitaciones de la Causa Principal en Áreas Activas

Las causas principales emergieron de un ejercicio en áreas activas completado por el Consejo Asesor. Las causas principales representan solamente las ideas y habilidades de los miembros del Consejo Asesor de Prevención del Suicidio del Condado Stanislaus.

Planteamiento del Problema

El planteamiento del problema fue creado colectivamente para describir y subrayar concisamente las causas del origen del problema que deben abordarse. El propósito del planteamiento del problema es establecer un enfoque y dirigir la atención y esfuerzos del Consejo Asesor.

Limitaciones del Planteamiento del Problema

El planteamiento del problema es un escrito colectivo que sólo representa las ideas y experiencia del Consejo Asesor de Prevención del Suicidio del Condado Stanislaus.

Causas de Origen del Problema: Amplitud del Problema

Los múltiples factores que contribuyen al suicidio y los comportamientos suicidas son complejos y a menudo, se atribuyen a la interacción de varios factores. Para identificar las causas de origen del intento de suicidio y suicidio en el condado Stanislaus, el Consejo Asesor utilizó el proceso de áreas activas de las causas de origen. El proceso produjo ocho causas compuestas (varios factores contribuyentes o una combinación de causas) y once factores contribuyentes (no causan directamente el problema, la relación entre causa y efecto que finalmente crea un problema), los cuales fueron luego divididos entre cuatro causas de origen: Estigma de salud mental, disminución de conectividad, desafíos para intercambiar información a través de los sectores y falta de mejores prácticas compartidas o estándares. A lo largo de las próximas páginas de esta Evaluación de Necesidades, las causas compuestas y de segundo nivel asociadas con cada causa de origen, serán analizadas con más detalle. Con una comprensión compartida de los datos de suicidio del condado Stanislaus, sus áreas activas y causas de origen, el Consejo Asesor pudo definir claramente el problema del suicidio.

Causas de Origen

Estigma de Salud Mental

El estigma de salud mental es negativo, dañino o actitud prejudicial, los valores o creencias sobre las enfermedades mentales, incluyendo las relacionadas con el suicidio. El estigma de salud mental puede ser visto a nivel social o individual. El estigma se correlaciona con aislamiento, baja autoestima, bajo apoyo social y mala calidad de vida. La percepción o auto-estigma se produce cuando una persona internaliza actitudes negativas y percepciones de discriminación (Graham, 2013). Las creencias estigmatizadas sobre el suicidio están sostenidas por una amplia gama de personas dentro de la sociedad en forma de suposiciones injustificadas, evitación, pérdida de amistades y rechazo social. El bajo valor que la sociedad dominante asigna a la salud mental alimenta actitudes y conductas de discriminación que fomentan el estigma asociado con el suicidio. El estigma y otros factores contribuyentes crean barreras a los servicios de prevención y disminuyen las conductas de búsqueda de autoayuda que pueden tener un impacto significativo en los resultados del tratamiento. Tanto en el nivel social como en el individual, existe una falta de concientización y educación en salud mental. Los medios de comunicación juegan regularmente un rol en la perpetuación de los estereotipos y el estigma asociado con el suicidio. El estigma de salud mental está además muy extendido en la profesión de medicina, en parte porque se le es dada una baja prioridad durante el entrenamiento de médicos y proveedores (Graham, 2013).

Disminución de Conectividad

La conectividad o conexión es definida por la cantidad de acercamiento social entre personas o grupos de personas y puede referirse también a la conectividad entre personas, familias, sectores comunitarios o la sociedad en sí. También se puede medir por la cantidad de áreas activas de la comunidad, compartidos entre sí. En relación a la conectividad, el capital social se refiere al nivel de confianza que una persona tiene en su "comunidad". El capital social denota los niveles de integración social y disponibilidad de organizaciones sociales o actividades comunitarias. Una disminución de conectividad se encuentra entre las causas de origen del suicidio en el condado Stanislaus. En general, estudios muestran que la conectividad es un atributo importante para la prevención del suicidio y es un factor de protección. La conectividad protege contra las conductas suicidas disminuyendo el aislamiento y aumentando el enfrentamiento y las habilidades de resolución de problemas y autoayuda. Si los factores de riesgo o tensiones de la vida, ya sean agudas o crónicas, pesan más que los factores de protección o habilidades de enfrentar el problema, el riesgo de suicidio aumenta. Por ejemplo, dificultad económica o tensión financiera, tal como desempleo, ganar un salario insuficiente, dificultad para cubrir costos médicos, de alimento o vivienda pueden aumentar el riesgo del suicidio (Stone, et al., 2017). Adicionalmente, sin un sueldo para vivir, las personas deben solventar sus necesidades básicas trabajando largas horas y múltiples trabajos a veces, lo cual deja poco tiempo para la familia, la iglesia o actividades cívicas o comunitarias (Konigsburg, 2017). Ganar un salario suficiente y escapar de la pobreza de alguna manera sostiene los medios de vida, restaura la dignidad humana y construye la conectividad. Con seguridad financiera, personas pueden participar en actividades familiares o comunitarias, por lo tanto aumenta la cantidad de conectividad como un factor de protección (Konigsburg, 2017).

Estigma de Salud Mental

Factores Contribuyentes

- Uso y abuso de sustancias
- Proveedores no informados/inexpertos
- Clientes no informados/sin educación
- Enfermedades mentales sin tratamiento/sin diagnosticar

Casos Compuestos

- Barreras de acceso
- Valores culturales y religiosos
- Aislamiento
- Falta de conocimiento o educación sobre salud mental
- Norma social para dar poco valor a la salud mental

Causa de Primer Nivel

- Insuficientes factores de protección

Disminución de Conectividad

Factores Contribuyentes

- Violencia doméstica
- Falta del padre
- Falta de vivienda asequible
- Ingreso limitado para vivir
- Ambiente familiar no tradicional (padres solteros, padres divorciados y vueltos a casar, familias con dos padres/madres, etc.)
- Uso y abuso de sustancias

Casos Compuestos

- Descomposición de la familia y la comunidad
- Valores culturales y religiosos
- Dificultades económicas, escasez, empobrecimiento
- Aislamiento
- Norma social para dar poco valor a la salud mental

Causa de Primer Nivel

- Insuficientes factores de protección

Causas de Origen

Desafíos Para Intercambiar Información

Factores Contribuyentes
- Sistemas de servicio complejos
- Impactos federales y estatales en el reparto de servicios locales
- Proveedores no informados/sin experiencia
- Enfermedades mentales no tratadas/no diagnosticadas

Casos Compuestos
- Barreras de acceso
- Limitaciones de capacidad de servicio

Causa de Primer Nivel
- Servicios preventivos no utilizados

Falta de Mejores Prácticas Compartidas y Estándares de Cuidado

Factores Contribuyentes
- Sistemas de servicio complejos
- Impactos federales y estatales en el reparto de servicios locales
- Requisitos de elegibilidad para servicios
- Proveedores no informados/sin experiencia
- Enfermedades mentales no tratadas/no diagnosticadas

Casos Compuestos
- Valores culturales y religiosos
- Barreras de acceso
- Falta de conocimiento o educación sobre salud mental

Causa de Primer Nivel
- Servicios preventivos no utilizados

Desafíos Para Intercambiar Información

Investigaciones sugieren que los servicios sean maximizados cuando los sistemas de cuidado y proveedores están configurados para compartir información con efectividad y eficiencia. El acceso a servicios preventivos es factor contribuyente relacionado con el bajo uso de servicios preventivos y puede conllevar a conductas suicidas no tratadas. Un mejor acceso a servicios oportunos, económicos y de calidad es fundamental para la prevención del suicidio (Stone, et.al, 2017).

Relaciones formales y fortalecidas entre agencias, organizaciones comunitarias, proveedores de servicios y sistemas de cuidado pueden aumentar el acceso y reparto de servicios, así como promover el valor de la salud mental y bienestar (CDC Connectedness ASAP, 2011). Relaciones formales también establecen una vía para que la información sea compartida entre agencias, organizaciones y proveedores.

La habilidad de brindar cuidado coordinado se basa en la capacidad de compartir información vital de manera oportuna y ética (SPRC, 2013). El intercambio de información y coordinación de la atención entre todos los proveedores es primordial para la prevención efectiva del suicidio. Sin embargo, agencias, proveedores de servicios y sistemas de cuidado enfrentan muchos desafíos y barreras en su habilidad para intercambiar información vital de atención/cuidado. Los sistemas de reparto de servicios a menudo son complejos y tienen una capacidad limitada para compartir información debido a políticas federales, estatales y/o de otro tipo. Además, existe una falta de recursos disponibles para abordar los complejos desafíos y barreras que impiden la capacidad de intercambiar/compartir información entre los sectores públicos y privados.

Falta de Mejores Prácticas Compartidas y Estándares de Cuidado

Una mejor práctica o estándar de cuidado se define como un nivel o tipo de cuidado que un profesional razonablemente competente y capacitado con un historial y educación similar habría proporcionado. La continuidad del cuidado se centra en la calidad del cuidado y la gestión continua del cuidado cooperativo con un objetivo compartido de cuidado de alta calidad y económica. La falta de una mejor práctica o enfoque, así como la falta de un estándar o la continuidad de cuidado para la prevención del suicidio, la intervención y el cuidado posterior al intento, es la causa principal del suicidio en el condado Stanislaus. Se ha comprobado que las mejores prácticas compartidas y estándares de cuidado reducen sustancialmente el número de muertes e intentos de suicidio. (Suicide Prevention Resource Center, 2013 [Centro de Recursos de Prevención del Suicidio]).

Descubrimientos y Recomendaciones Claves

Datos a Nivel Local Sobre Subpoblaciones y Poblaciones en Riesgo

Causas de Origen:

- Estigma de salud mental
- Falta de mejores prácticas compartidas y estándares de atención

Descubrimiento Clave:

- Si bien los datos actuales indican que la mayoría de las muertes por suicidio en el condado Stanislaus son similares a las de los datos demográficos estatales y nacionales, no se cuenta con datos consistentes a nivel local para las poblaciones indicadas o sub pobladas.
- Para disminuir los suicidios entre subpoblaciones específicas en el condado Stanislaus, es necesaria una recopilación válida y confiable de datos locales de estas poblaciones.

Recomendación:

- Alinear las intervenciones locales y las estrategias de prevención para llegar a la sub población identificada en los datos estatales y nacionales, tales como las personas que viven en pobreza o bajo nivel socioeconómico, que viven con una enfermedad mental o un problema de salud mental, están encarcelados, con previos intentos de suicidio, ser veteranos que no tienen hogar y los que tienen un estatus de minoría de género.

Acceso y Uso de Servicios Preventivos

Causas de Origen:

- Disminución de conectividad
- Desafíos para intercambiar información

Descubrimiento Clave:

- Mejorar y expandir los servicios por sí solo no garantiza un mayor uso por parte de las personas que más lo necesitan, ni tampoco necesariamente aumentará el cumplimiento con las recomendaciones de servicios, seguimiento de atención/cuidado o tratamiento.

Recomendación:

- Fortalecer los servicios de prevención e intervenciones que se enfoquen en fomentar relaciones positivas y estrategias de afrontamiento.
- Fortalecer la identificación y apoyo de las personas en riesgo a través de servicios de intervención de crisis y tratamiento posterior al intento de suicidio.

Conciencia y Educación

Causas de Origen:

- Estigma de salud mental
- Falta de mejores prácticas compartidas y estándares de atención

Descubrimiento Clave:

- Una falta de conocimiento y educación sobre prevención del suicidio entre ambos, proveedores y clientes está asociada con las conductas suicidas no diagnosticadas/no tratadas, barreras de acceso y bajo uso de servicios preventivos.

Recomendación:

- Aumentar la comunicación acerca del suicidio y los factores de riesgo del suicidio.
- Fortalecer e incrementar la prevención del suicidio a través de entrenamiento de protección.
- Fortalecer el acceso y la entrega de recursos y servicios relacionados con el suicidio por medio de la política y entrenamiento de proveedores de servicios.
- Crear políticas que promueven ambientes de protección y demuestran que la salud mental es valorada.

Conclusión

Durante los últimos cuatro años (2013 - 2016) 207 residentes del condado Stanislaus murieron por causa de suicidio, lo cual equivale a casi un suicidio cada semana. El número de muertes por suicidio refleja solamente una porción del problema. El comportamiento suicida no fatal, es un desafío serio y fuertemente asociado con el porcentaje de suicidio. El suicidio no tiene una sola causa. Los múltiples factores que contribuyen al suicidio y los comportamientos suicidas son complejos y pueden atribuirse a la interacción de las siguientes causas de origen:

- Estigma de salud mental y conceptos erróneos sobre el suicidio
- Disminución de conectividad, relaciones interpersonales y otras áreas sociales de una sociedad (capital social)
- Desafíos para intercambiar información a través de sistemas públicos y privados, impactando la calidad de atención/cuidados
- Falta de mejores prácticas compartidas o estándares de atención para conductas suicidas y prevención del suicidio

Aunque el suicidio es un problema complejo, se puede prevenir. Una colaboración de socios intersectoriales es necesaria en forma continua para apoyar, contribuir y proporcionar perspectivas multidisciplinarias para implementar estrategias efectivas de prevención del suicidio. Por lo tanto, la recomendación final de esta Evaluación de Necesidades es, desarrollar estrategias e intervenciones específicas y establecer resultados mensurables para abordar las causas de origen/causas fundamentales y los descubrimientos claves en este documento.

Trabajando Unidos Para Lograr un Impacto

Consejo Asesor *(Advisory Board)*

Fundación Americana para la Prevención del Suicidio ~ *(American Foundation for Suicide Prevention)*
Aspiranet
Universidad Estatal Stanislaus ~ (California State University Stanislaus)
Caridades Católicas ~ *(Catholic Charities)*
Centro de Servicios Humanos ~ *(Center for Human Services)*
Línea Directa de Prevención del Suicidio del Valle Central ~ *(Central Valley Suicide Prevention Hotline)*
Hospicio Comunitario ~ *(Community Hospice)*
Centro de Salud de Comportamiento de los Doctores ~ *(Doctors Behavioral Health Center*)
El Concilio
Centro de Salud Golden Valley *(Golden Valley Health Center)*
El Hogar de Jessica ~ *(Jessica's House)*
Colaboración Para Un Mayor Bienestar ~ *(LGBTQA Collaborative for Greater Well-Being)*
Salud de la Comunidad de Livingston *(Livingston Community Health)*
Colegio Junior de Modesto ~ *(Modesto Junior College)*
Alianza Nacional Para la Enfermedad Mental ~ *(National Alliance on Mental Illness)*
Psicoterapeuta Infantil – Práctica Privada ~ *(Private Practice - Child Psychotherapist)*
Servicios Infantiles y Familiares Sierra Vista ~ *(Sierra Vista Child and Family Services)*
Servicios de Recuperación y Salud Mental del Condado Stanislaus
(Stanislaus County Behavioral Health and Recovery Services)
Oficina del Director Ejecutivo del Condado Stanislaus – Enfoque en Prevención
(Stanislaus County Chief Executive Office - Focus on Prevention)
Agencia de Servicios Comunitarios del Condado Stanislaus ~ *(Stanislaus County Community Services Agency)*
Agencia de Servicios de Salud del Condado Stanislaus – Salud Pública
(Stanislaus County Health Services Agency - Public Health)
Agencia Probatoria del Condado Stanislaus ~ *(Stanislaus County Probation)*
Sutter Health / Fundación Médica Sutter Gould ~ *(Sutter Health/Sutter Gould Medical Foundation)*
Programas Comunitarios Punto de Retorno ~ *(Turning Point Community Programs)*
Comunidad Colaborativa del Oeste de Modesto ~ *(West Modesto Community Collaborative)*
Equipo de Trabajo de Cuidado de Salud Westside ~ *(Westside Health Care Task Force)*

Socios Colaboradores

Grupo Médico Forense de California
(California Forensics Medical Group)

Cuidado de Salud del Distrito
(Del Puerto Health Care District)

Plan de Salud de San Joaquín
(Health Plan of San Joaquin)

Kaiser Permanente

Protección de Derechos de los Soldados
(Protecting Soldier's Rights)

Oficina del Juez de Instrucción del Condado Stanislaus
(Stanislaus County Coroner's Office)

Oficina de Educación del Condado Stanislaus
(Stanislaus County Office of Education)

Sociedad Médica del Condado Stanislaus
(Stanislaus County Medical Society)

Oficina de Servicios para Veteranos del Condado Stanislaus
(Stanislaus County Veteran Services Office)

Comunidad Colaborativa de Turlock
(Turlock Community Collaborative)

Reconocimientos

El Proyecto de Innovación para la Prevención del Suicidio del Condado Stanislaus, operado por los Servicios de Recuperación y Salud Mental del Condado Stanislaus, desea agradecer a las numerosas organizaciones, agencias y personal que colaboraron en el desarrollo de esta Evaluación de Necesidades.

El éxito de la Evaluación de Necesidades dependió de la dedicación y la participación colaborativa del Consejo Asesor de Prevención del Suicidio del Condado Stanislaus, socios colaboradores, proveedores de servicios, personal del condado y miembros de la comunidad.

Línea Nacional de Prevención del Suicidio
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Red Nacional de Prevención del Suicidio
1-888-628-9454
prevenciondelsuicidio.org

Red Asiática Salvavidas
1-877-990-8585
(Cantonés, Mandarín, Japonés, Coreano, Fujianés)

Línea de Vida Transgénero
1-877-565-8860
www.translifeline.org

Línea Directa de Suicidio del Valle Central
1-888-506-5991
www.centralvalleysuicidepreventionhotline.org

Línea de Apoyo Condado Stanislaus
209-558-4600

Equipo del Proyecto de Innovación de Prevención del Suicidio

Amber Gillaspy
Especialista en Planificación de Eventos

Kirsten Jasek-Rysdahl, MA, MSW
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Sharrie Sprouse
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Theresa Fournier, MPH
Analista de Datos

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Proyecto de Innovación de Prevención del Suicidio
Servicios de Recuperación y Salud Mental del Condado Stanislaus
800 Scenic Drive
Modesto, CA 95350
209.558.6208

WELLNESS • RECOVERY • RESILIENCE

El Proyecto de Innovación de Prevención del Suicidio es fundado por la Ley de Servicios de Salud Mental.

Data Definitions

Age-Adjusted Rate (ADR) - A summary measure that uses the U.S. 2000 Standard Population to allow different populations to be comparable at specific points in time and during trending.

ADR controls for a population's age distribution. For more detailed information visit https://www26.state.nj.us/doh-shad/sharedstatic/AgeAdjustedDeathRate.pdf

Rate per 100,000 – The number of times an event occurs per 100,000 people within a specified population. It is customary to use rates per 100,000 population for deaths. There may or may not be 100,000 residents in the county under review, but multiplying the result by 100,000 makes that rate comparable with counties with more than 100,000 or less than 100,000.

For more detailed information visit https://www.stats.indiana.edu/vitals/CalculatingARate.pdf

Data Definitions

Percentage Point increase/decrease – Percentage Point increase/decrease refers to the actual difference in points between two percentages.

Example: In 2009 18% of the swim team wore blue fins and in 2010, 22% of the swim team wore blue fins. The percentage of the swim team that wore blue fins increased by 4% points [18% to 22%] from 2009-2010.

Percentage Change increase/decrease – Percent Change increase/decrease refers to the percentage difference between two points.

Percent Change is calculated by [(most recent number – previous number) / previous number x 100 = Percent Change]

Using (N) vs. (n) – (N) in uppercase format generally will be describing an entire population, while (n) in lowercase format describes a sample size or only a portion of an entire population.

Major Data Sources

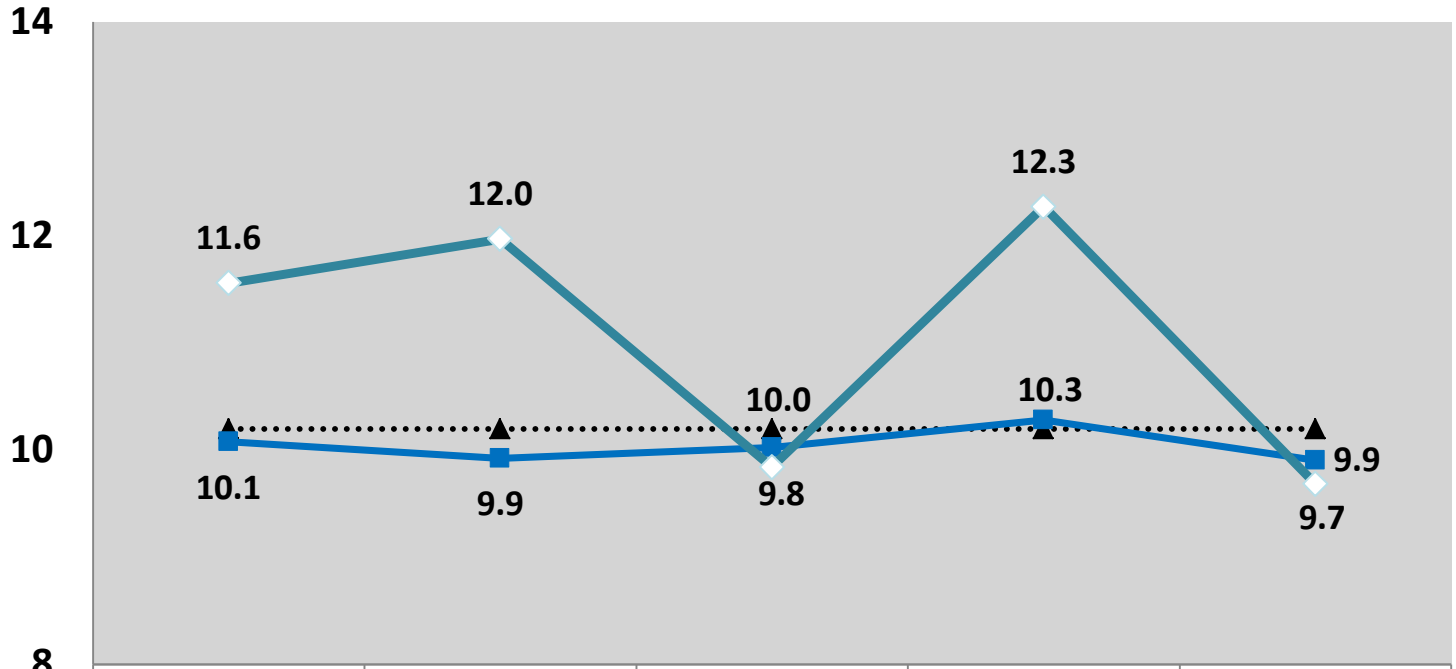
EpiCenter The most versatile and comprehensive source of California injury data. It includes all types of injuries that result in death, hospitalization, or an emergency department visit. EpiCenter is facilitated by the California Dept. of Public Health and open to the general public.

Vital Records Business Intelligence System (VRBIS) California Vital Record Data of birth, death and fetal death. VRBIS contains substantial quantities of confidential and personal information and is therefore closed to the general public. Local Health Departments are permitted access for the purpose of official government business, epidemiological analysis, surveillance and program evaluation. VRBIS is facilitated by the California Dept. of Public Health.

Healthy People 2020 Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For 3 decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Figure 1: Death by Suicide Age-Adjusted Rate per 100,000 Stanislaus County Residents, 2008-2012

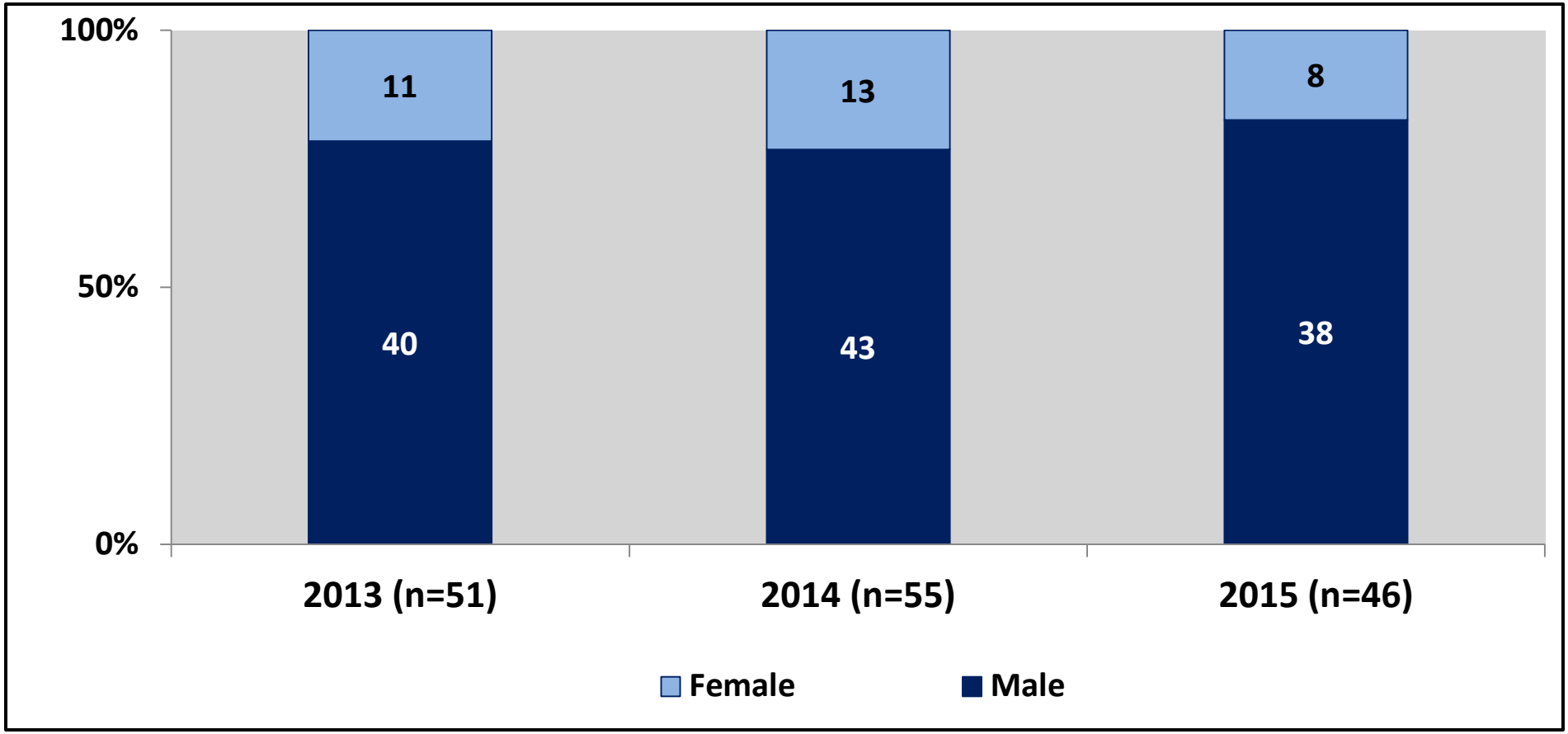


	2008	2009	2010	2011	2012
Healthy People 2020	10.2	10.2	10.2	10.2	10.2
California	10.1	9.9	10.0	10.3	9.9
Stanislaus	11.6	12.0	9.8	12.3	9.7

Death rate by suicide, 100,000 population.

Data Source: *California Dept. of Public Health, Vital Statistics Death Statistical Master Files. EPICenter (2017).*
Note: All ADR calculations completed by SPIP data analyst.

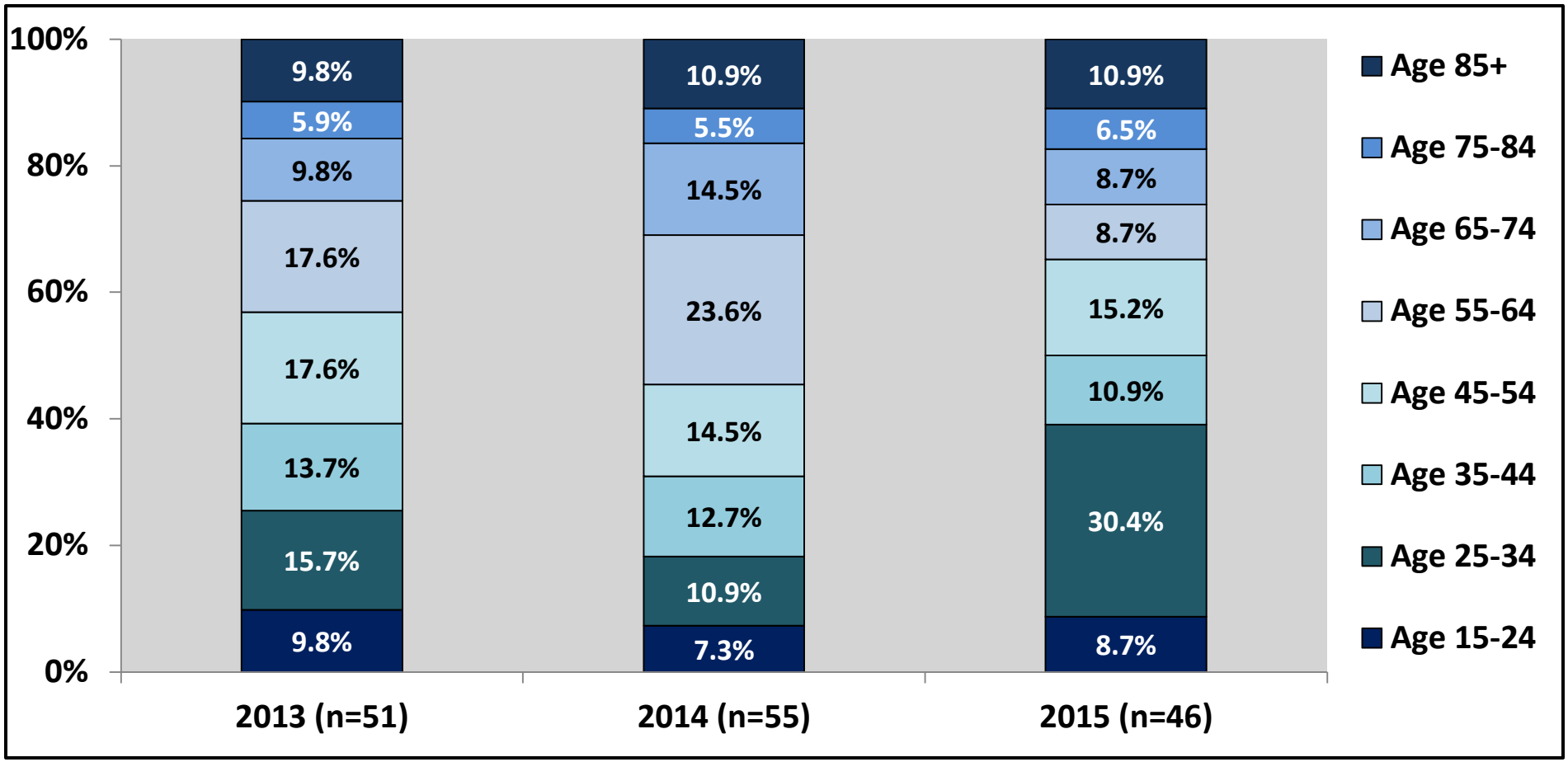
Figure 2: Suicide Deaths, by Gender 2013-2015



Distribution of death by suicide among Stanislaus County residents, by gender.

Data Source: *California Dept. of Public Health, Vital Records Business Intelligence System (VRBIS).*

Figure 3: Suicide Deaths by Age Group, Stanislaus County 2013-2015

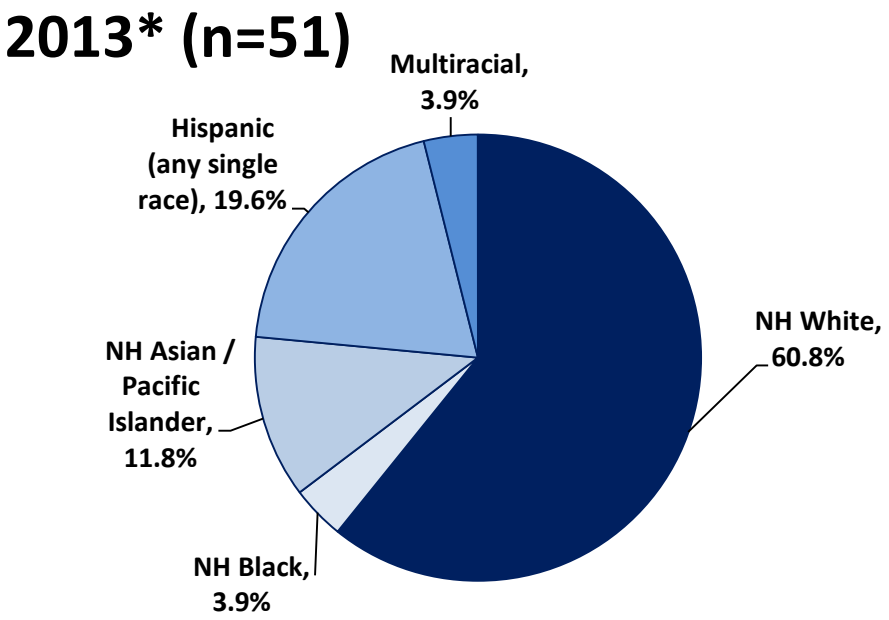


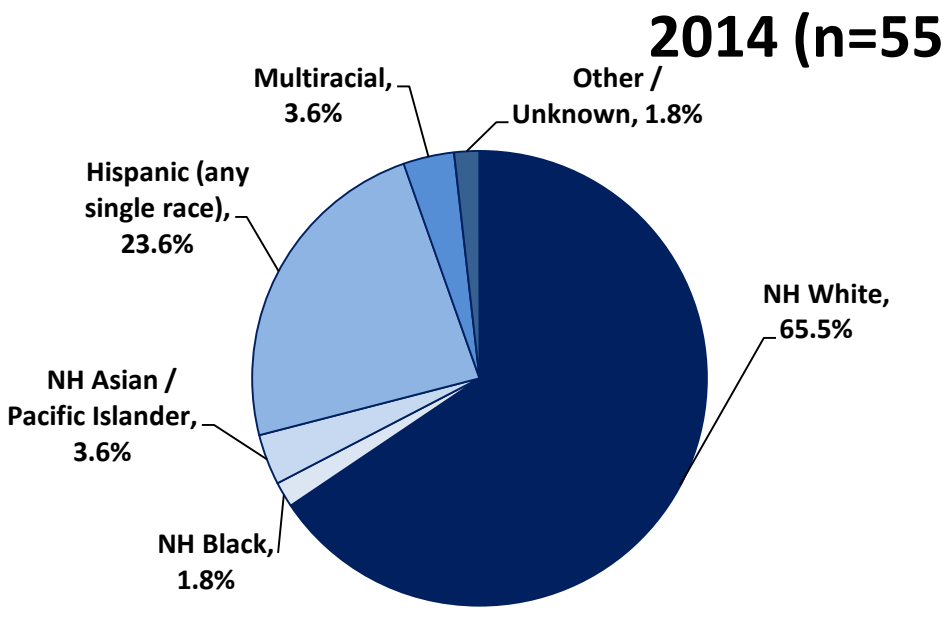
Age distribution of suicide deaths among Stanislaus County residents.

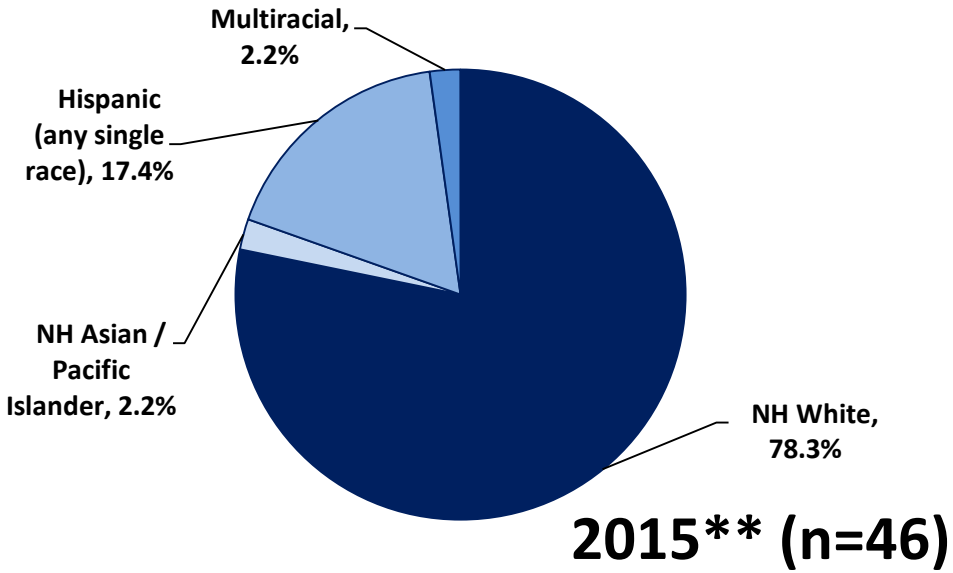
Data Source: *California Dept. of Public Health, Vital Records Business Intelligence System (VRBIS).*

Note: *Age groups (0 to 4) and (5 to 9) were intentionally omitted due to lack of events.*
*(n containing **(*)** include up to one suicide death <15 years old.)*

Figure 4: Suicide Deaths by Race, Stanislaus County 2013-2015





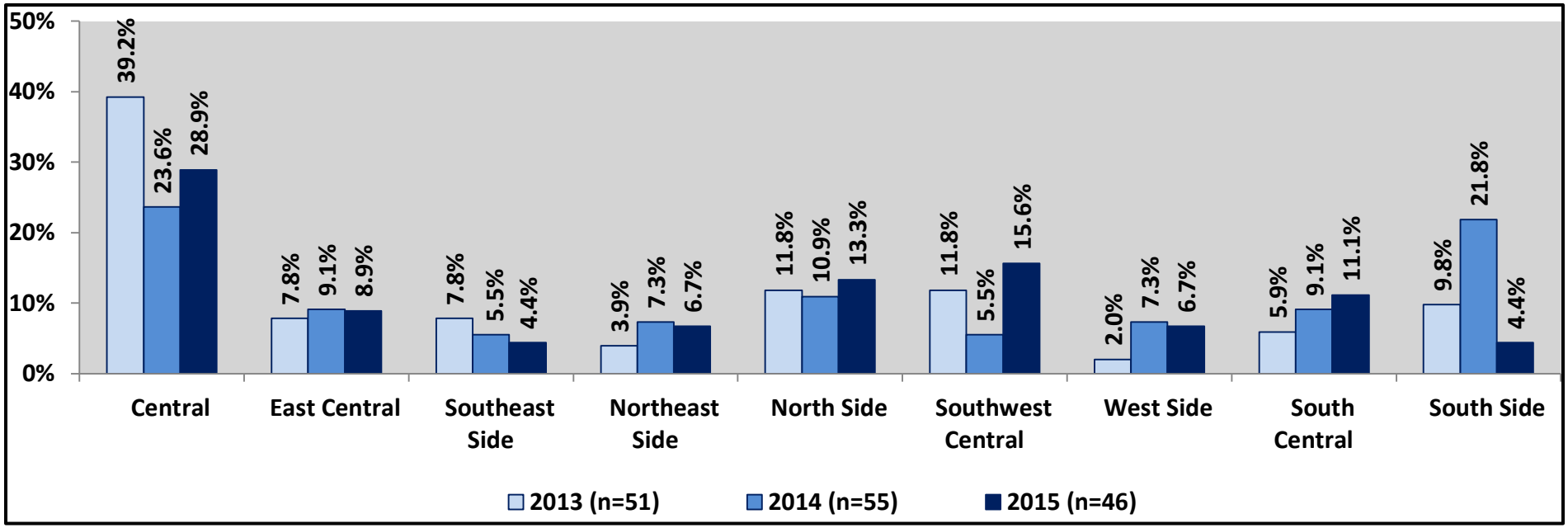


Data Source: *California Dept. of Public Health, Vital Records Business Intelligence System (VRBIS).*

*** "**Other/Unknown" category intentionally omitted due to lack of events.

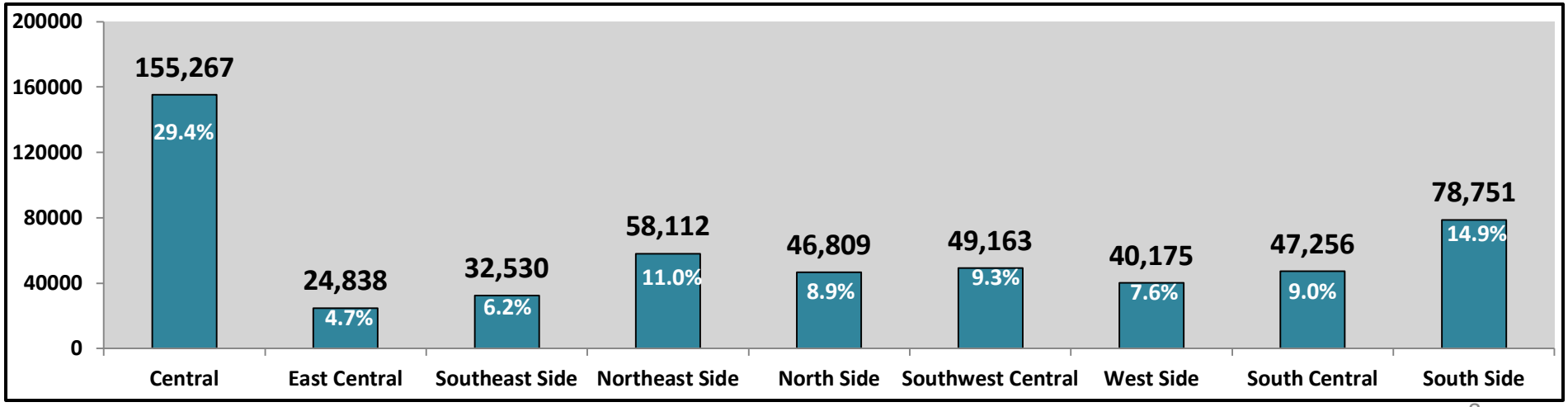
**** *"Other/Unknown and NH Black" categories intentionally omitted due to lack of events.*

Figure 5: Suicide Deaths by Region, Stanislaus County 2013-2015



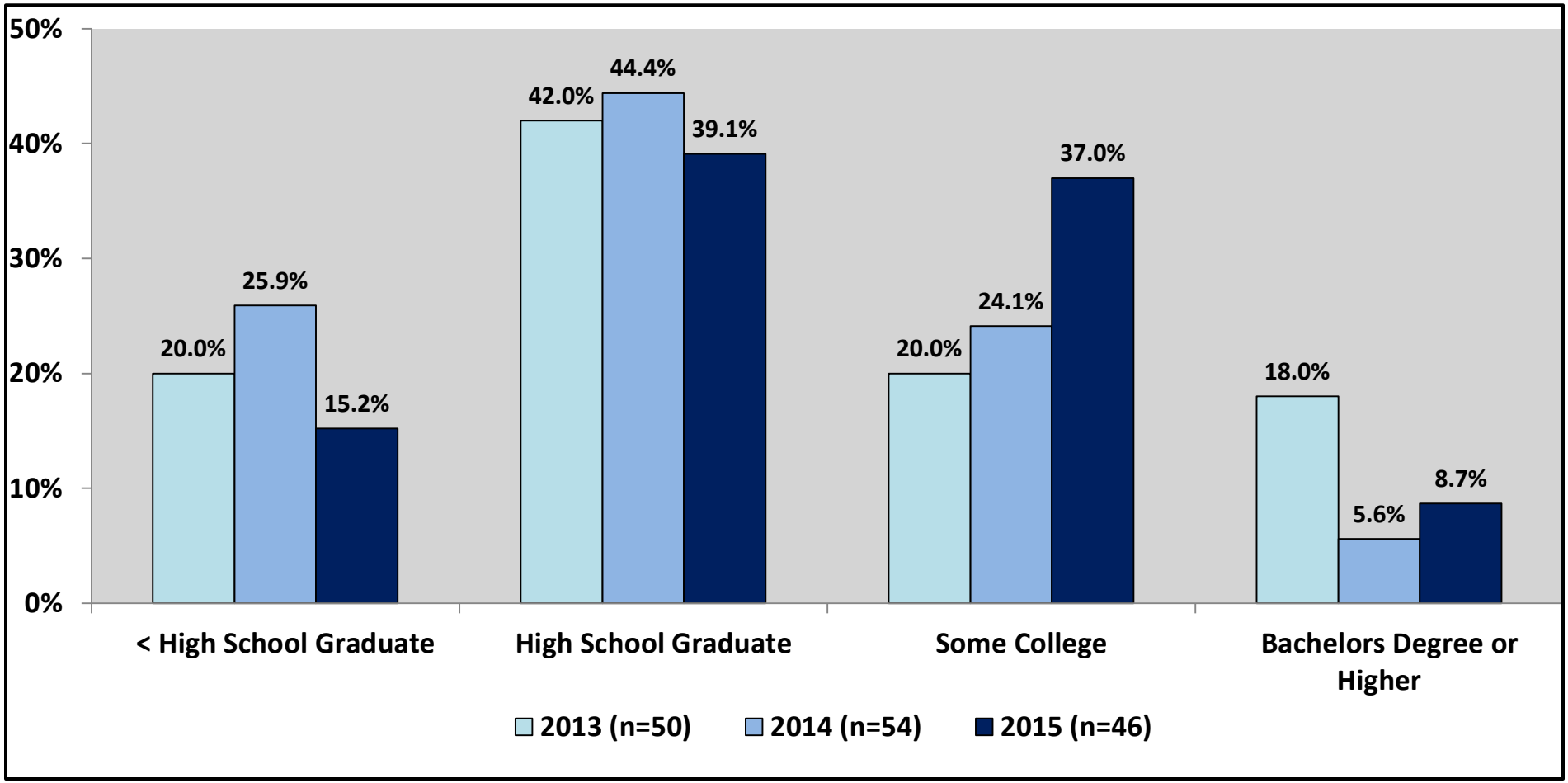
Data Source: *California Dept. of Public Health, Vital Records Business Intelligence System (VRBIS).*

Figure 6: Population by Region, Stanislaus County



Data Source*: 2011-2015 American Community Survey 5-Year Estimates. (N= 527,367)*

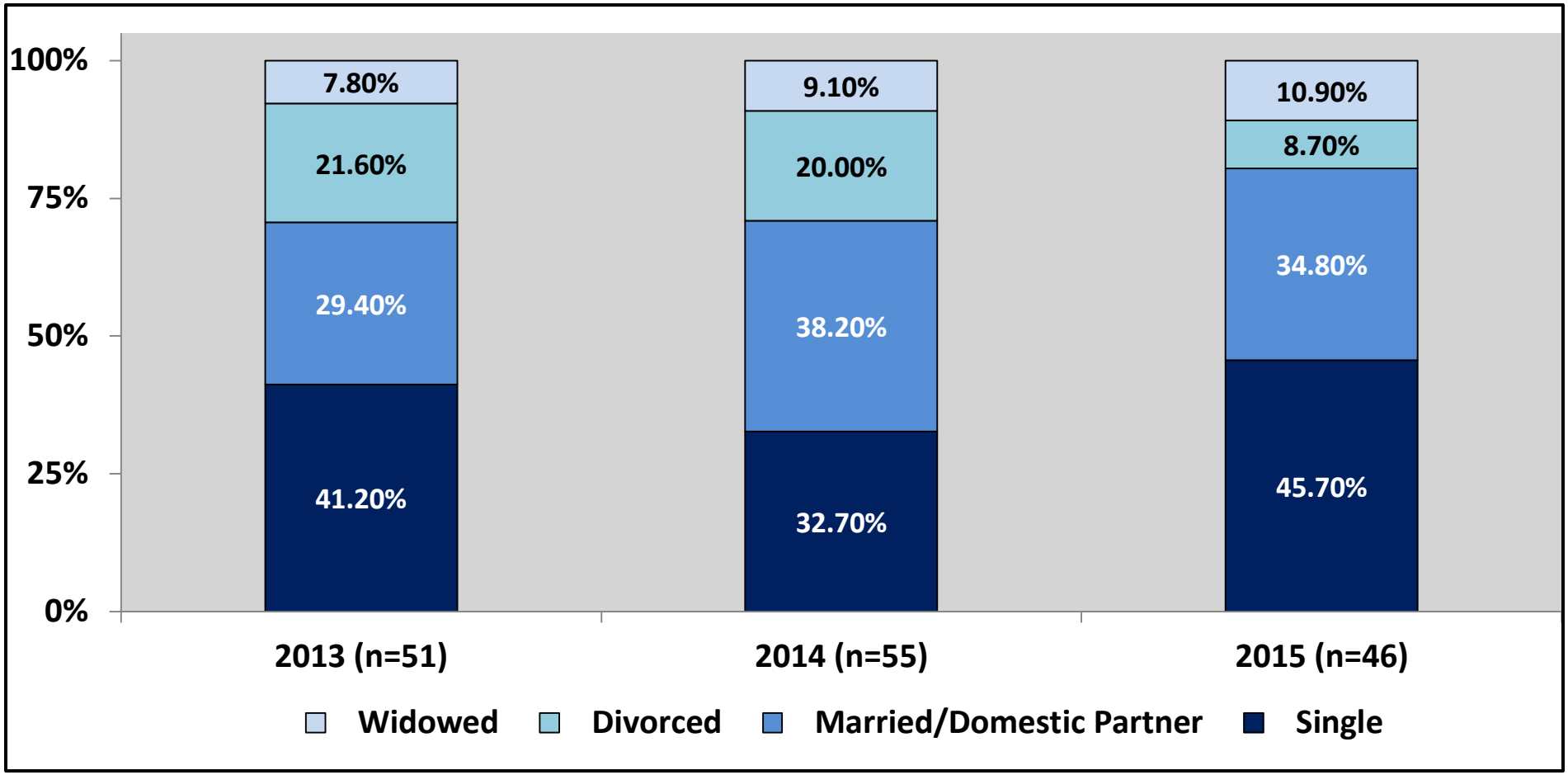
Figure 7: Suicide Deaths by Educational Attainment, Stanislaus County 2013-2015



Distribution of suicide deaths among Stanislaus County residents, by highest level of educational attainment.

Data Source: *California Dept. of Public Health, Vital Records Business Intelligence System (VRBIS).*

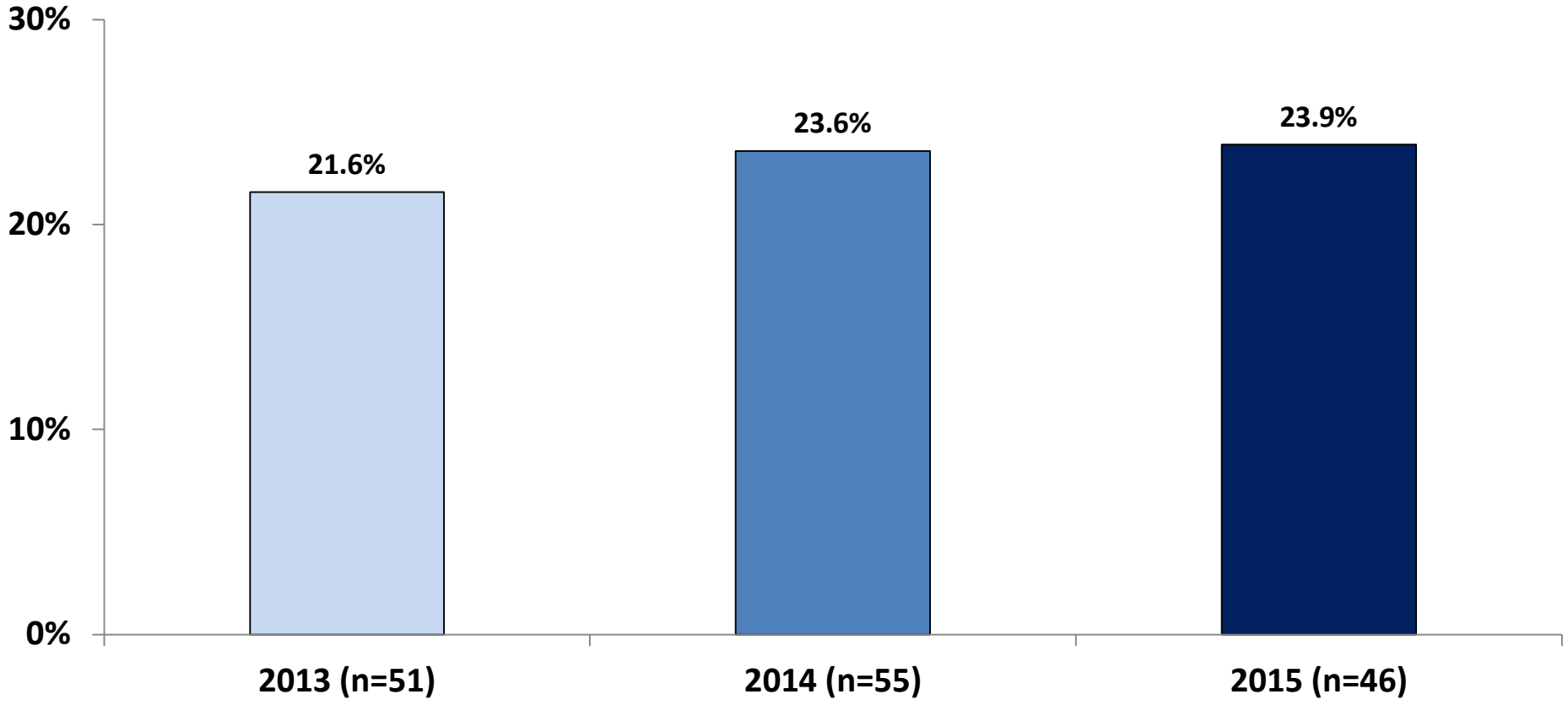
Figure 8: Suicide Deaths by Marital Status, Stanislaus County 2013-2015



Distribution of suicide deaths among Stanislaus County residents, by marital status.

Data Source: *California Dept. of Public Health, Vital Records Business Intelligence System (VRBIS).*

Figure 9: Suicide Deaths of Veterans, Stanislaus County 2013-2015



The percentage of veteran suicide deaths among Stanislaus County residents.

Data Source: *California Dept. of Public Health, Vital Records Business Intelligence System (VRBIS).*

Figure 10: Self-Inflicted/Suicide Deaths by Gender and Cause, Stanislaus County 2009-2013

Male	2009	2010	2011	2012	2013
Cut/Pierce	0	3	1	2	2
Firearm	22	20	19	18	24
Hanging/ Suffocation	12	11	16	17	13
Jump	0	1	1	0	0
Poisoning	11	1	8	1	4
Other	1	2	2	3	0

Female	2009	2010	2011	2012	2013
Cut/Pierce	0	0	0	0	0
Firearm	2	3	3	4	1
Hanging/ Suffocation	4	5	6	1	6
Jump	0	0	0	0	0
Poisoning	5	4	5	4	1
Other	1	0	1	0	4

Data Source: *California Dept. of Public Health, Vital Statistics Death Statistical Master Files. EPICenter (2017).*

Suicide Prevention Advisory Board

Meeting Activities Overview

Activity I: Develop the Problem Statement

A ***problem statement*** is a short 2 to 4 sentences description, that outlines the issues (root causes) that need to be addressed. A problem statement is a simple concept, but may not be easy or obvious.

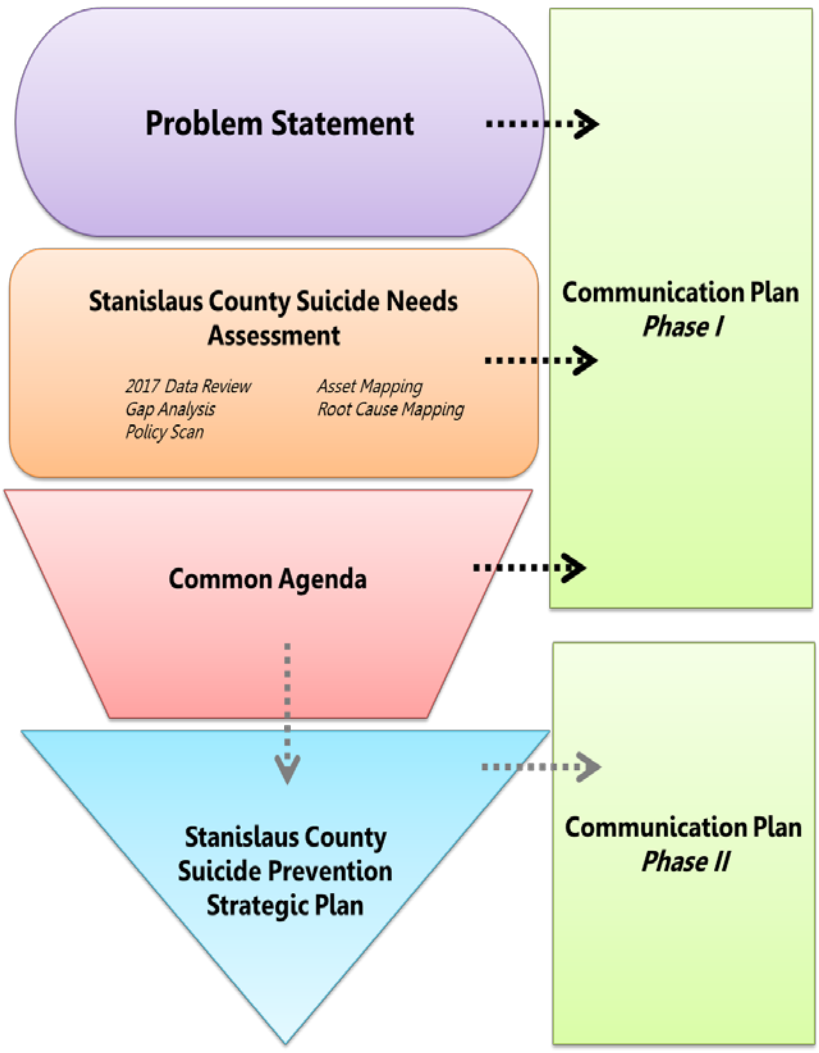
Purpose and Use of the Problem Statement:

The purpose of a problem statement is to establish a focus and direct the attention and efforts of the Advisory Board.

The problem statement will be used in the Stanislaus County Suicide Needs Assessment and Communication Plan.

Activity:

Considering the root causes and other project data, develop a problem statement.



Activity II: Develop the Common Agenda Statement

A ***common agenda*** is a shared vision for change. A common agenda statement translates a high-level vision, like reducing suicides, into an actionable statement.

Purpose and Use of the Common Agenda:

The purpose of a common agenda statement is to communicate the overarching strategic direction and/or approach to solve the problem statement. Development of the common agenda is a component of the strategic planning process.

The common agenda will be used in the conclusion and recommendations section of the Stanislaus County Suicide Needs Assessment. It will also be used in the Countywide Suicide Prevention Strategic Plan.

Activity:

Develop a common agenda statement that communicates the overarching strategic direction and/or approach to solve the problem statement.

The below samples are provided to assist in the Problem Statement and Common Agenda activities. The "Root Causes of Suicide in Stanislaus County" handout outlines the root causes to be included in the Problem Statement as well as addressed by the Common Agenda.

Sample Problem/Needs Statements

Adolescent Homelessness

There are an estimated 100,000 to 300,000 adolescents living on the streets of Hudson County, with no supervision, nurturance or regular assistance from a parent or responsible adult. Many young people have been forced into living on the streets. The reasons range from family dysfunctions such as abuse, sexual exploitation, neglect, and abandonment to inaction at the systems level with regard to an overburdened child protective system, inadequate minimum wage and lack of affordable housing. The consequences of adolescent homelessness are devastating to Hudson County and must be addressed.

Low Birthweight Infants

More infants are born with low birthweights in Bluffington County then in previous years. Babies born with low birthweights occurs most amongst disadvantaged mothers with low educational attainment and insufficient support systems. Infants born with a low birthweight are at higher risk of experiencing health problems as newborns and are at an increased risk for certain life-long health conditions. Low birthweight infants cause a significant cost burden to individuals, families and society.

Samples of Common Agenda/Mission Statement

Teen Homelessness

To ensure homeless adolescents have access to appropriate temporary shelter and comprehensive services that enable them to establish healthy support systems and secure sustainable housing.

Low Birthweight Infants

To prevent babies born with low birthweights through awareness, education and early intervention.

Sample Impact/Vision Statements

Adolescent Homelessness

To permanently end adolescent homelessness in Hudson County.

Low Birthweight Infants

A fighting chance for every baby to have a healthy future.

Collective Small Group Worksheet
Problem Statement

Considering the root causes and other project data, develop a problem statement.

Compile Individual Responses:

List Common Concepts & Similarities

List Alternative Concepts & Differences

Prioritize and Refine Statement Concepts / Main Ideas:

-
-
-

Brief Justification for Choices:

-
-
-

Final Collective Problem Statement:

(2 to 4 sentence)

Considering the root causes and other project data, develop a problem statement.
(i.e. word cloud, brainstorming, flow chart, 2 to 4 sentences describing the problem)

10C Considering the root causes and other project data, develop a problem statement.
(i.e. word cloud, brainstorming, flow chart, 2 to 4 sentences describing the problem)

Considering the root causes and other project data, develop a problem statement.
(i.e. word cloud, brainstorming, flow chart, 2 to 4 sentences describing the problem)

Considering the root causes and other project data, develop a problem statement.
(i.e. word cloud, brainstorming, flow chart, 2 to 4 sentences describing the problem)

Stanislaus County Suicide Fact Sheet

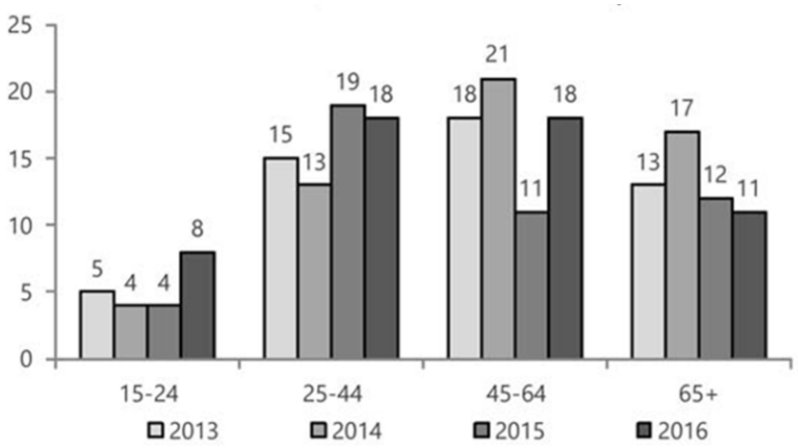
Attachment 11A

During the last four years (2013 - 2016) **207** Stanislaus County residents **died by suicide**, which equates to **nearly one suicide death every week**. The number of deaths from suicide reflects only a portion of the problem. Non-fatal suicidal behavior is a serious challenge and strongly associated with the suicide rate. Suicide has no single cause. The multiple contributing factors of suicide and suicidal behaviors are complex and can be attributed to the interaction of the following root causes:

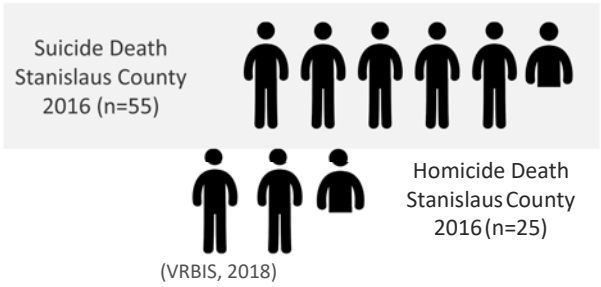
- Mental health stigma and misconceptions around suicide
- Decline in connectedness, interpersonal relationships, institutions and other social assets of a society (social capital)
- Challenges of sharing information across public and private systems, impacting the quality of care
- Lack of shared best practices or standard practices of care for suicidal behaviors and prevention

2016 Suicide Death Data

Suicide Death by Age, Stanislaus County 2013 - 2016

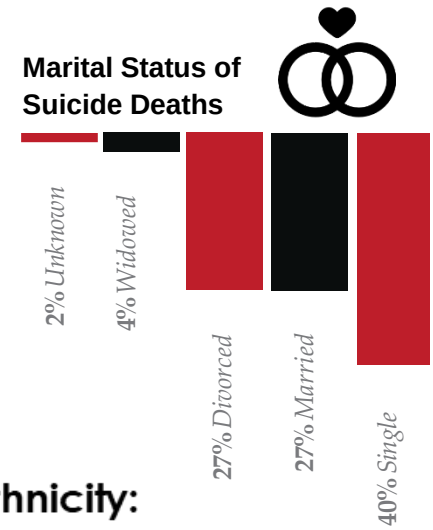


More Stanislaus County residents die by suicide than by homicide.



(VRBIS, 2018)

Marital Status of Suicide Deaths

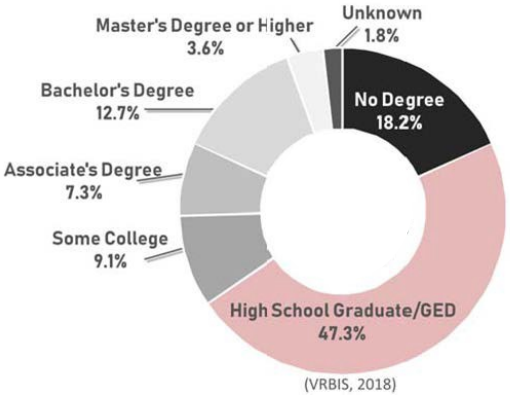


Gender:

24% Female

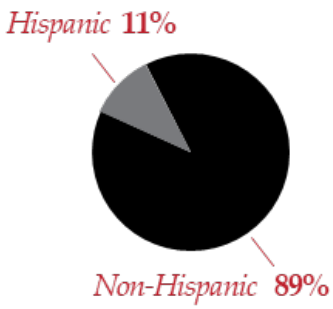
76% Male

Education Attainment of Suicide Deaths



(VRBIS, 2018)

Ethnicity:

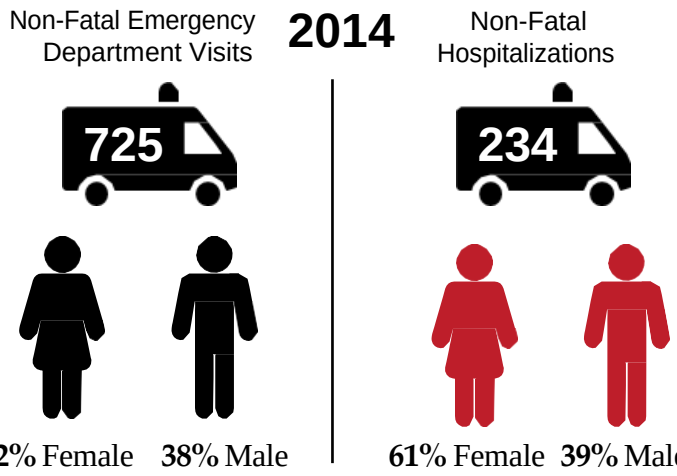


Source: Vital Records Business Intelligence System (2013-2016). Stanislaus County death data retrieval: January 1, 2016 through December 31, 2016.

Stanislaus County Suicide Fact Sheet

Suicide takes an emotional toll on families, affects the well-being of the larger community and carries a heavy societal cost burden. The number of deaths from suicide reflects only a portion of the problem. Non-fatal suicidal behaviors and attempts pose a serious challenge and are strongly associated with suicide rates.

Stanislaus County Suicide Attempt Data



Source: California Department of Public Health (2018). EpiCenter: Stanislaus County self-inflicted non-fatal injuries, 2014. Retrieved from http://epicenter.cdph.ca.gov/Default.aspx

Know the Signs

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

Find the Words

Start the Conversation – Ask About Suicide – Listen

Reach Out

Step In – Speak Up – Help is Available

The Cost of Suicide in California

$4,784,903,000

Combined medical and work loss cost, 2013

NCHS Vital Statistics System for number of deaths; NEISS All Injury Program operated by the U.S. Consumer Product Safety, 2018)

Suicide attempts **cost Stanislaus County an estimated $11,368,000** in combined medical and work loss costs during 2014. However, costs are calculated on known suicide attempts and **may actually be much higher.**

(n=959)

NCHS Vital Statistics System for number of deaths; NEISS All Injury Program operated by the U.S. Consumer Product Safety, 2018.

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Red Nacional de Prevención del Suicidio
1-888-628-9454
prevenciondelsuicidio.org

Asian Life Net Lifeline
1-877-990-8585
(Cantonese, Mandarin, Japanese, Korean, Fujianese)

Trans Lifeline
1-877-565-8860
www.translifeline.org

Central Valley Suicide Prevention Hotline
1-888-506-5991
www.centralvalleysuicidepreventionhotline.org

Stanislaus County Warm Line
209-558-4600

Acknowledgements

The Stanislaus County Suicide Prevention Innovation Project, operated by Stanislaus County Behavioral Health and Recovery Services, would like to thank the many organizations, agencies and individuals who assisted in the development of the Needs Assessment. The success of the Needs Assessment was dependent on the dedication and collaborative participation of the Stanislaus County Suicide Prevention Advisory Board, collaborative partners, service providers, county staff, and community members.

Suicide Prevention Innovation Project Team

Amber Gillaspy -- *Event Planning Specialist*

Kirsten Jasek-Rysdahl, MA, MSW -- *Project Evaluator*

Sharrie Sprouse -- *Project Manager*

Theresa Fournier, MPH -- *Data Analyst*

Stanislaus County Suicide Prevention Advisory Board
Suicide Prevention Innovation Project
Stanislaus County Behavioral Health and Recovery Services
800 Scenic Drive
Modesto, CA 95350
209.525.6208

The Suicide Prevention Innovation Project is funded by the Mental Health Services Act.

Datos Sobre Suicidios en el Condado Stanislaus

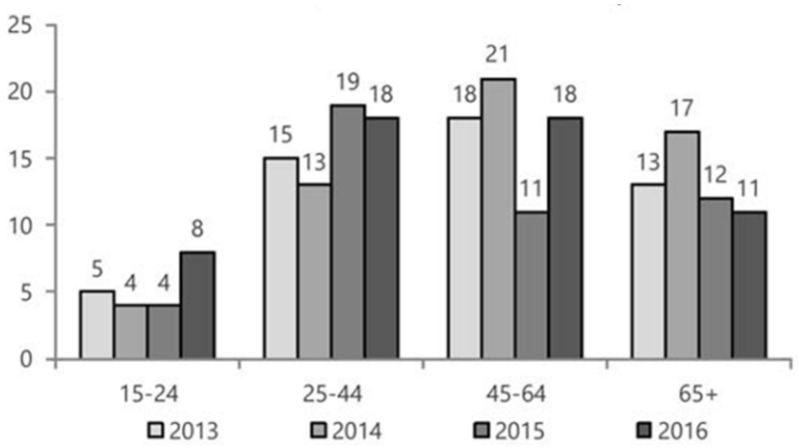
Attachment 11B

Durante los últimos cuatro años (2013 - 2016) **207** residentes del condado Stanislaus **murieron por causa de suicidio**, lo cual **equivale a casi un suicidio cada semana**. El número de muertes por suicidio refleja solamente una porción del problema. El comportamiento suicida no fatal, es un desafío serio y fuertemente asociado con el porcentaje de suicidio. El suicidio no tiene una sola causa. Los múltiples factores que contribuyen al suicidio y los comportamientos suicidas son complejos y pueden atribuirse a la interacción de las siguientes causas del origen:

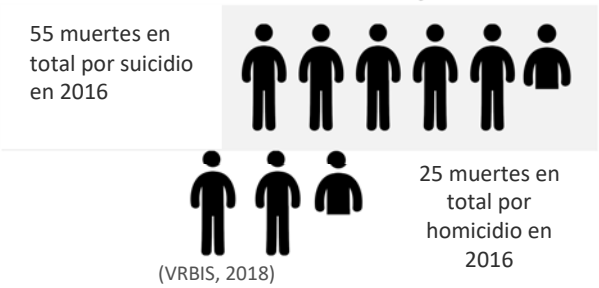
- Estigma de salud mental y conceptos erróneos sobre el suicidio
- Disminución de conectividad en, relaciones interpersonales, instituciones y otros activos sociales de una sociedad (capital social)
- Desafíos para intercambiar información entre sistemas públicos y privados, lo cual afecta la calidad de atención
- Falta de mejores prácticas compartidas o estándares de atención para conductas suicidas y de prevención

Datos de Muerte Suicida - 2016

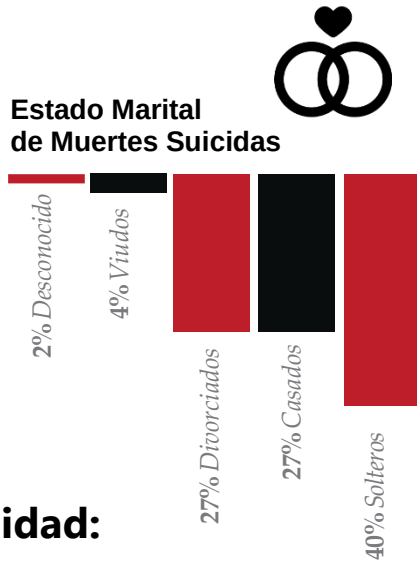
Muertes Suicidas por Edad en el Condado Stanislaus 2013 - 2016



Más residentes del condado Stanislaus **mueren** por **suicidio** que por homicidio.



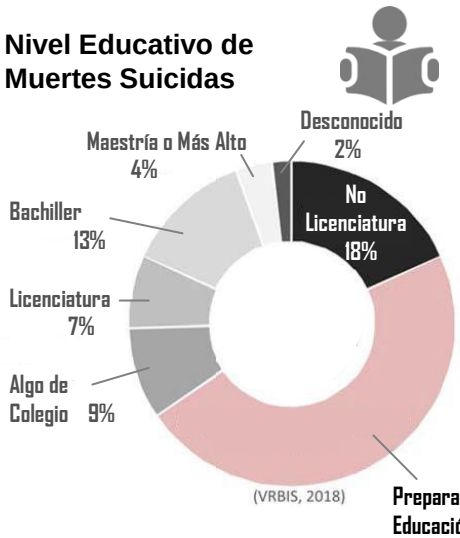
Estado Marital de Muertes Suicidas



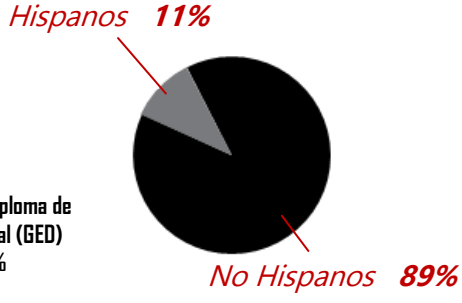
Género:

24% Femenino **76% Masculino**

Nivel Educativo de Muertes Suicidas



Etnicidad:



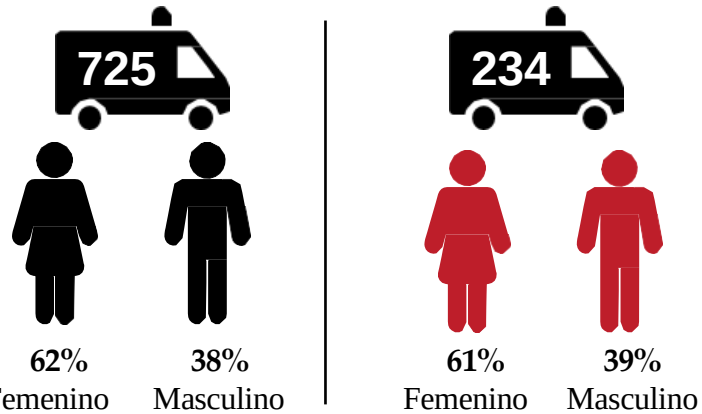
Fuente: Sistema de Inteligencia Empresarial de Registros Vitales (2013-2016).
Recuperación de datos de muertes del condado Stanislaus: 1º de enero de 2016 hasta 31 de diciembre, 2016.

Datos Sobre Suicidios en el Condado Stanislaus

El suicidio tiene un impacto emocional en las familias, afecta el bienestar de la comunidad en general y conlleva una gran carga de costos sociales. El número de muertes por suicidio refleja solamente una porción del problema. Los comportamientos e intentos de suicidio no fatales poseen un serio desafío y están fuertemente asociados con los porcentajes de suicidio.

Datos de Intentos de Suicidios en el Condado Stanislaus

2014



Fuente: Departamento de Salud Pública de California (2018). EpiCentro: Lesiones auto-infligidas no fatales, condado Stanislaus, 2014. Recuperado de http://epicenter.cdph.ca.gov/Default.aspx

El costo por suicidios en California en combinación con pérdidas médicas y laborales en el año 2013 fue de

$ 4,784,903,000

Sistema de Estadísticas Vitales de NCHS para el número de muertes; El Programa de Lesiones NEISS, operado por la seguridad de productos de consumo de los E. U., 2018

El costo por intento de suicidio en el **condado Stanislaus** en combinación con pérdidas médicas y laborales se **estimó ser $11,368,000** durante el 2014. Sin embargo, los costos se calculan en intentos de suicidio conocidos y **pueden ser mucho más altos**.

Sistema de Estadísticas Vitales de NCHS para el número de muertes; El Programa de Lesiones NEISS, operado por la seguridad de productos de consumo de los E. U., 2018

Conocer las Señales:

- Hablar acerca de querer morir o quitarse la vida
- Buscar una forma de quitarse la vida
- Hablar acerca de sentirse desesperanzado o sin razón de vivir
- Hablar acerca de sentirse atrapado o en un dolor insoportable
- Hablar acerca de ser una carga para alguien
- Aumentar el uso de alcohol o drogas
- Actuar ansioso o agitado; comportarse imprudentemente
- Dormir muy poco o demasiado
- Aislarse o sentirse retraído
- Mostrar rabia o hablar acerca de venganza
- Demostrar cambios de humor extremos

Encontrar las Palabras

Iniciar la Conversación – Preguntar Acerca de Suicidio – Escuchar

Extender la Mano/Comunicar

Intervención – Comunicación – La Ayuda Está Disponible

Línea Nacional de Prevención del Suicidio
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Red Nacional de Prevención del Suicidio
1-888-628-9454
prevenciondelsuicidio.org

Red Asiática Salvavidas
1-877-990-8585
(Cantonés, Mandarín, Japonés, Coreano, Fujianés)

Línea de Vida Transgénero
1-877-565-8860
www.translifeline.org

Línea Directa de Suicidio del Valle Central
1-888-506-5991
www.centralvalleysuicidepreventionhotline.org

Línea de Apoyo Condado Stanislaus
209-558-4600

Reconocimientos

El Proyecto de Innovación del Condado Stanislaus para la Prevención del Suicidio, operado por los Servicios de Recuperación y Salud Mental del Condado Stanislaus, quisiera agradecer a las muchas organizaciones e individuos que colaboraron en el desarrollo de la Evaluación de Necesidades. El éxito de la Evaluación de Necesidades dependió de la dedicación y participación colaborativa del Consejo Asesor de Prevención del Suicidio del Condado Stanislaus, colaboradores asociados, proveedores de servicios, personal del condado y miembros de la comunidad.

Equipo del Proyecto de Innovación de Prevención del Suicidio

Amber Gillaspy -- *Especialista de Planeación de Eventos*

Kirsten Jasek-Rysdahl, MA, MSW -- *Evaluadora del Proyecto*

Sharrie Sprouse -- *Gerente del Proyecto*

Theresa Fournier, MPH -- *Analista de Datos*

Consejo Asesor de Prevención del Suicidio del Condado Stanislaus
Proyecto de Innovación de Prevención del Suicidio
Servicios de Recuperación y
Salud Mental del Condado Stanislaus
800 Scenic Drive
Modesto, CA 95350
209.525.6208

El Proyecto de Innovación de Prevención del Suicidio es fundado por la Ley de Servicios de Salud Mental.

COMMUNITY COLLABORATIVE ASSESSMENT

How ready are we for collaborative work?

Attachment 12A

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

	Column A	Column B	Column C
1.	☐ My community has demonstrated interest in the issue we are trying to address (suicides in our county) over the past five years through the CEO's office, community initiatives, and in other ways.	☐ Ideas have been generated for collaborative efforts on this issue (suicides in our county), along with some early attempts, but no sustained collaborative efforts.	☐ My community has not demonstrated interest in this type of work.
2.	☐ My community has collaborated across sectors when necessary over the past five years (e.g., among nonprofit, government, business.)	☐ We have had conversations across sectors, but have not formally collaborated.	☐ While we needed to collaborate across sectors, we were not able to do so (due to lack of either interest or capacity.)
3.	☐ My community has a strong history of citizen engagement (parents, small business, etc.) in community affairs.	☐ My community has had some successes and some failures in engaging citizens.	☐ We have not tried to engage.
4.	☐ My community has a strong history of youth engagement in community affairs involving them.	☐ My community has had some successes and some failures in engaging youth.	☐ We have failed to engage youth.
5.	☐ Historically, a strong provider network (i.e. network of organizations) has focused on our issue.	☐ We have a moderately strong provider community, but it is not very aligned.	☐ We do not have a strong provider network focused on this issue.
6.	☐ We have a clear need for our collaborative; no other effective collaboratives exist addressing this or related issues.	☐ Similar collaborative efforts exist that we could join; but those collaboratives are only partially effective or only partially aligned on the issue.	☐ We are not sure what else is happening in our community on this issue.
7.	☐ The providers in my community are using evidence-based practices to address this issue.	☐ Some providers use evidence-based practices; some do not.	☐ Most providers do not use evidence-based practices, or are not familiar with evidence-based practices for this issue.
8.	☐ Providers or funders have acted successfully as leaders in my community by convening peers and facilitating collaborative conversations.	☐ Prior efforts have produced leadership that has gained mixed results.	☐ No one has done work in this area, or the leaders of that work were unsuccessful.
9.	☐ We have providers or funders that are respected and maintain a relatively neutral stance on the issue.	☐ The providers or funders have won the respect of some, but not all.	☐ We are not sure about the agendas of our providers or funders.
10.	☐ Over the past five years, my local funder community has worked well together, collaborating many times.	☐ We have seen some funder collaboration and organization.	☐ Our funder community is not organized and has not collaborated in the past.
11.	☐ Over the past five years, my community's funders have been aligned around a common set of goals about what to fund in my community.	☐ Some funder alignment has occurred on what to fund.	☐ There has been no funder alignment on what to fund.
12.	☐ Over the past five years, our community has used data to examine, assess and create shared understanding of our challenges.	☐ We have sometimes used data to create shared understanding of our challenges.	☐ We have not used data to create shared understanding of our challenges.
13.	☐ My community has tracked a set of indicators or outcomes related to the goals of my collaborative.	☐ Some tracking is happening in my community, but it is in very early stages.	☐ No data tracking is taking place.
14.	☐ My community has used data to create actionable plans for the future and set the current agenda.	☐ We sometimes use the data we collect to influence our plans for the future.	☐ Our plans are not determined by data.

COMMUNITY COLLABORATIVE ASSESSMENT

Do we have the core principles in place for a successful collaboration?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

	Column A	Column B	Column C
1.	☐ Our collaborative aspires to needle-moving change: 10%-plus change from the baseline on our outcomes.	☐ Some potential participants are committed to 10%-plus change from the baseline on our outcomes.	☐ The issues not on key leaders' radar screens; we do not have consensus yet.
2.	☐ We have a clear sense of what the collaborative uniquely can add to our community and how we can partner with existing work.	☐ We know what else is happening related to our issue and are figuring out how our work fits in.	☐ We have not looked deeply at related work happening in our community.
3.	☐ Our collaborative is focused on moving the entire community, city or region forward (i.e., graduation rates across the city).	☐ We have only somewhat defined our boundaries. Or, our boundaries represent a subset of the community.	☐ We have not defined our boundaries at all.
4.	☐ Key stakeholders are committed to this work for the long-term (three to five-plus years).	☐ Key stakeholders are committed to this work for at least the early phase of the work (i.e. one to two years); we are still building commitment for the long-term.	☐ Key stakeholders have not defined how long they will remain committed.
5.	☐ We have identified a key funder that has expressed interest in a long-term commitment (of three to five-plus years).	☐ We have held exploratory conversations, but no funder has expressed an interest in long-term commitment.	☐ We are still identifying potential funders.
6.	☐ We have multiple participants ready to support the collaborative from the sectors that are relevant to tour issue area, (i.e., government, philanthropy nonprofit, business, and the like).	☐ We have some, but not all, of the appropriate participants.	☐ We are missing many of the relevant participants.
7.	☐ We are committed to regularly using data that others or we collect in order to determine our direction and priorities.	☐ Data will be a part of our work, but secondary to some other aspects of the collaborative's work.	☐ We do not plan to collect data as a part of our collaborative.
8.	☐ We have a plan, now underway, for capturing and analyzing relevant data, considering the data as a group, and adjusting course based on the data.	☐ We have a plan for how to capture relevant data, but we have not determined how to regularly incorporate it into our work.	☐ We are in the process of developing a plan.
9.	☐ We have identified individuals from the community who should be involved in our collaborative process and have decided how they should be involved.	☐ We are thinking about the engagement of key individuals, but don't know who to engage or how.	☐ We have not thought about engagement beyond the institutional participants in our collaborative.
10.	☐ Our leadership has established a process for gaining buy-in from relevant community members in our community (e.g., parents and youth).	☐ We are developing a process to establish buy-in.	☐ We are not going to develop a buy-in process.

COMMUNITY COLLABORATIVE ASSESSMENT

How aligned and organized is our community?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

	Column A	Column B	Column C
1.	☐ The collaborative participants and broader community share a common vision for future about the issue.	☐ Parties have somewhat distinct visions about this issue in our community.	☐ No one has clearly articulated vision statements for the community; the issue is not on people's minds.
2.	☐ We have agreed upon a road map to guide how we will achieve communitywide change.	☐ We do have a road map, but it is under development. Or, we have only reached partial agreement on our path.	☐ We tried to create a road map, but there is no agreement.
3.	☐ We have data metrics that match up with our goals and action plan.	☐ We are not sure how to measure metrics to assess progress against the road map.	☐ We do not plan to use data.
4.	☐ We have achieved buy-in from engaged community leaders around the collaborative's vision, road map and defined goals.	☐ Some community leaders are engaged and have bought in.	☐ We have gained very little engagement and little buy-in from community leaders.
5.	☐ We currently have a respected, neutral leader at the head of our collaborative, who is able to convene and maintain a diverse collaborative.	☐ Our leadership lacks some characteristics and skills required to convene and maintain a collaborative.	☐ Our leadership lacks most of the necessary characteristics and skills to convene and maintain the collaborative.
6.	☐ We have engaged the full set of organizations and leaders that must be aligned to reach our goals.	☐ We are missing some of the necessary organizations and leaders in our collaborative.	☐ We are not sure if we have the right organizations and leaders at the table.
7.	☐ We have researched similar efforts outside our community to identify effective strategies that we can adapt.	☐ We have researched some effective strategies, but are unsure how to adapt them to our model.	☐ We have not researched other similar efforts.
8.	☐ Our roadmap specifies a complete set of interventions that logically lead to the changes we want to see.	☐ Our roadmap includes only some of the interventions we believe are necessary for change; our roadmap is partially complete.	☐ We have not thought about how our interventions lead to the change we want to see; our roadmap is not completed at all.
9.	☐ Where applicable, we have advocacy efforts focused on changing the policies, funding and systems in our community to better address the issue.	☐ We have a plan for how to create advocacy effectively.	☐ We need advocacy in our community, but we have not thought about how to create it.

COMMUNITY COLLABORATIVE ASSESSMENT

Do we have the capacity and resources in place to be successful?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

	Column A	Column B	Column C
1.	☐ We have a clear sense of the time and talent needed to run the collaborative itself (separate from participating organizations' capacity).	☐ We have not considered what capacity is needed, but will in the future.	☐ We do not plan to have dedicated capacity for the collaborative.
2.	☐ We have identified paid staff who can help coordinate or facilitate the collaborative process.	☐ We are not sure how to get paid staff.	☐ We do not plan to have paid staff.
3.	☐ We have clearly defined roles within the collaborative (such as a facilitator, data measurement specialist and so on).	☐ We have some roles, but they are not explicitly defined.	☐ We do not have clear roles.
4.	☐ We have the necessary structure, processes and system to support our work (committees, systems to analyze data and so on).	☐ We have some of this in place.	☐ We do not have any structures, processes or systems in place.
5.	☐ Providers in my community have the capacity to come together and collaborate or partner.	☐ Providers have some capacity, but not enough for our collaborative.	☐ Providers have minimal capacity to come together and collaborate.
6.	☐ We have a clear sense of what it will take to fund our collaborative, including dedicated capacity, over the next five years.	☐ We have estimates, but are not sure how to figure out what resources are required.	☐ We do not have estimates yet.
7.	☐ We have long-term financial commitment from funders to cover the dedicated capacity and collaborative work.	☐ We have short-term commitments from funders.	☐ We don't have any financial commitments.

Adapted from *Community Collaborative Assessment – A Diagnostic of Success Readiness*. Retrieved from https://www.serve.gov/new-images/council/pdf/community_collaborative_assessment.pdf

Community Collaborative Assessment Summary of Readiness

Baseline: October 3 - December 7, 2017

Section 1

How ready is my community for collaborative work?

Total Summary Score by Topic Area	History of Community Collaboratives	**86%**
	History of Community Engagement	**74%**
	Ecosystems of Providers	**71%**
	History of Funder Collaboration	**75%**
	History of Data Use	**77%**
	Total Summary Score Section 1	**75%**

Section 2

Do we have the core principles in place for a successful collaboration?

Total Summary Score by Topic Area	Aspires to "needle-moving" Change	**68%**
	Long-Term Investment in Success	**66%**
	Cross-Sector Engagement	**76%**
	Data & Continuous Learning	**72%**
	Community Engagement	**74%**
	Total Summary Score Section 2	**70%**

Total Score Part A: *Develop the Idea* ---------- **73%**

Section 3

How aligned and organized is our community?

Total Summary Score by Topic Area	Shared Vision and Agenda	**74%**
	Effective Leadership and Governance	**83%**
	Deliberate Alignment of Resources, Programs and Advocacy Toward What Works	**68%**
	Total Summary Score Section 3	**73%**

Section 4

Do we have the capacity and resources in place to be successful?

Total Summary Score by Topic Area	Dedicated Capacity and Appropriate Structure	**80%**
	Sufficient Resources	**61%**
	Total Summary Score Section 4	**75%**

Total Score Part B: *Plan and Align Resources* ---------- **74%**

OVERALL READINESS 74%

Attachment 12B

COMMUNITY COLLABORATIVE ASSESSMENT

How ready are we for collaborative work?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

		Column A	Column B	Column C
92	1.	☐ My community has demonstrated interest in the issue we are trying to address (suicides in our county) over the past five years through the CEO's office, community initiatives, and in other ways.	☐ Ideas have been generated for collaborative efforts on this issue (suicides in our county), along with some early attempts, but no sustained collaborative efforts.	☐ My community has not demonstrated interest in this type of work.
89	2.	☐ My community has collaborated across sectors when necessary over the past five years (e.g., among nonprofit, government, business.)	☐ We have had conversations across sectors, but have not formally collaborated.	☐ While we needed to collaborate across sectors, we were not able to do so (due to lack of either interest or capacity.)
81	3.	☐ My community has a strong history of citizen engagement (parents, small business, etc.) in community affairs.	☐ My community has had some successes and some failures in engaging citizens.	☐ We have not tried to engage.
76	4.	☐ My community has a strong history of youth engagement in community affairs involving them.	☐ My community has had some successes and some failures in engaging youth.	☐ We have failed to engage youth.
77	5.	☐ Historically, a strong provider network (i.e. network of organizations) has focused on our issue.	☐ We have a moderately strong provider community, but it is not very aligned.	☐ We do not have a strong provider network focused on this issue.
83	6.	☐ We have a clear need for our collaborative; no other effective collaboratives exist addressing this or related issues.	☐ Similar collaborative efforts exist that we could join; but those collaboratives are only partially effective or only partially aligned on the issue.	☐ We are not sure what else is happening in our community on this issue.
77	7.	☐ The providers in my community are using evidence-based practices to address this issue.	☐ Some providers use evidence-based practices; some do not.	☐ Most providers do not use evidence-based practices, or are not familiar with evidence-based practices for this issue.
79	8.	☐ Providers or funders have acted successfully as leaders in my community by convening peers and facilitating collaborative conversations.	☐ Prior efforts have produced leadership that has gained mixed results.	☐ No one has done work in this area, or the leaders of that work were unsuccessful.
82	9.	☐ We have providers or funders that are respected and maintain a relatively neutral stance on the issue.	☐ The providers or funders have won the respect of some, but not all.	☐ We are not sure about the agendas of our providers or funders.
79	10.	☐ Over the past five years, my local funder community has worked well together, collaborating many times.	☐ We have seen some funder collaboration and organization.	☐ Our funder community is not organized and has not collaborated in the past.
73	11.	☐ Over the past five years, my community's funders have been aligned around a common set of goals about what to fund in my community.	☐ Some funder alignment has occurred on what to fund.	☐ There has been no funder alignment on what to fund.
75	12.	☐ Over the past five years, our community has used data to examine, assess and create shared understanding of our challenges.	☐ We have sometimes used data to create shared understanding of our challenges.	☐ We have not used data to create shared understanding of our challenges.
82	13.	☐ My community has tracked a set of indicators or outcomes related to the goals of my collaborative.	☐ Some tracking is happening in my community, but it is in very early stages.	☐ No data tracking is taking place.
79	14.	☐ My community has used data to create actionable plans for the future and set the current agenda.	☐ We sometimes use the data we collect to influence our plans for the future.	☐ Our plans are not determined by data.

COMMUNITY COLLABORATIVE ASSESSMENT

Do we have the core principles in place for a successful collaboration?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

		Column A	Column B	Column C
75	1.	☐ Our collaborative aspires to needle-moving change: 10%-plus change from the baseline on our outcomes.	☐ Some potential participants are committed to 10%-plus change from the baseline on our outcomes.	☐ The issues not on key leaders' radar screens; we do not have consensus yet.
81	2.	☐ We have a clear sense of what the collaborative uniquely can add to our community and how we can partner with existing work.	☐ We know what else is happening related to our issue and are figuring out how our work fits in.	☐ We have not looked deeply at related work happening in our community.
82	3.	☐ Our collaborative is focused on moving the entire community, city or region forward (i.e., graduation rates across the city).	☐ We have only somewhat defined our boundaries. Or, our boundaries represent a subset of the community.	☐ We have not defined our boundaries at all.
83	4.	☐ Key stakeholders are committed to this work for the long-term (three to five-plus years).	☐ Key stakeholders are committed to this work for at least the early phase of the work (i.e. one to two years); we are still building commitment for the long-term.	☐ Key stakeholders have not defined how long they will remain committed.
67	5.	☐ We have identified a key funder that has expressed interest in a long-term commitment (of three to five-plus years).	☐ We have held exploratory conversations, but no funder has expressed an interest in long-term commitment.	☐ We are still identifying potential funders.
74	6.	☐ We have multiple participants ready to support the collaborative from the sectors that are relevant to tour issue area, (i.e., government, philanthropy nonprofit, business, and the like).	☐ We have some, but not all, of the appropriate participants.	☐ We are missing many of the relevant participants.
88	7.	☐ We are committed to regularly using data that others or we collect in order to determine our direction and priorities.	☐ Data will be a part of our work, but secondary to some other aspects of the collaborative's work.	☐ We do not plan to collect data as a part of our collaborative.
81	8.	☐ We have a plan, now underway, for capturing and analyzing relevant data, considering the data as a group, and adjusting course based on the data.	☐ We have a plan for how to capture relevant data, but we have not determined how to regularly incorporate it into our work.	☐ We are in the process of developing a plan.
77	9.	☐ We have identified individuals from the community who should be involved in our collaborative process and have decided how they should be involved.	☐ We are thinking about the engagement of key individuals, but don't know who to engage or how.	☐ We have not thought about engagement beyond the institutional participants in our collaborative.
72	10.	☐ Our leadership has established a process for gaining buy-in from relevant community members in our community (e.g., parents and youth).	☐ We are developing a process to establish buy-in.	☐ We are not going to develop a buy-in process.

COMMUNITY COLLABORATIVE ASSESSMENT

How aligned and organized is our community?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

		Column A	Column B	Column C
75	1.	☐ The collaborative participants and broader community share a common vision for future about the issue.	☐ Parties have somewhat distinct visions about this issue in our community.	☐ No one has clearly articulated vision statements for the community; the issue is not on people's minds.
73	2.	☐ We have agreed upon a road map to guide how we will achieve communitywide change.	☐ We do have a road map, but it is under development. Or, we have only reached partial agreement on our path.	☐ We tried to create a road map, but there is no agreement.
86	3.	☐ We have data metrics that match up with our goals and action plan.	☐ We are not sure how to measure metrics to assess progress against the road map.	☐ We do not plan to use data.
75	4.	☐ We have achieved buy-in from engaged community leaders around the collaborative's vision, road map and defined goals.	☐ Some community leaders are engaged and have bought in.	☐ We have gained very little engagement and little buy-in from community leaders.
91	5.	☐ We currently have a respected, neutral leader at the head of our collaborative, who is able to convene and maintain a diverse collaborative.	☐ Our leadership lacks some characteristics and skills required to convene and maintain a collaborative.	☐ Our leadership lacks most of the necessary characteristics and skills to convene and maintain the collaborative.
81	6.	☐ We have engaged the full set of organizations and leaders that must be aligned to reach our goals.	☐ We are missing some of the necessary organizations and leaders in our collaborative.	☐ We are not sure if we have the right organizations and leaders at the table.
75	7.	☐ We have researched similar efforts outside our community to identify effective strategies that we can adapt.	☐ We have researched some effective strategies, but are unsure how to adapt them to our model.	☐ We have not researched other similar efforts.
68	8.	☐ Our roadmap specifies a complete set of interventions that logically lead to the changes we want to see.	☐ Our roadmap includes only some of the interventions we believe are necessary for change; our roadmap is partially complete.	☐ We have not thought about how our interventions lead to the change we want to see; our roadmap is not completed at all.
77	9.	☐ Where applicable, we have advocacy efforts focused on changing the policies, funding and systems in our community to better address the issue.	☐ We have a plan for how to create advocacy effectively.	☐ We need advocacy in our community, but we have not thought about how to create it.

COMMUNITY COLLABORATIVE ASSESSMENT

Do we have the capacity and resources in place to be successful?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

		Column A	Column B	Column C
88	1.	☐ We have a clear sense of the time and talent needed to run the collaborative itself (separate from participating organizations' capacity).	☐ We have not considered what capacity is needed, but will in the future.	☐ We do not plan to have dedicated capacity for the collaborative.
78	2.	☐ We have identified paid staff who can help coordinate or facilitate the collaborative process.	☐ We are not sure how to get paid staff.	☐ We do not plan to have paid staff.
81	3.	☐ We have clearly defined roles within the collaborative (such as a facilitator, data measurement specialist and so on).	☐ We have some roles, but they are not explicitly defined.	☐ We do not have clear roles.
80	4.	☐ We have the necessary structure, processes and system to support our work (committees, systems to analyze data and so on).	☐ We have some of this in place.	☐ We do not have any structures, processes or systems in place.
84	5.	☐ Providers in my community have the capacity to come together and collaborate or partner.	☐ Providers have some capacity, but not enough for our collaborative.	☐ Providers have minimal capacity to come together and collaborate.
72	6.	☐ We have a clear sense of what it will take to fund our collaborative, including dedicated capacity, over the next five years.	☐ We have estimates, but are not sure how to figure out what resources are required.	☐ We do not have estimates yet.
68	7.	☐ We have long-term financial commitment from funders to cover the dedicated capacity and collaborative work.	☐ We have short-term commitments from funders.	☐ We don't have any financial commitments.

KEY:
- ❑ ≥ 90%
- ❑ 80-89%
- ❑ 70-79%
- ❑ ≤ 69%

Adapted from *Community Collaborative Assessment – A Diagnostic of Success Readiness*. Retrieved from https://www.serve.gov/new-images/council/pdf/community_collaborative_assessment.pdf

Community Collaborative Assessment Summary of Readiness

October 2018 - 2nd Administration (n=21)

Section 1

How ready is my community for collaborative work?

Total Summary Score by Topic Area		
	History of Community Collaboratives	91%
	History of Community Engagement	79%
	Ecosystems of Providers	80%
	History of Funder Collaboration	76%
	History of Data Use	79%
	Total Summary Score Section 1	**80%**

Section 2

Do we have the core principles in place for a successful collaboration?

Total Summary Score by Topic Area		
	Aspires to "needle-moving" Change	80%
	Long-Term Investment in Success	75%
	Cross-Sector Engagement	74%
	Data & Continuous Learning	85%
	Community Engagement	74%
	Total Summary Score Section 2	**78%**

Total Score Part A: *Develop the Idea* ---------- **79%**

Section 3

How aligned and organized is our community?

Total Summary Score by Topic Area		
	Shared Vision and Agenda	78%
	Effective Leadership and Governance	83%
	Deliberate Alignment of Resources, Programs and Advocacy Toward What Works	75%
	Total Summary Score Section 3	**78%**

Section 4

Do we have the capacity and resources in place to be successful?

Total Summary Score by Topic Area		
	Dedicated Capacity and Appropriate Structure	82%
	Sufficient Resources	70%
	Total Summary Score Section 4	**79%**

Total Score Part B: *Plan and Align Resources* ---------- **78%**

OVERALL READINESS 79%

Community Collaborative Assessment Summary of Readiness

Baseline: October 3 - December 7, 2017 (n=16)

Section 1

How ready is my community for collaborative work?

Total Summary Score by Topic Area		
	History of Community Collaboratives	86%
	History of Community Engagement	74%
	Ecosystems of Providers	71%
	History of Funder Collaboration	75%
	History of Data Use	77%
	Total Summary Score Section 1	**75%**

Section 2

Do we have the core principles in place for a successful collaboration?

Total Summary Score by Topic Area		
	Aspires to "needle-moving" Change	68%
	Long-Term Investment in Success	66%
	Cross-Sector Engagement	76%
	Data & Continuous Learning	72%
	Community Engagement	74%
	Total Summary Score Section 2	**70%**

Total Score Part A: *Develop the Idea* ---------- **73%**

Section 3

How aligned and organized is our community?

Total Summary Score by Topic Area		
	Shared Vision and Agenda	74%
	Effective Leadership and Governance	83%
	Deliberate Alignment of Resources, Programs and Advocacy Toward What Works	68%
	Total Summary Score Section 3	**73%**

Section 4

Do we have the capacity and resources in place to be successful?

Total Summary Score by Topic Area		
	Dedicated Capacity and Appropriate Structure	80%
	Sufficient Resources	61%
	Total Summary Score Section 4	**75%**

Total Score Part B: *Plan and Align Resources* ---------- **74%**

OVERALL READINESS 74%

Attachment 12C

COMMUNITY COLLABORATIVE ASSESSMENT

How ready are we for collaborative work?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

		Column A	Column B	Column C
95	1.	☐ My community has demonstrated interest in the issue we are trying to address (suicides in our county) over the past five years through the CEO's office, community initiatives, and in other ways.	☐ Ideas have been generated for collaborative efforts on this issue (suicides in our county), along with some early attempts, but no sustained collaborative efforts.	☐ My community has not demonstrated interest in this type of work.
95	2.	☐ My community has collaborated across sectors when necessary over the past five years (e.g., among nonprofit, government, business.)	☐ We have had conversations across sectors, but have not formally collaborated.	☐ While we needed to collaborate across sectors, we were not able to do so (due to lack of either interest or capacity.)
81	3.	☐ My community has a strong history of citizen engagement (parents, small business, etc.) in community affairs.	☐ My community has had some successes and some failures in engaging citizens.	☐ We have not tried to engage.
79	4.	☐ My community has a strong history of youth engagement in community affairs involving them.	☐ My community has had some successes and some failures in engaging youth.	☐ We have failed to engage youth.
79	5.	☐ Historically, a strong provider network (i.e. network of organizations) has focused on our issue.	☐ We have a moderately strong provider community, but it is not very aligned.	☐ We do not have a strong provider network focused on this issue.
88	6.	☐ We have a clear need for our collaborative; no other effective collaboratives exist addressing this or related issues.	☐ Similar collaborative efforts exist that we could join; but those collaboratives are only partially effective or only partially aligned on the issue.	☐ We are not sure what else is happening in our community on this issue.
81	7.	☐ The providers in my community are using evidence-based practices to address this issue.	☐ Some providers use evidence-based practices; some do not.	☐ Most providers do not use evidence-based practices, or are not familiar with evidence-based practices for this issue.
88	8.	☐ Providers or funders have acted successfully as leaders in my community by convening peers and facilitating collaborative conversations.	☐ Prior efforts have produced leadership that has gained mixed results.	☐ No one has done work in this area, or the leaders of that work were unsuccessful.
77	9.	☐ We have providers or funders that are respected and maintain a relatively neutral stance on the issue.	☐ The providers or funders have won the respect of some, but not all.	☐ We are not sure about the agendas of our providers or funders.
69	10.	☐ Over the past five years, my local funder community has worked well together, collaborating many times.	☐ We have seen some funder collaboration and organization.	☐ Our funder community is not organized and has not collaborated in the past.
74	11.	☐ Over the past five years, my community's funders have been aligned around a common set of goals about what to fund in my community.	☐ Some funder alignment has occurred on what to fund.	☐ There has been no funder alignment on what to fund.
86	12.	☐ Over the past five years, our community has used data to examine, assess and create shared understanding of our challenges.	☐ We have sometimes used data to create shared understanding of our challenges.	☐ We have not used data to create shared understanding of our challenges.
83	13.	☐ My community has tracked a set of indicators or outcomes related to the goals of my collaborative.	☐ Some tracking is happening in my community, but it is in very early stages.	☐ No data tracking is taking place.
83	14.	☐ My community has used data to create actionable plans for the future and set the current agenda.	☐ We sometimes use the data we collect to influence our plans for the future.	☐ Our plans are not determined by data.

COMMUNITY COLLABORATIVE ASSESSMENT

Do we have the core principles in place for a successful collaboration?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

		Column A	Column B	Column C
85	1.	☐ Our collaborative aspires to needle-moving change: 10%-plus change from the baseline on our outcomes.	☐ Some potential participants are committed to 10%-plus change from the baseline on our outcomes.	☐ The issues not on key leaders' radar screens; we do not have consensus yet.
79	2.	☐ We have a clear sense of what the collaborative uniquely can add to our community and how we can partner with existing work.	☐ We know what else is happening related to our issue and are figuring out how our work fits in.	☐ We have not looked deeply at related work happening in our community.
93	3.	☐ Our collaborative is focused on moving the entire community, city or region forward (i.e., graduation rates across the city).	☐ We have only somewhat defined our boundaries. Or, our boundaries represent a subset of the community.	☐ We have not defined our boundaries at all.
81	4.	☐ Key stakeholders are committed to this work for the long-term (three to five-plus years).	☐ Key stakeholders are committed to this work for at least the early phase of the work (i.e. one to two years); we are still building commitment for the long-term.	☐ Key stakeholders have not defined how long they will remain committed.
69	5.	☐ We have identified a key funder that has expressed interest in a long-term commitment (of three to five-plus years).	☐ We have held exploratory conversations, but no funder has expressed an interest in long-term commitment.	☐ We are still identifying potential funders.
76	6.	☐ We have multiple participants ready to support the collaborative from the sectors that are relevant to tour issue area, (i.e., government, philanthropy nonprofit, business, and the like).	☐ We have some, but not all, of the appropriate participants.	☐ We are missing many of the relevant participants.
87	7.	☐ We are committed to regularly using data that others or we collect in order to determine our direction and priorities.	☐ Data will be a part of our work, but secondary to some other aspects of the collaborative's work.	☐ We do not plan to collect data as a part of our collaborative.
81	8.	☐ We have a plan, now underway, for capturing and analyzing relevant data, considering the data as a group, and adjusting course based on the data.	☐ We have a plan for how to capture relevant data, but we have not determined how to regularly incorporate it into our work.	☐ We are in the process of developing a plan.
88	9.	☐ We have identified individuals from the community who should be involved in our collaborative process and have decided how they should be involved.	☐ We are thinking about the engagement of key individuals, but don't know who to engage or how.	☐ We have not thought about engagement beyond the institutional participants in our collaborative.
81	10.	☐ Our leadership has established a process for gaining buy-in from relevant community members in our community (e.g., parents and youth).	☐ We are developing a process to establish buy-in.	☐ We are not going to develop a buy-in process.

COMMUNITY COLLABORATIVE ASSESSMENT

How aligned and organized is our community?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

		Column A	Column B	Column C
90	1.	☐ The collaborative participants and broader community share a common vision for future about the issue.	☐ Parties have somewhat distinct visions about this issue in our community.	☐ No one has clearly articulated vision statements for the community; the issue is not on people's minds.
79	2.	☐ We have agreed upon a road map to guide how we will achieve communitywide change.	☐ We do have a road map, but it is under development. Or, we have only reached partial agreement on our path.	☐ We tried to create a road map, but there is no agreement.
83	3.	☐ We have data metrics that match up with our goals and action plan.	☐ We are not sure how to measure metrics to assess progress against the road map.	☐ We do not plan to use data.
71	4.	☐ We have achieved buy-in from engaged community leaders around the collaborative's vision, road map and defined goals.	☐ Some community leaders are engaged and have bought in.	☐ We have gained very little engagement and little buy-in from community leaders.
93	5.	☐ We currently have a respected, neutral leader at the head of our collaborative, who is able to convene and maintain a diverse collaborative.	☐ Our leadership lacks some characteristics and skills required to convene and maintain a collaborative.	☐ Our leadership lacks most of the necessary characteristics and skills to convene and maintain the collaborative.
79	6.	☐ We have engaged the full set of organizations and leaders that must be aligned to reach our goals.	☐ We are missing some of the necessary organizations and leaders in our collaborative.	☐ We are not sure if we have the right organizations and leaders at the table.
83	7.	☐ We have researched similar efforts outside our community to identify effective strategies that we can adapt.	☐ We have researched some effective strategies, but are unsure how to adapt them to our model.	☐ We have not researched other similar efforts.
79	8.	☐ Our roadmap specifies a complete set of interventions that logically lead to the changes we want to see.	☐ Our roadmap includes only some of the interventions we believe are necessary for change; our roadmap is partially complete.	☐ We have not thought about how our interventions lead to the change we want to see; our roadmap is not completed at all.
86	9.	☐ Where applicable, we have advocacy efforts focused on changing the policies, funding and systems in our community to better address the issue.	☐ We have a plan for how to create advocacy effectively.	☐ We need advocacy in our community, but we have not thought about how to create it.

COMMUNITY COLLABORATIVE ASSESSMENT

Do we have the capacity and resources in place to be successful?

*Please choose **one statement only** in each row from Column A, B, or C that best describes our community over the past five years.*

		Column A	Column B	Column C
81	1.	☐ We have a clear sense of the time and talent needed to run the collaborative itself (separate from participating organizations' capacity).	☐ We have not considered what capacity is needed, but will in the future.	☐ We do not plan to have dedicated capacity for the collaborative.
74	2.	☐ We have identified paid staff who can help coordinate or facilitate the collaborative process.	☐ We are not sure how to get paid staff.	☐ We do not plan to have paid staff.
81	3.	☐ We have clearly defined roles within the collaborative (such as a facilitator, data measurement specialist and so on).	☐ We have some roles, but they are not explicitly defined.	☐ We do not have clear roles.
81	4.	☐ We have the necessary structure, processes and system to support our work (committees, systems to analyze data and so on).	☐ We have some of this in place.	☐ We do not have any structures, processes or systems in place.
86	5.	☐ Providers in my community have the capacity to come together and collaborate or partner.	☐ Providers have some capacity, but not enough for our collaborative.	☐ Providers have minimal capacity to come together and collaborate.
71	6.	☐ We have a clear sense of what it will take to fund our collaborative, including dedicated capacity, over the next five years.	☐ We have estimates, but are not sure how to figure out what resources are required.	☐ We do not have estimates yet.
71	7.	☐ We have long-term financial commitment from funders to cover the dedicated capacity and collaborative work.	☐ We have short-term commitments from funders.	☐ We don't have any financial commitments.

KEY:
- ❑ ≥ 90%
- ❑ 80-89%
- ❑ 70-79%
- ❑ ≤ 69%

Adapted from *Community Collaborative Assessment – A Diagnostic of Success Readiness*. Retrieved from https://www.serve.gov/new-images/council/pdf/community_collaborative_assessment.pdf

Community Collaborative Assessment Summary of Readiness

August 2019 – 3rd (Final) Administration (n=14)

Section 1

How ready is my community for collaborative work?

Total Summary Score by Topic Area	
History of Community Collaboratives	95%
History of Community Engagement	80%
Ecosystems of Providers	83%
History of Funder Collaboration	71%
History of Data Use	85%
Total Summary Score Section 1	**83%**

Section 2

Do we have the core principles in place for a successful collaboration?

Total Summary Score by Topic Area	
Aspires to "needle-moving" Change	85%
Long-Term Investment in Success	75%
Cross-Sector Engagement	76%
Data & Continuous Learning	84%
Community Engagement	85%
Total Summary Score Section 2	**82%**

Total Score Part A: *Develop the Idea* ---------- **82%**

Section 3

How aligned and organized is our community?

Total Summary Score by Topic Area	
Shared Vision and Agenda	84%
Effective Leadership and Governance	82%
Deliberate Alignment of Resources, Programs and Advocacy Toward What Works	82%
Total Summary Score Section 3	**83%**

Section 4

Do we have the capacity and resources in place to be successful?

Total Summary Score by Topic Area	
Dedicated Capacity and Appropriate Structure	80%
Sufficient Resources	71%
Total Summary Score Section 4	**78%**

Total Score Part B: *Plan and Align Resources* ---------- **81%**

OVERALL READINESS 82%

Community Collaborative Assessment Summary of Readiness

October 2018 - 2nd Administration (n=21)

Section 1

How ready is my community for collaborative work?

Total Summary Score by Topic Area		
	History of Community Collaboratives	91%
	History of Community Engagement	79%
	Ecosystems of Providers	80%
	History of Funder Collaboration	76%
	History of Data Use	79%
	Total Summary Score Section 1	**80%**

Section 2

Do we have the core principles in place for a successful collaboration?

Total Summary Score by Topic Area		
	Aspires to "needle-moving" Change	80%
	Long-Term Investment in Success	75%
	Cross-Sector Engagement	74%
	Data & Continuous Learning	85%
	Community Engagement	74%
	Total Summary Score Section 2	**78%**

Total Score Part A: *Develop the Idea* ---------- **79%**

Section 3

How aligned and organized is our community?

Total Summary Score by Topic Area		
	Shared Vision and Agenda	78%
	Effective Leadership and Governance	83%
	Deliberate Alignment of Resources, Programs and Advocacy Toward What Works	75%
	Total Summary Score Section 3	**78%**

Section 4

Do we have the capacity and resources in place to be successful?

Total Summary Score by Topic Area		
	Dedicated Capacity and Appropriate Structure	82%
	Sufficient Resources	70%
	Total Summary Score Section 4	**79%**

Total Score Part B: *Plan and Align Resources* ---------- **78%**

OVERALL READINESS 79%

Community Collaborative Assessment Summary of Readiness

Baseline: October 3 - December 7, 2017 (n=16)

Section 1

How ready is my community for collaborative work?

Total Summary Score by Topic Area		
	History of Community Collaboratives	86%
	History of Community Engagement	74%
	Ecosystems of Providers	71%
	History of Funder Collaboration	75%
	History of Data Use	77%
	Total Summary Score Section 1	**75%**

Section 2

Do we have the core principles in place for a successful collaboration?

Total Summary Score by Topic Area		
	Aspires to "needle-moving" Change	68%
	Long-Term Investment in Success	66%
	Cross-Sector Engagement	76%
	Data & Continuous Learning	72%
	Community Engagement	74%
	Total Summary Score Section 2	**70%**

Total Score Part A: *Develop the Idea* ---------- **73%**

Section 3

How aligned and organized is our community?

Total Summary Score by Topic Area		
	Shared Vision and Agenda	74%
	Effective Leadership and Governance	83%
	Deliberate Alignment of Resources, Programs and Advocacy Toward What Works	68%
	Total Summary Score Section 3	**73%**

Section 4

Do we have the capacity and resources in place to be successful?

Total Summary Score by Topic Area		
	Dedicated Capacity and Appropriate Structure	80%
	Sufficient Resources	61%
	Total Summary Score Section 4	**75%**

Total Score Part B: *Plan and Align Resources* ---------- **74%**

OVERALL READINESS 74%

Attachment 13

Wilder Collaboration Factors Inventory - Group summary

For group: *Suicide Prevention Innovation Project*

Collaboration Factor scoring for your group (21 completed forms)

Average scores for each of the 22 factors:

Factor	Factor Average
History of collaboration or cooperation in the community	**3.6**
Collaborative group seen as a legitimate leader in the community	**3.7**
Favorable political and social climate	**4.5**
Mutual respect, understanding, and trust	**4.4**
Appropriate cross section of members	**3.5**
Members see collaboration as being in their self-interest	**4.4**
Ability to compromise	**4.0**
Members share a stake in both process and outcome	**4.1**
Multiple layers of participation	**3.9**
Flexibility	**4.2**
Development of clear roles and policy guidelines	**3.8**
Adaptability to changing conditions	**3.9**
Appropriate pace of development	**3.8**
Evaluation and continuous learning	**4.0**
Open and frequent communication	**4.3**
Established informal relationships and communication links	**3.8**
Concrete, attainable goals and objectives	**4.2**
Shared vision	**4.1**
Unique purpose	**4.5**
Sufficient funds, staff, materials, and time	**3.4**
Skilled leadership	**4.3**
Engaged stakeholders	**3.6**

As a general rule...
Scores of 4.0 to 5.0 - strengths, don't need special attention
Scores of 3.0 to 3.9 - borderline, deserve discussion
Scores of 1.0 to 2.9 - concerns that should be addressed

Item averages

Average scores for each of the 44 items:

Item	Item Average
1. Agencies in our community have a history of working together.	3.9
2. Trying to solve problems through collaboration has been common in this community. It has been done a lot before.	3.4
3. Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	3.7
4. Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	3.8
5. The political and social climate seems to be "right" for starting a collaborative project like this one.	4.5
6. The time is right for this collaborative project.	4.5
7. People involved in our collaboration trust one another.	4.3
8. I have a lot of respect for the other people involved in this collaboration.	4.5
9. The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	4.0
10. All the organizations that we need to be members of this collaborative group have become members of the group.	3.0
11. My organization will benefit from being involved in this collaboration.	4.4
12. People involved in our collaboration are willing to compromise on important aspects of our project.	4.0
13. The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	3.7
14. Everyone who is a member of our collaborative group wants this project to succeed.	4.7
15. The level of commitment among the collaboration participants is high.	3.9

16. When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	4.0
17. Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	3.7
18. There is a lot of flexibility when decisions are made; people are open to discussing different options.	4.2
19. People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	4.1
20. People in this collaborative group have a clear sense of their roles and responsibilities.	3.7
21. There is a clear process for making decisions among the partners in this collaboration.	3.9
22. This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership.	3.9
23. This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	3.9
24. This collaborative group has been careful to take on the right amount of work at the right pace.	3.9
25. This group is currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	3.8
26. A system exists to monitor and report the activities and/or services of our collaboration.	4.0
27. We measure and report the outcomes of our collaboration.	4.1
28. Information about our activities, services, and outcomes is used by members of the collaborative group to improve our joint work.	4.0
29. People in this collaboration communicate openly with one another.	4.1
30. I am informed as often as I should be about what is going on in the collaboration.	4.2
31. The people who lead this collaborative group communicate well with the members.	4.5
32. Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	4.0
33. I personally have informal conversations about the project with others who are involved in this collaborative group.	3.6
34. I have a clear understanding of what our collaboration is trying to accomplish.	4.2
35. People in our collaborative group know and understand our goals.	4.1
36. People in our collaborative group have established reasonable goals.	4.2
37. The people in this collaborative group are dedicated to the idea that we can make this project work.	4.3

38. My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	4.0
39. What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	4.6
40. No other organization in the community is trying to do exactly what we are trying to do.	4.3
41. Our collaborative group has adequate funds to do what it wants to accomplish.	3.2
42. Our collaborative group has adequate "people power" to do what it wants to accomplish.	3.5
43. The people in leadership positions for this collaboration have good skills for working with other people and organizations.	4.3
44. Our collaborative group engages other stakeholders, outside of the group, as much as we should.	3.6

Open ended responses

45. What is working well in your collaborative? (optional)
46. What needs improvement in your collaborative? (optional)

- ***Attendance at meetings by some organizations has dropped, disappointing to say the least.***

Note:

These results will not include data from forms that were started but not completed. *(1 found for this group)*

To complete an inventory yourself for this group, please **log out** and visit the group link provided in your registration email.

CLEAR IMPACT
reach your peak

THE
THE RESULTS-BASED ACCOUNTABILITY™ GUIDE

The *Results-Based Accountability™ Guide* uses and is based upon concepts and materials developed by Mark Friedman, author of *Trying Hard is Not Good Enough* (Trafford 2005) and founder and director of the Fiscal Policy Studies Institute.

TABLE OF CONTENTS

I. INTRODUCTION

What is Results-Based Accountability™?

Results-Based Accountability™ ("RBA") is a *disciplined way of thinking and taking action* used by communities to improve the lives of children, families and the community as a whole. RBA is also used by agencies to improve the performance of their programs.

How does RBA work?

RBA *starts with ends and works backward, step by step, towards means*. For communities, the ends are conditions of well-being for children, families and the community as a whole. For example: "Residents with good jobs," "Children ready for school," or "A safe and clean neighborhood" or even more specific conditions such as "Public spaces without graffiti," or "A place where neighbors know each other." For programs, the ends are how customers are better off when the program works the way it should. For example: The percentage of people in the job training program who get and keep good paying jobs.

Why use RBA?

RBA improves the lives of children, families, and communities and the performance of programs because RBA:

- gets from talk to action quickly;
- is a simple, common sense process that everyone can understand;
- helps groups to surface and challenge assumptions that can be barriers to innovation;
- builds collaboration and consensus; and
- uses data and transparency to ensure accountability for both the well being of children, families and communities and the performance of programs.

What is the RBA Guide?

The RBA Guide is a tool for leading or facilitating a group in the use of RBA in decision making. The RBA Guide is designed to be used as a roadmap with which to navigate the complete RBA decision-making process, step-by-step.

II. THE RBA "TURN-THE-CURVE" TEMPLATE

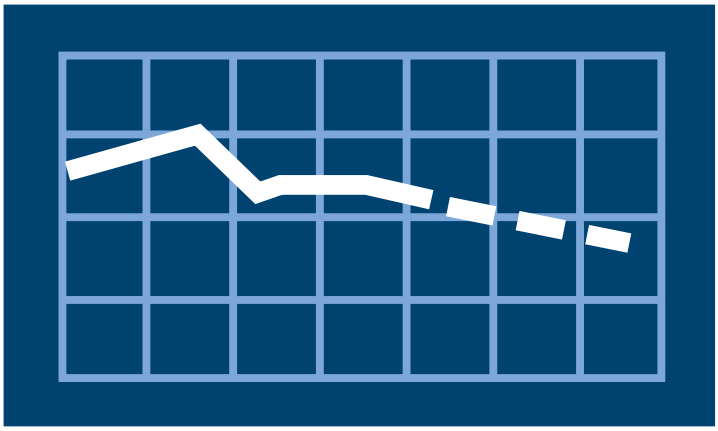
This template is an overview of the step-by-step RBA "turn-the-curve" decision-making process.

1 What is the "end"?

Choose either a result and indicator or a performance measure.

2 How are we doing?

Graph the historic baseline and forecast for the indicator or performance measure.



3 What is the story behind the curve of the baseline?

Briefly explain the story behind the baseline: the factors (positive and negative, internal and external) that are most strongly influencing the curve of the baseline.

4 Who are partners who have a role to play in turning the curve?

Identify partners who might have a role to play in turning the curve of the baseline.

5 What works to turn the curve?

Determine what would work to turn the curve of the baseline.
Include no-cost/low-cost strategies.

6 What do we propose to do to turn the curve?

Determine what you and your partners propose to do to turn the curve of the baseline.

III. STEP-BY-STEP RBA TURN-THE-CURVE PROCESS

The following is a step-by-step guide for conducting an RBA decision-making process to get from talk to action.

1. What is the end?

The starting point in "turn-the-curve" decision making is to identify the desired "end." Is it to improve the quality of life for a population (population accountability) or does it concern how well a program, agency or service system is performing (performance accountability)?[1]

If the focus is Population Accountability:

- Begin by identifying a *population* (e.g., all children in a county).
- Next ask what quality of life or condition is desired for that population (e.g., entering school fully ready) - which is called a "*result*."
- Then ask how will the extent to which that result is being achieved be gauged (e.g., a developmental assessment of kindergartners), which is called an "*indicator*."

To select an indicator (2 or 3 at the most) for a result, use the following criteria:

■ **Communication Power:** Does this indicator communicate to a broad range of audiences? Would those who pay attention to your work (*e.g.,* voters, legislators, agency program officers) understand what this measure means?

■ **Proxy Power:** Does this indicator say something of central importance about the result? Is this indicator a good proxy for other indicators? Data tend to run in a "herd" - in the same direction. Pick an indicator that will tend to run with the herd of all of the other indicators that could be used (so it is possible to use only 1 to 3 indicators).

■ **Data Power:** Is there quality data for this indicator on a timely basis? To be credible, the data must be consistent and reliable. And timeliness is necessary to track progress.[2]

If you are focused on Performance Accountability:

- Begin by identifying the program, agency, or service system.
- Next select a performance measure. There are three kinds of performance measures:
  - How much are we doing?
  - How well are we doing it?
  - Is anyone better off?

Appendix A describes the process for developing and selecting performance measures.

2. How are we doing?

After you have selected your indicator or performance measure, present the corresponding data on a graph with:

1 This distinction between population and performance accountability allows two different assessments: first, what efforts and programs should be undertaken to achieve a desired quality of life or "result" and, second, how well are those efforts and programs performing. This distinction also recognizes that a single program, agency or service system cannot take sole responsibility (or credit) for achieving a desired result.

2 Note: If an indicator is strong on the first two criteria but data is not available, consider putting that indicator onto a "data development agenda."

(a) an historic baseline (at least 5 years of data, if available) and

(b) a forecast *assuming no change in your current level of effort* (for 3 - 5 years, if possible).

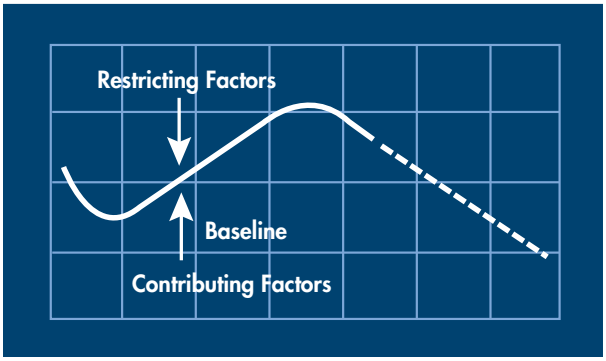
To provide the forecast, you will need to complete step 3, the "Story Behind the Curve." Turn-the-curve decision making is systematically determining the best actions to take to improve on the forecasted trend for the baseline - to "turn the curve."

3. What is the story behind the curve?

In this section, list the key factors underlying the historic baseline and forecast for the indicator or performance measure. Identify: (1) contributing factors that are supporting progress and (2) restricting factors that are hindering progress. Progress is defined as turning the curve of the baseline (or accelerating the curve if it is already headed in the right direction).

This "force field analysis," below, illustrates how factors may be viewed according to their contributing and restricting influences on the curve of the baseline.

Force Field Analysis



It is important to identify not just the most immediate and easily observed factors impacting the baseline (i.e., the "proximate causes"), but to engage in the kind of rigorous analysis that will identify the underlying or more systemic factors (i.e., the "root causes"). It is also important to conduct additional research where necessary and feasible.

Once the root causes have been identified, prioritize those root causes according to which have the greatest influence on progress and, therefore, are the most critical to address to improve progress.

The best format is a "bullet" for each root cause with a brief header that is underlined and a brief description of the root cause.

4. Who are partners who have a role to play in turning the curve?

Identify potential partners who may have a role to play in improving progress. The identification of root causes impacting progress will often point the way to the types of partners who should be engaged.

5. What works to turn the curve?

Before selecting a strategy to undertake to turn the curve of the baseline, it is necessary to determine whether what would work to turn the curve is known. And it is important to be sure to explore the full range of options for strategies. A strategy may, of course, involve the discontinuation of existing activities as well as the implementation of new ones. And a strategy should be multi-year and integrated. The following are criteria to consider in developing options:

- *Does the option address one or more of the root causes you have identified?*

  The alignment of a proposed option with a root cause provides the rationale for selecting that particular option: it is the link between the "end" (as measured by the indicator or performance measure and the "means" (the strategy).

- *Is the proposed option evidence-based?*

  What research or other evidence is available to demonstrate that the strategy has a reasonable chance of turning the curve of the baseline? There may, of course, be times that data are limited and you must move forward with the best judgment of experienced professionals; however, in most cases a strategy should be supported by research or evidence.

- *Have "no-cost/low-cost" options been developed?*

  Funding is often a critical need and careful thought must be given to ways to increase funding where needed. However, it is equally important to explore "no-cost/low-cost" options (*i.e.,* options that may be pursued with existing resources). This line of inquiry, in turn, can help to surface outdated assumptions that stand in the way of innovation.

- Is additional research necessary to determine what would work or to identify other options?

6. What do we propose to do to turn the curve?

Selecting the proposed strategy involves applying four criteria to each of the options: leverage, feasibility (or reach), specificity, and values.

■ **Leverage:** *How strongly will the proposed strategy impact progress as measured by the baselines?*

Given that resources are finite, decisions with respect to the dedication of resources to a proposed strategy must be based on the expected impact of those resources on progress. One way to gauge impact is to assess the importance of the underlying root cause(s) an option is designed to address. In other words, the strategy that is proposed should address the most important root causes identified and, therefore, be geared to having the greatest potential impact on the trend for the corresponding baseline. This concept is sometimes referred to as "leverage."

■ **Feasibility (or reach).** *Is the proposed strategy feasible?*

Can it be done? This question is the necessary counterpart to the question of leverage. Questions of feasibility should be handled so as not to limit innovation. Sometimes the consideration of an apparently infeasible option will be the catalyst in the thinking process that leads to a highly creative and feasible option. Once ways to improve feasibility have been adequately explored, however, then leverage and feasibility must be weighed and balanced in choosing the strategy. A strategy that has high leverage and high feasibility will, of course, be a prime candidate for action. The choice among other options, however, will likely involve trade-offs between leverage and feasibility and will need to be weighed accordingly.

■ **Specificity.** *Is the strategy specific enough to be implemented?*

Is there a timeline with deliverables that answers the questions: *Who? What? When? Where? How?* There should be budget detail for the strategy, including implications for future budgets.

■ **Values.** *Is the strategy consistent with the values of the community and/or agency?*

Once the proposed strategies are selected, list them in order of priority. The best format is a "bullet" for each strategy which provides a brief header that is underlined and a brief description of the strategy.

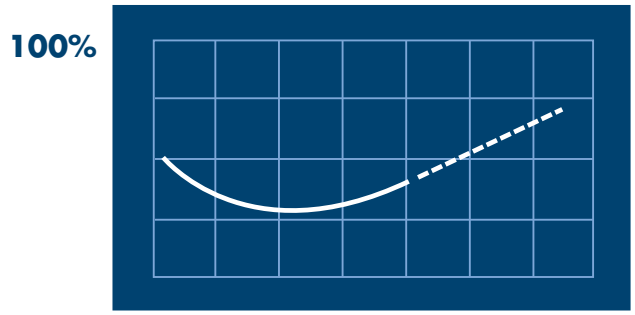
IV. AN ACCOUNTABILITY TOOL

The "Turn-the-Curve" template is not meant to be used to produce a static document; rather, it is intended to be used as a tool. On an ongoing basis, in consultation with key partners, stakeholders should use the data to assess progress and systematically adjust strategies where necessary to improve progress. The following schematic, a succinct RBA reporting format, demonstrates the nature of this ongoing process.

Results-Based Accountability™

Result and Indicator or Performance Measure

Data presented as a graph, with both an historic baseline and a forecast.



Story behind the curve

Key factors (positive and negative, internal and external) impacting progress (*i.e.,* impacting the curve of the baseline).

What we propose to do to improve progress

Feasible, high-impact actions/strategies with specific timelines and deliverables. Partners with roles to play in improving progress.

Monitor both implementation and the baseline for improvement and, as new data are obtained, repeat the process.

APPENDIX A

Performance Measures

Introduction

The selection of performance measures is the first and most essential step in the performance planning process for each element of the Population Accountability strategy. The following directions will assist you in choosing your headline performance measures.

What are Performance Measures?

Your agency/division/program provides services that improve, in some way, the quality of life of its customers/clients. Performance measures simply give you the means to know how well the agency/division/program is doing at providing those services and improving those lives.
A good performance measure gives you and your staff the ability to make changes and see whether those changes improve the agency/division/program's performance, that is, its ability to improve customers/clients' quality of life.

Importantly, performance measures are data - they quantitatively measure the agency/division/program's performance.

The following Data Quadrant, Figure 1, is a useful tool for sorting and categorizing performance measures.

Sorting Performance Measures: The Data Quadrant

All performance measures fit into one of four categories. The categories, the four quadrants, are derived from the intersection of *quantity* and *quality* and *effort* and *effect*.

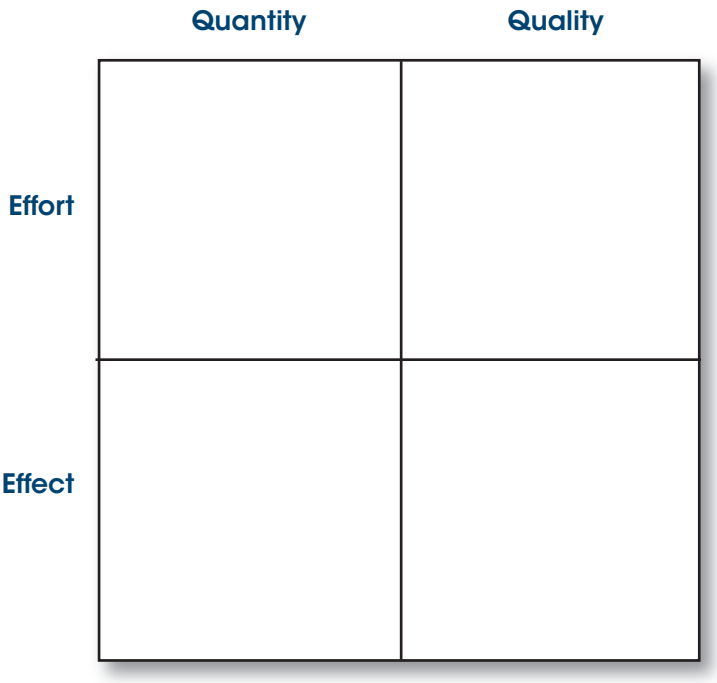


Figure 1

The rows separate measures about effort (what is done and how well) from measures about effect (the change or impact that resulted), the columns separate measures about quantity (of the effort or effect) from measures about quality (of the effort or effect).

Figure 2 shows how these combinations lead to three universal performance measures: *How much did we do? How well did we do it? Is anyone better off?* The most important performance measures are those that tell us whether our clients or customers are better off as a consequence of receiving the services ("client results," the lower left and right quadrants). The second most important measures are those that tell us whether the service or activity is done well (upper right quadrant). The least important measures are those that tell us what and how much we do. To answer the two most important questions, that is, to identify candidate for the most important performance measures, follow the following steps, using the Data Quadrant.

Step 1: How much did we do? *Upper Left Quadrant*

First, list the number of clients served. Distinguish different sets of clients as appropriate. Next, list the activities or services the department/division/program performs for its clients. Each activity or service should be listed as a measure. For example, "child welfare casework" becomes "# of child welfare cases" or "# of FTEs conducting child welfare case work." "Road maintenance" becomes "# of miles of road maintained." "Stream monitoring" becomes "# of stream sites monitored." "Provide health care" become "number of patients treated."

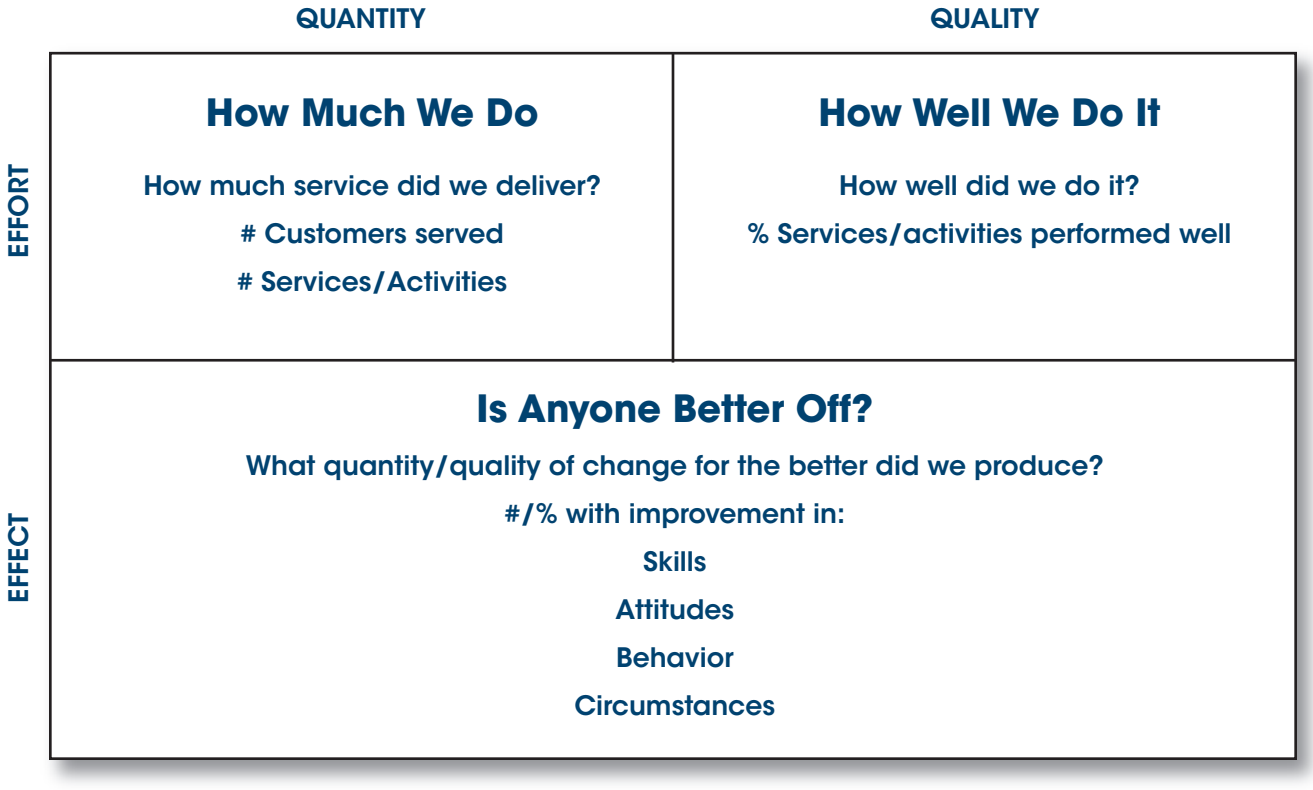


Figure 2

Step 2: How well did we do it? *Upper Right Quadrant*

This quadrant is where most traditional performance measures are found. For each service or activity listed in the upper left quadrant, choose those measures that will tell you if that activity was performed well (or poorly). The measures should be specific. For example, ratio of workers to child abuse/neglect cases; percent of maintenance conducted on time; average number of sites monitored per month; percent of invoices paid in 30 days; percent of patients treated in less than an hour; percent of training staff with training certification.

Step 3: Is anyone better off? *Lower Left and Lower Right Quadrants*

Ask "In what ways are your clients better off as a result of getting the service in question? How would we know, in measurable terms, if they were better off?" Create pairs of measures (# and %) for each answer. Four categories cover most of this territory: skills/knowledge, attitude, behavior, and circumstances (e.g., a child succeeding in first grade or a parent fully employed). Consider all of these categories in developing measures of whether clients are better off. Examples are: #/% of child abuse/neglect cases that have repeat child abuse/neglect; #/% of road miles in top-rated condition; #/% of cited water quality offenders who fully comply; #/% of repeat audit findings;

Selecting Headline Performance Measures

Key to ensuring the usefulness of performance measures is to limit the number used. In most cases, select from the list of candidate measures 3 to 5 "headline measures" (in total, from both the upper right and lower right quadrants). To select these headline measures, rate each candidate measure using the following three criteria (similar to the criteria for selecting indicators):

Communication Power: Does this measure communicate to a broad range of audiences? Would those who pay attention to your work (*e.g.,* voters, legislators, agency program officers) understand what this measure means?

Proxy Power: Does this measure say something of central importance about your department/division/program? Is this measure a good proxy for other measures? For example, reading on grade level might be considered a proxy for other measures such as attendance, quality of the curriculum, quality of the teachers, etc.

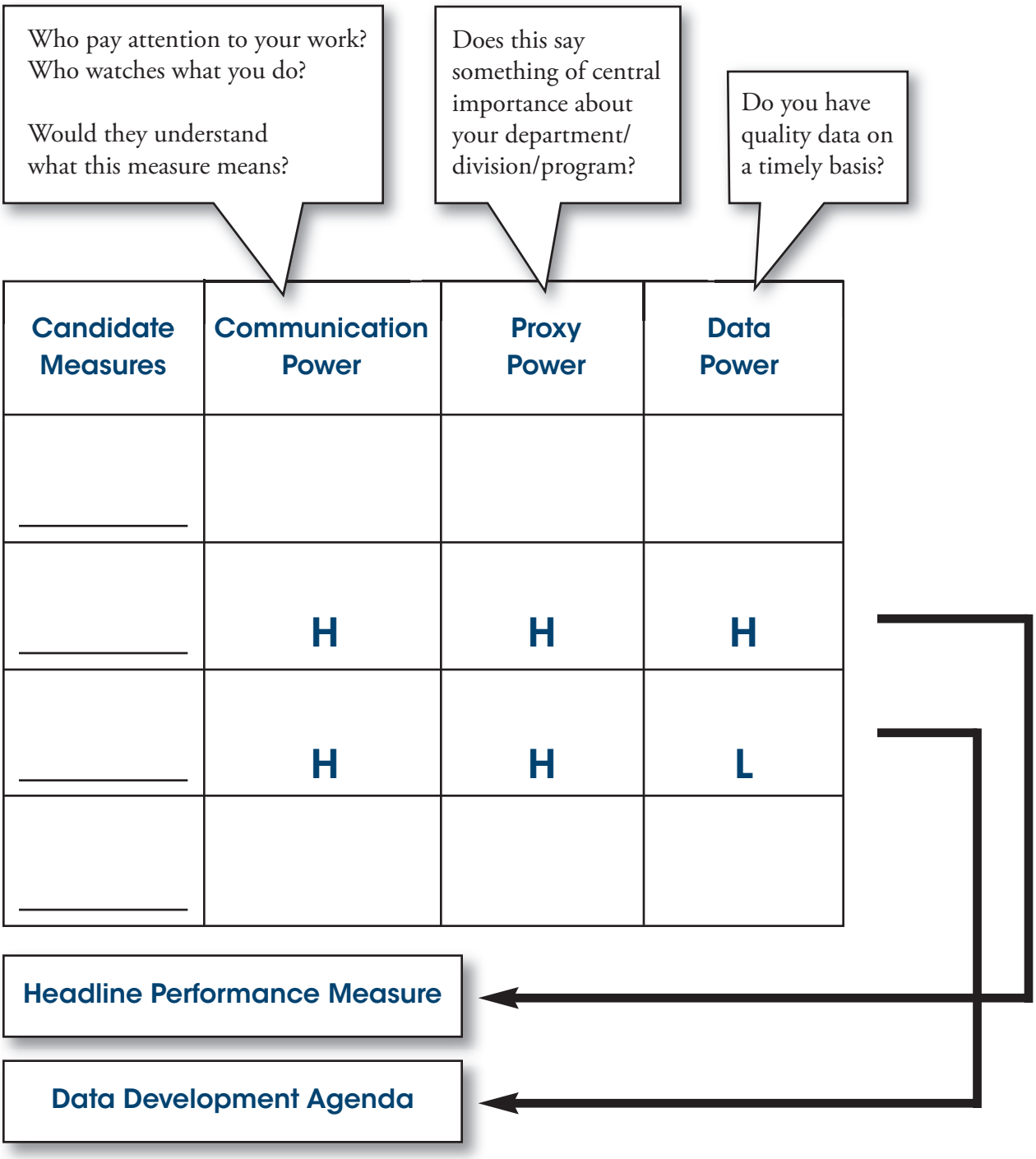
Data Power: Do you have quality data for this measure on a timely basis? To be credible, the data must be consistent and reliable. And timeliness is necessary to track progress.

Rate each candidate measure "high," "medium," or "low" for each criterion. Use a chart, like the one shown below, "Selecting Headline Performance Measures." The candidate measures that have high ratings for all three criteria are good choices for headline measures.

For those measures that are rated high for communication and proxy power, but medium or low for data power, start a data development agenda. These are measures for which you might want to invest resources to develop quality data that would be available on a timely basis.

Selecting Headline Performance Measures

Directions: List candidate performance measures and rate each as **H**igh, **M**edium, or **L**ow on each criterion: Communication Power, Proxy Power, and Data Power.



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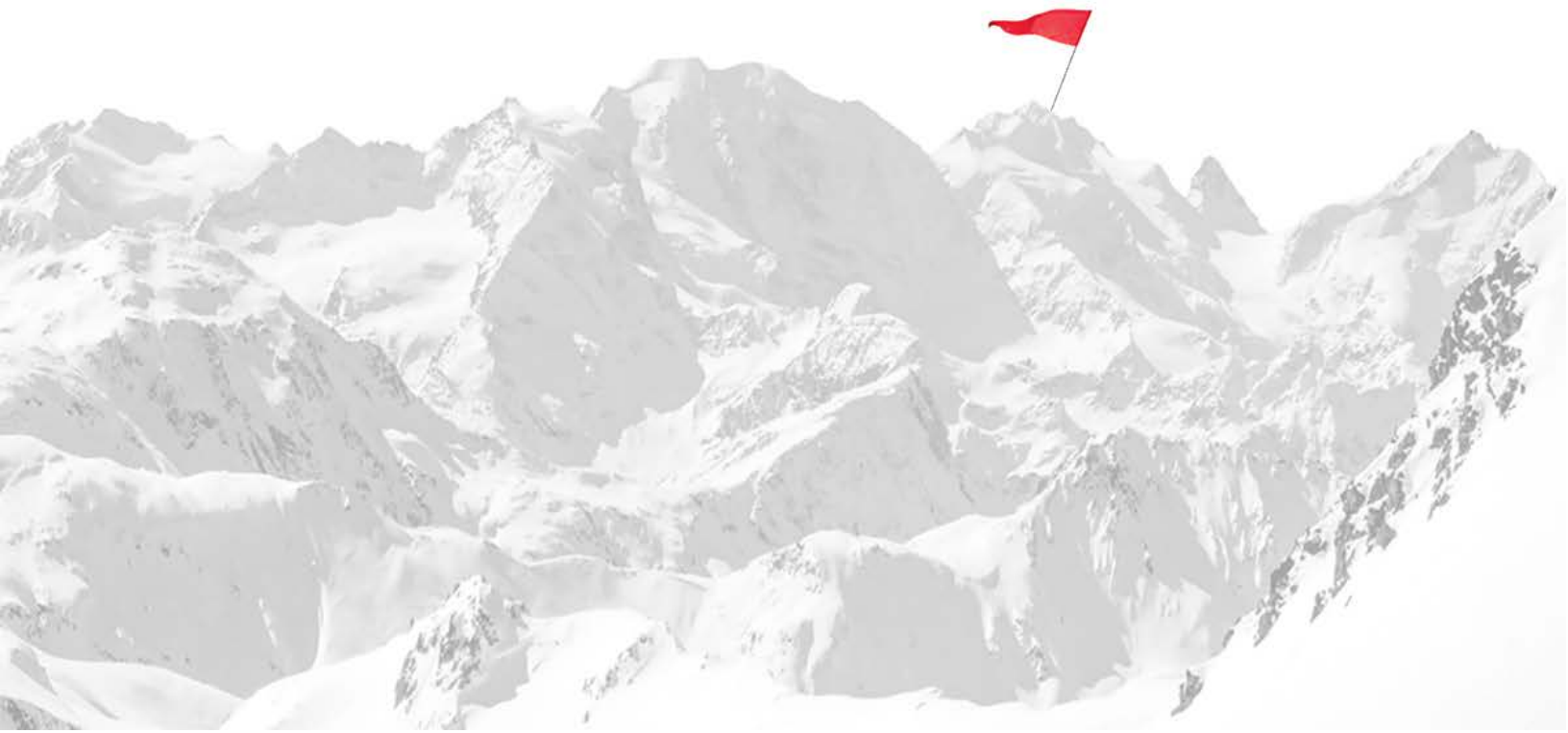


Suicide Prevention Innovation Project - Project Learning and Strategic Recommendations

Attachment 15A

Who We Are

Stanislaus County Suicide Prevention Advisory Board is a partnership of thirty-five organizations and agencies dedicated to collectively addressing the problem of suicide through leadership, a structured approach and sustainable prevention programs.

Our Vision

A community free of stigma and suicide.

Our Mission

To facilitate knowledge, attitude and behavior change among individuals, communities and environments that reduce stigma and prevent suicide in Stanislaus County.

For more detailed statistics Click Here

Our Community Result and Indicators	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
R SP Stanislaus County is a community free from stigma and suicide				
I SP # of Total Suicide Deaths	2016	55	↗ 1	8% ↑
I SP # of Total Suicide Deaths - Disaggreaged by Age	2016	55	↗ 1	8% ↑
I SP # of Suicide Deaths -Disaggregated by Race/Ethnicity	2016	55	→ 0	0% →
I SP # of Total Suicide Attempts (Non-Fatal ER and Hospitalizations) - Disaggregated by Gender	2014	876	→ 0	0% →
I SP # of Total Suicide Deaths - Disaggregated by Gender	2016	55	→ 0	0% →
I SP # of Total Suicide Attempts (Non-Fatal ER and Hospitalizations)	2014	876	→ 0	0% →
I SP # of Total Suicide Attempts (Non-Fatal ER and Hospitalizations) - Disaggregated by Age	2014	876	→ 0	0% →
I SP # of Total Suicide Attempts (Non-Fatal ER and Hospitalizations) - Disaggregated by Race/Ethnicity	2014	876	→ 0	0% →

Overarching Recommendations	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
S SP Continued community collaboration and strategic planning				

Recommended Strategies - Community-Based Organizations	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
S SP #1 Public Education and Awareness - Stanislaus County Believes Each Mind Matters - Campaign				
S SP #2 Public Education and Awareness - Sanamente				
S SP #3 Public Education and Awareness - Peer Support Groups				
S SP Intervention				

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
S SP Education and Training Initiatives				
S SP #1 Outreach - Brief Intervention Counseling				
S SP #2 Outreach - Family Resource Centers				
S SP #3 Outreach - Telecare Program				
S SP #4 Outreach - Out of Darkness Walk				
S SP #5 Outreach - Training Support - Mental Health First Aid for Youth, Teen ASSIST				
S SP #6 Outreach - Grief Support Programs Marketing and Expansion of Services Based on Need/Demand				
Recommended Strategies - Education Sector				
S SP #1 Public Education and Awareness - Peer Support Program				
S SP #2 Pubic Education and Awareness - Campus Walk; Active Minds				
S SP Outreach				
Recommended Strategies - Government				
S SP Education and Training Initiatives				
S SP Intervention				
Recommended Strategies - Faith-Based Organizations				
S SP Education and Training Initiatives				
Recommended Strategies - Business				
S Education and Training Initiatives				
Recommended Strategies - Healthcare Sector				
S SP Education and Training Initiatives				

Suicide Prevention Innovation Project - Strategic Plan - Draft

Attachment 15B

Who We Are

Stanislaus County Suicide Prevention Advisory Board is a partnership of thirty-five organizations and agencies dedicated to collectively addressing the problem of suicide through leadership, a structured approach and sustainable prevention programs.

Our Vision

A community free of stigma and suicide.

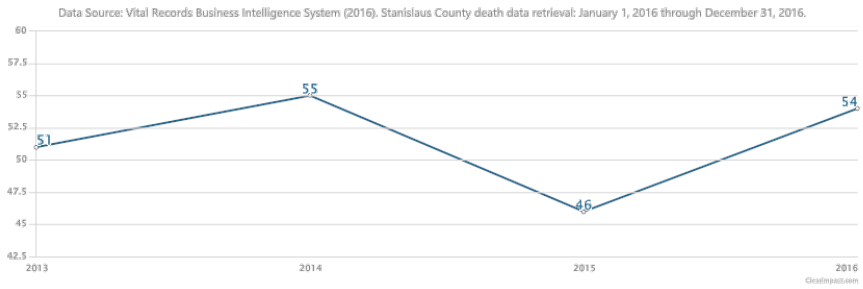
Our Mission

To facilitate knowledge, attitude and behavior change among individuals, communities and environments that reduce stigma and prevent suicide in Stanislaus County.

Population Result and Indicator

R Demo Stanislaus County is a community free from stigma and suicide

	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
I SP # of Total Suicide Deaths - Disaggreaged by Age	2016	54	↗ 1	6% ↑
	2015	46	↘ 1	-10% ↓
	2014	55	↗ 1	8% ↑
	2013	51	→ 0	0% →



Story Behind the Curve

Factors that increased the trend

- Stigma (Provider Bias) and discrimination, not knowing how to respond, fear, judgment, or lack of understanding, fear of judgment
- Standards of care/resources: access to services, lack of resources/services, unaware of services or how to obtain care/resources, unavailable care, lack of culturally available services, biased services, medical services are unavailable, don't know where to get help/unaware, unable to reach services/unavailable, awareness of services
- Sharing across systems and coordinated services
- Alienation or isolation
- Mental Health untreated
- Not knowing how to respond/fear
- Bullying
- Situational stress
- Substance Abuse
- Untreated mental illness

Factors that decreased the trend

- Outreach of and for mental health

- Community Engagement
- Medical Services at schools
- Improved training services
- Awareness events
- normalizing; normalizing the conversation and well-being
- providing access to resources
- Appropriate screening and follow-up
- Access and linkage to resources
- awareness events
- culturally appropriate services
- improve training services including front line providers - training about mental health/capacity building
- Prrovide additional Mental Health First Aid training
- Sharing data
- Establishing standards of care across sectors

Partners

Who are partners that could help decrease the trend?

- Suicide Prevention Advisory Board member, SCOE, Supeintendent of schools office/council, Modesto City School, including SCSU, and MJC, CSU Stanislaus, Sylvan, Modesto, Stanislaus Union, Empire, Ceres, Oakdale, Riverbank, all school districts, Superintendent Council
- Central Valley Pride Center
- Center for Human Services
- NAMI
- American Foundation Suicide Prevention
- Other Advisory Board members , Suicide Prevention Advisory Board Membership
- Hospitals - Sutter Health, Kaiser, Golden Valley, Doctors Hospital
- Law Enforcement - Modesto Police Department (Crisis Intervention), Stanislaus Sherriff's Department, and Turlock Police Department, Ceres Police Department
- Coroner Office - Death Review Team
- Faith Based Organizations - Clergy
- Family Resource Center
- Workforce Developoment Resources
- Inviting and starting conversations with Partners
- Define resources for all participating agencies

What Works

Evidence-based practices

- Mental Health First Aid (adult and youth)
- Zero suicide framework for medical staff capacity building, Safe Talk, MH First Aid, Fresno/website
- Peer support
- Crisis team
- Community inclusion
- more mental health providers

- education training for providers
- myth buster, stigma prevention
- culturally appropriate stigma prevention

Promising practices

- Resource and referral
- Education doctors (physicians) and medical staff
- "S" Word Campaign Awareness

Low-cost/No-cost

- Community presentations
- Awareness events like "Active Minds"

Off the wall ideas

- Engagement and Outreach Community van

I SP # of Total Suicide Deaths - Age 15 -24	2016	7	↗ 1	40% ↑
I SP # of Total Suicide Deaths - Age 25 -44	2016	18	↘ 1	20% ↑
I SP # of Total Suicide Deaths - Age 45 - 64	2016	18	↗ 1	0% →
I SP # of Total Suicide Deaths - Age 65+	2016	11	↘ 2	-15% ↓
I SP # of Student Suicide Related Data	2016	1	→ 0	0% →
I SP Seriously Considered Suicide	2016	0.07	→ 0	0% →
I SP Intentionally Injured Themselves	2016	1:23	→ 0	0% →
I SP Attempted Suicide	2016	1 :110	→ 0	0% →
I SP Percentage of Suicide Attempt Data, Non Fatal Emergency Department Visits = Disaggreaged by Age	2014	25	→ 0	0% →
I SP % of Suicide Attempts - Age 15 -19	2014	20%	→ 0	0% →
I SP % of Suicide Attempts - Age 25 -44	2014	33%	→ 0	0% →
I SP % of Suicide Attempts - Age 45 - 64	2014	23%	→ 0	0% →
I SP Percentage of Suicide Attempt Data, Non Fatal Emergency Department Visits = Disaggreaged by Race/Ethnicity	–	–	–	–
I SP % of Suicide Attempts - White Race/Ethnicity	2014	64%	→ 0	0% →
I SP % of Suicide Attempts - Hispanic Race/Ethnicity	2014	25%	→ 0	0% →
I SP Percentage of Suicide Attempt Data, Non Fatal Emergency Department Visits = Disaggreaged by Type of Injury	–	–	–	–
I SP % of Suicide Attempts - Poisoning	2014	57%	→ 0	0% →
I SP % of Suicide Attempts - Cut/Pierce	2014	29%	→ 0	0% →
I SP Percentage of Suicide Attempt Data, Non Fatal Hospitalizations = Disaggreaged by Age	–	–	–	–

I SP % of Suicide Attempts - Age 15 -19	2014	12%	→ 0	0% →
I SP % of Suicide Attempts - Age 25 -44	2014	32%	→ 0	0% →
I SP % of Suicide Attempts - Age 45 - 64	2014	35%	→ 0	0% →
I SP Percentage of Suicide Attempt Data, Non Fatal Hospitalizations = Disaggreaged by Race/Ethnicity	2014	46%	→ 0	0% →
I SP % of Suicide Attempts -White Race/Ethnicity	2014	67%	→ 0	0% →
I SP % of Suicide Attempts -Hispanic Race/Ethnicity	2014	20%	→ 0	0% →
I SP Percentage of Suicide Attempt Data, Non Fatal Hospitalizations = Disaggreaged by Type of Injury	–	–	–	–
I SP % of Suicide Attempts - Poisoning	2014	79%	→ 0	0% →
I SP % of Suicide Attempts - Cut/Pierce	2014	15%	→ 0	0% →
I SP Education Attainment of 2016 Suicide Deaths	2016	200%	→ 0	0% →
I SP Master's Degree or Higher	2016	4%	→ 0	0% →
I SP Associates Degree	2016	7%	→ 0	0% →
I SP Some College	2016	9%	→ 0	0% →
I SP Bachelor's Degree	2016	13%	→ 0	0% →
I SP No Degree	2016	18%	→ 0	0% →
I SP High School	2016	47%	→ 0	0% →
I SP Female	2016	24%	→ 0	0% →
I SP Male	2016	76%	→ 0	0% →
I SP Marital Status of 2016 Suicide Deaths	–	–	–	–
I SP Unknown	2016	2%	→ 0	0% →
I SP Widowed	2016	4%	→ 0	0% →
I SP Divorced	2016	27%	→ 0	0% →
I SP Married	2016	27%	→ 0	0% →
I SP Single	2016	40%	→ 0	0% →

Strategic Plan Strategies

S SP Enter Strategy #1	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM How much:	–	–	–	–
PM How well:	–	–	–	–
PM Better off:	–	–	–	–

S SP Enter Strategy #2	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM How much:	–	–	–	–
PM How well:	–	–	–	–

PM Better Off:	–	–	–	–

Programs

S SP Enter Program #1	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM How much	–	–	–	–
PM How well:	–	–	–	–
PM Better off:	–	–	–	–

S SP Enter Program # 2	Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
PM How much:	–	–	–	–
PM How well:	–	–	–	–
PM Better off:	–	–	–	–

Stanislaus County

Suicide Prevention Innovation Project

Advisory Board 2017 Annual Report

Coming together is a beginning. Keeping together is progress. Working together is success.
Henry Ford - Innovator

The Suicide Prevention Innovation Project Team would like to thank our Advisory Board and Collaborative Partners for being an integral part of the learning project and Collective Impact journey.

Advisory Board Organizations and Agencies

American Foundation for Suicide Prevention (AFSP) Central Valley Chapter

Aspiranet

The Bridge

Center for Human Services

Central Valley Suicide Prevention Line

Community Hospice

Doctor's Behavioral Health Center

El Concilio

Family Resource Centers

Golden Valley Health Centers

Jessica's House

LGBTQA Collaborative for Greater Well-Being

Livingston Community Health

MHSA Steering Committee Stakeholders

Modesto Junior College

National Alliance on Mental Illness (NAMI)

Patterson Family Resource Center

Private Practice - Child Psychotherapist

Sierra Vista

Stanislaus County Behavioral Health and Recovery Services:
Evaluation and Outcomes
Josie's Place
MHSA Administration
Prevention and Early Intervention
Workforce, Education and Training

Stanislaus County Chief Executive Office
Focus on Prevention

Stanislaus County Community Services Agency

Stanislaus County Health Services Agency - Public Health

Stanislaus County Probation

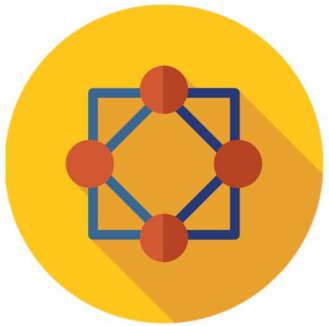
Sutter Health/Sutter Gould Medical Foundation

Turlock Family Resource Center

Turning Point Community Programs

West Modesto Community Collaborative

Westside Health Care Task-Force



Collaborative Partner Organizations and Agencies

California Forensics Medical Group

Del Puerto Health Care District

Health Plan of San Joaquin

Kaiser Permanente

Protecting Soldier's Rights

Stanislaus County Coroner's Office

Stanislaus County Office of Education

Stanislaus County Medical Society

Stanislaus County Veteran Services Office

Turlock Community Collaborative

Overview

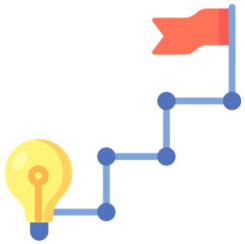
Project Strategy

The Suicide Prevention Innovation Project will utilize and evaluate the ***Collective Impact Model*** *as the promising community-driven best practice that has been widely adopted as an effective approach to cross-sector collaboration to address complex social problems.*

The ***Collective Impact Model*** *was selected as the innovative approach because cross-sector perspectives and collaboration are needed to address the complex causes and multiple risk factors of suicide.*

Project Results

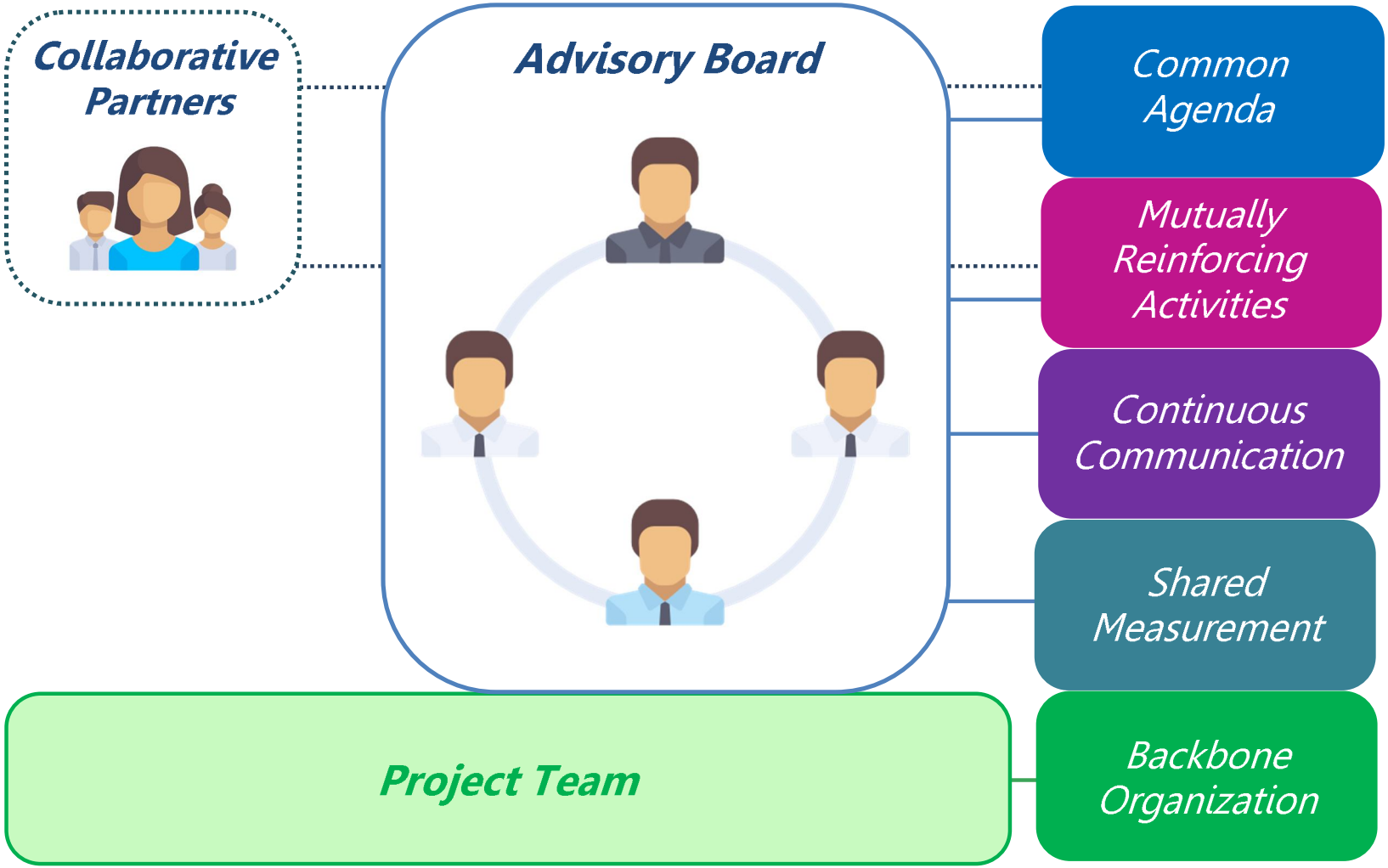
The Suicide Prevention Innovation Project will use the Collective Impact Model to ***learn about*** *and* ***address the suicides in Stanislaus County*** *by convening an Advisory Board comprised of stakeholders from different sectors of the community to develop a countywide strategic plan that integrates* ***suicide awareness and prevention.***



The result will be an ***increase*** *in the* ***quality of mental health services,*** *including* ***measurable outcomes.***

Collective Impact Model framework

Collective Impact brings people together, in a structured way, to achieve social change



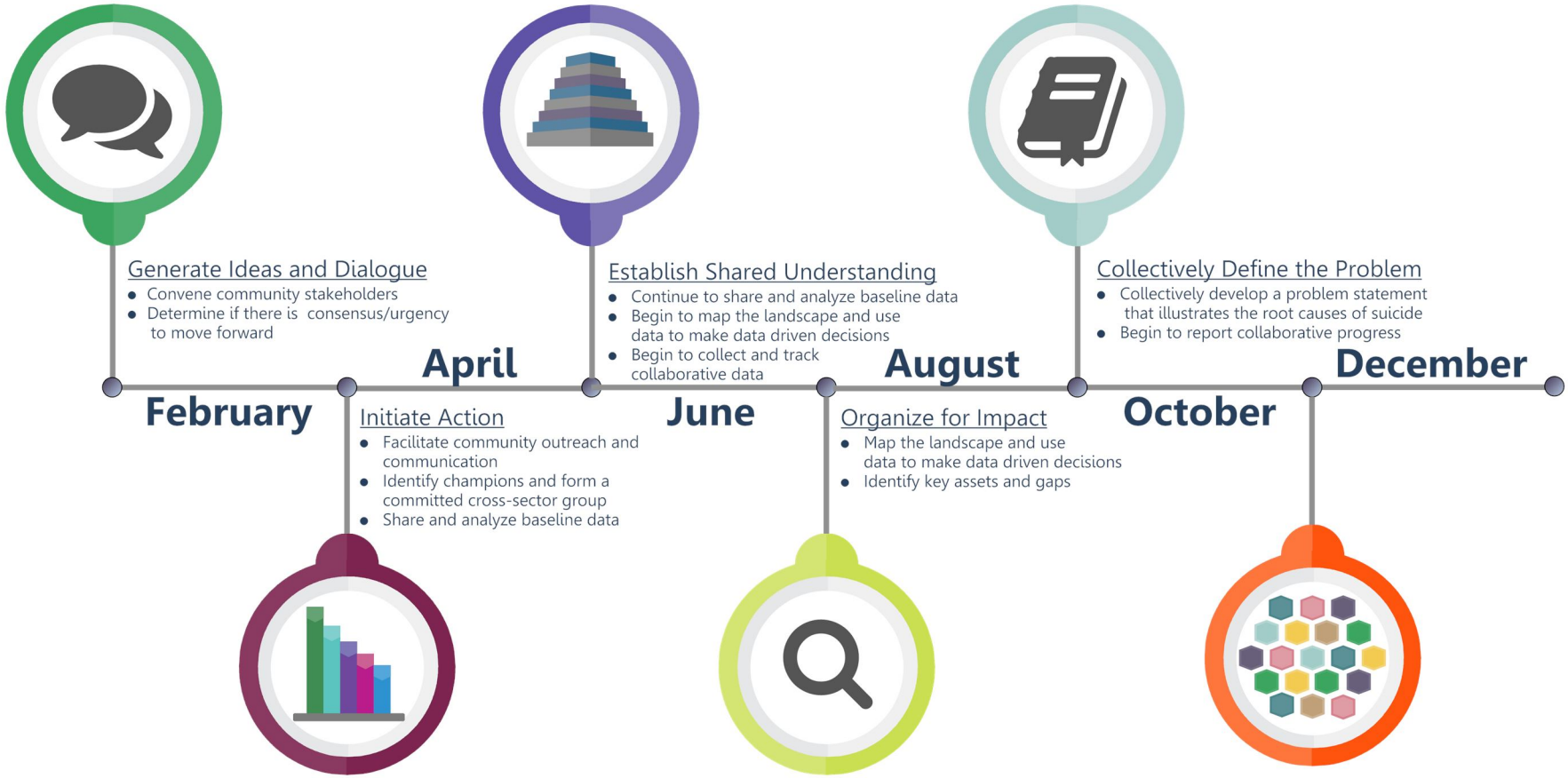
com·mon a·gen·da ('kämen e'jende)

noun

stakeholders come together to collectively define the problem and create a shared vision to solve it

Mutually Reinforcing Activities

2017 At a glance . . .



mu·tu·al·ly re·in·for·cing ac·tiv·i·ties ('myooCH(Oo)ele , rein'fôrs , ak'tivede')

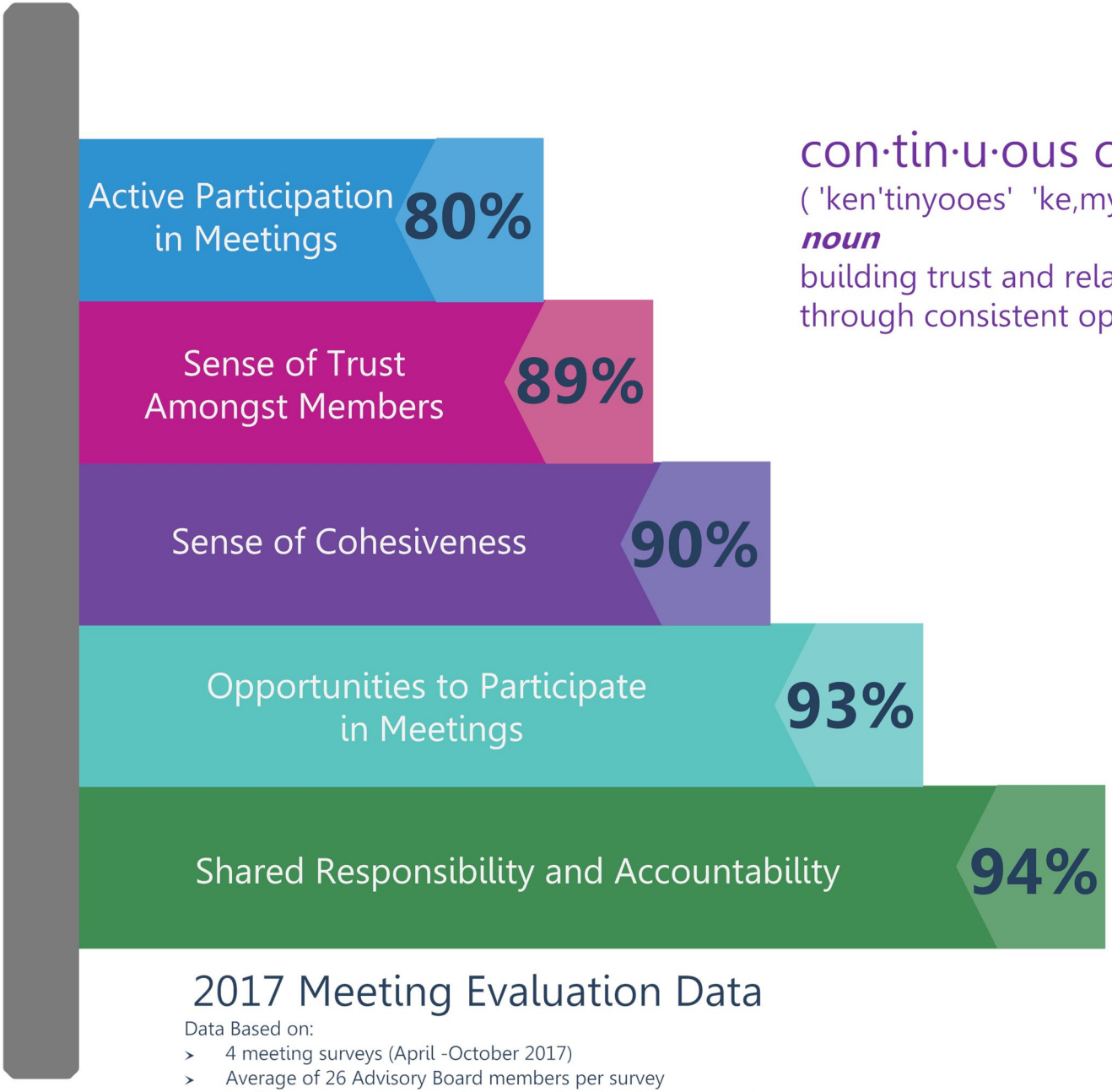
noun

diverse actions among stakeholders that are coordinated through an agreed upon plan to maximize results

. . . Looking Ahead to 2018

Common Agenda	create common goals and strategies
Continuous Communication	engage community and build public support advocate for practices and strategies proven to produce local results
Mutually Reinforcing Activities	continue to use data to integrate results-based practices and strategies
Shared Measurement	continue to collect, track and report on Advisory Board collaboration progress establish shared indicators

Continuous Communication



con·tin·u·ous com·mu·ni·ca·tion

('ken'tinyooes' 'ke,myoone'kaSH,(e)n')

noun

building trust and relationships among all stakeholders through consistent open communication

2017 Meeting Evaluation Data

Data Based on:

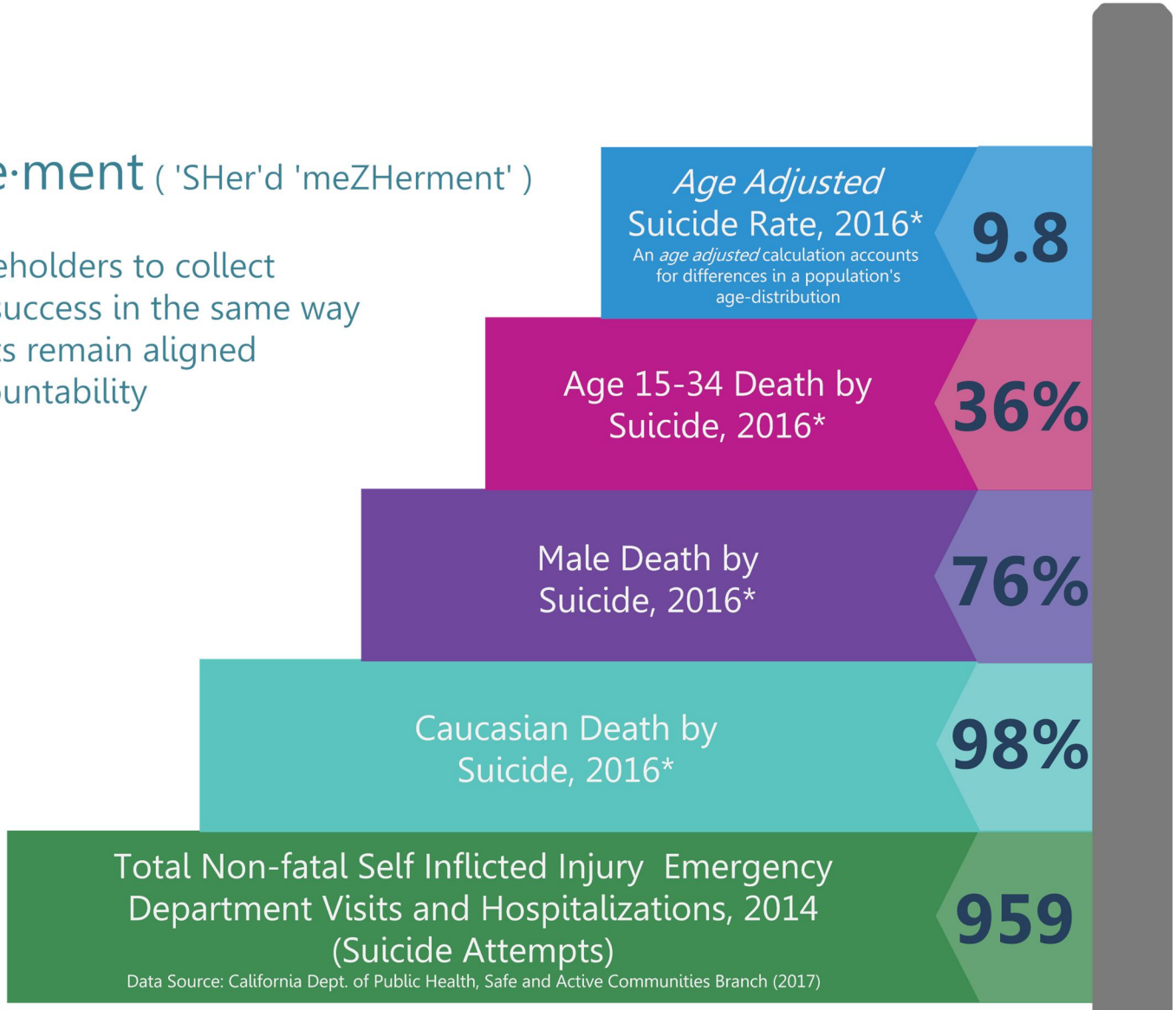
- 4 meeting surveys (April -October 2017)
- Average of 26 Advisory Board members per survey
- Positive responses to questions regarding the above categories

Shared Measurement

shar·ed meas·ure·ment ('SHer'd 'meZHerment')

noun

agreement amongst stakeholders to collect data, track progress and success in the same way over time to ensure efforts remain aligned and supports shared accountability



Stanislaus County Suicide Data

2016 Total Deaths by Suicide (55)

Data above depicts the highest percentage for age group, gender and race

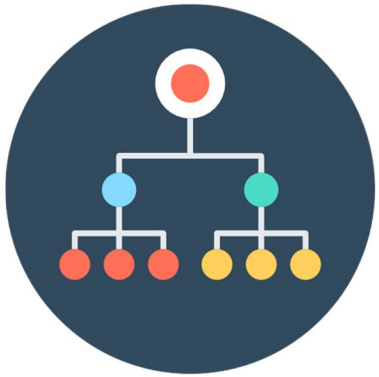
*Calculated by the Suicide Prevention Innovation Project Data Analyst

Backbone Organization

back·bone or·gan·i·za·tion ('bak,bon' 'orgene'zaSH(e)n')

noun

a dedicated team to convene and coordinate the participation and work among the stakeholders



Project Team

Sharrie Sprouse - Project Manager

Theresa Fournier, MPH - Data Analyst

Amber Gillaspy - Event Planner

Kirsten Jasek-Rysdahl, MA, MSW - Project Evaluator

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Red Nacional de Prevenvión del Suicidio
1-888-628-9454
prevenciondelsuicidio.org

Asian LifeNet Hotline
1-877-990-8585
(Cantonese, Mandarin, Japanese, Korean, Fujianese)

Trans Lifeline
1-877-565-8860
www.translifeline.org

Stanislaus County Warm Line
209-558-4600

Suicide Prevention Innovation Project

Stanislaus County Behavioral Health and Recovery Services
800 Scenic Drive
Modesto, CA 95350
209·525·6208

WELLNESS • RECOVERY • RESILIENCE

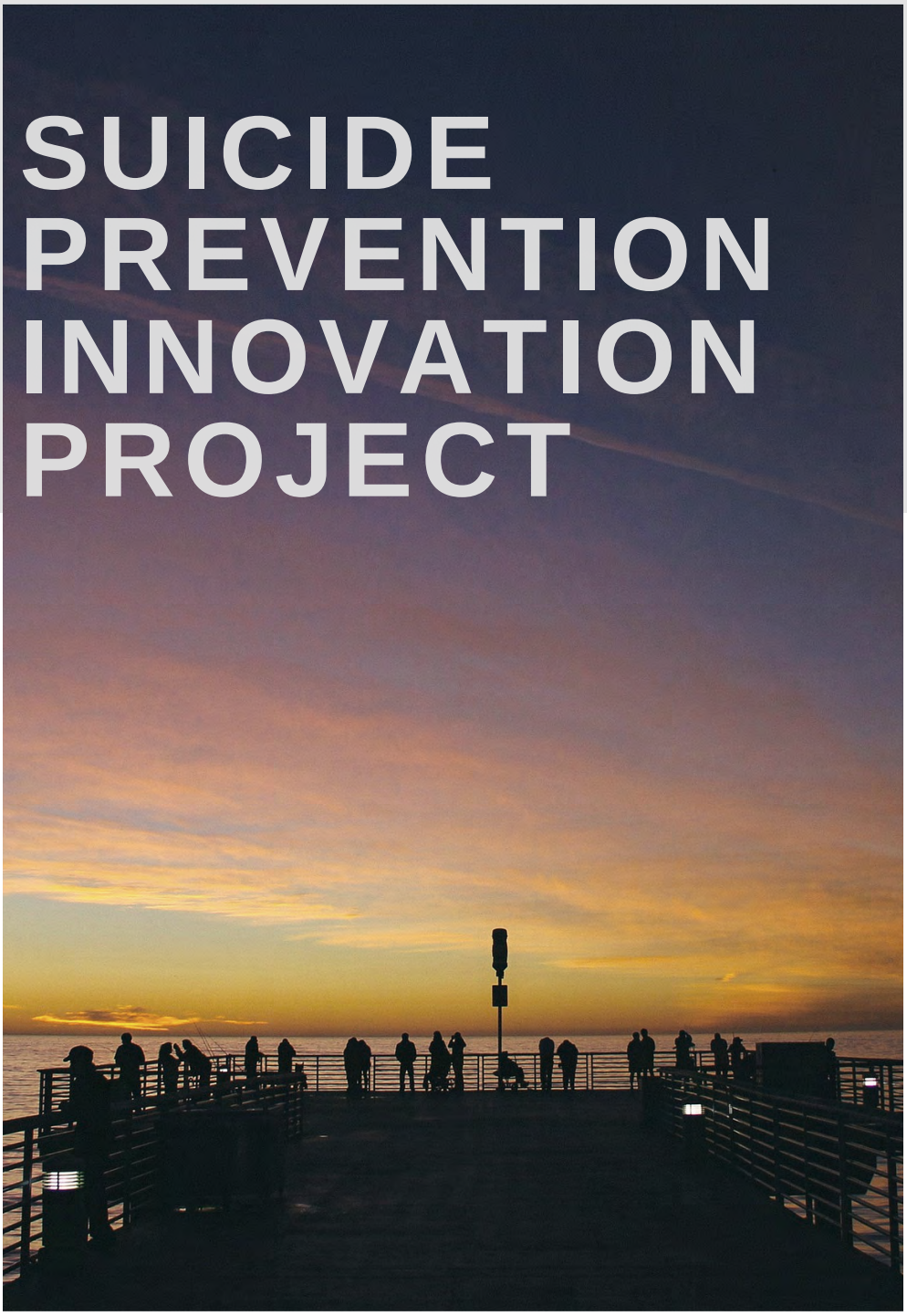
Striving to be the Best

The Suicide Prevention Innovation Project is funded by the Mental Health Services Act.

Attachment B

STANISLAUS COUNTY
ADVISORY BOARD
2018 ANNUAL REPORT

SUICIDE PREVENTION INNOVATION PROJECT



"Good teams incorporate teamwork into their culture, creating the building blocks for success."
-Ted Sundquist

ANNUAL REPORT 2018

The Suicide Prevention Innovation Project Team would like to thank our Advisory Board and Collaborative Partners for being an integral part of the learning project and Collective Impact journey.

The Annual Report is a document for the Advisory Board Members and is intended to highlight the achievements as well as provide a vision of the work ahead in the coming year.

PROJECT OVERVIEW

In 2015, the Stanislaus County Board of Supervisors and the local Mental Health Services Act (MHSA) Representative Stakeholder Steering Committee (RSSC) identified concerns that statewide efforts to reduce suicides had not yielded the desired results in Stanislaus County. A funding recommendation and project proposal for the Suicide Prevention Innovation Project was submitted and subsequently approved by the MHSA Oversight and Accountability Commission.

The Suicide Prevention Innovation Project was funded to use the Collective Impact Model to learn about and address suicides in Stanislaus County. The plan included the convening of an Advisory Board comprised of stakeholders from different sectors of the community to develop a countywide strategic plan integrating suicide awareness and prevention efforts.

The Collective Impact Model is a framework used to tackle deeply rooted and complex social problems. It is the commitment of a group of stakeholders from different sectors of the community, with a shared vision for solving a specific and complex social problem. The Collective Impact Model was selected as the innovative approach because cross-sector perspectives and collaboration are needed to address the complex causes and multiple risk factors of suicide.

Advisory Board Organizations and Agencies

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Aspiranet

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Kaiser Permanente

Stanislaus County Coroner's Office

Stanislaus County Office of Education

Stanislaus County Medical Society

Stanislaus County Veteran Services Office

Protecting Soldier's Rights

Turlock Community Collaborative

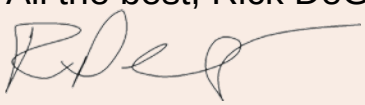
Backbone Organization

Message from Stanislaus County Behavioral Health and Recovery Services Director

Hello!

I am pleased to welcome you to review the 2018 Stanislaus County Suicide Prevention Innovation Project annual report. This report summarizes the continued effort of the Advisory Board to work collectively to find solutions to the escalating suicide rate that causes so much distress in our communities. In early 2017, the Advisory Board was convened to explore root cause factors that are contributing to the suicide rate. I am very appreciative for the efforts of this group to delve deeply into this critical area of concern and I remain hopeful our efforts will enhance the collective understanding of suicide and inform our ability to save lives.

All the best, Rick DeGette



Project Team

Sharrie Sprouse - Project Manager

Theresa Fournier, MPH - Data Analyst

Amber Gillaspy- Event Planner

Kirsten Jasek-Rysdahl, MA, MSW- Project Evaluator

STRATEGY

The Suicide Prevention Innovation Project will utilize and evaluate the Collective Impact Model as the promising community-driven best practice that has been widely adopted as an effective approach to cross-sector collaboration to address complex social problems.

The Collective Impact Model was selected as the innovative approach because cross-sector perspectives and collaboration are needed to address the complex causes and multiple risk factors of suicide.

RESULTS

The Suicide Prevention Innovation Project will use the Collective Impact Model to learn about and address the suicides in Stanislaus County by convening an Advisory Board comprised of stakeholders from different sectors of the community to develop a countywide strategic plan that integrates suicide awareness and prevention.

The result will be an increase in the quality of mental health services, including measurable outcomes.

MAKING AN IMPACT

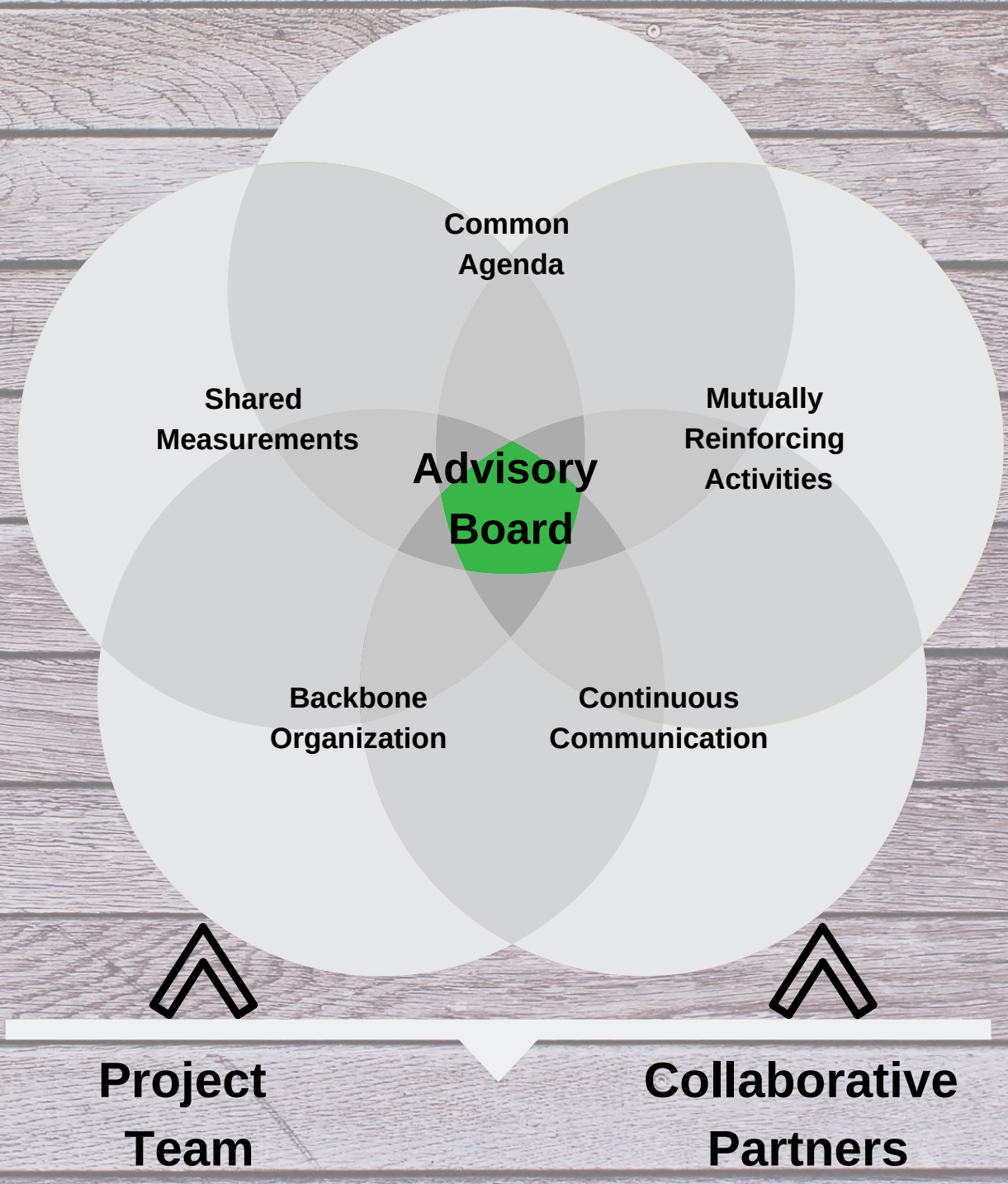
In early 2017, potential member organizations and agencies were convened to launch the Suicide Prevention Innovation Project by exploring and defining the problem of suicide in Stanislaus County. In attendance were stakeholders from various sectors of the community that included service providers, faith based leaders, government agencies, law enforcement, healthcare, education and several community based organizations representing diverse and under-served populations.

Diverse perspectives and collaboration are needed to address the complex and multifaceted nature of the root causes of suicide. The commitment of 35 collaborative partners and stakeholders was made to form the Suicide Prevention Advisory Board.

The Advisory Board Annual Report is intended to highlight the Board's achievements over the past year; as well as a brief look ahead for the coming year.

Collective Impact Model

Collective Impact brings people together, in a structured way, to achieve social change.



MUTUALLY REINFORCING ACTIVITIES 2018 HIGHLIGHTS

JANUARY/FEBRUARY/MARCH

- Develop and finalize communication plan in collaboration with advisory board
- Refine branding, key messages for common agenda, local strategy, and needs assessment findings

APRIL/MAY/JUNE

- Engage community to build public will
- S Word Documentary Screening Events / Awareness Campaign
- Conduct Needs Assessment / Community Report / Communication Brief

JULY/AUGUST/SEPTEMBER

- Conduct community presentations of Needs Assessment
- Convene advisory board members to develop Common Agenda and Shared Measurements

OCTOBER/NOVEMBER/DECEMBER

- Collaborate with community partners to host Suicide Prevention Symposium
- Research tools and platforms for strategic planning efforts to take place in 2019

MUTUALLY REINFORCING ACTIVITIES

Diverse actions among stakeholders that are coordinated through an agreed upon plan to maximize results

Looking Ahead: 2019

COMMON AGENDA

To facilitate knowledge, attitude and behavior change among individuals, communities and environments that prevent suicide and reduce stigma in Stanislaus County

CONTINUOUS COMMUNICATION

Advocate for practices and strategies proven to produce local results. Build capacity for advisory board members to leverage network resources.

MUTUALLY REINFORCING ACTIVITIES

Continue to use data to integrate results-based practices and strategies

SHARED MEASUREMENTS

Continue to collect, track and report on Advisory Board collaboration progress. Develop and measure shared indicators

STRATEGIC PLAN

The advisory board will move into the strategic planning portion of the project to draft and work towards sustaining a Suicide Prevention Strategic Plan for Stanislaus County.

THE LEARNING QUESTIONS

1. Through collective efforts, will the group develop a shared understanding of suicide data in our county? If so, how will the shared understanding impact suicide prevention planning?
2. Can a collaborative use data and combined information from multiple sources to develop a suicide prevention strategic plan that is effective in reducing suicide rates?
3. What target interventions are most effective in decreasing suicides in Stanislaus County?
4. Will different demographic groups be successfully impacted?

2018 Meeting Evaluation Data

76%

Active Participation in Meetings

88%

Sense of Trust Among Members

86%

Sense of Cohesiveness

88%

Shared Responsibility and Accountability

2018 Meeting Evaluation Data
Data Based on:
- 4 meeting surveys (February-October 2018)
- Average of 17 Advisory Board Members per survey

Positive responses to questions regarding the above categories

NATIONAL SUICIDE PREVENTION LIFELINE

1-800-273-TALK (8255)
suicidepreventionlifeline.org

RED NACIONAL DE PREVENCIÓN DEL SUICIDIO

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TRANS LIFELINE

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www.translife.org

STANISLAUS COUNTY WARM LINE

209-558-4600

CENTRAL VALLEY SUICIDE PREVENTION HOTLINE

1-888-506-5991
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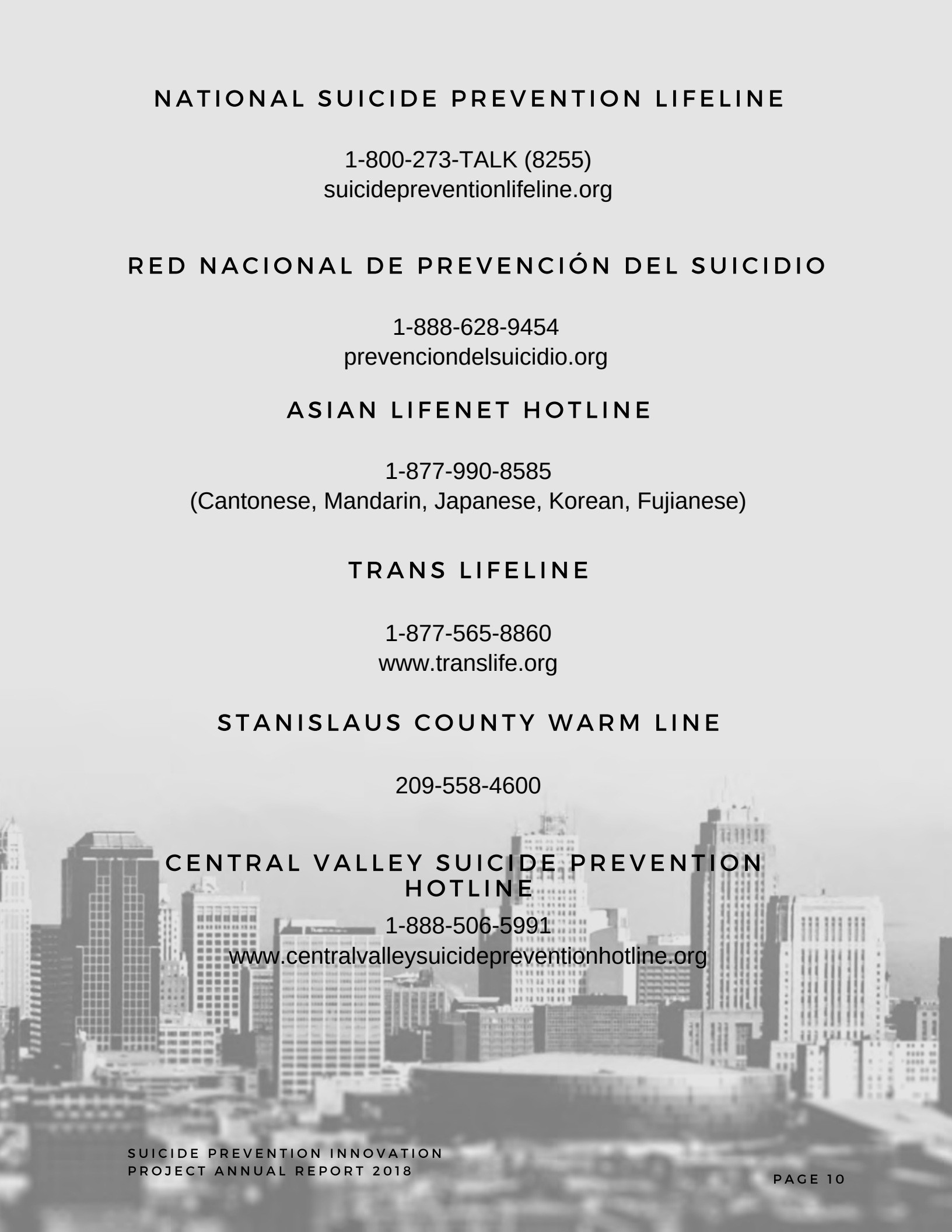

Suicide Prevention Innovation Project

Stanislaus County Behavioral Health and Recovery Services
800 Scenic Drive
Modesto, CA 95350
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The Suicide Prevention Innovation Project is funded by the Mental Health Services Act.