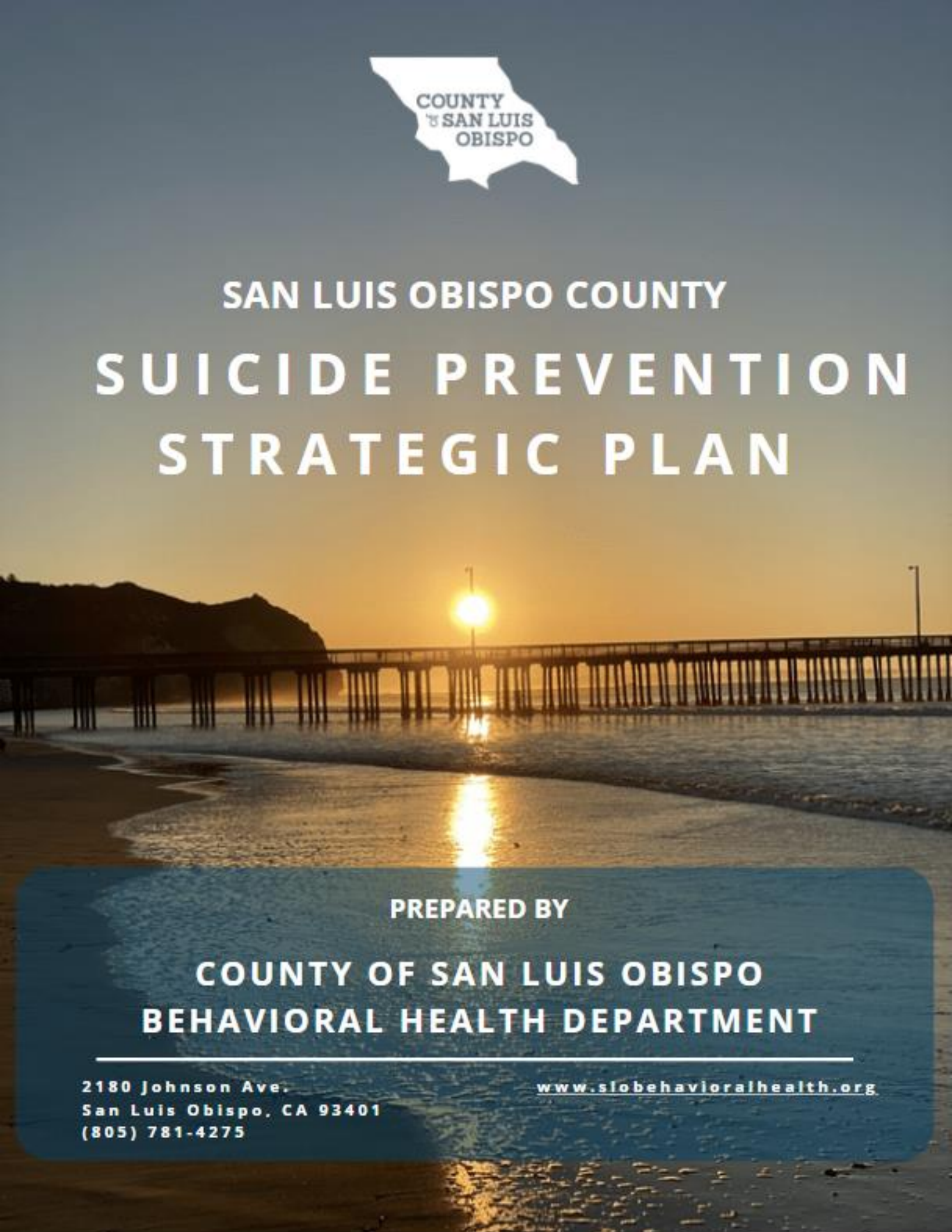

SAN LUIS OBISPO COUNTY

SUICIDE PREVENTION STRATEGIC PLAN

PREPARED BY

COUNTY OF SAN LUIS OBISPO
BEHAVIORAL HEALTH DEPARTMENT

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Introduction

Suicide is a public health issue in San Luis Obispo County. Suicide is an important topic and a reality that affects this community profoundly, and as such, everyone has a role in suicide prevention efforts. The collective effort to prevent suicide can have a strong impact on the wellbeing of all members of the community and in saving lives.

San Luis Obispo County's Suicide Prevention Strategic Plan is the result of community engagement and planning from various stakeholders. The plan lays out strategic aims, goals, and objectives to address suicide and ensure prevention, intervention, and postvention approaches are established countywide. This document also includes various local, state, and national resources as part of prevention activities. Primarily, the Suicide Prevention Strategic Plan provides a roadmap with clear goal and objective development to build upon successful engagement processes and expand suicide prevention efforts.

Dedication

This plan is dedicated to all those we have lost to suicide and to those who have the lived experience of thinking about or wanting to end their own life. Our hearts go out to the families, friends, and our community of individuals who honor the memory of their loved ones lost and to those who support loved ones through daily acts of kindness and words of encouragement. Lastly, we dedicate this plan to suicide attempt survivors, whose stories are not often told but whose experiences we honor and seek to support.

Get Help Now

If you or someone else needs support, a trained crisis counselor can be reached by calling the National Suicide Prevention Lifeline at **800-273-TALK (8255)** or by texting TALK to **741741**

- Central Coast Hotline at **800-783-0607**
- Personas que hablan español, llamen a REd Nacional de Prevención del Suicidio al **888-682-9454**
- For teens, call the TEEN LINE at **310-855-4673**
- For Veterans, call the National Suicide Prevention Lifeline at **800-273-TALK (8255)** and **press 1**
- For LGBTQ+ youth, call The Trevor Project at **866-488-7386** or text START to **678678**
- For transgender people, call the Trans Lifeline at **877-565-8860**
- For people who are hearing impaired, call the Lifeline at **800-799-4889**
- For law enforcement personnel, call the COPLINE at **800-267-5463**
- For other first responders, call the Fire/EMS Helpline at **888-731-FIRE (3473)**
- For older adults and adults living with diverse abilities, call The Friendship Line at **800-971-0016**

All of the resources above provide confidential help and are available 24 hours a day, seven days a week. Suicide risk assessment is a collaborative and transparent process between the person at risk and the person conducting the assessment. Working together, support services and referral options are identified based on risk and need.

If someone is ***showing warning signs of suicide or communicating a desire to die, take the following steps:***

1. ASK "Are you thinking about about suicide or feeling that life may not be worth living?" and assess the person's safety by asking if the person has a specific plan and any intent to act on that plan. Ask if the person has already begun acting on these thoughts or made a suicide attempt. Risk of death by suicide increases significantly as people put more pieces of a plan in place. See page ** for a list of warning signs.

2. EXPRESS compassion. The desire to die by suicide can be frightening and isolating experience. Express compassionate care to emphasize the help is available, including confidential resources.

3. REACH OUT for support by calling the crisis lines (see above) to be connected to resources. All crisis lines are available to people in crisis AND individuals supporting people in crisis.

4. FOLLOW-UP by calling, texting, or visiting to ask how the person is doing and if additional support is needed.

Take a screen shot of this of page if you're on your mobile device or make a copy if you're viewing the print version. This page can be saved for future use or sent to a loved one. Originally from Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025 with edits made by County of SLO Behavioral Health, adding the SLO Hotline, Friendship Line, and formatting adjustments.

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Stigma, Myths, & Warning Signs

Stigma is a Major Obstacle to Preventing Suicide

While stigma cuts across many other issues, suicide and mental health challenges carry the weight of stigma across cultures. Stigma refers to negative attitudes and beliefs about people with behavioral health needs, such as problematic substance use, disordered eating issues, serious psychological distress, and other mental health needs. The severity of these behavioral health problems can range from distress to diagnosable illnesses and disorders. Stigma not only discourages individuals from seeking help for themselves or others but also can prevent people, families, and communities from becoming connected with meaningful support. Stigma affects the reporting and recording of suicides and the circumstances leading up to a suicide, such as a previous attempt or death in the family. Consequently, prevention efforts are hindered by the underreporting of suicidal behavior. To help combat stigma, this document will model appropriate use of non-stigmatizing, person-first language. Below are examples of outdated, stigmatizing language previously commonly used to talk about suicide, along with a non-stigmatizing alternative.

Stigmatizing:	Non-Stigmatizing:
Committed Suicide	Died by Suicide
Suicidal Person	Person at Risk of Suicide
Failed Suicide Attempt	Non-Fatal Suicide Attempt
Successful Suicide	Fatal Suicide Attempt
Mentally Ill Person	Person Living with Mental Health Needs

Myths and Misconceptions About the Prevention of Suicide Also Hinder Prevention Efforts[1]

Below are examples of common myths and the facts associated with each.

Myth	Fact
Most suicides are impulsive and happen without warning.	Most people who die by suicide communicated their plans for the attempt to someone prior to death.[2]

[1] World Health Organization. (2014). *Preventing suicide: A global imperative.* Luxembourg: Author.
[2] Western Interstate Commission for Higher Education Mental Health Program (WICHE MHP) & Suicide Prevention Resource Center (SPRC). (2017). *Suicide prevention toolkit for primary care practices. A guide for primary care providers and medical practice managers* (Rev. ed.). Boulder, Colorado: WICHE MHP & SPRC.

	Suicide planning, including obtaining the means by which to attempt suicide and identifying a location, often happens well before the attempt—sometimes years in advance. Most suicides are preceded by warning signs, such as communicating the desire to die, of having no reason to live, or feeling of being a burden. Additional warning signs include fearlessness, being unafraid to die, and exhibiting risk-taking behaviors.[3]
People who want to die are determined and there is no changing their minds.	Over 90 percent of people who were interrupted in a suicide attempt will not go on to die by suicide at another location or by other methods.[4] Research suggests that those at risk for suicide often show extreme ambivalence about the desire to die or live and express a high degree of suffering. The accounts of attempt survivors suggest that many people are relieved to have lived through an attempt and regain their desire to live.[5] This fact highlights the opportunity to intervene and separate the person at risk from lethal means for a suicide attempt.
Communicating about suicide will plant the seed for thoughts of suicide, increasing risk.	Communicating openly about suicide and asking about risk has been shown to be lifesaving and encourages people to seek help, promotes a sense of belonging, and connects people to care.

SUICIDE WARNING SIGNS[6]

For more information about warning signs and how to help, visit suicideispreventable.org

- Talking about wanting to die or suicide
- Making a plan to kill oneself
- Giving away prized possessions
- Putting affairs in order
- Feelings of hopelessness

[3] Joiner, T.E., Jr. (2005). *Why people die by suicide.* Cambridge, MA: Harvard University Press.
[4] Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm: Systematic review. *British Journal of Psychiatry, 181,* 193-199.
[5] Talseth, A. G., Jacobsson, L. & Norberg, A. (2001). The meaning of suicidal psychiatric inpatients' experiences of being treated by physicians. *Journal of Advanced Nursing, 34(1),* 96-106.
[6] https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml

- Feeling like a burden
- Changes in sleep
- Reckless behavior
- Uncontrolled anger
- Anxiety or agitation
- Sudden mood changes, appearing sad or depressed
- Withdrawal
- Loss of interest
- Changes in appearance
- Increase in substance use
- Self-Injury

Suicide Prevention Council of SLO County

History

Community suicide prevention efforts in San Luis Obispo County date back to the 1950's with the first volunteer-based suicide call line provided by local churches. SLO Hotline (now Central Coast Hotline) was officially created in the 70's, and soon thereafter, efforts to provide community wide awareness and training began to evolve. San Luis Obispo County's Behavioral Health Department (SLOBHD), SLO Hotline and other community providers brought Applied Suicide Intervention Skills Training (ASIST) to San Luis Obispo County in the early 90's.

The ASIST team would meet regularly for planning, and the ideas to create and deliver an annual Suicide Prevention Forum soon came out of those conversations. SLOBHD, SLO Hotline, Area Agency on Aging, Cuesta Community College, Hospice of SLO, San Luis Obispo County Probation Department, Community Counseling Center, California Polytechnic University San Luis Obispo (Cal Poly), and other community providers began to hold annual forums based on the interests and needs of the community. This included forums that would focus on Veterans, seniors, and LGBTQ+ populations. This band of trainers and volunteers would hold the forum wherever they could, including school gymnasiums and the San Luis Obispo Library conference room.

In 2009, SLO Hotline was on the verge of being eliminated due to loss of funding. Seeing the vital role that this service plays in the community, Transitions-Mental Health Association (TMHA) stepped in to provide a parent agency for sustained service, supported by the SLOBHD and Mental Health Services Act (MHSA) funding. In 2010, California initiated a three-year Suicide Prevention initiative for all MHSA providers throughout the state. Through this initiative, regional and statewide networks were established, helping to strengthen local community prevention efforts through shared knowledge and consultation. TMHA began to

assist the informal planning committee of the Suicide Prevention Forum, providing access to grant funding and spearheading the event coordination.

Through these efforts and the phenomenal collaboration between a wide variety of partners in San Luis Obispo County, TMHA saw the potential to develop a Suicide Prevention Council, similar to the council in San Diego, CA. TMHA quickly began implementing a strategic planning process with the many community partners that would provide a working foundation for the future, along with a clear mission, logo, and council name: The Suicide Prevention Council of San Luis Obispo County. The Council was established in 2014-2015.

The Suicide Prevention Council Today

With the Council infrastructure in place, SLOBHD, in partnership with TMHA, worked to create a Suicide Prevention Coordinator (SPC) position, funded through MHSA Prevention and Early Intervention. The Coordinator would lead efforts to assist schools and the community with suicide prevention training, and act as the chair of the Council. Since 2018, the SPC has held regular monthly meetings from January through October, engaging diverse community stakeholders and partnering agencies to help increase public awareness about suicide.

Part of the public awareness campaign includes the distribution of literature, the creation of a Suicide Loss Survivor informative brochure, and a Facebook page dedicated to the Council's messaging and activities. Meetings include data sharing, discussion of best practices, and presentations. An important function of the meetings involves event planning. The Council has put its energy into community outreach through public activities such as the annual Suicide Prevention Forum and a handful of resource fairs for targeted audiences (Older Adults, Veterans, LGBTQ+ Individuals).

The Council is currently developing sub-committees including the formation of a Suicide Loss Survivor Outreach Team and a Suicide Means Safety work group. This work group would build on efforts of the Opioid Safety Coalition, for example, to help disseminate means safety and Naloxone trainings. A Means Safety work group will also partner with local law enforcement agencies for guidance on safe storage, community outreach, and other educational strategies to help keep firearms out of the hands of those in a suicide crisis.

San Luis Obispo County Suicide Prevention Council Mission

To prevent suicide and respond to the consequences in a culturally sensitive way through community collaboration between agencies, organizations, and community members by means of public education, training, and the sharing of resources.

- To advocate for a stronger support system and create lasting change for those at risk of suicide;
- To challenge the misconceptions regarding mental illness and suicide through community collaboration;
- To create a community that supports and embraces those who struggle with suicide; and
- To create an environment of HOPE.

Members

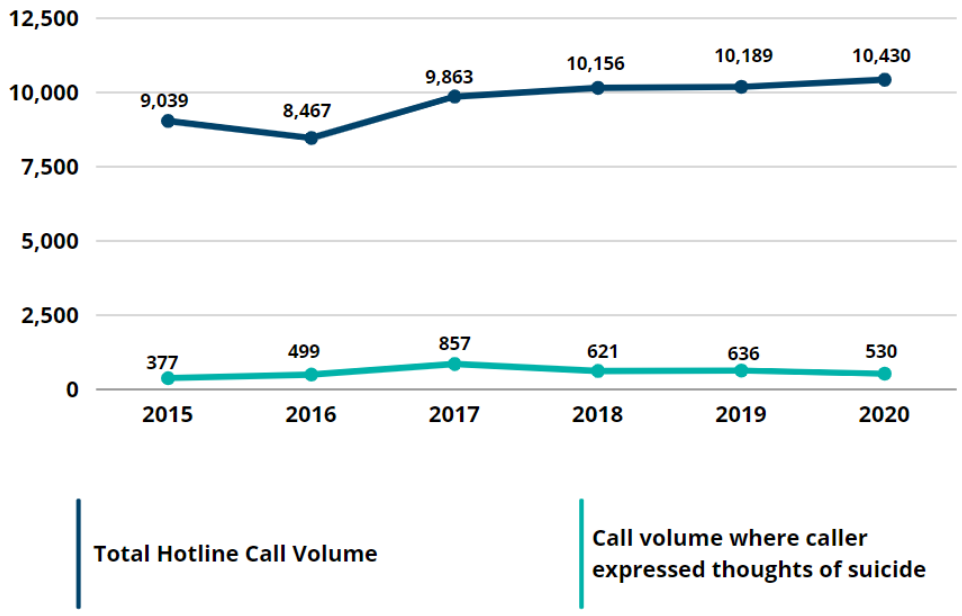
- Access Support Network
- Adult Protective Services
- American Foundation for Suicide Prevention (AFSP)
- Area Agency on Aging
- Aspire Counseling
- California Polytechnic State University San Luis Obispo
- Central Coast Hotline
- County of San Luis Obispo Behavioral Health Department
- Cuesta Community College Health Services
- Family Care Network
- The Gala Pride and Diversity Center
- Home Instead Senior Care
- Hospice of SLO County
- LGBTQ+ Mental Health and Equity Task Force of SLO County
- National Alliance on Mental Illness (NAMI)
- RISE (A non-profit that serves both survivors of intimate partner violence and sexual assault/abuse and their loved ones)
- Sierra Mental Wellness Group (Crisis Stabilization Unit and Mental Health Evaluation Team)
- Stand Strong
- Suicide Loss, Healing, and Empowerment Support Group
- Transitions-Mental Health Association (TMHA)
- VA Vet Center
- Veterans Services Collaborative
- Veterans Services Office
- Wilshire Community Services
- Wilshire Hospice Bereavement

The Central Coast Hotline (Formerly the SLO Hotline)

Central Coast Hotline (Hotline) is an accredited crisis center, as evaluated by the American Association of Suicidology, which establishes and monitors the criteria for crisis lines in the U.S.

Hotline strives to reduce stigma and educate and inform the community about mental illness. Hotline is a valuable resource in San Luis Obispo and Northern Santa Barbara Counties, supporting the work of local government and mental health service agencies and relieving call volume for local 911 services by taking non-emergency calls. Hotline may refer callers with other needs to 2-1-1, the universal, three-digit dialing code information line operated locally by United Way. 2-1-1 is a free information and referral service which connects individuals and families with community resources.

For non-crisis calls, Central Coast Hotline may also refer callers to the California Peer Support WarmLine at 855-845-7415; or for those over the age of 60, the Friendship Line at 1-800-971-0016. Data for Central Coast Hotline volume and suicide-specific calls between 2015-2020 is presented below:



AB 2246 & Youth Suicide Prevention

California Assembly Bill 2246, passed in 2016, requires California school districts with students in grades 7-12 to adopt suicide prevention, intervention, and follow-up plans (postvention). Suicide prevention plans in schools need to include strategies specific to higher risk students, such as those with mental health challenges, students who identify as LGBTQ+, and other vulnerable groups. A model school policy can be accessed and adopted through The California Department of Education.

School plans for prevention, intervention, and postvention need to include an annual prevention training for educators and school staff to help identify the warning signs of suicide in students and how to approach and intervene so students get the support needed. Annual trainings include:

- Question, Persuade, Refer (QPR)
- More Than Sad (American Foundation for Suicide Prevention)
- Youth Mental Health First Aid
- LivingWorks Start

Supplemental prevention strategies include outreach and marketing materials such as awareness posters, local hotline cards, self-care materials, and more. The SLOBHD works closely with the San Luis Obispo County Office of Education and eight public school districts in the county to bring annual suicide prevention trainings, awareness events, and mental health counselor support to young people.

Prevention and Early Intervention programs include:

Friday Night Live

Friday Night Live is California's leading youth development and substance use prevention program. Programs are youth-led and youth-driven and provide support opportunities for youth to build skills, knowledge, and attitudes that promote future success. Friday Night Live programs are offered in more than 20 middle and high schools across the county, including a chapter at Cal Poly.

Student Support Counseling

SLOBHD partners with seven school districts to provide student support counselors in high schools and middle schools. Services include identification of youth with

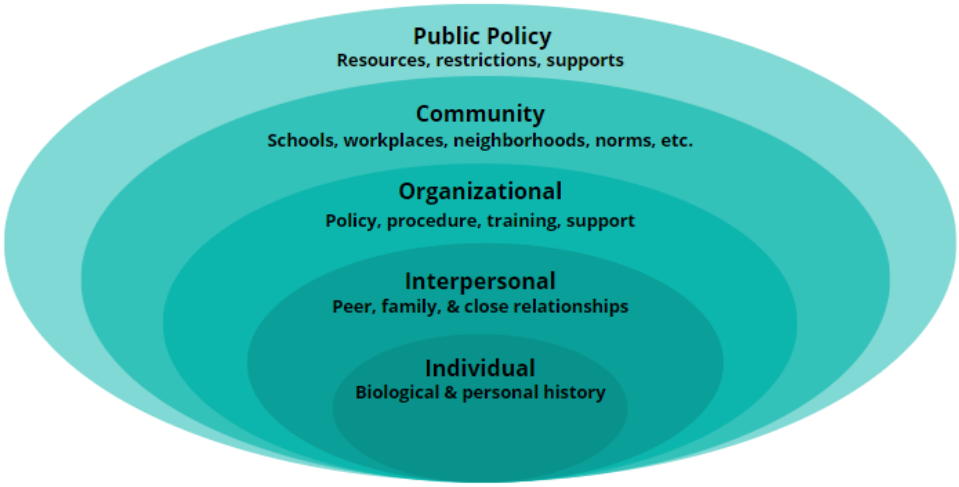
elevated risk factors, assessment, educational groups, skill building, individual interventions, and referrals. Support Counseling focuses on substance use and mental health prevention and early intervention, all supporting the end goal of suicide prevention.

Middle School Comprehensive Program

This program is an integrated collaboration between SLOBHD, middle schools across San Luis Obispo County, and community-based organizations. The program services include Student Support Counseling, family support, and youth development opportunities.

The Socio-Ecological Model

Suicide is a public health issue and prevention strategies must operate with the understanding of individual-level and population-level risk and protective factors. Interventions will be most effective when they address and include all levels of the socio-ecological model (SEM). A deeper understanding of the decision of suicide can illuminate how, when, and where to intervene and support the individual through the multi-layered lenses of intervention (individual, interpersonal, organizational, community, and public policy).



As modeled in the Santa Cruz County Strategic Plan for Suicide Prevention[7], SEM can be explored through the fictitious character Jason -a white cisgender male in his late 20's with a high school diploma and some college. Jason identifies as pansexual, is

[7]http://www.santacruzhealth.org/Portals/7/Pdfs/MHSA/2019%20Santa%20Cruz%20County%20Suicide%20Prevention%20Strategic%20Plan%20Draft%20for%20Public%20Review.pdf

dating but not in a committed relationship and has a history of adverse childhood experiences (ACE's). He was diagnosed with schizophrenia five years ago **(individual)**. He has a few close friends, yet he often feels lonely. He has been struggling since his sister passed away a year ago. A trusted friend encouraged him to seek counseling support and attend a support group **(interpersonal).** Jason was able to access counseling services at the community college he attends **(organizational)**. The school counselor has been trained in Assessing and Managing Suicide Risk (AMSR) and is helping Jason process his grief and engage in healthy and productive coping skills. Although initial counseling was helpful, Jason has had recent difficulty making his appointments because he has to catch the bus to make it to work on time, and the bus only comes once an hour **(community)**. However, months later, the community college and county office of transportation passed a local policy that offers transportation assistance to qualifying students, including Jason **(public policy).**

This example demonstrates how an individual's risk and protective factors can be influenced by their environment, and how each layer of SEM can affect another, ultimately resulting in a better or worse outcome for someone who has a higher risk of suicide.

Strategic Areas

Suicide is a complicated phenomenon with no single cause, and therefore, no single solution. Prevention encompasses a range of prevention services, activities, trainings, marketing, and communication to meet the needs of people of all ages and backgrounds. Three strategic areas to focus on include: (1) prevention and early intervention, (2) intervention, and (3) postvention.

Prevention & Early Intervention

As outlined in the Mental Health Services Act (MHSA), Prevention and Early Intervention (PEI) services embrace a preventive approach that engages individuals *before* the development of mental illness, including suicidal behavior, as well as providing services to intervene early to reduce negative mental health and suicide symptoms, thereby reducing prolonged suffering.

Intervention

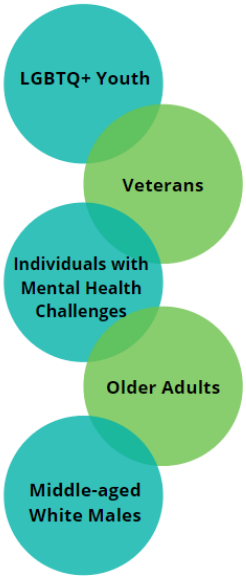
Intervention is a strategy or approach that is intended to prevent an outcome or to alter the course of an existing outcome.

Postvention

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

Priority Populations

Suicide is a complex public and behavioral health issue. While it affects all corners of society, there are some populations with higher risk of suicide than the general population. It is therefore important to prioritize these groups when creating a plan to ensure appropriate representation and cultural humility are addressed in each strategy. These populations were identified through California Health Kids Survey (CHKS) and local public health data.



Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025

Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025, provides a guiding framework for suicide prevention through four strategic aims, each with unique goals and objectives. San Luis Obispo County's prevention efforts will utilize these strategic aims to build upon local efforts. San Luis Obispo County's strategic plan will follow the strategic aims and goals as the structure for the local plan.

The strategic aims and associated goals are as follows:

Strategic Aim 1: Establish suicide prevention infrastructure.

Goal 1: Enhance visible leadership and networked partners.

Goal 2: Increase development and coordination of suicide prevention resources.

Goal 3: Advance data monitoring and evaluation.

Strategic Aim 2: Minimize risk for suicidal behavior by promoting safe environments, resiliency, and connectedness.

Goal 4: Create safe environments by reducing access to lethal means.

Goal 5: Empower people, families, and communities to reach out for help when mental health and substance use disorder needs emerge.

Goal 6: Increase connectedness between people, family members, and community.

Goal 7: Increase use of best practices for reporting on suicide and promote healthy use of social media and technology.

Strategic Aim 3: Increase early identification of suicide risk and connect to services based on risk.

Goal 8: Increase detection and screening to connect people to services based on suicide risk.

Goal 9: Promote a continuum of crisis services throughout the county and across neighboring counties.

Strategic Aim 4: Improve suicide-related services and supports.

Goal 10: Deliver best practices in care targeting suicide risk.

Goal 11: Ensure continuity of care and follow-up services after suicide-related services.

Goal 12: Expand and support services following a suicide loss.

San Luis Obispo County Suicide Prevention Strategic Aims and Goals

Strategic Aim 1:
Establish a Suicide Prevention Infrastructure

Goal 1: Enhance Visible Leadership and Networked Partnerships

Objective 1a Increase community leadership capacity of the Suicide Prevention Council by 2022 to provide clear direction for suicide prevention efforts and prioritize goals with maximal impact, by 2025

- Recruit organizational stakeholders with suicide prevention experience, not previously represented on the Suicide Prevention Council, to become active members. These may include but are not limited to Sheriff's Department representatives and other law enforcement officials, drug and alcohol professionals, and faith leaders.
- Form an Executive Team on the Council to drive membership expansion and track objective.
- Identify community and organizational leaders who can champion suicide prevention as a public health priority. This includes assigning Council members to engage leaders of other agencies and the community at large, supporting loss survivor initiatives and events, and providing educational opportunities for community leaders.

Objective 1b Conduct regularly scheduled Council meetings monthly to convene stakeholders, prioritize suicide prevention activities based on data and community input, leverage resources to build capacity across systems and communities, and expand services based on effectiveness.

- Future capacity building should include sub-committees as either an extension of, or addition to, regular meetings.

Objective 1c Expand the Suicide Prevention Council by two new members to include private and public partners to advance suicide prevention efforts by being an "action arm" to local and regional leaders, by June 30, 2022.

- Identify private and public leaders who will leverage their influence and champion efforts prioritized in their own sectors. This will strengthen the Council by creating sub-groups with focused expertise, which will keep members energized and engaged.
- Consistent logistical support, strategic guidance, technical assistance, and other infrastructure should be provided to the coalition by local leadership.

Goal 2: Increase Development and Coordination of Suicide Prevention Resources

Objective 2a Implement the local suicide prevention plan and strategy to prevent suicidal behavior across the lifespan and to address the goals outlined in the state's strategy, in addition to addressing local needs by June 30, 2022.

- The Suicide Prevention Plan will be overseen and monitored by the County's Suicide Prevention Coordinator, whose activities are reported as part of local the Mental Health Services Act plan.

Objective 2b Map local and regional assets across sectors to coordinate resources and align funding priorities, and report findings to Council annually.

- Develop data that demonstrates how investments in specific suicide prevention strategies could lead to improved outcomes and cost savings in other areas, such as emergency services and healthcare. Assets may include programs or features of the community, such as safe and welcoming community spaces, parks, or centers. Assets will be mobilized through planning processes that identify underutilized community strengths, such as Asset-Based Community Development Strategies.
- Document the roles and responsibilities of each partner, and any data or funding streams associated with partners and their affiliation. Each partner has a role to play, and all partners bring potential for innovating.

Objective 2c Integrate suicide prevention strategies into existing services being delivered through local settings, systems, and programs with no less than three documented examples annually.

- Community health workers and in-home service providers, for example, could be trained to recognize warning signs of suicide and be able to connect people at risk to care or crisis services.
- Leverage partnerships through the Suicide Prevention Council to identify shared prevention goals across diverse settings and communities, such as education, child welfare, social services, healthcare, justice settings, and groups that represent marginalized community members. These partners may share goals with suicide prevention for reducing risk and increasing protective factors, such as creating safe and active communities to reduce social isolation. All can be leveraged to reduce suicidal behavior and meet other goals for health and wellness promotion.

Goal 3: Advance Data Monitoring and Evaluation

Objective 3a Collect local data and information which defines the problem of suicidal behavior; identify factors that increase or lessen risk or suicide; develop interventions, conduct evaluations, and disseminate effective preventive practices; and report this information to stakeholders annually.

- Continue relationship with the County's Epidemiologist to standardize data collection and develop a sharing tool with the Suicide Prevention Council and data workgroup.
- Strengthen relationships with local colleges and universities and identify capacity for research to support local and state suicide prevention goals.

Objective 3b Collect suicide death and attempt data to evaluate the proportion of suicidal behavior that results in death and report this information to stakeholders quarterly.

- The results of that report should be used to identify high-risk groups, target them with selective prevention strategies, and focus resources on specific lethal means restriction strategies.
- Create new systems of data collection in partnership with local emergency rooms, behavioral health providers, and inpatient facilities. New data collection systems should include sexual orientation and gender identity (SOGI) indicators.
- Consider the use of a death review team for clinician and forensic review of suicide deaths (psychological autopsies). Team members should include representatives of coroners and medical examiners, law enforcement, subject matter experts, and others with legal access to confidential information. Data compiled by the team should be used to support prevention goals using the Public Health Model.
- This team will address the process of psychological autopsies.
- Designate 1-3 people to be trained in The American Association of Suicidology's Psychological Autopsy training

Objective 3c Partner with coroners, medical examiners, and local health department representatives to identify and eliminate barriers to the electronic reporting of suicide death data into the California Death Reporting System by June 30, 2023.

- The effort should enable access to data to strengthen suicide prevention, while establishing policies and procedures to protect privacy.

Objective 3d Continue the use of anonymous community surveys to provide the County, Council, and community stakeholders with evolving information on the public's opinions and understanding of suicide prevention, issuing one survey annually.

- Surveys should engage underserved populations. For example, people with non-fatal, self-directed violence may not seek medical attention following the injury, thereby reducing the number of such reports. Surveys should communicate that help is available by listing or displaying suicide prevention resources directly on the survey.

Strategic Aim 2:
Minimize Risk for Suicidal Behavior by Promoting Safe Environments, Resiliency, and Connectedness

Goal 4: Create Safe Environments by Reducing Access to Lethal Means

Objective 4a Increase use of the Public Health Model, to evaluate risk and identify the methods of suicidal behavior used by community members and by specific demographic (such as race/ethnicity, age, sexual orientation, and gender identity) and cultural groups to guide development of focused prevention efforts, and report this information to stakeholders annually.

- Once identified, develop tailored means restriction strategies and evaluate impact.

Objective 4b Promote safe medication disposal methods in the community by partnering with pharmacies and other health care providers to increase the availability of methods to dispose of used medication while also highlighting suicide and overdose prevention resources for people filling prescriptions, by June 30, 2022.

- This may include activities such as "take back" campaigns led by local public health departments that help people dispose of unused or expired medications.
- Enhance partnership with local Opioid Safety Coalition to increase capacity for drug take back days, disposal bags, and pharmacy relationships.

Objective 4c Increase awareness of suicide prevention efforts, suicide warning signs, and available resources to local gun shop and range owners by distributing information least bi-annually.

- Resources to support this strategy can be found here: https://emmresourcecenter.org/resources/suicide-prevention-gun-shop-activity
- Partner with local firearm safety trainers to incorporate suicide prevention awareness into trainings.
- Invite local gun shop and range owners to join the Suicide Prevention Council.
- Partner with law enforcement to guide dissemination of lawful options for temporarily transferring firearms for storage in times of suicide crisis or when Gun Violence Restraining Orders apply.
- Leverage relationships and experience from Veteran organizations to increase reach for gun safety initiatives.

Objective 4d Disseminate information to community partners about available overdose prevention resources, methods, and medications to counteract overdose, such as naloxone for opioid overdose, by June 30, 2022 and annually thereafter.

- Train all members of the Suicide Prevention Council on naloxone practices.
- Facilitate community naloxone trainings and safety points for emergency public use.
- Increase programs that provide naloxone to local organizations and businesses.

Objective 4e Identify specific sites in the community frequently used for suicide, or those that provide the opportunity for suicide and report information to the Council quarterly.

- This will be accomplished by forming local workgroups composed of community members, first responders, transportation representatives, coroners and medical examiners, and crisis service providers.
- These sites can be in the built environment or natural sites. Common types of sites include buildings, bridges, beach cliffs, and train railways. Characteristics communities should consider in identifying sites are places that provide the opportunity for a person at risk to fall from a height and sites from which falling would place a person in front of a moving vehicle, such as a train or car. More than one suicide at a site should raise safety concerns.

- Once sites are identified, develop and implement plans to construct barriers to deter or prevent falling. Consider the benefits and risks of installing signs that list crisis services resources, such as suicide prevention hotline information, and provide positive, life-affirming messages. One risk, for example, could be drawing attention of people at risk to a particular site.

Objective 4f Create partnerships with local bridge and rail authorities, first responders, and crisis services providers to collect data documenting events in which people were prevented from falling, any services they received, and the outcomes by June 30, 2023.

- Include reporting requirements, such as biannual or quarterly reports.

Goal 5: Empower People, Families, and Communities to Reach Out for Help When Mental Health and Substance Use Disorder Needs Emerge

Objective 5a Expand community-based services to include activities that increase life skills, including mindfulness practices, critical thinking, stress management, conflict resolution, problem-solving, and coping skills; tailor activities based on age group, setting, and other demographic identifiers, and according to how different groups experience and mitigate stress by developing one new program annually.

- Cultural models of suicide can clarify how culture affects the experiences of stressors, the cultural meaning of stressors, and how different cultures express suicidal behavior.[8] Additional layers of intersectional identities can compound suicide risk factors.
- Subgroups include, but are not limited to:
  - Adolescents
  - LGBTQ+ Youth
  - Foster Youth
  - Veterans (divided into different age groups)
  - Older Adults
  - Domestic Violence Survivors
  - Individuals with visible and invisible diverse abilities

Objective 5b Increase organizational capacity to identify barriers that community members face in seeking services for behavioral health needs, and develop

[8] Chu, J.P., Goldblum, P., Floyd, R., & Bongar, B. (2010). The cultural theory and model of suicide. *Applied and Preventative Psychology, 14 (1-4)*, 25-40.

strategies to make services more accessible, convenient, and culturally respectful to increase the likelihood people will pursue and stay connected to such services by providing training on the importance of diversity, equity, and inclusion in suicide prevention to local behavioral health providers annually.

- Provide an annual presentation to Behavioral Health Department's Cultural Competence Committee and other stakeholders to promote the value of staffing diversity, equity, and inclusion in suicide prevention.

Objective 5c Increase suicide prevention awareness campaigns, including social marketing designed to reduce mental health stigma and discrimination and reduce relevant public safety threats, such as misuse of medication or unsafe gun storage practices by one new campaign annually.

- Work with Suicide Prevention Council and its partnering agencies, organizations, and stakeholders to produce annual awareness and information campaigns.
- Engage local news media for press coverage and dissemination.
- Develop partnerships with local Parks & Recreation programs as an avenue for skills trainings.
- Partner with community organizations and businesses to expand awareness of suicide warning signs and prevention resources.

Objective 5d Expand efforts to increase mental health literacy all age groups, encourage people to seek help for health, mental health, and substance use disorder needs, and promote messages of hope that lives can be saved from suicide, as measured by bi-annual surveys.

- Engage local K-12 school districts, college campuses, adult learning, and community-based learning platforms to incorporate mental health curriculum options.

Objective 5e Establish a network of peer support providers to help people navigate health, mental health, and substance use disorder care systems by June 30, 2023.

- Peer support providers are people with lived experience with suicidal behavior or behavioral health needs.
- Assess the importance of ensuring cultural congruency between people with lived experience and a target audience, such as youth helping youth or veterans helping veterans.

- Ensure youth peers have clear and easy pathways to caring adults who can help them navigate their options. Create a transparent feedback loop to encourage peer support providers to identify ways health, mental health, and substance use disorder systems can be more responsive to people at risk for suicide.
- Use the Behavioral Health Navigator Model from Transitions-Mental Health Association to increase peer support in private and public sectors.

Goal 6: Increase Connectedness Between People, Family Members, and Community

Objective 6a Increase services intended to build positive attachments between children, youth, their families, other adults, and social supports in their community to increase a sense of belonging, strengthen a sense of identity and personal worth, and provide access to larger sources of support by June 30, 2023.

- Social support can be found in schools, faith-based communities, cultural centers, and other community-based organizations.
- Tailor strategies to be responsive to needs based on age and culture: e.g. create social support groups, led by veterans or active-duty members of the military, which allow military service members to safely share their experiences (VTC Mentor Model), disseminate talk-based warmline phone numbers targeting older adults to reduce feelings of isolation and loneliness (San Francisco-based Friendship line), and use communication methods relevant to an older population, such as advertising in health care settings or through traditional media.

Objective 6b Promote a culture free of stigma and discrimination, allowing for an open dialogue about mental health and mental health resources by delivering supportive messages of hope and recovery for people with mental health needs and substance use disorders by targeting at least one industry per year (e.g. wine, cannabis, brewery, food, etc.).

- Establish policies and methods to create cultures that support healthy lifestyles and environments that are affirmative and that prevent violence, including bullying and discrimination.
- Partner with agency and organization Employee Assistance Programs to encourage open dialogue in places of work.
- Support suicide prevention in faith-based communities.

- Encourage local wineries, breweries, and companies who sell alcohol to engage in dialogue and support for mental health and substance use disorders.
- Encourage local cannabis dispensaries to engage in dialogue and support for mental health and substance use disorders.

Objective 6c Integrate suicide prevention strategies into services intended to reduce other forms of violence, such as child and elder maltreatment or intimate partner violence, by increasing outreach to 10 annual events by 2023.

- These forms of violence may share risk and protective factors with suicidal behavior. For example, reducing interpersonal stress and teaching conflict resolution skills among at-risk families has the potential to increase a sense of connectedness and protect against suicide.

Objective 6d Partner with three new community-based organizations annually to build and promote opportunities for volunteerism to increase connectedness and a sense of purpose.

Local examples include:

- Wilshire Community Services Volunteer Program
- Transitions-Mental Health Association and Central Coast Hotline Volunteer Programs
- The Gala Pride and Diversity Center Volunteer Opportunities

Goal 7: Increase Use of Best Practices for Reporting of Suicide and Promote Healthy Use of Social Media and Technology

Objective 7a Provide annual trainings to key stakeholders on best practices for public communication about suicide.

- Provide annual training to media and entertainment industry partners and deliver training on best practice guidelines for reporting about suicide.
- Disseminate information found online at http://reportingonsuicide.org/ and http://suicidepreventionmessaging.org/ to members of the media—reporters, editors, and producers—regarding how risk is conferred and to improve understanding of guidelines supporting suicide prevention on a broad scale.

- Resources to support this strategy can be found here: https://emmresourcecenter.org/ resources/making-headlines-guide-engaging-media-suicide-prevention-california.
- Provide annual training to local public information officers and spokespeople, including first responders and law enforcement officials on best practices for messaging following a suicide.
- Minimize the circulation of misinformation by creating communication strategies for use in the event of a suicide—including preexisting agreements with media partners.

Objective 7b Create a media workgroup within the Suicide Prevention Council to partner with entertainment, print, and traditional media to disseminate information about resources, encourage people to seek help for mental health needs and substance use disorders, and reduce stigma and discrimination that may prevent people from accessing services and supports, by June 30, 2022.

- Entertainment media include film, television, podcasts, music, and theatre.
- Provide positive feedback and reinforcement with media partners who model best practices.
- Disseminate information about how suicide risk can effectively be expressed by people on various social media sites and highlight social media resources for identifying and reporting concerns about content. Most social media sites now have a method for reporting content that raises alarms.

Objective 7c Create a Social Media strategy within the Media Workgroup to integrate best practices for developing healthy social media habits and using social media in a way that promotes connectedness to reduce isolation into public campaigns and school health and mental health curriculum, by June 30, 2022.

- Include a formal strategy for managing information on the most used social media sites and monitor social media posts by others related to the suicide death.
- Manage support groups through social media and video conferencing technology.

Strategic Aim 3:
Increase Early Identification of Suicide Risk and Connection to Services Based on Risk

Goal 8: Increase Detection and Screening to Connect People to Services Based on Suicide Risk

Objective 8a Deliver suicide prevention training to 1,000 people annually who are in positions to identify warning signs of suicide and refer those at risk to mental health and substance use disorder services and culturally appropriate supports; with follow-up sessions three (3) to six (6) months after the training to support reinforcement efforts.

- Support youth gatekeepers by identifying trusted adults who can help them with next steps once a young person is identified as at risk. Provide people the opportunity to reinforce knowledge and skills acquired during training through periodic booster sessions.
- Build capacity and sustainability for suicide prevention trainings across systems using the train-the-trainer models or evidence-based online trainings.
- Support Teen Mental Health First Aid programs for high school students. Consider the intensity of training needed and offer a variety of sessions to expand capacity and meet varied demand. For example, in a school setting, teachers, administrators, and other school personnel might receive brief trainings on suicide prevention awareness. Selected teachers—especially those who lead youth groups or coach youth sports—and counselors might receive intensive trainings focused on how to deliver brief interventions.

Objective 8b Ensure people seen in health, mental health, and substance use disorder care settings (including correctional facilities) are screened for suicide risk and are delivered best practices in suicide risk assessment and management to those who screen positive for risk, as monitored and reported to the Council annually. Suicide screenings can follow positive results on other screening tools. For example, screening specific to suicide risk should follow positive screens for depression, anxiety, trauma, physical pain, and problem substance use, and problem eating. Comprehensive suicide risk assessments follow screening.

- The Joint Commission recommended the use of screening and assessment tools that include the following: Ask Suicide Screening Toolkit (ASQ) by the

National Institute of Mental Health; the Columbia—Suicide Severity Rating Scale (C-SSRS) Triage Version; Patient Health Questionnaire 9 (PHQ-9) Depression Scale; Suicide Behavioral Questionnaire Revised; Scale for Suicidal Ideation- Worst; and the Beck Scale for Suicide Ideation.

- Evaluate clinical practices and encourage universal use of above scales to encourage evaluation fidelity.

Objective 8c Ensure health, mental health, and substance use disorder care settings are integrating best practices in suicide risk assessment and management in workflows, as monitored and reported to the Council annually.

- Create uniform policies and procedures to make screening, assessments, and decision-making routine.
- Support County funded Assessing and Managing Suicide Risk (AMSR) training for all Behavioral Health providers.
- Clarify billing methods for services.

Objective 8d Deliver training to 50 key action partners, annually, to conduct suicide screening in clinic-based settings when a person is identified as exhibiting warnings signs or communicating a desire to die.

- Encourage universal implementation of the Columbia-Suicide Severity Rating Scale across all public and private health and mental health practices.
  The Columbia-Suicide Severity Rating Scale has been adapted to meet the needs of diverse settings and populations and can be accessed for free here: http://cssrs.columbia.edu/.
- Publicly acknowledge agencies, businesses, and organizations which participate in suicide trainings.

Objective 8e Train 50 first responders and other personnel patrolling or monitoring community sites, annually, to identify suicidal behavior in locations such as bridges and parking structures.

- The training should include how to identify warning signs, use de-escalation techniques, and disseminate information on local suicide prevention resources, including crisis hotline numbers.
  - Consider pairing first responders with trained behavioral health or crisis service providers to deliver interventions, if needed. Community Action Team (CAT) Model.

Goal 9: Promote a Continuum of Crisis Services Throughout within the County and Across Neighboring Counties

Objective 9a Evaluate the continuum of crisis services available through private and public resources and identify gaps in the continuum, such as warm lines to reduce loneliness and isolation and access lines to connect people to local resources, as reported to the Council by June 30, 2022.

- Promote the use of crisis services as alternatives to hospitalization and as a resource to support people in distress by advertising crisis hotline and warmline numbers and other methods.
- Deliver suicide prevention training to all providers of such services.

Objective 9b Ensure that information on available crisis service resources is known to health, mental health, and substance use disorder care partners, as reported to the Council by June 30, 2022.

- Encourage these partners to include crisis services in safety plans developed through an alliance between partners and people at risk.

Objective 9c Ensure agreements are in place between systems of care and community-based crisis services to provide follow-up for people transitioning out of care systems, including protocols for protecting the confidentiality of people at risk., as reported to the Council by June 30, 2022.

- Health, mental health, and substance use disorder care systems should have protocols in place for obtaining consent for follow-up care from people at risk. To coordinate efforts, document clear methods of communication between crisis service providers and other systems, such as community corrections, child welfare, and Veterans' services.
- Utilize Transitions-Mental Health Association's outreach services model to adapt for various audiences and needs.

Strategic Aim 4:
Improve Suicide-Related Services and Supports

Goal 10: Deliver Best Practices in Care Targeting Suicide Risk

Objective 10a Increase the use of web-based tools to support care targeting suicide risk, as monitored by the Council annually.

Promote the use of telehealth and telemedicine and ensure providers are trained in best practices for suicide-related treatment—especially in rural communities—to enhance timely access to care targeting suicide risk.

- Promote safety planning by prompting health, mental health, and substance use disorder providers to record safety plans in electronic medical record systems and by making plans accessible to people via commonly used portals. Create a local online, public directory that lists providers delivering suicide-related treatment and includes information about insurance eligibility and criteria for new clients.
- Expand the County's Suicide Prevention landing page on established website.

Objective 10b Partner with health, mental health, and substance use disorder care systems and providers to improve delivery of services and supports to caregivers and family members of people transitioning from care settings following services for suicidal behavior, as monitored by the Council annually.

- The efforts should prioritize safety and address service gaps. People at risk should be key decision makers in defining support networks and the role each member of the network plays in creating safety and recovery.

Objective 10c Disseminate information to caregivers and family members on how to support a person at risk by serving as a resource identified by the person in safety planning; how to reduce environmental safety risks by promoting means safety, especially at home; and how to help manage harmful behaviors stemming from underlying health, mental health, and substance use disorder needs, such as escalating alcohol or drug use, by June 30, 2022.

Goal 11: Ensure Continuity of Care and Follow-Up After Suicide-Related Services

Objective 11a Increase the use of electronic health records to document a person's safe transition to another provider, and ensure life-saving information is transmitted, while protecting the person's privacy, as reported by the Behavioral Health Department to the Council by June 30, 2023.

Objective 11b Evaluate the efficacy of safe and timely care transitions which provide linkages to culturally and linguistically appropriate outpatient mental health and substance use disorder providers, crisis services, safety planning or crisis response planning, as monitored by the Council annually.

- Expand capacity to provide support for youth in both outpatient and inpatient facilities. San Luis Obispo County does not have a dedicated youth psychiatric facility; youth are often transferred out-of-county for inpatient care.
- Expand capacity for patients who have critical health needs to also receive psychiatric healthcare in county hospitals.

Objective 11c Increase awareness of safe discharge practices, including the reduction of access to lethal means, for people seen for suicide-related services at the county's hospitals by June 30, 2023.

- Engage local emergency department administrators who do not already have access to the *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments* found at http://www.sprc.org/sites/default/files/EDGuide_full.pdf, along with the *Quick Guide for Clinicians* found at http://www.sprc.org/sites/default/ files/EDGuide_quickversion.pdf. Train health care providers to deliver lethal means counseling to family members and caregivers supporting people who are discharged from a health care setting after suicidal behavior._Disseminate information on lethal means counseling to health care providers across hospital settings. Prioritize providers who predominantly serve at-riskgroups or work in high-risk settings, such as emergency departments.
- Promote free online training, such as Counseling on Access to Lethal Means available at https://training.sprc.org/, and the use of online toolkits, such as https://health.ucdavis. edu/what-you-can-do/.

Objective 11d Review and evaluate the local continuum of care, bi-annually, to ensure policies and procedures are in place which promote continuity of care and follow-up after suicide-related services.

- Create uniform policies and procedures for safely transitioning people or students back into the workforce and home or school following a suicide attempt, suicide, or hospitalization for a mental health crisis. Create uniform policies and procedures to connect people released from correctional settings who have been identified as at risk for suicide, or who were receiving suicide-related services in custody, to appropriate services in the community. Include a standardized process for transferring confidential data and information. Create uniform policies and protocols to support health, mental health, and substance use disorder providers in the creation or revision of safety plans for persons at risk. Examples include uniform procedures for establishing a connection between the person and a new provider; policies ensuring timely delivery of information to the new provider; and policies addressing the importance of follow-up within 24 to 48 hours of the transition.
- Create memorandums of understanding among local crisis service providers to establish relationships with people prior to discharge and ensure follow-up after discharge. Create uniform protocols for counseling people discharged from emergency departments and hospitals after receiving suicide-related services on restricting access to lethal means. Families and caregivers should be included in such counseling.

Goal 12: Expand Support Services Following a Suicide Loss

Objective 12a Develop an integrated postvention services plan to guide delivery of best practices following a suicide loss by June 30, 2023.

- The plan should tailor strategies to settings and cultures, including schools, workplaces, faith communities, hospitals and health care settings, tribal communities, funeral homes, and correctional facilities.
- The plan should identify a lead agency or organization responsible for ensuring adequate capacity, training, and effectiveness in the delivery of activities that support survivors, service providers, and community members after a suicide loss. The plan should clearly define roles and procedures to increase the effectiveness of coordinated responses, such as procedures for sharing private information and data based on the role of each provider. Resources to guide creation of a community postvention response can be found here: https://www.cibhs.org/pod/after-rural-suicide.

Objective 12b Develop an online bereavement toolkit consisting of community-specific resources, by June 30, 2023.

- Partner with Hospice, hospitals, first responders, funeral directors, faith-based communities, and coroners and medical examiners to distribute the toolkit in print or via web links. Resources to support funeral directors' participation in this strategy can be found here: https://www.sprc.org/resourcesprograms/help-hand-supporting-survivors-suicide-loss-guide-funeral-directors.
- Build upon the *After a Suicide Loss* support guide created by Suicide Prevention Council

Objective 12c Provide training to first responders, crisis service providers, and access line responders on best practices in supporting suicide loss survivors, from understanding their unique needs to helping them access resources, by June 30, 2023.

Objective 12d Create local suicide bereavement support programs or expand capacity and sustainability of existing programs using *Pathways to Purpose and Hope,* found at https://emmresourcecenter.org/ resources/pathways-purpose-and-hope-guide-creating-sustainable-suicide-bereavement-support-program , by June 30, 2023.

- Expand capacity to different areas of the county outside of San Luis Obispo and Nipomo, where two support groups currently exist. Consider using virtual spaces to expand services while addressing geographic and transportation barriers.
- Develop support groups for youth who have lost someone to suicide.

Objective 12e Expand support services designed and facilitated by survivors of suicide loss, by June 30, 2023.

- Train survivors of suicide loss to speak safely and effectively about their loss and create a local speakers bureau to give a forum for survivors to deliver suicide prevention messaging to the public.
- Provide training for suicide loss survivor service facilitators and create opportunities for service facilitators to support each other, including group debrief sessions.
- Partner with Knowing You Matter to deliver Hope Bags and support to recent loss survivors.
- Work to support a loss survivor outreach team that works to connect recent loss survivors to local resources and a network of support to assist in the initial grief process.

Objective 12f Develop partnerships with coroners and medical examiners to establish coordinated, timely, and respectful responses following a suicide loss, and establish policies and protocols to govern activities in the event of a suicide, by June 30, 2023.

- Expectations should include how information is shared, and with whom, and how the privacy of families is respected, including a process for determining how and when to reach out to family members with resources and support. This strategy includes people who die by suicide in correctional or hospital settings.

Plan Development

San Luis Obispo County's Suicide Prevention Strategic Plan (Plan) was developed in partnership with SLOBHD, the Suicide Prevention Council of San Luis Obispo County, and assistance from Each Mind Matter consultants who provided guidance on plan development and writing techniques. The County's Suicide Prevention Coordinator led the plan development, including stakeholder engagement.

The Plan's strategic aims, goals, and many of the objectives align with Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025. Each strategic aim mentioned above is represented to address the local and regional objectives recommended by the state with additions and alterations made according to the local needs of San Luis Obispo County.

A county-wide community survey was conducted online from July 24, 2020 - September 30, 2020 to help inform the objectives for each strategic aim unique to San Luis Obispo County (i.e., for community and education-based trainings and suggestions for the development of a youth psychiatric health facility). See Community Survey for more information, results, and survey design.

Learning Collaborative

The County's Behavioral Health Department (SLOBHD) participates in a state-wide Learning Collaborative for suicide prevention where counties across the state come together to share best practices, collaborate on prevention and outreach strategies, and connect through monthly webinars and an annual in-person conference.

Consultants from the Learning Collaborative have made unique trips to San Luis Obispo County to meet with members from the Suicide Prevention Council and the County's Suicide Prevention Coordinator to create a roadmap and timeline for writing the strategic plan. The Community-Based Assessment and Community Engagement Process below are both results of the consultation from the Learning Collaborative.

In December 2019, the Learning Collaborative facilitated an in-person conference to assist counties in writing their suicide prevention strategic plans. Three members of the Suicide Prevention Council of San Luis Obispo County attended the conference, learning theory and writing techniques that have informed the construct of this plan. Elements of this plan reflect format and content of information shared at the conference, such as plan structure. An extra thank you to The Learning Collaborative and Noah Whitaker for sharing their expertise and allowing San Luis Obispo County to adopt elements of their publications.

Suicide Prevention Community Survey

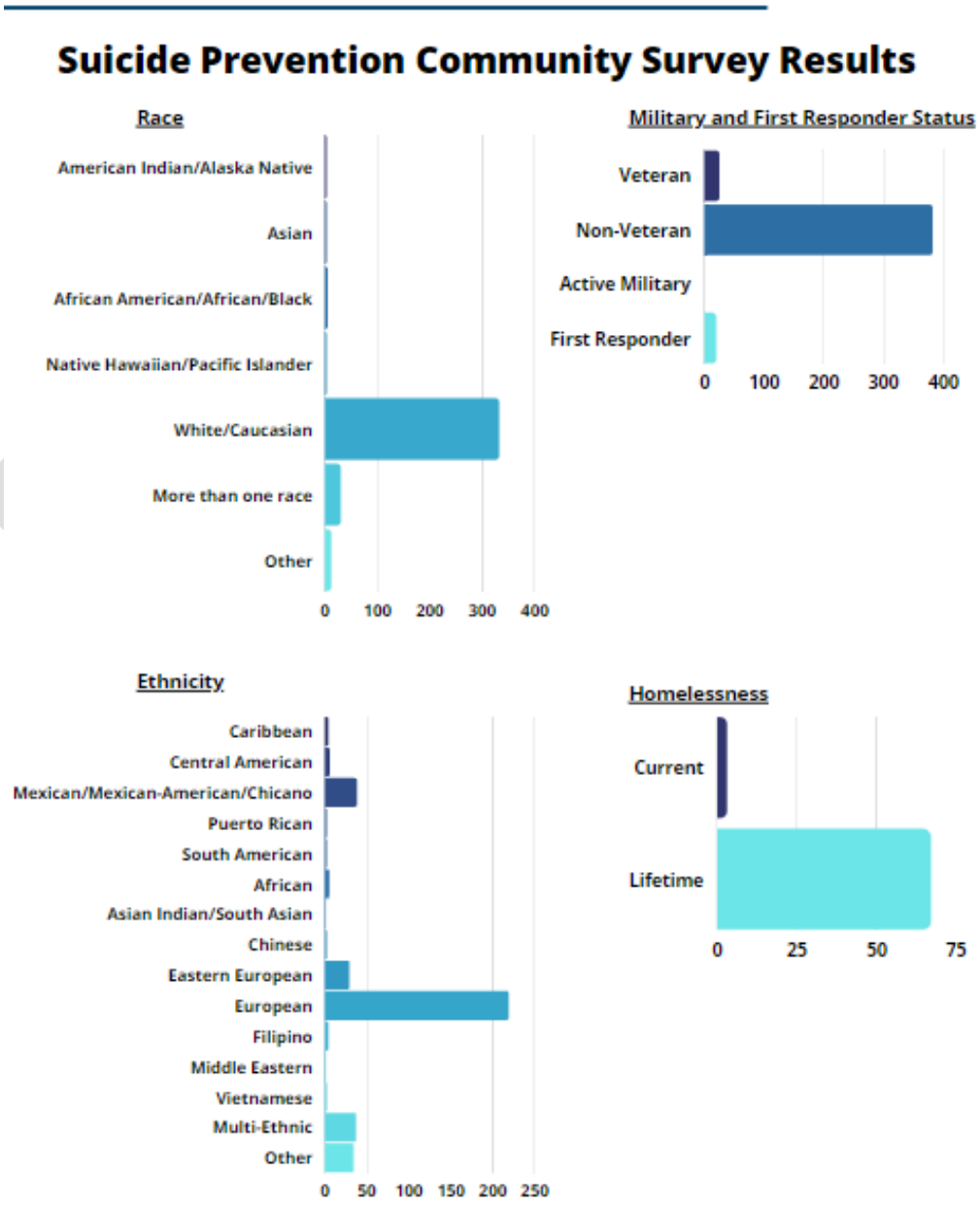
The County's Behavioral Health Department partnering with the Suicide Prevention Council of San Luis Obispo County, published a community survey to assess community knowledge about suicide as a public health issue and help inform future plans for suicide prevention in San Luis Obispo County.

The survey was available to take online in English and Spanish and circulated throughout the community from July 24, 2020 through September 30, 2020. The survey included 30 statements and questions, covering knowledge assessment of suicide, suicidal behavior, self-efficacy for help-seeking, and knowledge of local resources in San Luis Obispo County. Respondents were able to skip questions if they did not want to respond. The results of the survey were considered when addressing the strategic aims, goals, and objectives of the Plan.

Survey results reveal that there needs to be an increase in suicide knowledge, community-based trainings, and presentations to help raise awareness of how suicide affects San Luis Obispo County. Suicide awareness efforts should begin with adolescents and continue targeting all adults. Information and awareness campaigns should target mental health literacy and advertise what services are available for people who experience suicide ideation or behaviors. And lastly, efforts should continue to help reduce stigma around mental health and suicide, which could lead to respondents' main concern of making it easier to access mental health services across the county.

Considerations for future community surveys should include a question to determine if the individual taking the survey is: (1) a client or not of behavioral health services, and/or (2) a behavioral health clinician, and/or (3) works in the behavioral health field. Other considerations include survey questions that explore diverse experiences and concerns of equity in care.

The process of data collection should also consider more diverse partners to assist in marketing the survey. As noted below, 512 people responded in English, whereas only nine (9) individuals responded in Spanish. By expanding the method of data collection beyond an online survey through means of in-person focus groups, paper-copies, and offering it other languages, a more thorough evaluation of community needs can be made.



Community Knowledge about Suicide in San Luis Obispo County

Responses are presented in percentages and include both English and Spanish survey responses.

When asked if San Luis Obispo (SLO) County has a higher suicide rate than the ***state***, roughly seventeen percent (17%) of respondents knew SLO County does have a higher suicide rate; most respondents, sixty-six percent (66%), answered *I do not know*; and roughly sixteen percent (16%) responded *No*. (n = *465 Total responses for this question).*

When asked if San Luis Obispo County has a higher suicide rate than the ***national*** average, roughly eight percent (8%) of respondents knew SLO County does have a higher rate; Sixty-seven percent (67%) responded with *I do not know*; eight percent (8%) answered *Yes*. There were more *No* responses (25%) than the previous question. *(n = 466 Total responses for this question).*

Twenty-eight percent (28%) of respondents answered that youth in San Luis Obispo County have a higher rate of suicide than adults. Data shows that adults have a higher rate of suicide than youth. Fifteen percent (15%) responded *No*; and more than half (57%) responded *I do not know* if youth have a higher rather of suicide than adults. (*n = 464 Total responses for this question.)*

Conversely, when asked if San Luis Obispo County adults have a higher rate of suicide than youth, eighteen percent (18%) knew that adults have a higher rate of suicide; roughly twenty-five percent (25%) responded *No;* and fifty-seven percent (57%) responded *I do not know*. (*n = 465 Total responses for this question.)*

When presented with the statement *SLO County has a Crisis Stabilization Unit*. Nearly fifty-five percent (55%) of respondents are aware that San Luis Obispo County has a Crisis Stabilization Unit. Three percent (3%) responded *No*; and forty-two percent (42%) indicated *I do not know*. *(n = 465 Total responses for this question.)*

Seventy percent (70%) of respondents were aware that SLO County has a psychiatric health facility (PHF); twelve percent (12%) indicated that there is not a PHF; and eighteen percent (18%) responded *I do not know* if there is a PHF in SLO County. *(n = 462 Total responses for this question.)*

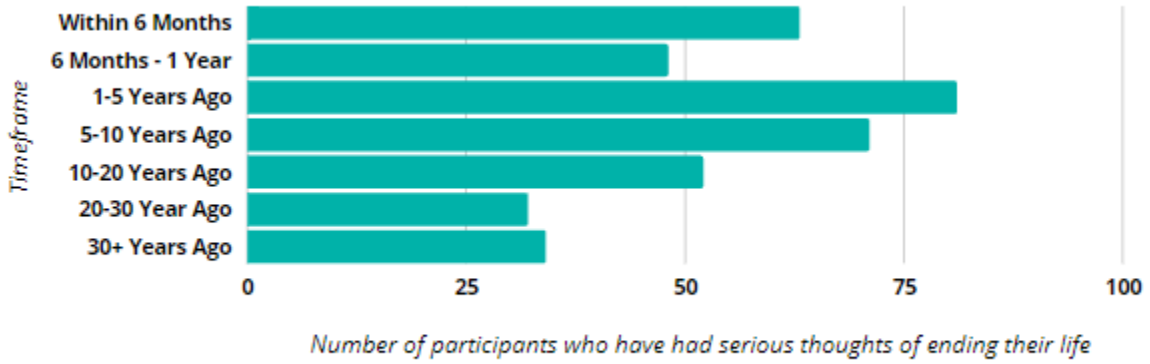
Suicide Behavior in San Luis Obispo County

When asked if they knew someone that has attempted suicide, seventy-five percent (75%) of respondents indicated *Yes*; twenty percent (20%) indicated *No*; and roughly five percent (5%) responded *I do not know*. *(n = 464 Total responses for this question.)*

More than half of respondents, sixty-one percent (61%), indicated that they have had at least one friend, co-worker, or loved one die by suicide. Roughly thirty-seven percent (37%) indicated that they have not lost a friend, co-worker, or loved one to suicide, and two percent (2%) did not know. (n = *464 Total responses for this question.)*

Forty-four percent (44%) of respondents revealed that within their lifespan, they have had serious thoughts about ending their life; fifty-four percent (54%) have not thought about ending their life; and two percent (2%) selected *I do not know*. Of the forty-four percent (44%) that responded *Yes* to the statement, *Within my lifespan, I have had serious thoughts of ending my life*, participants also responded to a timeframe of when those thoughts occurred. See graph below for responses. *(n = 463 Total responses for this question.)*

Eleven percent (11%) of respondents indicated they have had a non-fatal suicide attempt in their life.



Knowledge of Resources and Participation in Trainings

When asked if participants had knowledge of where to get help if they experienced thoughts of ending their own life, eighty-three percent (83%) of survey participants indicated *Yes;* nine percent (9%) indicated *No*; and eight percent (8%) selected the option *I do not know*. (*n = 465 Total responses for this question)*

Fifty-seven percent (57%) of participants indicated that they have accessed informational resources about suicide prevention; forty-two percent (42%) have not; and one percent (1%) responded *I do not know*. *(n = 465 Total responses for this question.)*

Thirty-one percent (31%) of respondents have participated in a suicide prevention training; more than half, sixty-eight percent (68%), have not participated in a suicide prevention training; and one percent (1%) responded *I do not know*. *(n = 465 Total responses for this question.)*

Noticing Signs, Reaching Out, and Providing Support

Nearly half of respondents, forty-seven percent (47%), indicate that they would recognize if a friend or family member was thinking about suicide; eleven percent (11%) responded *No*, they would not recognize if a friend or family member was thinking about suicide; and about forty-one percent (42%) responded *I do not know*. *(n = 464 Total responses for this question.)*

Eighty-seven percent (87%) of participants indicated that if they were concerned that a loved one is considering suicide, they would ask that person; five percent (5%) indicated they would not ask their loved one; and eight percent (8%) responded *I do not know*. *(n = 465 Total responses for this question.)*

Nearly three quarters of respondents, seventy-four percent (74%), indicated that they know how and where to get help for a friend or family member who is having thoughts about suicide; seventeen percent (17%) responded *No* they do not know where or how to get support; and nine percent (9%) responded *I do not know*. *(n =465 Total responses for this question.)*

Stigma, Myths, and Facts About Suicide

More than half of respondents, sixty-six percent (66%), knew that asking someone if they are thinking about suicide will not plant the idea in their head; eight percent (8%) thought that asking would plant the idea; and twenty-six percent (26%) of respondents did not know if asking someone about suicide would plant the idea in their head. *(n = 464 Total responses for this question.)*

When presented with the statement, *Only people with a known mental illness attempt suicide*, nearly all respondents, about ninety-seven percent (97%), indicated the

correct response of *No*; three percent (3%) did not know; and less than one percent (0.4%) incorrectly responded *Yes*. *(n = 464 Total responses for this question.)*

Participants were asked to respond to a series of statements by indicating their level of agreement on a Likert-Scale between 1 (Strongly disagree) and 5 (Strongly agree). The information below depicts the weighted average of responses.

Suicide is a problem in my community **3.91**
Stigma (fear/shame) makes it difficult to talk about mental illness **4.52**
Stigma (fear/shame) makes it difficult to talk about suicide **4.49**
People feel embarrassed/scared when it comes to getting help **4.44**
People can recognize if a friend or family member was planning to end their life **2.4**
People know where to go for help if they are having a hard time **2.49**
I am interested in learning how to help someone who is considering suicide **3.97**
I would be willing to attend an in-person training about suicide prevention **3.6**
I would prefer to learn on my own about suicide prevention through written or web-based materials **3.38**
I would be willing to talk with family/friends about the issue of suicide **4.04**

California Healthy Kids Survey

The California Health Kids Survey (CHKS), is a modular, anonymous assessment recommend for students age 10 (grade 5) and above. It is focused on the five most important areas for guiding school and student improvement:

- Student connectedness, learning engagement/motivation, and attendance
- School climate, culture, and conditions
- School safety, including violence perpetration and victimization/bullying
- Physical and mental well-being and social-emotional learning
- Student supports, including resilience-promoting developmental factors (caring relationships, high expectations, and meaningful participation)

In San Luis Obispo County, CHKS is administered to students in grades 7, 9, 11, and students at “non-traditional” schools. Data collected in CHKS can be used for suicide prevention efforts as school safety, drug and alcohol prevention, connectedness, and housing and food security are all protective factors when present and risk factors when essential needs are not being met. San Luis Obispo County’s Suicide Prevention Strategic Plan (Plan) countywide strategic plan for suicide prevention, data specific to

mental health will be examined. Individual school districts should use a comprehensive evaluation of CHKS for their districts' suicide prevention strategic plan to create audience-specific goals and objectives that are appropriate for each unique campus.

The information below reflects the most recent CHKS data, 2017-2019 for grades 9 and 11 and nontraditional schools. Students in grade 7, although surveyed, are not asked about suicide. Results from the question, '*in the past 12 months have you seriously considered suicide?*', indicate that LGBTQ+ youth are at higher risk of suicide than their cisgender, straight peers based on their higher reporting of suicidal ideation.

In the past 12 months, have you seriously considered suicide?[9]

Grade Level	Percent of "Yes" response to above question
Grade 9	17% of all students 61% of transgender students 48% of not straight-Gay/Lesbian/Bisexual
Grade 11	18% of all students *Data not available for gender identity* 48% of not straight-Gay/Lesbian/Bisexual
Nontraditional	24% of all students *Data not available for gender identity* 52% of not straight-Gay/Lesbian/Bisexual

San Luis Obispo County

San Luis Obispo (SLO) County was developed on the yakʔitɣutɣu Northern Chumash ancestral land and Salinan ancestral land, whose people still reside on the Central Coast, preserving and promoting their traditional kinships and ways, native language, song, dances, and world view. As many local residents are guests to this land it is important to honor the rich and vast history and humbly thank the indigenous community for sharing this space with so many.

SLO County is located on the Central Coast of California midway between Los Angeles and San Francisco along U.S. Highway 101 and is known for its rolling landscapes of

[9] https://calschls.org/reports-data/public-dashboards/secondary-student/

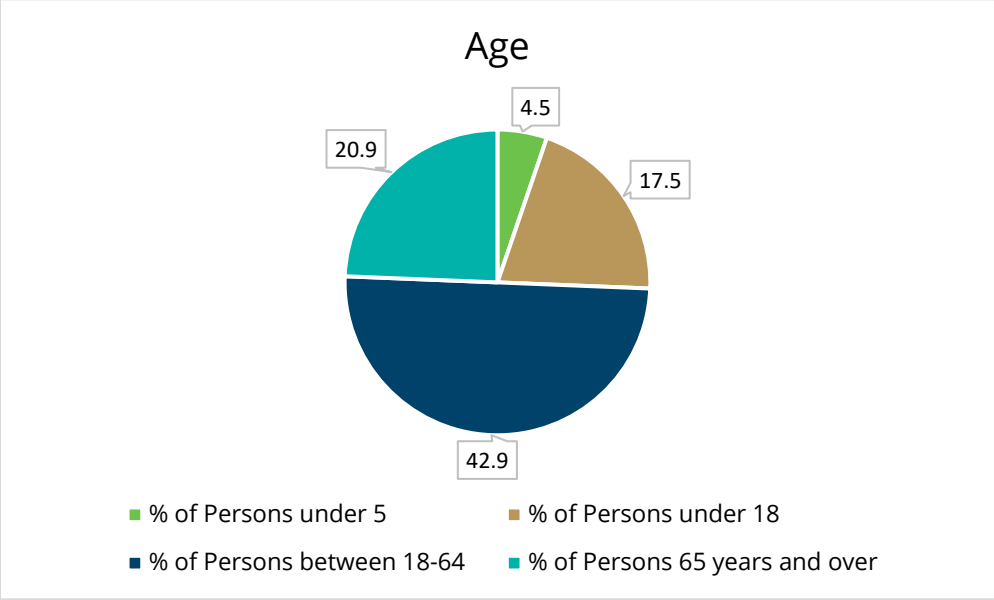
beaches, mountains, farms, and small towns and neighborhoods. SLO is a popular tourist destination with wine country, beach communities, and pop star attractions, such as Hearst Castle and The Madonna Inn.

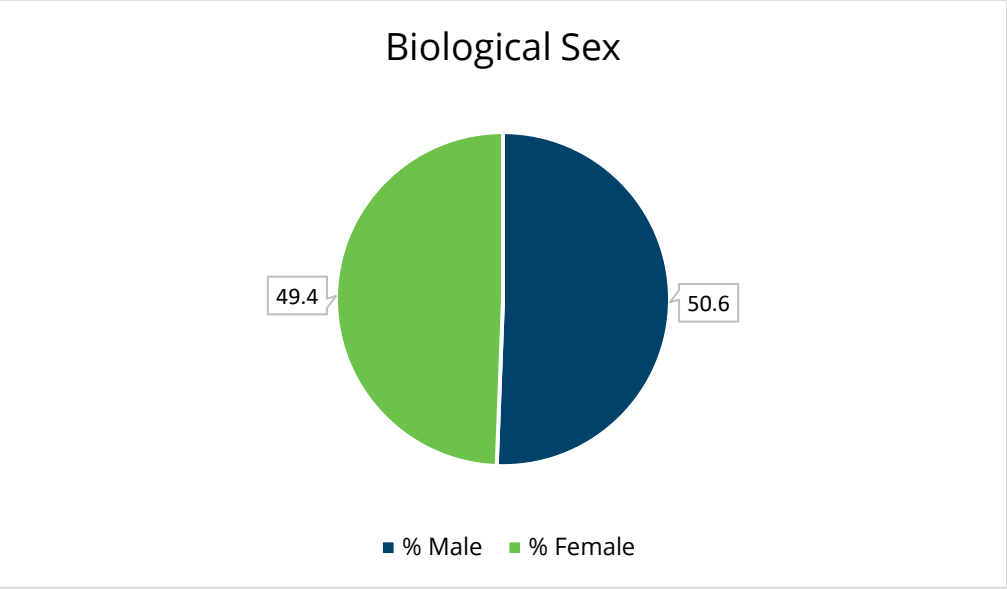
The county is comprised of seven incorporated cities, including Arroyo Grande, Atascadero, Grover Beach, Morro Bay, Paso Robles, Pismo Beach, and San Luis Obispo, and additional, smaller unincorporated areas. The population of SLO County is approximately 283,111 people (2019). The local economy is fueled primarily by a cluster of tourism, agriculture, and wine, in addition to health care, building, design, and construction, knowledge and innovation, specialized manufacturing, and energy.

The average value of a single-family home is $666,000 while the average annual wage for residents of SLO County is $53,800.

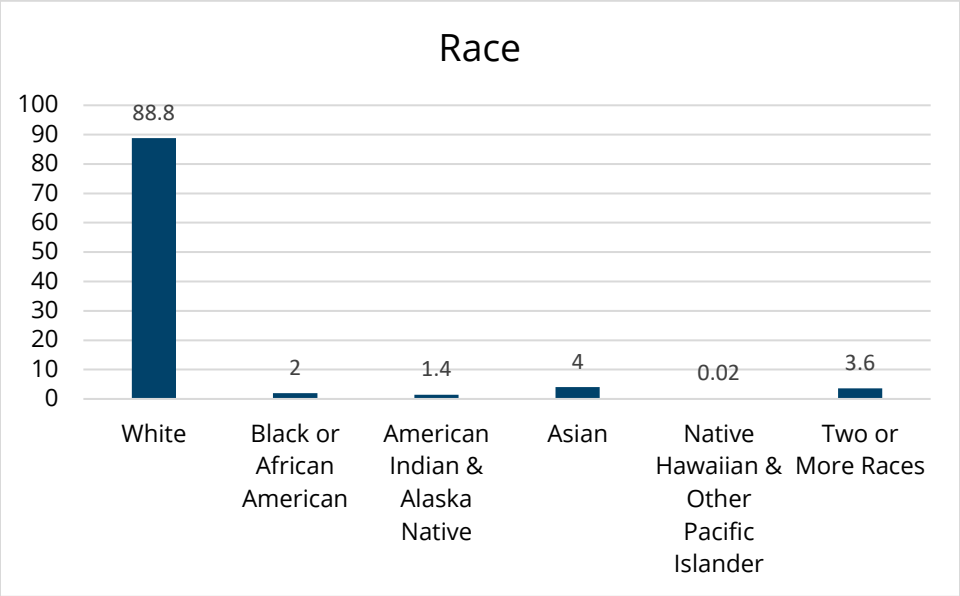
San Luis Obispo County Demographic Makeup[10]

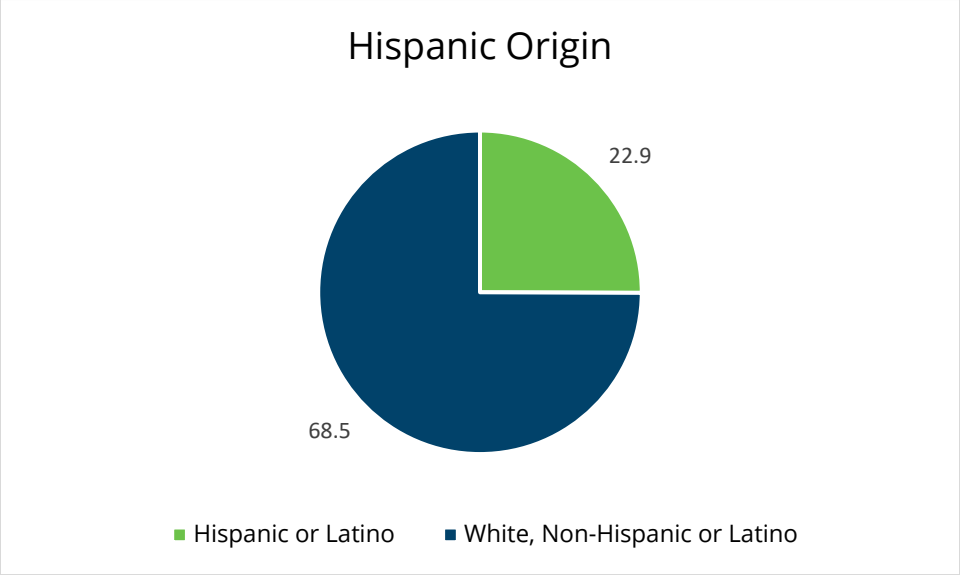
Demographic information is displayed in percentages





[10] *United States Census Bureau 2019*



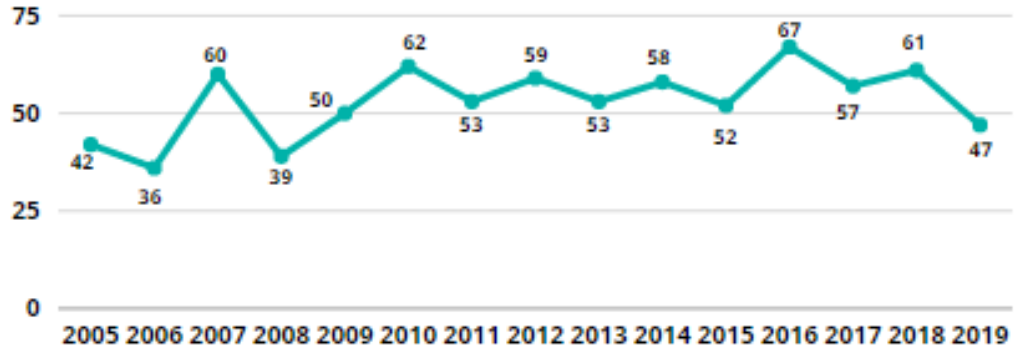


[11] According to the U.S. Census Bureau (2020), the concept of race is separate from the concept of Hispanic Origin. The race-breakdown in the graph above does not account for Hispanic or Latino Origin. Hispanic or Latino refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish-speaking culture or origin regardless of race.

This includes people who reported detailed Hispanic or Latino groups such as: Mexican; Puerto Rican; Cuban; Dominican Republic; Costa Rican; Guatemalan; Honduran; Nicaraguan; Panamanian; Salvadorian; Argentinian; Bolivian; Chilean; Colombian; Ecuadorian; Paraguayan; Peruvian; Uruguayan; Venezuelan; Spaniard; and all other Hispanic or Latino.

San Luis Obispo County Suicide Death Data

San Luis Obispo County Suicide Deaths 2005-2019



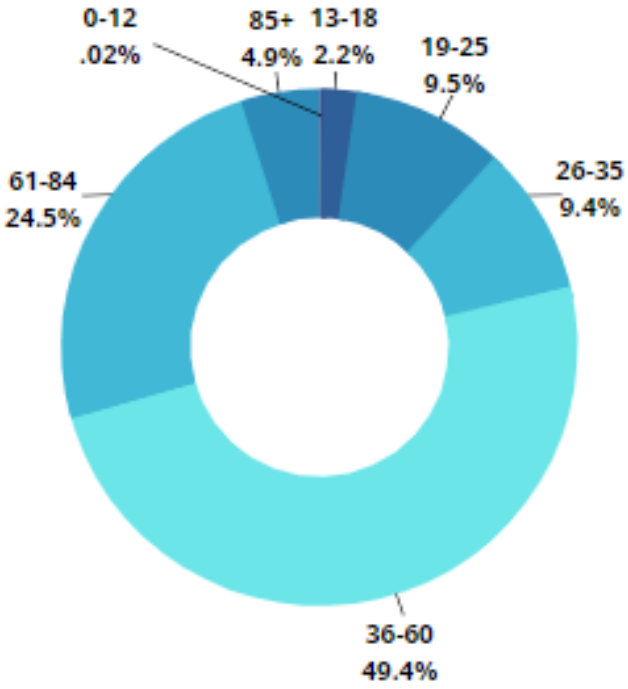
San Luis Obispo County Suicide Deaths by Biological Sex* 2005-2019

*Note that Gender Identity is not collected on California State death certificates

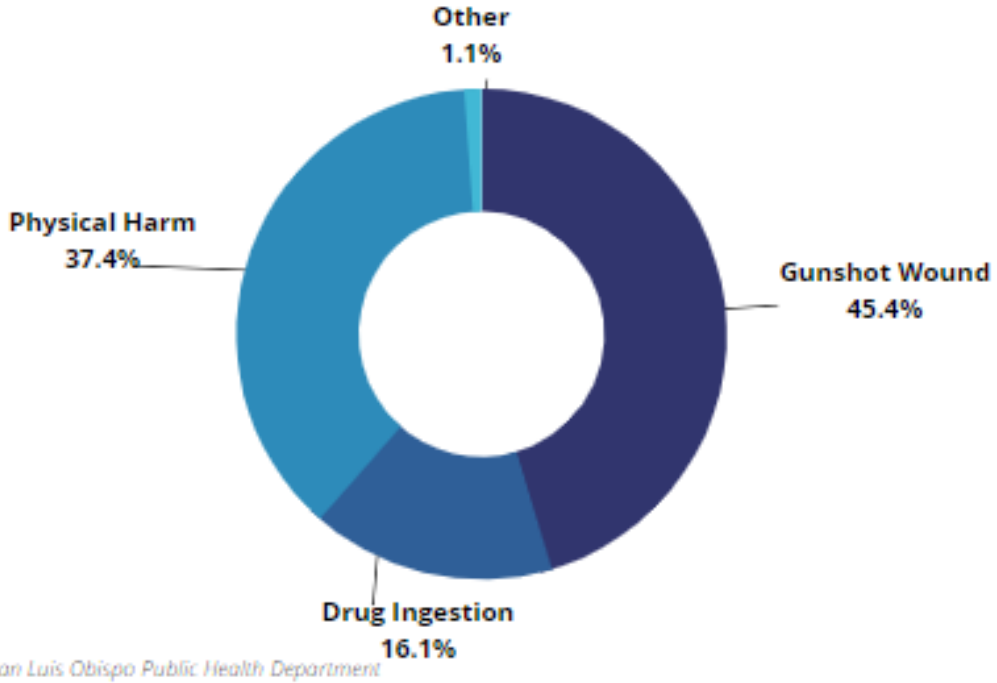
Source: County of San Luis Obispo Public Health Department

San Luis Obispo County Suicide Death Data

San Luis Obispo County Suicide Deaths by Age 2005-2019



San Luis Obispo County Suicide Deaths by Method 2005-2019

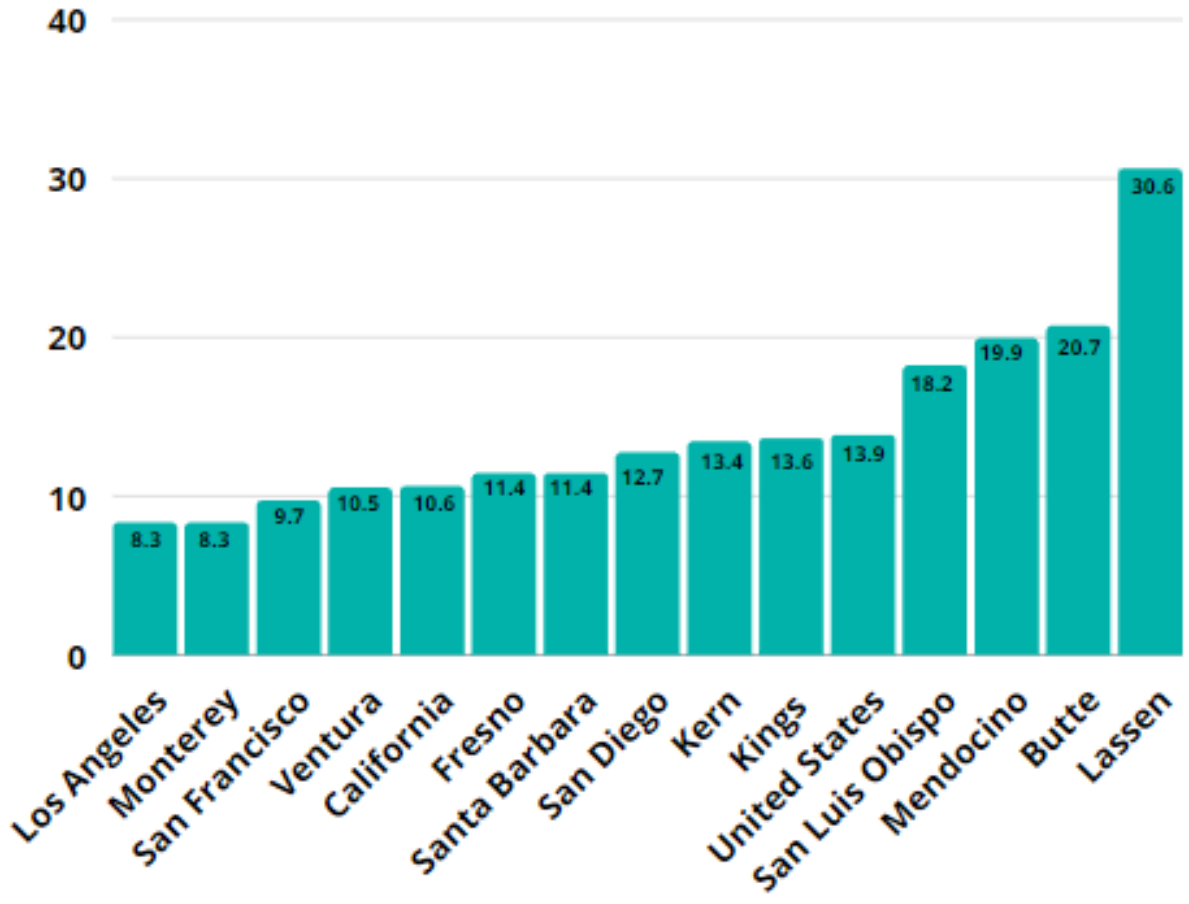


Source: County of San Luis Obispo Public Health Department

SAN LUIS OBIPSO COUNTY SUICIDE DEATH AGE-ADJUSTED RATE* COMPARED TO OTHER CALIFORNIA COUNTIES AND UNITED STATES 2016-2018

**Suicide rates are based on the number of people who have died by suicide per 100,000 population. Because changes in population size are taken into account, rates allow for comparisons from one year to the next, and from one location to another.*

San Luis Obispo County ranks 39th for highest suicide rate in California. This means that 38 counties, some presented below, have a *lower* rate of suicide/100,000 people, and 19 counties, a few listed below, have a *higher* rate/100,000 people.



Source: California Department of Public Health (2020)

The Path Forward

San Luis Obispo County was once touted as "The Happiest Place in America" by none other than Oprah Winfrey[12]. However, while the rolling landscapes of hills, beaches, wineries, and open space surely provide happy and healthy spaces for recreation, San Luis Obispo County, as many other California counties, has challenges that can lead some community members to non-fatally and fatally attempt suicide.

The cost of living, access to physical and mental health care, job availability, transportation, and other economic and social factors often compromise the ability to live the 'ideal, happy' Central Coast lifestyle. With the anticipation of the unforeseen effects the global pandemic will surely have on the well-being of so many, it has never been a more important time to strategically approach suicide prevention.

This strategic plan is a starting point, an opening conversation in which both private and public agencies must have together. Through consistent collaboration, safety nets can be built stronger, wider, and more equitable to be inclusive of all community members in San Luis Obispo County.

Intrinsic to equitable services is a foundation based on representation, cultural humility and sensitivity, and the elevated voices of marginalized communities. While death data suggests that suicide is over-represented in middle-aged white males, prevention strategies should never overlook any one group or community.

Through the process of increasing community awareness campaigns and trainings, services offered in threshold languages, like Spanish, should be equitably represented so that no community member is left out of the conversation.

As quoted in the documentary film, *The S Word*, "The only way through the future of suicide prevention is together." Consider this an invitation to any and all community members who want to join the efforts of the County of SLO Behavioral Health Department and the Suicide Prevention Council of SLO County in the fight against suicide.

[12] https://www.sanluisobispocollection.com/oprah-calls-san-luis-obispo-the-happiest-town/

Suicide Prevention in San Luis Obispo County

Local Resources

A comprehensive list of local resources was established through resource mapping following the Suicide Crisis Model. Resources identified:

Continuum Point	Response	Examples	
Hazardous Atmospheres	**Prevention and Wellness Promotion**	• Education and Outreach • Suicide Prevention Forum • Journey of Hope • Suicide Prevention Council • Domestic violence, intimate partner violence, and homeless shelters • Supported employment programs • Promatores	• Physicians and advanced practitioners • Wellness Centers • Medication management and assisted treatment • Cal Poly Safer program • Peer-based organizations and activities • Schools • Veterans Outreach Program • College Wellness PEI
Precipitating Events	**Early Intervention**	• Community and school-based counseling • SUD treatment • Cal Poly Safer • GALA and other LGBTQ+ support groups • MHET • Wellness Center programs • Domestic violence shelter support groups	• Community-based treatment • Central Coast Hotline • Community action teams • Homeless outreach and other Full Service Partnerships (FSP) • First Episode Psychosis program
Crisis	**Clinical Intervention, Crisis Response, and**	• MHET (mobile crisis) • Crisis Stabilization Unit • Law enforcement • FSP	• Psychiatric evaluation • Cal Poly health center and counseling • Cuesta College counseling

	Emergency Rescue	• Emergency department	• Psychiatric Health Facility (5150 holds)
Aftercare	**Postvention**	• County Behavioral Health and community outpatient services (incl. SUD) • MHET follow-ups • Residential placement (adults)	• Out of County placements (adults with private insurance, all youth) • TMHA Wellness centers, Hospice, Knowing You Matter

Suicide Loss Survivor Outreach Team

San Luis Obispo County does not currently have an outreach team dedicated to the specific act of reaching out to suicide loss survivors. However, this is a priority of the Suicide Prevention Council. The Council is working on establishing a direct relationship with the Sheriff - Coroner's Office as contact and referral with the loss survivors is made through the Sheriff's office.

The Suicide Prevention Council of SLO County compiled an outreach document for loss survivors to help navigate the first steps after a friend or family member's suicide. This document, titled *After Losing a Loved One: A support guide for suicide loss survivors in San Luis Obispo County,* walks individuals through information on grief, practical information for immediately after a loss, social support, trauma support, and bereavement and grief support counseling available in the county. The loss guide, available in both English and Spanish, has been distributed to each of the Council's partnering agencies, in addition to the Sheriff Coroner's Office and local funeral homes.