Oregon Alliance to Prevent Suicide Meeting Norms:

1. Chair calls on people to speak
2. Remember to include phone participants
3. No assumptions—except for best intentions.
4. Step up, step back. (Be aware of how much you are speaking. Create space for others.)
5. Correct gently, but do correct if something is offensive.
6. Lean into discomfort. (Be willing to experience some discomfort in service of learning from each other and honoring diverse perspectives.)
7. Uphold commitments
8. Avoid Acronyms

Logo Design Comps for Oregon Alliance to Prevent Suicide

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2017

Youth Suicide Intervention and Prevention Plan Annual Report

Oregon Health Authority

HEALTH SYSTEMS DIVISION

Contents

Executive summary

The tragedy of youth suicide affects all communities in Oregon. Along with profound human tragedy, the loss of a young life to suicide sends lasting ripple effects throughout the community. In the most recent yearly data reported to the Oregon Health Authority (2016), there were 98 suicides by youths age 24 and younger.

The Oregon Health Authority's implementation of Youth Suicide Intervention and Prevention Plan for 2016-2020 continued to progress in 2017. The plan focuses on youth connection and belonging to families, peers and adults in their communities. The plan approaches prevention and intervention on these levels:

- Building human connections
- Increasing resiliency and positive decision-making
- Upstream prevention
- Increasing access to competent and confident behavioral and physical health care providers.

The Oregon Health Authority's Health Systems and Public Health divisions and community partners took many actions to reduce the toll of youth suicides on youth, families, friends, classmates, school staff and communities. Initiatives include the following:

- A collaboration with the University of Oregon to do these things:
  - » Evaluate effectiveness of:
    - » Prevention
    - » Intervention
    - » Post-suicide response programs
  - » Monitor influences that have implications for suicide, including the following:
    - » Child abuse
    - » Trauma
    - » Poverty
    - » Homelessness
    - » Domestic violence
    - » Parental unemployment
- An Oregon Alliance to Prevent Suicide, formed by OHA in response to the Youth Suicide Intervention and Prevention Plan (YSIPP) for 2016-2020.
  - » Initiated activities relating to:
    - » Continuity of care
    - » Outreach and awareness
    - » Workforce development
    - » Schools
    - » Policy
    - » Legislation
    - » Data and evaluation.

The following is a summary of some of the actions OHA and partners took in 2017. These actions meet goals of the legislatively mandated Youth Suicide Intervention and Prevention Plan for 2016-2020:

- **Assessment of workforce competency:** OHA worked with behavioral and medical health licensing and school counselor boards to implement Senate Bill (SB) 48 (2017). This bill requires licensees to report at relicensure whether they have voluntarily taken any suicide assessment, treatment and management courses. In November 2017, surveys started going out to gain statistics on courses taken. There are plans to provide access to best practice training for providers at an Oregon Suicide Prevention Conference in March 2018.
- **Policymaking support:** OHA provided technical help to a work group led by state Representative Alissa Keny-Guyer on House Bill (HB) 3090 and HB 3091. These bills require risk-reduction strategies when individuals in behavioral health or suicide crises are released from emergency departments. Rulemaking was underway in December 2017.
- **Spreading best practices for community providers:** OHA issued rules requiring Community Mental Health Programs (CMHPs) and substance use providers use the following:
  - » Best practice, research-informed suicide risk assessments
  - » Safety plans
  - » Lethal means counseling

  OHA expects to work more on those rules is in 2018.
- **Peer-led school prevention and resiliency programs:** Two pilots of Sources of Strength began in the Albany and North Clackamas school districts, with OHA assistance. Both sites successfully implemented the program in their high schools. So impressive are the results that they are expanding the program to other schools. All middle and high schools in Albany now have the program for the 2017-2018 school year. North Clackamas has a plan to begin a similar process in 2018.
- **Education for families:** The Children's System Advisory Council drafted a handbook for parents. This handbook is for use when parents have youth seen in the emergency department for a behavioral or suicide crisis. There will be field testing of the handbook in 2018.
- **Minimizing harm in public discussions:** Trauma Informed Oregon (TIO) is a center of excellence for trauma work in Oregon. TIO and OHA issued a guide for public meeting organizers on how to discuss, safely, suicide in those settings. TIO also began incorporating trauma impacts on suicide risk into its statewide trainings and materials offered to various personnel in these fields in Oregon, including the following:
  - » Behavioral
  - » Medical
  - » School
  - » Emergency response

- **Training for pediatricians and family practice providers:** The Oregon Pediatric Society formed an expert panel of providers to create a new module for its Screening Tools and Referral Training (START). The START program focuses on depression and substance use screening as well as suicide risk assessment, treatment and management. The expectation is for suicide trainings to begin in January 2018.
- **Fostering safe online spaces:** A team of youth and other stakeholders developed a youth-informed strategic plan to guide electronic communication by and for this team included the following:
  - » Lines for Life
  - » Youth ERA (formerly Youth MOVE Oregon).
  - » Reachout.com

  The expectation is for the Health Systems Division to begin to roll the plan out in 2018.
- **Post-suicide interventions and death reporting under SB 561 (2015):** Twenty-one community mental health programs (CMHPs) across the state prepared and submitted as mandated under SB 561 (2015):
  - » Post-suicide cross-agency information-sharing
  - » Community plans for a coordinated response to suicides

  Fifty-six deaths of individuals age 24 and younger were reported to OHA by CMHPs under SB 561 in 2017. OHA expects final death certificate data for 2017, when available, to reflect more suicides. This is because SB 561 reporting was still in the planning stages in some counties in 2017. To support CMHPs and communities in implementing the law, OHA provided the following supports:
  - » CONNECT best practice post-suicide intervention (postvention) training was offered in these counties in 2017:
    - » Malheur
    - » Linn
    - » Lincoln
    - » Umatilla
    - » Benton
    - » Yamhill

  A cadre of CONNECT trainers now is available in each county. These trainers spread best practices in postvention to reduce the risk of suicide contagion across their communities. The University of Oregon, which is evaluating the effectiveness of CONNECT in Oregon, recommended statewide expansion. OHA will add three additional counties in 2018.
- **Youth awareness:** The Alliance to Prevent Suicide worked with an ad hoc group of communication professionals and youth to develop an outreach and awareness plan for suicide prevention and post-suicide intervention, including social media strategies. The expectation is for the plan to be finished in 2018.

Introduction and background

Background

Suicide was the second leading cause of death among youth aged 10 to 24 years in Oregon in 2016.(1) Overall, Oregon suicide rates among youth aged 10 to 24 years have been higher than U.S. rates and have been rising since 2011 (Figure 2). Concerned by this increasing rate, the Oregon Legislature in 2014 passed HB 4124. This bill mandated a five-year Youth Suicide Intervention and Prevention Plan. It also created the position of youth suicide intervention and prevention coordinator in the Oregon Health Authority's Health Systems Division. This report fulfills the requirement that OHA present an annual progress report to the Legislature.

Suicide numbers, rates, and rankings by county or state fluctuate by year. Monitoring for trends across time is the most effective way to study the data. The number of youth suicides in Oregon varies:

- 97 in 2014
- 90 in 2015
- 98 in 2016

In 2016, out of 50 states and the District of Columbia, Oregon ranked number 15 for suicide among youth aged 10 to 24 years. Oregon was number 16 in 2015.(2)

Male youth are four times more likely to die by suicide than female youth, who have a higher rate of attempts.(3) Suicide rates also increase with age. The rate increased from about one per 100,000 among youth aged 10 to 14 years to 16 per 100,000 among youth aged 20 to 24 years.(3) The most recent data available show that suicide rates among male veterans were more than four times higher than non-veteran males.(3) During 2013 to 2015, five known youth suicides among lesbian, gay, bisexual, transgender or queer/questioning (LGBTQ) Oregonians were reported to OHA. This accounts for 1.9 percent of Oregon youth suicide deaths.

Youth Suicide Intervention and Prevention Plan

Over nine months in 2015, 100 experts in suicide prevention, intervention and children's behavioral health developed the Oregon Youth Suicide Intervention and Prevention Plan (YSIPP). The plan fulfills the mandate of HB 4124 (ORS 418.704). The group modeled the plan after the National Strategy for Suicide Prevention (NSSP), but with customization to meet the unique needs of Oregonians. Based on Thomas Joiner's interpersonal theory of suicide, the plan focuses on increasing connectedness and belongingness of youth to their families, peers and adults in their communities. The plan approaches prevention and intervention on these levels:

- Building human connections
- Increasing resiliency and positive decision-making
- Upstream prevention
- Increasing access to competent and confident behavioral and physical health care providers

Participating in writing the YSIPP were the following:

- Public service providers
- Private advocacy organizations
- People who lost a friend or family member to suicide
- People who attempted suicide
- Parents
- Youth
- Insurers
- Coordinated care organizations (CCOs)
- Behavioral health providers
- Medical providers

Youth focus groups were held around the state. Work groups also were developed to represent high-risk groups:

- LGBTQ Oregonians
- People who have attempted suicide
- People who have lost a loved one to suicide
- Native Americans
- Military members, veterans and their families

Stakeholders called for "Zero Suicide" in Oregon, a commitment to suicide prevention. This commitment is through collective action among health and behavioral health systems, schools, communities, parents and other systems that touch the lives of youth. The Youth Suicide Intervention and Prevention Plan is available at http://www.tinyurl.com/hr94228.

In 2017, two years into implementation, OHA and stakeholders have achieved many objectives of the plan. Work is underway on many others.

Oregon Alliance to Prevent Suicide

Oregon Alliance to Prevent Suicide, formed in September 2016, is responsible for the following:

- Overseeing implementation of the plan
- Evaluating effectiveness of prevention programs
- Monitoring risk factors
- Advancing a public policy agenda for suicide prevention across the state

The multi-disciplinary Alliance includes the following:

- Legislators
- Parents
- Youth
- Clergy
- Law enforcement
- Health systems
- Behavioral and medical providers
- Insurers and CCOs
- Consumer advocates
- Community mental health and substance use providers
- Educators
- Child welfare workers
- School-based health center staff
- Representatives of groups at disproportionate risk of suicide from across Oregon.

Committees of the Alliance are at work to address the following:

- Workforce development
- Continuity of care
- Outreach and awareness
- Data and evaluation

In September 2017, a schools committee was formed, due to the extent of school involvement in youth suicide prevention. The Alliance developed by-laws and built an executive committee in 2017. This will promote leadership and self-governance in the future. The Alliance sent its first set of recommendations to the Oregon Health Authority in 2017. Work is ongoing to identify needed funding for implementation.

Implementing SB 48 (2017) for continuing education

Behavioral health and medical professional licensing boards and the Teachers Standards and Practices Commission began carrying out the work of SB 48. The bill addresses continuing education for these identified professions:

- Social workers
- Marriage and family therapists
- Counselors
- Psychologists
- Occupational and physical therapists
- School counselors
- Nurses
- Chiropractors
- Naturopaths
- Physicians
- Physician assistants

SB 48 requires licensing boards to report any suicide assessment, treatment and management continuing education courses licensees take and report at relicensure. OHA staff administers a survey to licensees for most behavioral and medical providers. OHA has added questions to that survey, relevant to SB 48, at the request of the boards. The Oregon Medical Board and the Teachers Standards and Practices Commission planned to run their own surveys. The Legislature will receive a data report in even number years. Data will help to find out how many licensees are taking training to improve their competency in suicide assessment, treatment and management.

Implementing SB 561 (2015) to address grief and contagion

Contagion occurs when a suicide influences the suicidal behaviors of others. Research shows contagion risk is higher among youth than for older individuals. For this reason, SB 561 became law. SB 561, sponsored by state Senator Sara Gelser, mandated each Local Mental Health Authority (LMHA) in Oregon develop postvention plans. These plans are in partnership with local entities, including schools and colleges, medical examiners and others.

Thirty-three community mental health programs (CMHPs) implement community mental health on behalf of the LMHAs. As of December 2017, 17 CMHPs submitted their postvention plans to OHA. These plans include protocols for sharing information among local partners and for managing postvention response, when needed. CMHPs also are responsible for reporting suspected suicides among individuals aged 24 and younger to OHA within seven days of death. OHA received reports of 56 suicides, in this age group, in 2017. The law provides no enforcement authority to OHA that all CMHPs create plans or report deaths. Therefore to encourage CHMPs to do so, the coordinator:

- Promoted submission of the protocols.
- Offered technical assistance in preparing them.
- Promoted SB 561 through the Association of Oregon Community Mental Health Programs.
- Reviewed the protocols submitted, offering comments and suggestions for best practices.
- Provided technical assistance on suicide response.

The state medical examiner asked county medical examiners to work with the CMHPs on death notifications. Attorneys for schools and colleges and CMHPs are grappling with sharing information because of their respective privacy statutes. Some were exploring a legislative amendment to resolve these barriers.

Cultural relevance

The Alliance Executive Committee created a special project to address unique suicide prevention and intervention needs of the LGBTQ population. This population experiences an extremely high rate of suicide and suicide attempts. Recruitment of stakeholder experts was underway in December 2017 to form a work group. This work group will review the plan's recommendations for LGBTQ interventions and implement them. The Alliance also expects to create special project work groups in the future to address the needs of other groups at disproportionate risk of suicide. These groups include the following:

- Military members, veterans and their families
- Native Americans and other minority populations
- People with mental illnesses
- People with chronic medical conditions
- People bereaved by the loss of a loved one
- People who previously attempted or seriously thought about suicide.

OHA also is working with the tribes to identify suicide prevention needs. The Oregon National Guard provides training to private behavioral health providers on military cultural competency.

In 2017, the Oregon Pediatric Society delivered culturally appropriate Screening Tools and Referral Training (START) for providers. These trainings on depression, suicide prevention, substance abuse and trauma-informed care were for providers in Native American communities in Warm Springs and Grand Ronde.

The expected agenda for the March 2018 Oregon Suicide Prevention Conference includes presentations by national suicide bereavement and attempt survivors.

Evaluation plan

In 2017, OHA entered an intergovernmental agreement with the University of Oregon to develop an evaluation action plan for carrying out the YSIPP and monitoring key risks relating to suicide. This work involved four steps:

1) Objective mapping and identification of key measures.
2) Identification of available Oregon and national data pertaining to suicide and risk.
3) Review of best practices in suicide prevention, intervention and postvention.
4) Analysis of training activities.

The efforts are based on recommendations from the Centers for Disease Control and Prevention (Preventing Suicide: A Technical Package of Policy, Programs, and Practices, 2017). The following factors that contribute to suicide risk were created for the evaluation plan. Progress on these factors will be monitored, analyzed and reported to the Legislature annually by OHA and the Alliance. (Figure 1)

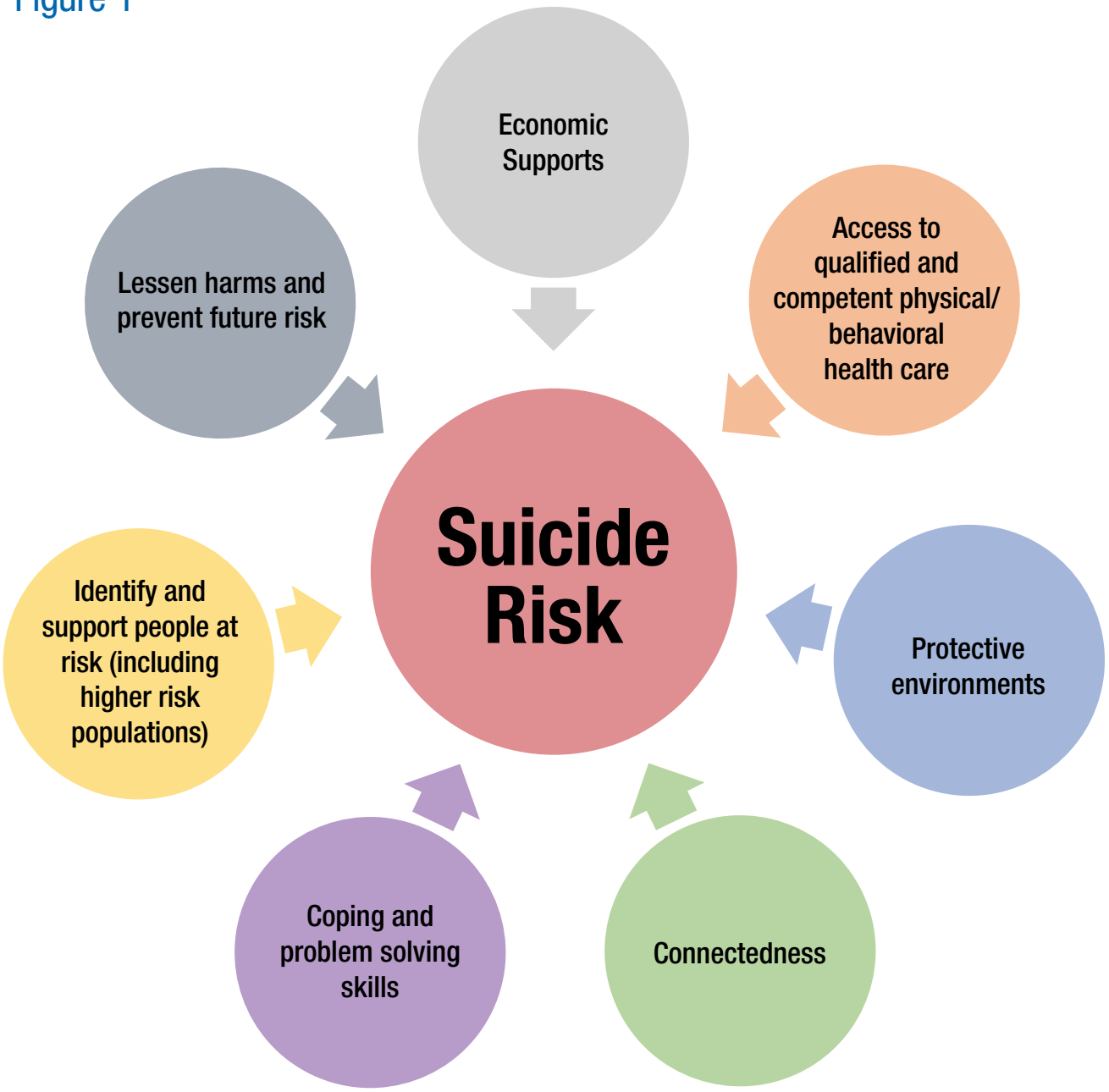
YSIPP objectives do not address the following economic supports, which will be monitored in the evaluation:

- Affordable housing
- Food security
- Abuse or neglect
- Unemployment or homelessness

The Centers for Disease Control and Prevention (CDC) recommend the above as part of comprehensive suicide prevention initiatives. To move forward, evaluators recommended OHA identify and monitor activities already taken by the state to increase economic supports. Doing so will bring the YSIPP into full alignment with the CDC recommendations. It will also provide another set of metrics for monitoring suicide prevention efforts.

University of Oregon evaluators also began gathering access to major OHA and Department

Figure 1



of Human Services databases. Evaluators will mine them for metrics relating to the evaluation plan. They further conducted a literature review of best practices in school protocols for suicide prevention, intervention and postvention. This information will shape Alliance recommendations to address school initiatives. Evaluators are gathering and analyzing data for the roll-out of the best practice CONNECT postvention program piloted in 2017. This will support CMHPs and their community partners in implementing SB 561.

Suicide and trauma

Trauma Informed Oregon (TIO), the Oregon Pediatric Society (OPS) and other partners working on YSIPP with OHA began multiple innovative strategies in 2017 to increase learning opportunities and spread best practices relating to trauma and suicide. Recognizing the impact of trauma on suicide risk, TIO updated all of its trainings and materials to include suicide data, reports and protocols. Additionally, all TIO trainings now address adverse childhood experiences and current or historical trauma, both of which contribute to suicides. During 2017, 4,975 providers from various systems, communities and people with lived experience throughout Oregon received training with this information. In 2017, there was development of a Peer Support Training on trauma informed care. The training will go through a review in 2018.

These are some highlights from TIO:

- The addition of resources to the TIO webpage.
- Work with OHA to develop a tip sheet of recommendations for safely discussing suicide in public meetings.
- Development of a website community page and discussion forums. These help connect others to doing trauma work and sharing suicide prevention and postvention plans.
- Development of a website resource folder called "Suicide Prevention" with resources for providers, youth, families, and survivors of trauma (https://traumainformedoregon.org/?s=suicide).
- Formation of a youth-led Oregon Trauma Advocates Coalition (OTAC). OTAC focuses on expanding and enhancing TIO resources and supports that directly address needs of young people affected by trauma. OTAC developed, vetted and disseminated two tools for youth engagement in the emergency room. One is for staff providing services to youth in crisis. The other is for youth to advocate for themselves in emergency departments.
- Collaboration with early childhood agencies and other stakeholders. This work is to identify and document best practice education programs and services that address the relationship between early childhood trauma and suicide risk.

OPS convened an expert panel on suicide prevention to identify components for best practice training for pediatricians and other health care providers around:

- Research-informed tools
- Protocols and referral processes.

This included reviewing best practice for providers in these areas:

- Youth suicide risk assessment
- Lethal means counseling
- Safety planning.

Members of the panel represented various perspectives and clinical practices:

- Pediatric primary care
- Family practice
- Emergency departments
- Mental health
- Public health
- School-based health centers
- Urban communities
- Rural communities
- Native American communities

The content was incorporated into its START behavioral health training program on depression and substance abuse. The new module on suicide is to launch in 2018. In addition, OPS collaborated with the Oregon Psychiatric Access Line about Kids (OPAL-K) and Lines for Life Youth Line. This partnership is to plan to provide follow-up resources and support for health care providers, and youth and families experiencing a behavioral health crisis, after identification of the risk.

Policy highlights from 2017

SB 48, initiated by OHA and reviewed by the Alliance to Prevent Suicide, was passed by the Legislature in 2017. The bill requires licensing boards of certain behavioral and physical health providers and school counselors to gather data at relicensure about any continuing education licensees have taken on suicide assessment, treatment and management. OHA, at the request of most of the licensing boards, is distributing a survey at relicensure to gather data. The Oregon Medical Board is distributing separate surveys to physicians. The Teachers Standards and Practices Commission also is sending separate surveys to school counselors. The OHA electronic survey asks licensees to report if they have taken any continuing education courses in suicide assessment, treatment and management. Licensees provide a yes or no answer and the duration of any class. If licensees are willing to discuss the course with the OHA suicide intervention and prevention coordinator, they are asked to provide their contact information. The Legislature will receive a report with de-identified data from the surveys in August of even-numbered years. The Legislature will also receive a report on activities to promote continuing education by the boards. Per legislation, OHA developed a list of suggested classes. OHA began distribution of the list to licensing boards in November 2017 (http://www.oregon.gov/OHA/HSD/AMH/Pages/Youth-Suicide-Prevention.aspx). The Board of Dentistry also is promoting training, although it is not required to do so.

SB 561 (2015), which mandates post-suicide information-sharing and response activities in all Oregon counties, is being implemented. OHA received reports of 56 suspected suicides of individuals aged 24 and younger within seven days of death, as required by law.

Details about work associated with the law is available at http://www.oregon.gov/OHA/HSD/AMH/Pages/Youth-Suicide-Prevention.aspx.

As the program ramped up in 2016-2017, OHA identified in real time the communities with disproportionate suicide rates. OHA also provided technical assistance, including funding for peer support and school programs. In addition, OHA is funding Sources of Strength and CONNECT:

- Four pilot sites within counties were identified and funded for the CONNECT suicide postvention training program:
  - » Linn-Benton-Lincoln
  - » Umatilla
  - » Yamhill
  - » Malheur

Jefferson County also adopted the program, including work with youth leaders. Multiple CONNECT trainers are now available in all pilot communities to coordinate postvention and teach others on best practices for safe post-suicide response. Among those trained:

- Schools
- Colleges
- Tribes
- Behavioral health providers
- Medical examiners
- Juvenile justice
- Law enforcement
- District attorneys
- Clergy
- Prevention specialists
- Recreation and after-school sites
- Other partners

Oregon State University started on-campus trainings in the fall of 2017. The University of Oregon is evaluating CONNECT to find out if on-the-ground practices change because of the program. Initial analysis indicated the pilots were successful and the evaluators have recommended statewide implementation. Evaluators also recommended that trainers be offered technical assistance. As a result, quarterly learning collaborative calls began in 2017. Plans are for three more CONNECT train-the-trainer sessions in 2018 for Deschutes, Lane and Jackson counties.

While OHA was neutral on the legislation, OHA is watching implementation of SB 719 (2017). SB 719 allows for extreme risk protective orders for individuals at risk to self or others. The legislation allows household members or police to seek a court order to remove, for 12 months, a firearm from the home of someone who is a threat to self or others. There is a provision for firearm owners of a legal path to appeal. Connecticut has had these orders in effect for some time. Research there indicates that suicides have been averted. It also indicates that many people subject to the orders seek mental health care.

The coordinator provided technical assistance to rules advisory committees implementing HB 3090 and HB 3091 advanced by state Representative Alissa Keny-Guyer. HB 3090 specifies services to be provided at release from hospital emergency departments (EDs) to individuals in behavioral health crisis. HB 3091 sets up a payment mechanism for those services and case management supports. As of December 2017, proposed language considered for the draft rules included provision of "caring contacts" at ED release to assist individuals and designated caregivers with the transition to outpatient care. Draft rules include provisions of safety planning and lethal means counseling, as well as provision of peer and family support.

OHA in late 2017 was updating its outpatient substance use and mental health rules to reflect best practices in suicide risk assessment, lethal means counseling and safety planning. OHA expects final adoption in mid-2018.

A youth suicide prevention subcommittee of the Children's System Advisory Council (CSAC) developed a guide for parents whose children are seen in the emergency department for a behavioral health crisis. Once reviewed by all members of CSAC and the Alliance in early 2018, the expectation is for family support specialists to vet the draft statewide. After review, the plan is for a final draft to be ready for distribution in 2019.

Lines for Life, Youth ERA, Reachout.com, a team of youth and other stakeholders developed a youth-informed strategic plan and funding recommendations to promote safe online spaces for youth. OHA received recommendations in December 2017 and began exploring funding options. Meanwhile, a committee of communication directors from public and private agencies volunteered to create an overall outreach and awareness plan to promote safe messaging and suicide prevention. This committee anticipates plan completion and implementation to begin in 2018.

Grant-funded activities

The Oregon Health Authority Public Health Division manages Garrett Lee Smith Memorial Act (GLSMA) youth suicide prevention funding. Funding comes from the Substance Abuse and Mental Health Services Administration (SAMHSA). During development of the YSIPP, objectives and activities underway as part of this GLSMA funding were included in the state plan. This was in order to maintain alignment among the grant efforts underway and efforts proposed as part of the emerging state plan in 2015. GLSMA activities include gatekeeper training, clinical training and improved continuity of care for youth discharged from health care systems. Activities also include implementation of the Zero Suicide initiative, promotion of the National Suicide Prevention Lifeline and project evaluation. Details about grant-funded efforts underway are in Appendix I.

Report on OHA activities in 2017

Listed below are the legislatively mandated sections of the plan (per ORS 418.704). Each section has a bulleted list of action items completed or underway.

Section 1

Section 1 (2)(a): A suicide intervention and prevention coordinator hired as of Dec. 1, 2014.

Status: Completed

Progress: Completed

Section 1 (2)(b): Outreach to special populations

Status: Ongoing

Progress:

The Alliance to Prevent Suicide launched a special project to address suicide attempts and deaths among LGBTQ youth and young adults. Recruitment for members was underway in December 2017. The ad-hoc group will review LGBTQ action items from YSIPP and begin implementing them. OHA continues to collaborate with other groups at disproportionate risk of suicide, for example:

1) Members of the Alliance include these representatives:
   - The Oregon National Guard
   - Oregon Department of Veteran Affairs (ODVA)
   - Suicide bereavement survivors
   - Individuals who attempted suicide
   - LGBTQ Oregonians
   - Native Americans
   - People with behavioral health conditions

2) The National Guard offered training in cultural competency to the following:
   - Civilian behavioral health providers
   - Those that provide services to members and families

3) ODVA and OHA were collaborating on a project to expand services to veterans and their families. The legislature provided funding for that purpose in 2017.

4) OHA is also working with tribes to examine needs for behavioral health.

Section 1 (2)(c): Identify barriers to accessing intervention services

Status: Ongoing

Progress:

Action items in the plan address barriers to accessing intervention services.

This includes:

- Improving discharge and safety planning for youth in emergency or inpatient care.

  OHA is working with stakeholders on rules for services to individuals in behavioral health crisis at release from emergency departments (HB 3090 and 3091). Draft language for HB 3090 as of December 2017 included the following:
  - » Best practice suicide risk assessment
  - » Lethal means counseling
  - » Safety planning
  - » Peer and family support services
- HB 3091 sets up a payment infrastructure for the new aspect of case management services. Also included was provision for caring contacts (by phone, electronically and telehealth) to bridge the gap between hospital or ED release and outpatient care. OHA in 2017-2018 also will update its rules for substance use and crisis outpatient services to reflect suicide prevention. The final rules went into effect in 2017 for including suicide prevention for Psychiatric Emergency Services (PES).
- OHA expanded its Crisis and Transition Services/Supports (CATS) project. The CATS project was formerly called the Emergency Department Diversion Pilot Project. CATS offers insurance-blind clinical services and family support at ED release to certain youth and their families not referred to inpatient services who are in behavioral health crisis. In 2016, around 75 percent of youth in the pilot were in suicide crisis. Oregon Health & Science University (OHSU) is conducting an evaluation of the pilots. OHSU will make recommendations on outcomes and promising practices. There will be a statement of results in future reports.

- Provider competency and confidence in treating and managing suicidal patients.

  OHA and licensing boards began implementing SB 48 in 2017. The legislation requires licensing boards to collect data from licensees on any courses taken in suicide assessment, treatment and management at relicensure. OHA began issuing an electronic survey for an array of physical and behavioral health care providers at the request of the licensing boards. The Oregon Medical Board (physicians) issue their own surveys. The Teachers Practices and Standards Commission (school counselors) also issue their own surveys. The Legislature will receive tabulated results of the surveys in even-numbered years. As required by legislation, OHA prepared a list of suggested courses and distributed it in 2017 (http://www.oregon.gov/OHA/HSD/AMH/Pages/Youth-Suicide-Prevention.aspx). There is a plan for annual updates to the list.

- Training for behavioral and physical health providers in conducting timely best practice suicide risk assessments, intervention and treatments.

  The Oregon Pediatric Society and Trauma Informed Oregon designed suicide prevention, intervention and postvention practice interventions into their training curricula for physical and behavioral health providers. This includes school-based health centers. An expert panel formed by OPS evaluated best practices and made commendations for including specific practices for risk assessment, safety planning and lethal means counseling when its START courses begin in 2018.

- Parent guide to ED services and guidelines for use of peer and family support for at-risk youth.

  The Children's System Advisory Council completed a review draft of a guide for families of youth seen in emergency departments for behavioral health crises. The guide includes an innovative template for a family suicide safety plan. The guide is on a schedule for presentation to the Alliance in January 2018. CSAC will then approve. Family support specialists across the state will then vet. CSAC expects a final draft ready to publish in 2019.

  Once the above is completed, CSAC plans to collaborate with stakeholders to prepare a proposed statewide protocol. Family and peer support will use this protocol with suicidal youth and their families in outpatient care.

Section 1 (2)(d): Technical assistance

Status: Ongoing

Progress:

The Health Systems Division (HSD) youth suicide intervention and prevention coordinator continued to provide technical assistance to the following:

- State and local partners
- Communities
- Schools
- Behavioral and physical health providers
- Parents
- Youth
- Suicide prevention advocates
- Health systems and hospitals
- CCOs

The coordinator has conducted several literature reviews at the request of the Alliance. This informs decision-making on these areas:

- Safety planning
- Lethal means counseling
- Suicide risk assessment
- Continuing education
- Workforce development

The coordinator provided additional technical assistance to OHA staff, including staff from these areas:

- Data analytics
- Adult behavioral health
- Youth and family behavioral health
- Medicaid
- OHA Behavioral Health Collaborative

The coordinator assisted a committee of the Behavioral Health Collaborative in developing a proposal. The proposal is to standardize the use of research-informed suicide risk assessment tools for the Oregon Health Plan. Since hired in December 2014, the coordinator has provided technical assistance on the Youth Suicide Prevention email list moderated by the Public Health Division (PHD). The list reaches more than 300 individuals across Oregon. Technical assistance has been offered to Community Mental Health Programs with SB 561 (2015) along with best practices in suicide postvention. The coordinator also provided technical assistance on suicide issues to the legislatively mandated School Safety Task Force on its initiatives to intervene with youth who pose a threat to self or others.

Section 2

Section 2 (1): Recommendations for access to mental health intervention, treatment and supports for depressed and suicidal youth.

Status: Ongoing

Progress:

The coordinator has emphasized infrastructure development for long-term sustainability of suicide prevention in Oregon. Efforts include the below:

- OHA rules for the following:
  - » Psychiatric emergency services
  - » CMHP outpatient services and substance use services (updates to reflect best practices in prevention)
  - » Risk assessment
  - » Lethal means counseling
  - » Safety planning
- Efforts to develop and enhance a competent and confident physical and behavioral health workforce through SB 48. This bill also supports improvements in long-term access to suicide-safe care.
- Oregon Pediatric Society START trainings, with a new suicide prevention module, provides an avenue for long-term training for the following:
  - » Pediatricians
  - » Primary care providers
  - » School-based health centers
  - » Providers serving Native Americans.

- SB 561 and the associated CONNECT trainers can ensure best practices in suicide postvention and are set in communies to reduce the risk of contagion.
- OHA is looking for funds for a system to provide rapid deployment of support services to communities experiencing suicides and suicide contagion.
- Use of family support specialists for youth and families after ED release. CATS can demonstrate the viability of these cost-effective interventions. CATS lays the groundwork for expansion statewide. CATS services bridge from ED release to safe engagement in outpatient care.
- Expansion of the Zero Suicide initiative with hiring of a new Zero Suicide coordinator in the Public Health Division. The coordinator will work to make improvements in suicide-safer care in hospitals and health systems.

Section 2 (2): Recommendations to improve access to care and supports, including affordability, timeliness, cultural appropriateness and availability of qualified providers.

Status: Ongoing

Progress:

- The Alliance saw much momentum forming on its important work to expand use of the following in a variety of settings across Oregon:
  - » Best practice suicide risk assessments
  - » Lethal means counseling
  - » Safety planning
- Many activities in this report concentrate on these three interventions as a package in outpatient, inpatient and ED settings. Free tools and free online training are identified so Oregon clinicians and partners can be trained to use research-based tools.
- OHA also specified funds in the 2017-2019 biennium for a suicide prevention Alliance liaison housed at the Association of Oregon Community Mental Health Programs. This level of service will allow the Alliance to take additional strides to make improvements along these lines:
  - » Access to care and supports
  - » Social media exposure
  - » Cultural appropriateness for populations at disproportionate risk of suicide
  - » Further development of the behavioral and physical health care workforce to enhance access to timely services.

- Communities implementing SB 561 for postvention response have confronted barriers to information sharing among partners due to privacy statutes. Additionally, some LMHAs and CMHPs continue to advance postvention on their own without the support of other community partners, despite their best efforts. Amending the statute to address these confidentiality barriers is a solution some counties have begun exploring to ensure community-wide collaboration to address grief and prevent contagion.

Section 2 (3) Recommendations including best practices to identify and intervene with youth who are depressed, suicidal or at risk of self-injury.

Status: Ongoing

Progress:

- The Oregon Pediatric Society expanded START trainings for primary care physicians on depression and substance use screening to include the following:
  - » Best practices in suicide risk assessment
  - » Safety planning
  - » Lethal means counseling

  OPS simultaneously worked with the OPAL-K telephone support for providers and Lines for Life adult and youth programs to provide follow up to providers, youth and families after suicide risk is identified. This contract will expire in October 2018. Therefore, there will be a need for a request for proposals.
- As noted in this report, several OHA rules are going to change to adhere to best practices in suicide risk assessment, lethal means counseling and safety planning. It will be necessary to add these and other suicide prevention provisions over time as there are updates to other OHA rules.

Section 2 (5): Recommendations for use of social media for intervention and prevention of youth suicide and self-inflicted injury.

Status: Ongoing

Progress:

- Lines for Life, Youth MOVE (now called Youth ERA), and Reachout.com completed a youth-guided strategic plan to advance the goal of safe online spaces for youth. Implementing this plan will require funding and OHA is examining resources to support it.
- The Outreach and Awareness Committee of the Alliance formed an ad hoc work group of communication directors from private and public organizations to develop an overall communication plan for suicide prevention and postvention. There is an expectation for the work group, formed in November 2017, to make recommendations for specific audiences in 2018. Funding will be needed.

Section 2 (6): Recommendations to respond to schools and communities following completed youth suicides.

Status: Ongoing

Progress:

- To address a number of suicides in Linn and Benton counties in 2016 and 2017, OHA mobilized resources to support postvention and prevention activities. OHA also funded a peer-delivered activity in Benton County by Youth MOVE to engage youth. Additionally, OHA funded a youth resiliency program at Philomath High School. OHA also partnered with Albany schools to bring the successful youth-led resilience program, Sources of Strength, to students and staff. The Corvallis hospital also was awarded a CATS project contract to provide clinical services and family support to youth and families seen in the ED in a behavioral health crisis. As of December 2017, OHA was exploring funding resources to set up a statewide rapid-response network to offer similar interventions to other communities experiencing multiple suicides.
- LMHAs and CMHPs were implementing or preparing their postvention plans under SB 561. As noted above, they have confronted barriers to sharing information due to privacy laws. Some counties have been considering requesting a legislative fix to allow information sharing among partners (including schools) responsible for postvention in communities. In addition, for CMHPs without existing relationships with schools, creating a truly community response was challenging. Under SB 561, only LMHAs have the sole legal responsibility for ensuring a community wide response to suicides.
- The Oregon Medical Examiner contacted all medical examiners in the state to encourage them to work with LMHAs on SB 561 implementation. Many LMHAs and CMHPs had no prior relationships with their medical examiners and forged new systems for working together to implement SB 561.

Section 2 (7-8). An analysis of intervention and prevention strategies used by states with the five lowest suicide rates.

Status: Completed

Progress:

- A comparison of Oregon's youth suicide rates and prevention strategies with other states is in the plan, as required. Rankings for 2015 are included in the statistics provided in Appendix II of this report.

Section 2 Action items requiring additional resources to complete

Status: Underway

Progress:

- The coordinator prepared budget proposals for resources needed to implement the plan fully. There was not an approval of the budget, due to funding constraints. However, the Legislature's $21.5 million budget note to OHA for behavioral health may have freed $1 million for youth suicide prevention in the 2017-2019 biennium. A budget reviewed by the Alliance for use of these funds was under OHA leadership review at the time of this report.
- At publication, OHA was looking for funding to expand the Sources of Strength youth-led resilience program to more sites in 2018-2019. In 2016-2017, partial OHA funding launched two pilots of the best practice program in the Albany and North Clackamas school districts. OHA has been exploring options with the national Sources of Strength organization to see if it is possible to offer a train the trainer to schools statewide.

Section 2 (4). Recommendations for collaborations among schools, school-based health clinics and CCOs for school-based programs.

Status: Pending

Progress:

- The Alliance Continuity of Care Committee expects to examine confidentiality requirements for the following:
  - » Schools
  - » Behavioral health providers
  - » Substance use providers

  This will help to know barriers for information exchange and methods to overcome them.
- The committee also expects to examine uniform methods of being able to encourage parents to sign information releases. This would enable schools and behavioral health providers to share certain information to aid student success.
- The coordinator and Alliance liaison have begun collecting sample memoranda of understanding that school and behavioral health providers are using to enable information exchange.
- There is an expectation that overcoming legal barriers to information exchange — e.g. HIPAA and the Family Educational Rights and Privacy Act (FERPA) — will take time and require legal review. Some counties are considering a possible amendment to SB 561 to facilitate information sharing.

Section 2 (3) Recommendations including best practices to identify and intervene with youth who are depressed, suicidal or at risk of self-injury.

Status: Ongoing

Progress:

- As noted in the 2016 report, there is need for analysis to determine the types of risk assessments used in medical and behavioral health care settings. Also, there is a need to disseminate best practices. OHA and AOCMHP staff resources are insufficient to complete this labor-intensive inventory.
- As expressed in the 2016 report, a needs assessment is necessary to discover the number of schools and colleges that have adopted suicide prevention and postvention protocols. Also, it is necessary to analyze what best practices the schools and colleges have added. OHA and AOCMHP staff resources are insufficient to complete this labor-intensive inventory.
- There is hope that SB 48 will encourage physical and behavioral health care providers to seek out trainings in suicide assessment, treatment and management. OHA has prepared a list of suggested trainings and distributed it to licensees and licensing boards. SB 48 does not require licensees to take such training.

Section 3

Section 3: Review data and prepare an annual report to the Legislature.

Status: Ongoing

Progress:

The following data analysis addresses Section 1 (3)(a-g) of HB 4124. Included in the data below are the number of youth and young adults aged 10 to 24 years who died by suicide and those hospitalized due to self-inflicted injury. Oregon's Violent Death Reporting System, funded by the Centers for Disease Control and Prevention since 2003, collects information relating to all suicide deaths that occur in Oregon each year:

- Demographics
- Circumstances
- Risk factors

Information covering more than 250 variables about these deaths is collected from the below, then entered into a web based national data system:

- Death certificates
- Police reports
- Medical examiner reports

The Oregon Hospital Association collects hospitalization data that documents a small set of demographic and diagnostic codes. The association provides data to OHA annually for use in monitoring various health issues. At publication of this report, work was underway on a standardized emergency department data set for use in monitoring various health problems in Oregon. OHA expects that data will be available in 2018.

Basic facts

Suicide numbers, rates and rankings by county or state vary by year. Monitoring for trends across time is the most effective way to study the data. For example, the number of youth suicides in Oregon changed over the last several years:

- 97 in 2014
- 90 in 2015
- 98 in 2016.

Suicide was the second leading cause of death among youth aged 10 to 24 years in Oregon in 2016.(1)

Overall, Oregon suicide rates among youth aged 10 to 24 years were higher than the U.S. rates in the past decade. Oregon rates began rising after 2011 (Figure 1).(2)

In 2016, the Oregon rate of suicide among youth aged 10 to 24 years is ranked number 15 among all U.S. states.(Table 7) It was the 16th highest state rate reported in 2015 and 12th highest state rate reported in 2014.(2)

Male youth were four times more likely to die by suicide than female youth.(3)

Suicide rates increased with age. The rate increased from approximately 1.0 per 100,000 among youth aged 10 to 14 years to 16.0 per 100,000 among youth aged 20 to 24 years.(3)

The most recent data available indicate that suicide rates among male veterans were more than four times higher than non-veteran males.(3)

During 2013 to 2015, five youth suicides were identified as among LGBTQ Oregonians. This accounts for 1.9 percent of Oregon youth suicide deaths.

Figure 1. Suicide rates among youth aged 10 to 24 years, U.S. and Oregon, 2003-2016.(2)

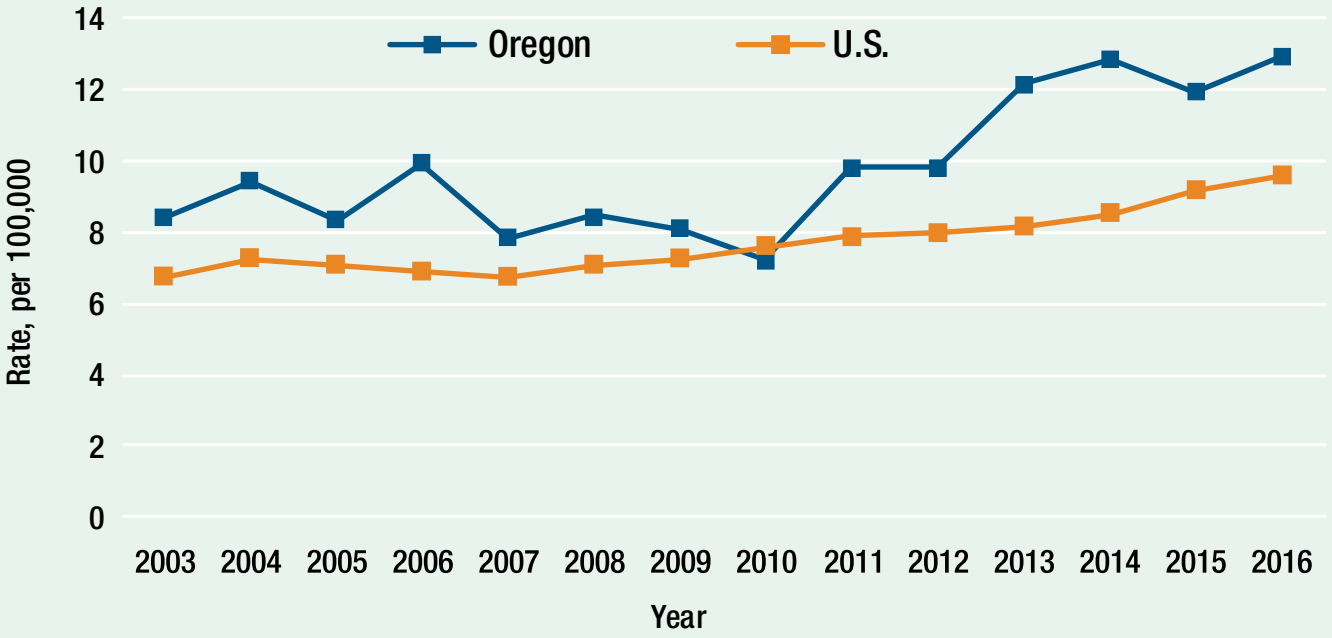


Table 1. Comparison of suicide completion rates per 100,000, among youth aged 10 to 24 years in Oregon and the U.S., 2003-2016(1)(2)*

Year	Oregon	U.S.
2003	8.4	6.7
2004	9.4	7.3
2005	8.3	7.0
2006	9.9	6.9
2007	7.9	6.8
2008	8.5	7.0
2009	8.1	7.2
2010	7.2	7.6
2011	9.8	7.9
2012	9.8	8.0
2013	12.2	8.2
2014	12.9	8.5
2015	12.0	9.2
2016	13.0	9.6

Common risk factors for suicide tracked in Oregon's Violent Death Reporting System (Table 2):

- Mental illness and substance abuse
- Previous suicide attempts
- Interpersonal relationship problems or poor family relationships
- Recent criminal legal problems
- School problems
- Exposure to a friend or family member's suicidal behavior

In 2016

- Ninety-eight suicides occurred among Oregon youth aged 10 to 24 years. Most suicides occurred among males (73 percent), White (85 percent) and those aged 20 to 24 years (61 percent).
- Twenty-seven of the deaths were among middle school and high school students.(3)
- In 2016, and these were the most frequently observed mechanisms of injury in suicide deaths among youth(3):
  - » Firearms (43 percent)
  - » Suffocation or hanging (41 percent)
  - » Poisoning (9 percent)

Table 2. Characteristics of youth suicides, Oregon 2016(3)

		Deaths*	% of total
Age	10–14	9	10%
	15–19	28	30%
	20–24	57	61%
Sex	Male	69	73%
	Female	25	27%
Race/Ethnicity**	White	84	89%
	African American/Black	2	2%
	Am. Indian/Alaska Native	3	3%
	Asian/Pacific Islander	5	5%
	Multiple race	4	4%
	Other/Unknown	5	5%
	Hispanic	15	16%
Student status	Middle school	6	6%
	High school	21	22%
Mechanism of death	Firearm	40	43%
	Hanging/Suffocation	39	41%
	Poisoning	8	9%
	Other	7	7%
Other	Veteran	5	5%

* Four out-of-state suicides of Oregonians are not included. This is because death certificate information is not accessible to Oregon for these suicides in other states.

** Includes any race (one or more, any mention) and ethnicity mention. Race categories will not sum to the total. This is because each decedent may have been multiple races.

Suicide attempts*

- Each year, more than 500 Oregon youth ages 10 to 24 years are hospitalized for self-inflicted injury or attempted suicide. There were 691 youth hospitalizations in 2016 (Table 3).†
- In contrast to suicide, females were far more likely to be hospitalized for suicide attempts than males.†

* Oregon Public Health Division, Injury and Violence Prevention Program, 2016
† Oregon Hospital Discharge Index

Table 3. Numbers and percentage of self-harm hospitalizations and completed suicide deaths among youth aged 10 to 24 years by county and statewide, Oregon, 2016

	Hospitalizations		Deaths*	
County	**Count**	**% of total**	**Count**	**% of total**
Baker	2	0.3	0	0.0
Benton	11	1.6	6	7.1
Clackamas	67	9.7	7	8.3
Clatsop	2	0.3	1	1.2
Columbia	9	1.3	1	1.2
Coos	16	2.3	0	0.0
Crook	2	0.3	0	0.0
Curry	0	0.0	0	0.0
Deschutes	26	3.8	5	6.0
Douglas	16	2.3	1	1.2
Gilliam	0	0.0	0	0.0
Grant	0	0.0	1	1.2
Harney	1	0.1	0	0.0
Hood River	3	0.4	0	0.0
Jackson	54	7.8	9	10.7
Jefferson	3	0.4	0	0.0
Josephine	18	2.6	2	2.4
Klamath	11	1.6	0	0.0
Lake	4	0.6	0	0.0
Lane	83	12.0	11	13.1
Lincoln	5	0.7	2	2.4
Linn	20	2.9	4	4.8
Malheur	4	0.6	3	3.6
Marion	74	10.7	5	6.0
Morrow	1	0.1	0	0.0
Multnomah	117	16.9	11	13.1
Polk	19	2.7	3	3.6
Sherman	0	0.0	1	1.2
Tillamook	7	1.0	1	1.2
Umatilla	7	1.0	4	4.8
Union	5	0.7	0	0.0
Wallowa	1	0.1	0	0.0
Wasco	2	0.3	1	1.2
Washington	73	10.6	10	11.9
Wheeler	0	0.0	0	0.0
Yamhill	28	4.1	5	6.0
State	**691**	**N/A**	**94**	**N/A**

* Four out-of-state deaths are not included because death certificate information is not accessible.

Source: Injury and Violence Prevention Program, Oregon Public Health Division

Note: According to the Center for Health Statistics, OHA, there were 98 suicides aged 10 to 24 in 2016.

Suicidal ideation

- Percentage of youths that seriously considered suicide in the past 12 months, in 2017*:
  - » 17 percent of eighth graders
  - » 18 percent of 11th graders
- Percentage of youths that attempted suicide one or more times in the previous 12 months, in 2017*:
  - » 9 percent of eighth graders
  - » 7 percent of 11th graders
- Percentage of lesbian and gay youth that contemplated suicide in the past 12 months, in 2017†:
  - » 46 percent of eighth graders
  - » 38 percent of 11th graders

Limitations of data used for suicide surveillance

Suicide is one of leading causes of death in Oregon and an important public health issue nationally. Oregon Public Health Division has set suicide prevention as one of top priority areas. Oregon uses various existing administrative data sets, surveys and active surveillance efforts to monitor and track suicide. Administrative data sets include death certificates collected by the Center for Health Statistics at the Oregon Public Health Division and hospitalization discharge data from the Oregon Association of Hospitals and Health Systems. Survey data come, in part, from the following:

- Oregon Healthy Teens Survey
- Student Wellness Survey
- National Survey on Drug Use and Health
- American Community Survey

The Oregon Violent Death Reporting System and the Oregon Child Fatality Review Data Systems also collect active surveillance data. In addition, ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics) provides real-time data for public health and hospitals to monitor what is happening in emergency departments across the state.

*Oregon Healthy Teens Survey, Oregon Health Authority, Public Health Division, Center for Health Statistics.

These data sets, surveys and surveillance activities include data elements of interest to policy makers. Some variables contain or partially cover requirements mandated by HB 4124. However, they may fall short in other areas of interest. The following complete data are not available for youth who died by suicide:

- School attended
- Previous admissions or treatment for depression or suicidality
- Primary spoken language
- Foster care status
- Depression-related intervention services in the past 12 months
- Previous attempts, emergency department visits or hospitalizations in the last 12 months

Generation of missing data described above would involve many components:

- Linkage of several large administrative data sets
- In-person case interviews
- Requirements for law enforcement agencies and health care providers to release individual information
- Additional personnel for data entry and database management

These initiatives would require significant additional resources, position authority and planning.

Implementation of SB 561 by the LMHAs may allow for collection of limited data:

- School attended
- Whether the youth was in treatment with the CMHP
- Whether the youth was in the custody of an agency, if that information is available to the LMHA.

As of December 2017, LMHAs were not aware of the school or college attended or justice involvement, unless they received notification by that institution. This information is not normally available in medical examiner death reports.

Obtaining a standardized emergency department discharge data set is an objective of the State Health Improvement Plan and a high priority for OHA. During the 2017 legislative session, OHA introduced SB 816 to require the hospital association to compile data and provide them to OHA. The bill did not pass, and OHA likely will continue its efforts in 2019.

Appendix I

Public Health Division: 2017 Garrett Lee Smith grant activities

The Oregon Health Authority, Public Health Division, manages the Garrett Lee Smith Memorial Act (GLSMA) funding through the Substance Abuse and Mental Health Services Administration (SAMHSA). At time of publication, Oregon was in the middle of the grant implementation (2014-2019), referred to as the Oregon Caring Connections Initiative (OCCI). Oregon receives $736,000 a year during the five-year grant to implement activities required in the SAMHSA funding opportunity announcement. These objectives align with Strategic Direction 2 and Strategic Direction 4 of the Youth Suicide Intervention and Prevention Plan. Grant objectives include the following:

- **Gatekeeper training** to increase by 30 percent the number of individuals in youth-serving organizations trained to identify and refer youth at risk by these activities:
  - » Hosting quarterly Applied Suicide Intervention Skills Trainings (ASIST) to behavioral health clinicians, and/or Question, Persuade and Refer (QPR) or SafeTALK trainings to community members annually
  - » Establishing RESPONSE in 50 percent of the high schools in three CMHP catchment areas
  - » Providing Kognito *At Risk for High School Educators* and *Kognito Step In! Speak Up!* LGBTQ module training to 20,000 educators and school staff.
- **Clinical training** to increase health, mental health and substance abuse clinicians trained to assess, manage and treat youth at risk for suicide by these activities:
  - » Hosting 11 trainings in Assessing and Managing Suicide Risk (AMSR) for 550 behavioral health clinicians
  - » Implementing Kognito At-Risk for Primary Care training for staff at all School-Based Health Centers, and to pediatricians in three counties
  - » Implementing Kognito At-Risk for EDs for Emergency Department staff in all four Portland metro health systems that treat more than 300,000 patients annually.

- **Improving continuity of care:**
  - » Youth discharged from emergency departments and inpatient psychiatric units
  - » Veterans and military families receiving care in the community
  - » Improved county crisis response plans for full wrap around services.
- **Comprehensive implementation of goals 8 and 9 of National Strategy for Suicide Prevention.** Focus on Zero Suicide Initiative approach to reduce rates for the following:
  - » Suicidal ideation
  - » Suicide attempts
  - » Suicide deaths.
- **Promotion of the National Suicide Prevention Lifeline** and **Project Evaluation** with all partners.

Four counties (Deschutes, Jackson, Josephine and Washington) received funding in the first two years to implement the above set of prevention strategies. One additional county (Umatilla) received funding in the fall of 2016, after completing a set of activities that would prepare Umatilla to implement the project.

Year three grant activities

The following section reports on activities completed in year three (October 2016 – September 2017) of the five-year SAMHSA Oregon Caring Connections Initiative. Sections are by the Strategic Directions and Objectives listed in the Youth Suicide Intervention and Prevention Plan.

Gatekeeper training is provided through the OCCI funded projects. This is consistent with Goal 6 of the Oregon Youth Suicide Intervention and Prevention Plan. Trainings include the following:

- Applied Suicide Intervention Skills Training (ASIST)
- safeTALK
- Persuade and Refer (QPR)
- Kognito (web based training)

Gatekeeper training are best or evidence-based practices to prepare lay people and professionals to identify and refer persons at risk for suicide to appropriate care. This activity is an objective in the national suicide prevention plan and Objective 6.1 under Strategic Direction 2 in Oregon's Youth Suicide Intervention and Prevention Plan.

Funded counties achieved and exceeded the target for implementing one gatekeeper training per quarter (Table 4) in year three.

Table 4. Counties and completed QPR, ASIST and safeTALK Trainings and participants trained during the OCCI grant, by grant year

County	QPR	ASIST	safeTALK	Total
Deschutes	8 (193)	2 (86)		10 (279)
Jackson	34 (943)	7 (172)		41 (1,115)
Umatilla	5 (67)	1 (15)		6 (82)
Josephine	19 (555)	3 (40)		22 (595)
Year 3 Total	66 trainings (1,758 people)	13 trainings (313 people)	—	79 trainings (2,071 people)
Year 2 Total	42 trainings (1,300 people)	21 trainings (492 people)	1 training (17 people)	64 trainings (1,809 people)
Year 1 Total	10 trainings (274 people)	21 trainings (567 people)	—	31 trainings (841 people)
Cumulative	**118 trainings 3,332 people**	**55 trainings 1,372 people**	**1 training 17 people**	**174 trainings 4,721 people**

Note: Washington County trainings are in-kind (not funded through OCCI)

Through the grant, OHA provided an opportunity for professionals to use a web-based gatekeeper training. Individuals working in schools, emergency departments, in primary care, and in school-based health centers can complete their training online. The name of this training is Kognito. Table 5 provides data on the settings, locations and users who completed Kognito training.

OHA PHD contracted with an organization in year three to work with schools. The aim was to increase participation and implementation of youth suicide prevention in schools. This led to increased utilization of the Kognito programs for schools. The Oregon Health Authority, PHD Injury and Violence Prevention Program continued to work with the School-Based Health Center (SBHC) program to promote Kognito for Primary Care. (HSD also funds behavioral health services at SBHCs.) The Public Health Division Zero Suicide Program coordinator gave a presentation on suicide prevention and Kognito at the in-person SBHC coordinator meeting in October 2016. Based on requests from the SBHC coordinators, the Public Health Division is organizing a webinar series on suicide prevention and intervention strategies for this group in year four of the grant.

Table 5. Implementation and completion of Kognito gatekeeper training by setting, year 1 through year 3

Type of setting	Locations	Users completed training
Schools	35	417
Emergency departments*	6+	14
Primary care providers/school based health centers*	18+	46
Total	59+	**477**

* Promotion of Kognito programs stated in year two.

\+ Participants grouped in the "Other" category could not be identified by location. Therefore, the exact number of locations is unknown.

County projects completed other types of trainings in prevention and early intervention skills for persons who work with youth at risk for suicide. County implementation of Counseling on Access to Lethal Means (CALM), Response, and Mental Health First Aid (MHFA) continued in 2017. Grant funding for these activities did not extend into year three of the grant. However, counties are working on their own with other funding sources to provide trainings around the state. Year three activities included working with a contractor to start revisions of the Response curriculum. Response is a comprehensive high school-based prevention program designed to do these things:

- Increase awareness
- Heighten sensitivity to depression and suicidal ideation
- Change attitudes
- Offer response procedures to refer a student at risk for suicide

Work on Response continuing into 2018 includes the following:

- Bringing the program up to best practices in pedagogy and adult learning
- Ensuring alignment with National Health Education Standards and CDC's Health Education Curriculum Analysis Tool
- Identifying possible gaps
- Proposing and infusing engaging activities that focus on skills-based education, where possible and appropriate

At publication of this report, a broad group of stakeholders including educators experienced in implementing Response, as well as suicide prevention experts in Oregon, continued involvement in the revision of the curriculum. The revisions will be finalized in year four. Given these pending revisions, some schools continued to use Response in 2017. Other schools were using other nationally recognized best practice school curricula.

Mental Health First Aid (MHFA) trainings contribute to increased identification of mental health problems and identified persons receiving early support. There are no GLSMA grant funds for these trainings. However, HSD funds MHFA training and a learning collaborative under a state-funded grant with the Association of Oregon Community Mental Health Programs. AOCMHP reported training 7,838 individuals in the youth or adult models in 2017 and a total of 21,391 since 2013.

Suicide is one module within MHFA and is designed to inform participants:

- Of myths and facts
- How to tell when a young person is suicidal
- How to assist during a crisis.

Clinical professionals training in Assessing and Managing Suicide Risk (AMSR)

The OCCI required funded counties to implement a clinical training designed for mental health service providers known as Assessing and Managing for Suicide Risk. Table 6 includes information that documents the county level implementation of AMSR training. In 2017, the grant was on target to reach this goal.

Table 6. Total AMSR trainings completed year 1 – year 3 (Target: Complete 11 trainings and train 550 participants by Dec. 29, 2019)

Training date	Training location	Clinicians trained
2/27/2015	Washington	49
Year 1 Total	**1**	**49**
10/30/2015	Jackson	42
03/30/2016	Josephine	41
08/05/2016	Malheur	47
09/16/2016	Lane/Douglas	51
09/22/2016	Multnomah	46
Year 2 Total	**6**	**276**
09/01/2017	Umatilla	17
09/22/2017	Jackson	20
Year 3 Total	**2**	**37**
Total to date	**9**	**362**
Total remaining to train	2	188

Youth suicide prevention conference

The 2016 report provided information on the Youth Suicide Prevention Conference held September 22 and 23, 2016. On March 13 and 14, 2018 there will be another Oregon Suicide Prevention Conference. Budget note funding to HSD and OCCI funding, as well as other sources are supporting the 2018 conference and another in 2019. OHA has a contract with Lines for Life to organize the conference. OHA representatives serve on the planning committee.

Firearm safety materials for firearm owners and primary care providers

A brochure for firearm owners and a tip sheet for Primary Care Providers (PCPs) is now available, thanks to OCCI funding. Researchers worked with both PCPs and firearm owners in rural Central Oregon. The goal was to develop and test culturally appropriate education and outreach materials on means reduction. These materials are specifically for use in primary care with patients at risk of suicide. The research team developed and tested two research-informed communication tools:

1. A brochure "from firearm owners" to "firearm owners" who might be at risk of suicide.
2. A research brief and tip sheet for PCPs on how to interact effectively with a patient at risk of suicide on the topic of limiting access to firearms.

Previous research(4)(5) by Oregon State University-Cascades and the La Pine Community Health Center suggested that public health messaging about suicide prevention was more effective in motivating people to give up a firearm voluntarily, if combined with culturally informed firearm safety messaging. As part of OCCI, the research team tested an initial brochure with rural firearm owners. The team used feedback on content and format to produce a final product. Likewise, the team tested an initial tip sheet with primary care providers and used input from this group to inform the final product.

Testing suggested that a research-focused tip sheet about firearms, to set it apart from other tip sheets that flood the desks of PCPs, was necessary. Firearm owners in the test group were very positive about the brochure. These firearm owners have requested copies to distribute in their home communities. The brochure for firearm owners and research brief for PCPs are available in print. The brochure is also now web accessible.* For the primary care research brief, buttons are part of the landing page:

1. One button allows primary care practices to upload the tools to the provider section of their website.
2. The second button allows primary care practices to upload a link to the firearm owner brochures to place on the patient section of their website.

* Primary Care Provider site: http://oregonfirearmsafety.org/addressing-firearm-safety/
Access to the firearm owner site: http://oregonfirearmsafety.org/firearm-safety/

In November 2017, a CD Summary titled A NEW Approach to Preventing Firearm Deaths was released.* The CD Summary is a publication of the Oregon Health Authority PHD. The intended audience includes these groups:

- Licensed health care providers
- Public health and health care agencies
- Media representatives
- Medical laboratories
- Hospitals
- Other individuals and institutions with an interest in epidemiology and public health

This CD summary includes an overview of the above research as well as links to the firearm safety materials (for both firearm owners and PCPs). This CD summary includes research by OSU on how to engage firearm owners and primary care practitioners in firearm safety. OCCI year four grant activities will include development of strategies to disseminate these materials by both web and hard copy.

Zero Suicide initiative promotion and implementation

All five OCCI county grantees made progress on Zero Suicide Initiative implementation in year three. Zero Suicide is a goal for hospitals and health systems, as well as the overall aspirational goal of the YSIPP. OCCI county grantees are providing materials developed for Zero Suicide implementation. These materials will go in a systematic order for future review and selection as part of the Oregon Zero Suicide toolkit. The toolkit will be available in year five of the grant. County grantees are working both within their own organizations as well as with other county health care partners in Zero Suicide initiative implementation.

* CD Summary: http://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/CDSUMMARYNEWSLETTER/Documents/2017/ohd6613.pdf

To help support these efforts and other health care organizations, the PHD Zero Suicide initiative contracted with EDC to provide a Zero Suicide Academy in September 2018. The Zero Suicide Academy is a two-day training for senior leaders of health and behavioral health care organizations that seek to dramatically reduce suicides among patients in their care. Using the Zero Suicide framework, participants learn how to incorporate best and promising practices into their organizations. They also learn processes to improve care and safety for individuals at risk. Zero Suicide faculty provide both interactive presentations and small group sessions, and collaborate with participants to develop organization-specific action plans. As of December 2017, PHD was planning for the Zero Suicide Academy and preparing the application process for Oregon health care organizations to apply for this opportunity.

Summary of the Oregon Caring Connections Initiative activities

The Garrett Lee Smith Memorial Act Oregon Caring Connections Initiative cumulative accomplishments from October 2014 through September 2017 included work in five key strategies:

1. **Gatekeeper trainings:**
   - ASIST, QPR, SafeTALK: 4,721 gatekeepers at 174 trainings
   - Kognito: 477 gatekeepers at over 59 schools, emergency departments and school-based health centers
   - AMSR: 362 clinicians at 7 locations

3. **Crisis response and continuity of care:**
   - Enhancing plans and systems in all five funded counties.

4. **Zero Suicide:**
   - Being implemented in all five funded counties

5. **National Suicide Prevention Lifeline (NSPL):**
   - Ongoing promotion in multiple venues and events around state.

OCCI grant activities and county grantees increased relationships with partners and created system change to reduce youth suicide in the state. One county grantee, Deschutes County Health Services, has produced the Central Oregon Primary Care Suicide Prevention Toolkit designed to help practices support the patient who may be at risk of suicide. The tools provided in the toolkit do the following:

- Examine the role of primary care in suicide prevention.
- Describe the suicide prevention roles, responsibilities and workflows of everyone within a practice site who comes in contact with a patient.
- Provide practical tips and materials for assessing risk and creating collaborative safety plans.
- Suggest research-based tips for communicating about firearm safety and access to other lethal means.
- Provide important local and national resources to support both providers when working with a suicidal patient and patients at risk of suicide.

The toolkit is available via hard copy packets. There is going to be a web page designed for online distribution in year four. Lifeworks Northwest, a large behavioral health agency in the state, continued their Zero Suicide initiative efforts in 2017 and dedicated executive level staff working on these efforts. The OCCI grant funding continued to support implementation of evidenced-based practices across health systems to provide suicide safer care in both funded counties, as well as other Oregon counties and the state level.

As called for in the plan, OHA will continue to collect data from OCCI grantees, compile the results and report on outcomes by January 2019. The Public Health Division will complete an annual report by Dec. 29, 2019. That report will summarize the results at that time. The report will be shared with funded counties, the Alliance, AOCMHP, HSD and the suicide prevention email list.

Appendix II

Table 7: Suicide rates among youth aged 10 to 24 years by state, U.S. 2016

State	Deaths	Crude Rate*
Alaska	53	34.1
Montana	47	23.5
South Dakota	36	20.5
North Dakota	28	17.2
Colorado	180	16.3
Oklahoma	130	16.1
Idaho	56	15.7
Maine	36	15.6
Wyoming	18	15.6
Utah	111	14.8
Missouri	170	14.1
New Mexico	59	13.9
Oregon	**98**	**13.0**
Kansas	79	12.8
New Hampshire	32	12.6
Wisconsin	143	12.4
Nebraska	49	12.2
Hawaii	31	12.0
Washington	164	11.9
Nevada	65	11.8
Kentucky	103	11.8
South Carolina	111	11.5
Indiana	157	11.4
Arizona	160	11.4
Arkansas	68	11.3
Michigan	217	10.9

State	Deaths	Crude Rate*
Georgia	233	10.8
Louisiana	101	10.8
Virginia	175	10.6
Tennessee	134	10.3
Iowa	67	10.3
Minnesota	111	10.2
West Virginia	34	10.2
Alabama	98	10.2
Pennsylvania	242	10.0
Texas	570	9.5
Ohio	215	9.4
North Carolina	188	9.3
Mississippi	58	9.3
Vermont	11	8.9
Florida	286	7.9
Delaware	13	7.3
Illinois	184	7.2
Massachusetts	90	6.7
California	517	6.5
Maryland	73	6.3
New York	224	5.9
Rhode Island	12	5.7
Connecticut	37	5.2
New Jersey	81	4.8
District of Columbia	<10	Not calculated

*Rates are deaths per 100,000.

Appendix III

Glossary

Applied Suicide Intervention Skills Training (ASIST): Through a two-day workshop, ASIST teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety. Although ASIST is widely used by health care providers, participants do not need any formal training to attend the workshop — anyone 16 or older can learn and use the ASIST model.

Assessing and Managing for Suicide Risk (AMSR): AMSR is a one-day training workshop for behavioral health professionals. The 6.5-hour training is based on the latest research in clinical care. Participants learn how to provide safer suicide care.

Attempt survivor: An individual who has attempted suicide or has experience with suicidal ideation.

Bereavement survivor: An individual who has lost a loved one, friend or community member to suicide.

Caring contacts: Caring contacts are brief communications with patients that start during care transitions. Times for caring contacts, for example, may be during the following:

- During transitions from hospital or ED release and outpatient care
- When patients miss appointments
- When patients drop out of treatment

Completed suicide: Used interchangeably with "died by suicide" to note when an intentionally lethal act of self-injury leads to death.

CONNECT: A best practice program from the National Alliance on Mental Illness (NAMI) New Hampshire affiliate. CONNECT trains communities on best practices in responding to suicides (postvention).

Contagion: Sometimes called "copycat" suicide, contagion occurs when an individual's suicide causes others to attempt or complete suicide.

Counseling on Access to Lethal Means (CALM): A best practice, free online skills course to discuss safety and access to lethal means with suicidal patients. The course is for providers who counsel people at risk for suicide. This includes mental health and physical health providers.

Family support specialists*: Trained and certified family support specialists have experience parenting a child who is any of the following:

- A current or former consumer of mental health treatment.
- A current or former consumer of addiction treatment.
- Facing or has faced difficulties in accessing education due to a mental health or behavioral health barrier.
- Facing or has faced difficulties in accessing health and wellness services due to a mental health or behavioral health barrier.

Kognito: Online, interactive, best practice courses to develop skills to talk to youth and adults about behavioral health and suicide risk. These courses are for these groups:

- Educators
- Students
- Medical health providers
- Behavioral health providers

Mental Health First Aid (MHFA): A best practice program to teach the skills to respond to the signs of mental illness and substance use. Instructors customize courses to identify and respond to youth and adults with mental health concerns.

Postvention: Used interchangeably with "post-suicide intervention." Best practice postvention refers to the activities after a suicide occurs to assist bereavement survivors with grief and reduce the risk of contagion.

Question. Persuade. Refer. (QPR): QPR is a best practice that teaches how to recognize the warning signs of a suicide crisis. Instructors also teach how to question, persuade and refer someone to help. Online and in-person gatekeeper trainings are available. There is also a module for behavioral and physical health providers.

Response: A comprehensive high school-based program that increases awareness about suicide among high school staff, students and parents. Program components are designed to heighten sensitivity to depression and suicidal ideation. The program also offers response procedures to refer a student at risk for suicide. The program includes technical assistance for key staff to ensure that suicide prevention efforts continue at the school.

*Family support specialists are defined in ORS 414.025 and certified by the Authority's Office of Equity and Inclusion as required by OAR 410-180-0300 to 0380. Family support specialists meet qualification criteria adopted by the OHA under ORS 414.665.

SafeTALK: A half-day alertness training that prepares anyone over the age of 15, to become a suicide-alert helper. This is regardless of prior experience or training. Most people with thoughts of suicide do not truly want to die, but are struggling with the pain in their lives. Through their words and actions, they invite help to stay alive. SafeTALK-trained helpers can recognize these invitations. In addition, they can take action by connecting them with life-saving intervention resources, such as caregivers trained in ASIST.

Sources of Strength: A best practice youth suicide prevention project. The project is designed to use the power of peer social networks to change unhealthy norms and culture, ultimately preventing suicide, bullying and substance abuse

Zero Suicide: The aspirational goal of the Oregon Youth Suicide Intervention and Prevention Plan. Zero Suicide also is a set of interrelated activities that health systems can implement with the goal of reducing suicides among their patients to zero.

Endnotes

1. Deaths and Perinatal Deaths Data [Internet]. Oregon Health Authority: Deaths and Perinatal Deaths Data: Annual Report Volume 2: State of Oregon. [cited 2017 Dec 13]. Available from: http://www.oregon.gov/oha/PH/BirthDeathCertificates/VitalStatistics/annualreports/Volume2

2. WISQARS Fatal Injury Reports [Internet]. Centers for Disease Control and Prevention. Centers for Disease Control and Prevention; 2017 [cited 2018 Jan 17]. Available from: https://webappa.cdc.gov/sasweb/ncipc/mortrate.html

3. Oregon Public Health Division, Oregon Violent Death Reporting System, 2003-2012. Available from: http://www.oregon.gov/oha/ph/diseasesconditions/injuryfatalitydata/pages/index.aspx

4. Marino, E., Wolsko, C., Keys, S.G. et al. "A culture gap in the United States: Implications for policy on limiting access to firearms for suicidal persons". J Public Health Pol (2016) 37: 110. doi:10.1057/s41271-016-0007-2.

5. Marino, E., Wolsko, C., Keys, S.G. et al. "Addressing the Cultural Challenges of Firearm Restriction in Suicide Prevention: A Test of Public Health Messaging to Protect Those at Risk." Archives of Suicide Research (2017). doi:10.1080/13811118.2017.1355285

Oregon Health Authority
HEALTH SYSTEMS DIVISION

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact the Health Systems Division at 503-945-5763, 711 for TTY, or email kids.team@dhsoha.state.or.us.

OHA 8874C (02/2018)

Implementing Standardized Suicide Risk Assessment in Oregon

Background:

The Behavioral Health Collaborative established a Standards and Competencies (S&C) Workgroup with the aim of improving the behavioral health (BH) system in Oregon through better integration with physical and dental health. The S&C workgroup recommended that a standardized assessments across providers would streamline the behavioral health system, help providers speak a common language when identifying level of risks for certain outcomes in individuals, and move behavioral health another step towards integration with physical health. The priority outcome area that was chosen was Suicide. This is because suicide is one of the leading causes of death in Oregon.

Current efforts:

Oregon Youth Suicide prevention Plan: In 2014, the Oregon Legislature mandated development of a five-year Youth Suicide Intervention and Prevention Plan. The Oregon Health Authority's Health Systems Division (HSD) and Public Health Division (PHD) worked with interested parties from across Oregon to adopt strategic directions, goals and objectives from the 2012 National Strategy for Suicide Prevention (NSSP), develop actions to operationalize and start discussions to implement the plan in 2016. The Youth Suicide Prevention Plan recommendations include OHA to work with community providers to strategize and implement assessment, intervention and treatment of individuals experiencing suicidal ideation or who have attempted suicide. This plan addresses use of best-practice suicide risk screening tools, including risk assessment in emergency departments and primary care offices where immediate suicide risk and environmental risk factors are assessed.

Administrative Rules: OAR 309-019 requires CMHPs to use research-based suicide risk assessment, Emergency Departments are also required to do caring contacts at discharge and until a patient is situated in outpatient care.

Oregon's Zero Suicide Initiative: January 2016, OHA will collaborate with partners on outreach to health systems to educate them about and provide tools for Zero Suicide in their patient safety initiatives. OHA promotes the adoption of Zero Suicide as an aspirational goal by health care and community support systems that provide continuity of care and support a defined patient population.

Current Gaps

Even though current OARs require providers to use a standardized assessment for all individuals they serve, there is significant gap in use of research-based or evidence-based assessment tools being used across providers. In addition, there is significant gap in standardized reporting to and data collection by, OHA: 1) lack of information on assessment tool used by each provider and whether it is research-based or evidence-based, 2) lack of data on whether all individuals served by a provider are offered a suicide risk assessment, 3) lack of data on the point during treatment an individual is assessed for risk, and 4) lack of data on how many individuals are identified to be at high risk.

Behavioral Health Collaborative Recommendation

Establish standardized Suicide Risk Severity Assessment amongst licensed, non-licensed, certified, and non-certified BH providers.

Option I

Ideally implementation of a single standardized suicide risk assessment tool, which is research-based, among all providers would lead to the greatest improvement of integration of behavioral health with physical health. The Columbia-Suicide Severity Rating Scale (C-SSRS) is a questionnaire used for suicide assessment developed by multiple institutions, including Columbia University, with NIMH support. The Oregon Youth Suicide Prevention Plan also recommends the C-SSRS.

Pros for Option I

- Less chance of individuals experiencing "assessment burnout"
- Evidence based and culturally appropriate, multi-language, free tool and training already available
- Available tool is appropriate for pediatric (down to age 3), adolescents, adults, geriatric populations, parents and customized for specific sites, e.g. ED, primary care, community settings, etc.
- Ongoing TA available
- Other state have implemented the tool (with caveat)
- Assessment will follow individual across all treatment types
- Providers will speak a common language of assessment thus standardizing decision making and referral across sites of care (continuity of care)

Option II

OHA will identify a list of evidence-based suicide risk assessment tools. All providers will use one of the OHA approved assessment tools. If a provider is using a tool outside the OHA identified list of best practices, they will provide a justification to OHA on how the assessment tool was identified as a best-practice. In addition, OHA and providers will 1) ensure that all providers are using a research-based standardized tool on all the individuals who receive their service and 2) OHA will collect the following data from providers:

- How many individuals were identified at risk of suicide
- At what point of treatment were individuals assessed for risk

Pros for Option II

- More accountability from providers due to relatively easier transition into a standardized system
- Standardized reporting is an incremental improvement to current situation
- The public can be assured that a research based tool is addressing public safety
- May not require changes to EHR
- OHA can provide or arrange for TA for certain evidence based tools

Option III

All providers will use the same short assessment tool for initial assessment of all individuals they provide services to. For those individuals identified to be at risk of suicide, will be assessed by providers using one or more of the longer research-based assessment tools pre-identified by OHA. If a provider is using a tool outside the OHA identified list of best practices, they will provide a justification to OHA on how the assessment tool was identified as a best-practice.

In addition, OHA and providers will 1) ensure that all providers are using the standardized tool identified by OHA for initial assessment and 2) OHA will collect the following data from providers:

- If all individuals were offered a suicide risk assessment
- How many individuals were identified at high risk of suicide
- At what point of treatment were individuals were assessed for risk

Pros for Option III

- Providers would still speak a common language of risk identification to a certain extent
- More accountability from providers due to relatively easier transition into a standardized system
- Standardized reporting is an incremental improvement to current situation
- The public can be assured that a research based tool is addressing public safety
- May not require changes to EHR
- OHA can provide or arrange for TA for certain evidence based tools

What OHA is asking stakeholders

- What are providers' feedback on barriers to implement option I?
- What are providers' feedback on barriers to implement option II?
- What are providers' feedback on barriers to implement option III?
- How can OHA support providers in implementing any one of the proposed options?

Deepening our impact through storytelling

Oregon Alliance to Prevent Suicide
April 12, 2018

Oregon Health Authority

COMMUNICATIONS
External Relations Division

OHA's communications office

- Part of External Relations Division
- Team of eight
- My portfolio: Medicaid, opioid crisis, behavioral health, plus more

Communications goals

- Transform…
- OHA culture and relationships
- Health system
- Health outcomes*
- *This is where you all come in

What is our role in a health crisis?

- Display leadership
- Provide context and data
- Point to solutions that are working
- Discuss future solutions
- Tell success stories and share gaps and barriers
- We don’t need to have all the answers!

Questions to consider

- Should the alliance play a role in publicly discussing suicide?
- What are the risks and benefits?
- What are your key messages?
- What are some current and future communications opportunities?

Copy of Email to OHA Public Health Division Regarding the OAR for HB3090

March 26, 2018

OHA Public Health Division
Brittany Hall, Administrative Rules Coordinator
800 NE Oregon St., Ste 930
Portland, OR 97232

Dear Ms. Hall-

On behalf of the *Oregon Alliance to Prevent Suicide***,** I am submitting recommended changes to the proposed administrative rules developed in response to the passage of HB3090 (Oregon Laws 2017, chapter 272).

Members of the Oregon Alliance to Prevent Suicide are appointed by the Oregon Health Authority. They are a cross-systems advisory group which includes a diverse range of thought-leaders in the field of suicide prevention and intervention, suicide attempt and loss survivors, and youth/young adults from across Oregon. The Alliance oversees implementation and outcome evaluation of the Oregon Health Authority's Youth Suicide Prevention and Intervention Plan for the years 2016 – 2020.

The Alliance recommends the following changes to clarify the intent of the rules in Chapter 333, divisions 500, 505, 520, 525 "Hospital Discharge and Release from the Emergency Department Requirements."

Proposed Changes:

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(d) "Caring contacts" mean brief communications with a patient that starts during care transition such as discharge or release from treatment, or when a patient misses an appointment or drops out of treatment, and continues as long as a qualified mental health professional deems necessary; (USE PLURAL ON ALL REFERENCES AS CARING CONTACTS ARE OFFERED MORE THAN ONCE DURING THE TIME BETWEEN HOSPITAL SERVICES AND OUTPATIENT CARE)

Page 13

(e) A process to coordinate care through the deliberate organization of patient care activities including but not limited to at least one of the following: notification to a patient's primary care provider, referral to other provider including peer support as defined in OAR 333-505-0055, follow-up after release from the emergency department, or creation and transmission of a plan of care with the patient and other provider; (DELETES "MAY INCLUDE" AND REPLACES WITH AT LEAST ONE SUCH INTERVENTION WILL BE DONE)

(g) A process to arrange caring contacts between a patient and a provider or follow-up services for the patient in order to successfully transition a patient to outpatient services. For purposes of this subsection "provider" includes a behavioral health clinician, peer support specialist, peer wellness specialist, family support specialist or youth support specialist as those terms are defined in ORS 414.025 and who are certified in accordance with OAR chapter 410, division 180. (CARING CONTACTS SHOW AS PLURAL FOR CONSISTENCY ACROSS OTHER RULES AND TO REFLECT IT'S NOT JUST ONE CALL BUT MORE THAN ONE OCCURING ACROSS THE GAP BETWEEN HOSPITAL SERVICES AND OUTPATIENT CARE.)

(A) A hospital may facilitate caring contacts through contracts with a qualified community-based behavioral health provider, or through a suicide prevention hotline;

(B) Caring contacts may be conducted in person, via telemedicine or by phone;

(C) Caring contacts must be attempted within 48 hours of release if a behavioral health clinician has determined a patient has attempted suicide or experienced suicidal ideation; (DELETES "IF POSSIBLE")

_____

I have also attached a copy of the OAR which uses track changes to highlight our proposed revisions.

On behalf of the Alliance, thank you for your attention to this important matter,

Annette A. Marcus, MSW
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