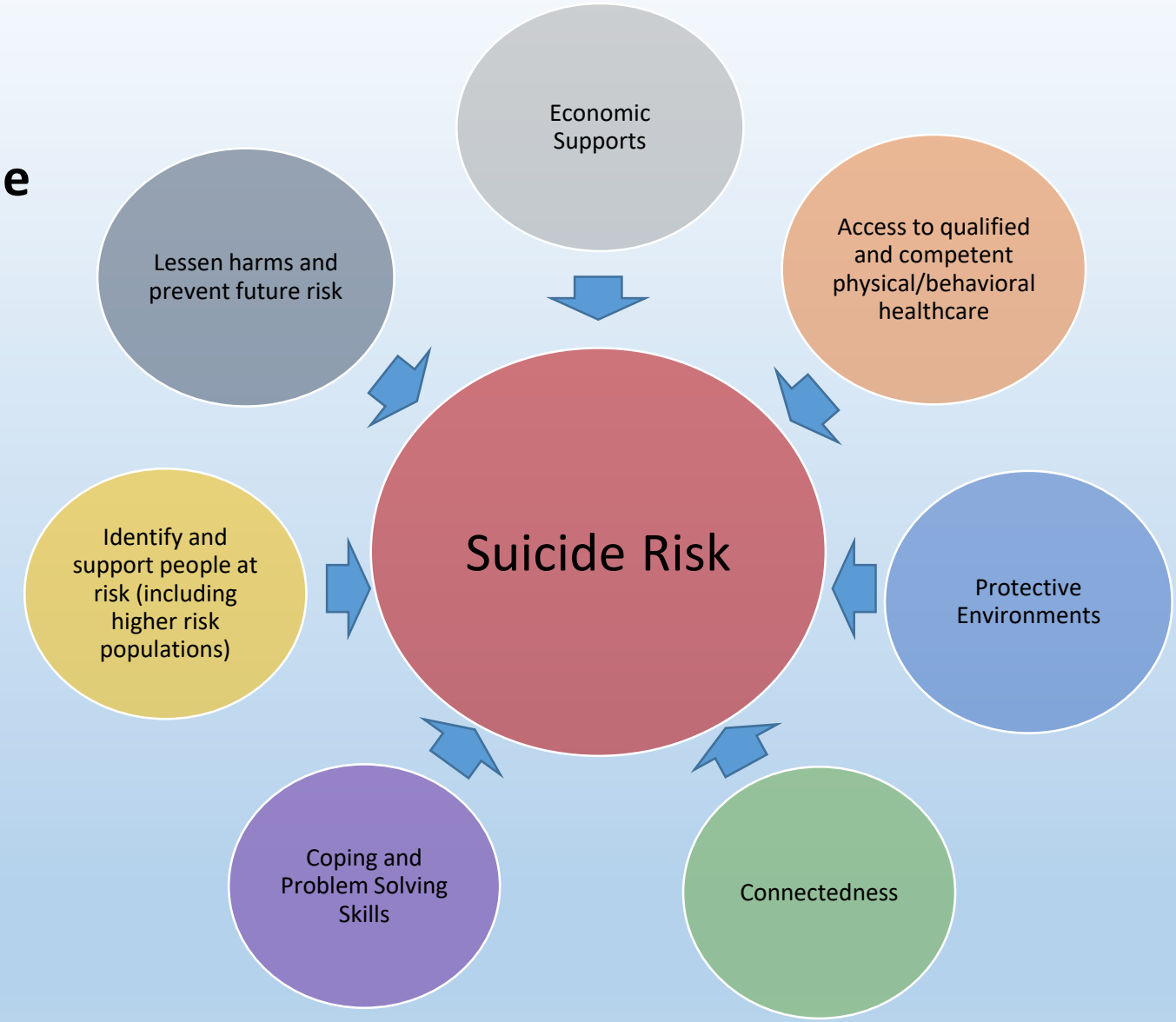
Executive Committee Members-Oregon Alliance to Prevent Suicide	
Chair of Executive	Gary McConahay
Vice Chair of Executive/Continuity of Care Committee	Julie Magers
Evaluation and Data Committee	John Seeley
Outreach and Awareness	Dwight Holton
Workforce Development	Deborah Martin
Schools	
Youth	Phaedra Whitty
Youth	Riley Murphy
Healthcare Professional	
OHA/HSD Representative	Ann Kirkwood
Bereavement Survivor	Stephanie Willard

Continuity of Care	Evaluation and Data	Outreach & Awareness	Workforce Development	Schools
Mitch Kruska	John Seeley, Chair	Dwight Holton, Chair	Deborah Martin, Chair	Phaedra Whitty
Julie Magers, Co-Chair	Michael Hayes	Rep. Alissa Keny-Guyer	Galli Murray	Dwight Holton/Donna Limbeday
Amy Baker, Co-Chair	Laura Chisholm	Laura Rose Misaras	Julie Scholz	Bergen Nigro
Gary McConahay	Sandy Bumpus	Kristi Nix	John Seeley	
Galli Murray	Cherryl Ramirez	Martin Rafferty	Kirk Wolfe	
Jerry Gabay		Brad Sargent	Cameron Smith	
Kristi Nix	Kirk Wolfe	Susan Keys	Nan Waller	
Tanya Pritt		Allie Forsterer	Stephanie Willard	
Martin Rafferty		Riley Murphy	Karen Meadows	
Stephanie Willard		Phaedra Whitty		
		Brian Cooper		

Seven Key Approaches for Attenuating Suicide Risk in Oregon Communities



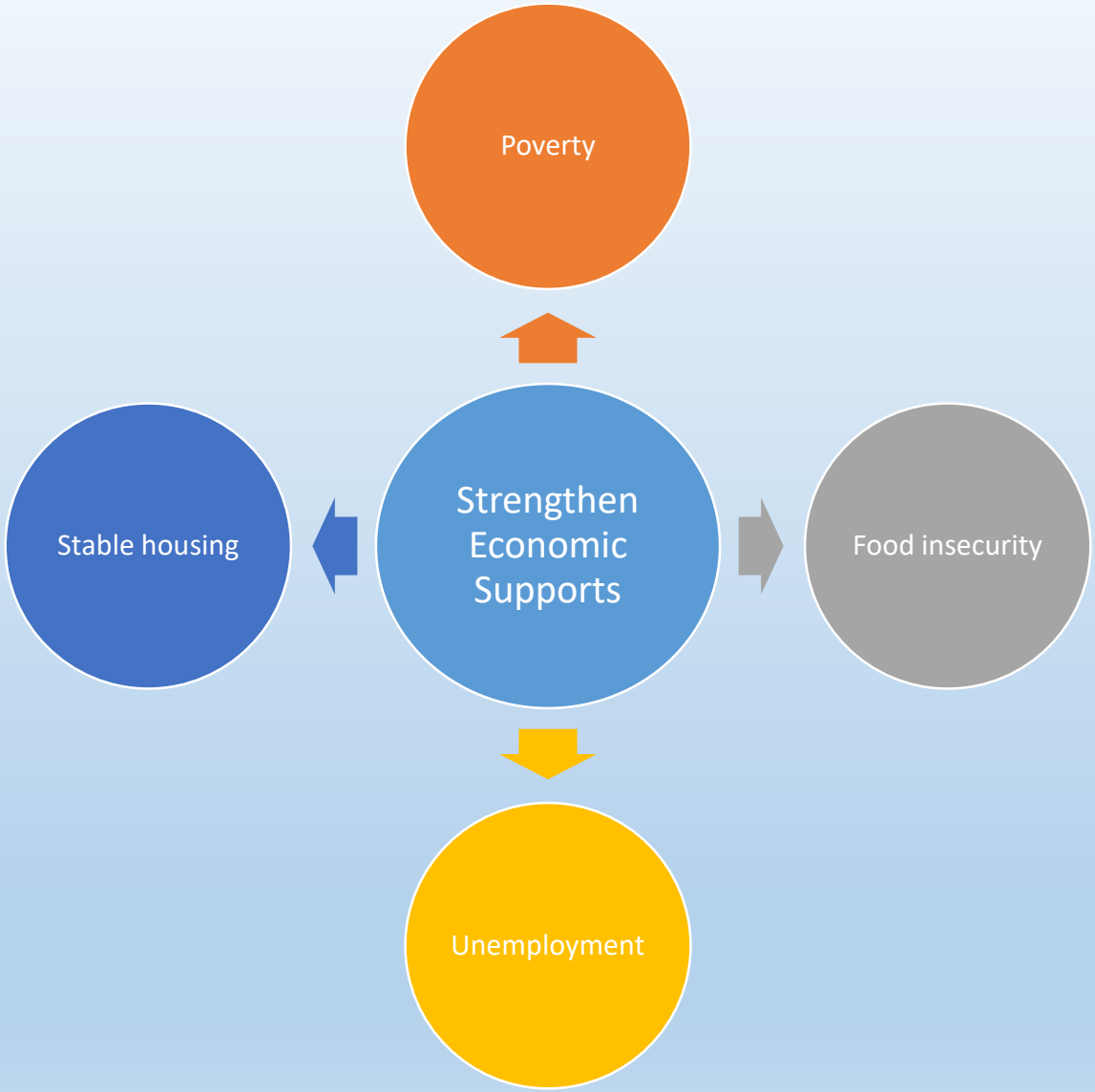
Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

Approach #1:

Not addressed in YSIPP but poverty and unemployment are documented risk factors for youth suicide.

Metrics

- Track Oregon poverty rate
- Track Oregon unemployment rate
- Track Oregon homeless statistics
- Track HSD housing data



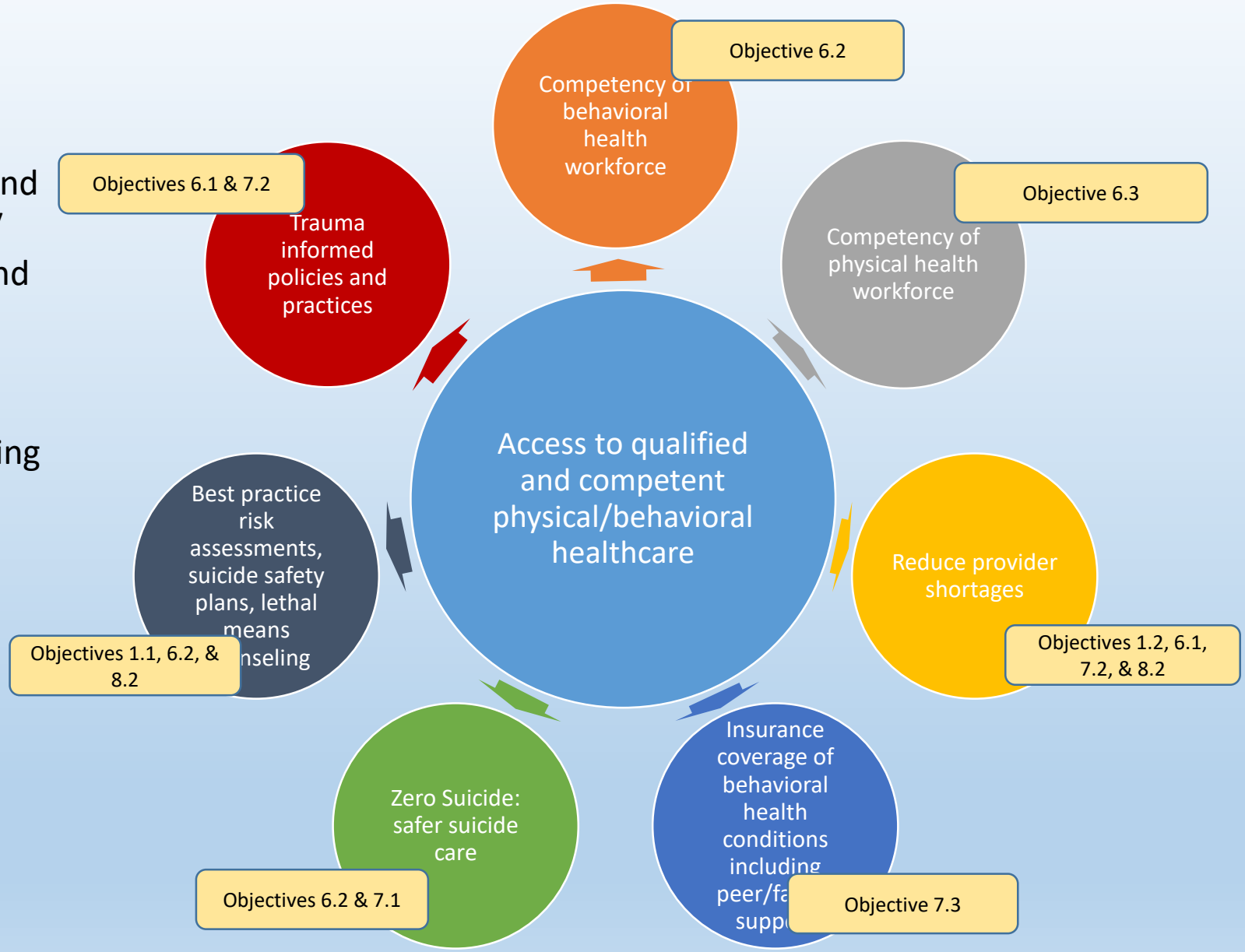
Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

Approach #2:

Strengthen access and delivery of physical/ behavioral health and suicide care

Metrics:

- SB 48 data (starting 2019)
- OHA 309 crisis response rules



Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

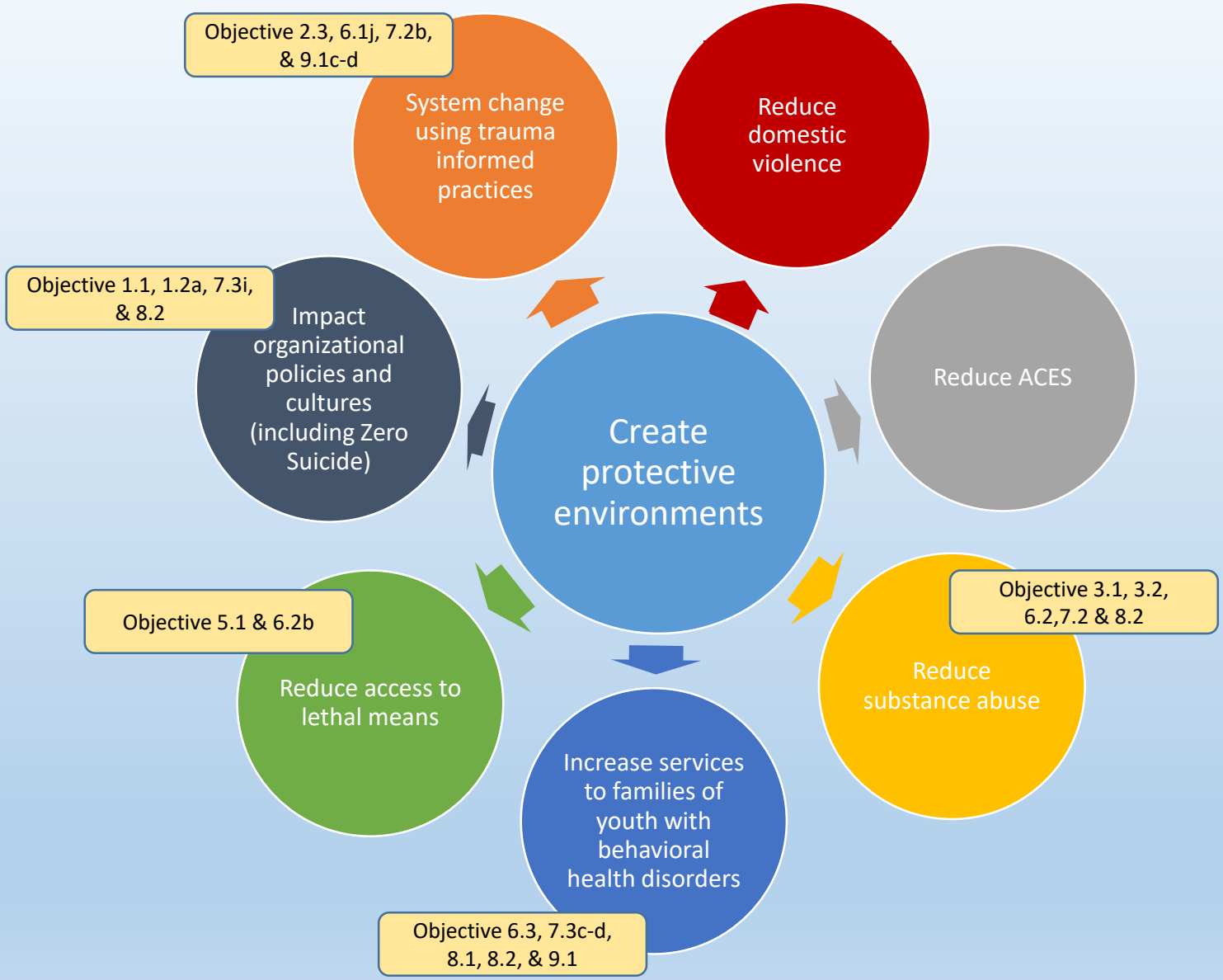
Approach #3:

Create Protective Environments.

Metrics:

-Aces

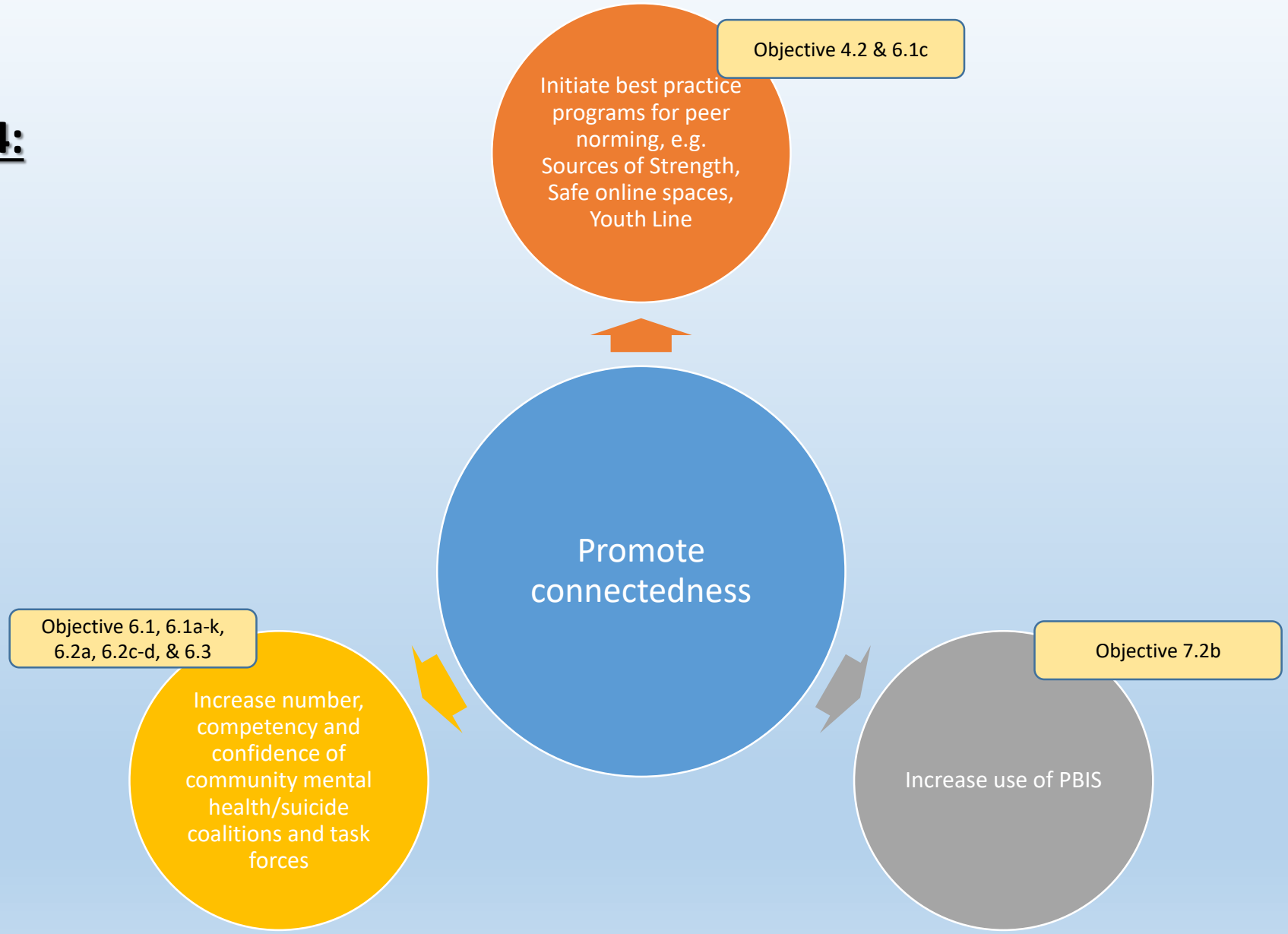
-Foster Home Placements



Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

Approach #4:

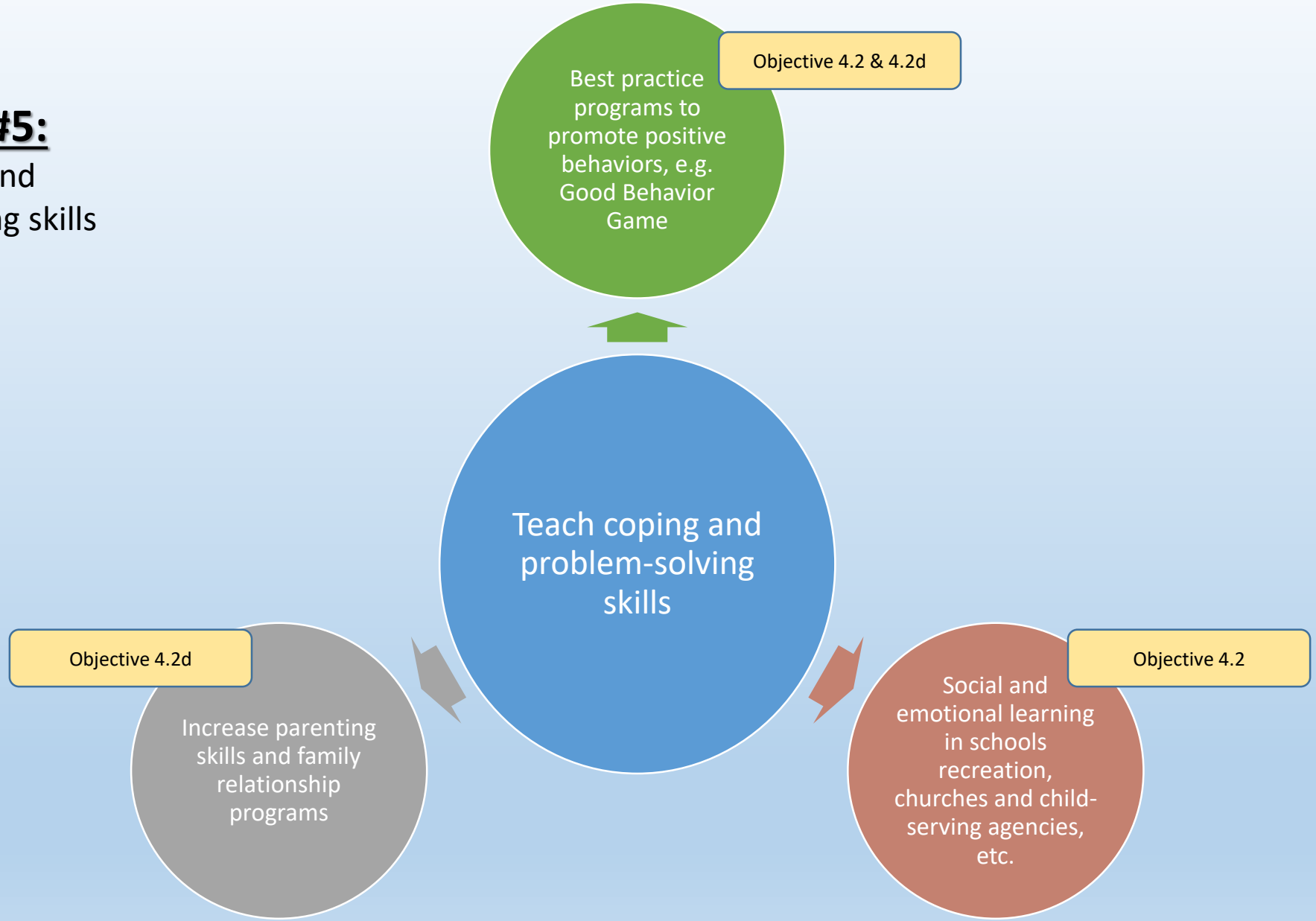
Promote connectedness



Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

Approach #5:

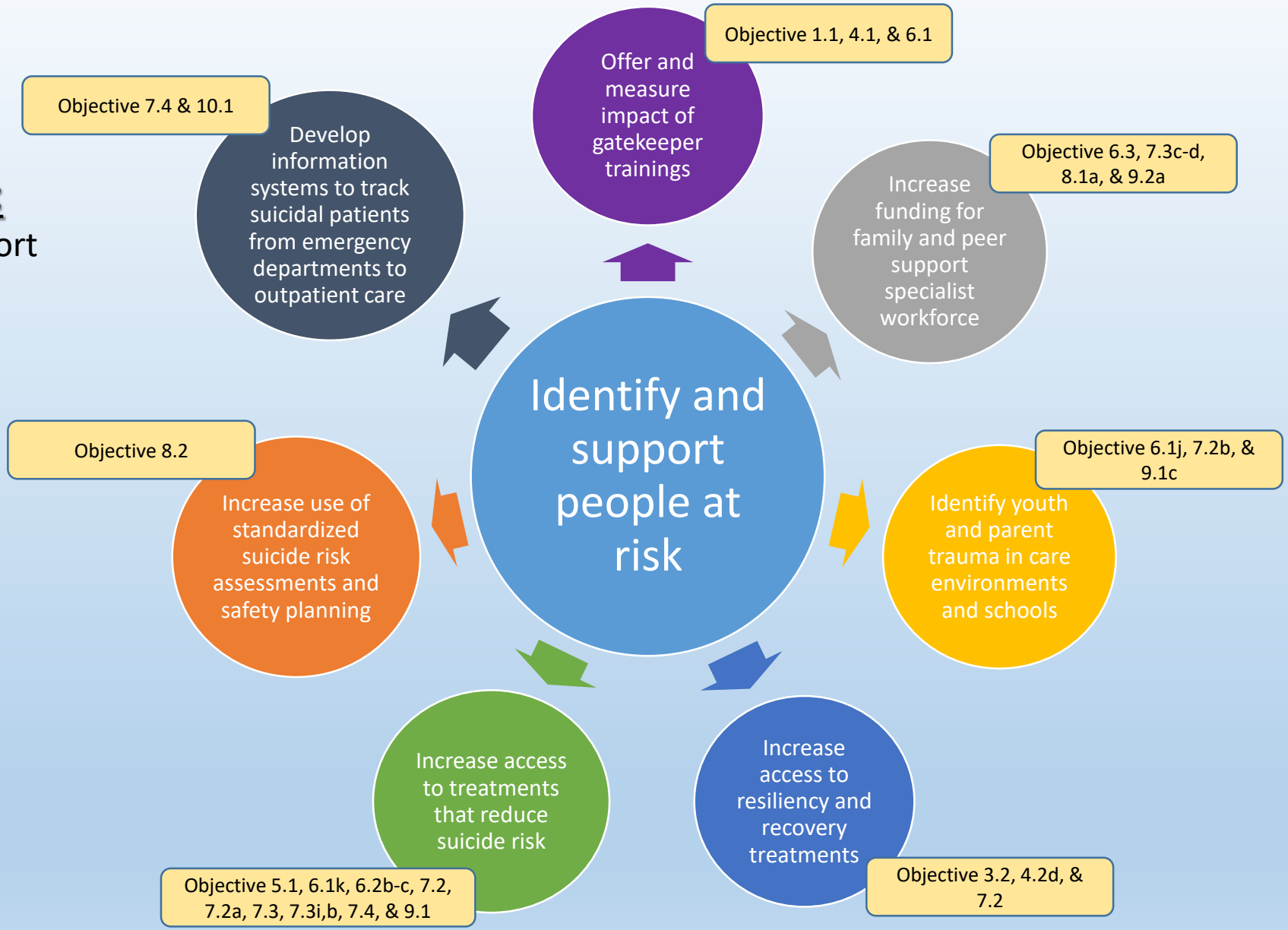
Teach coping and problem-solving skills



Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

Approach #6:

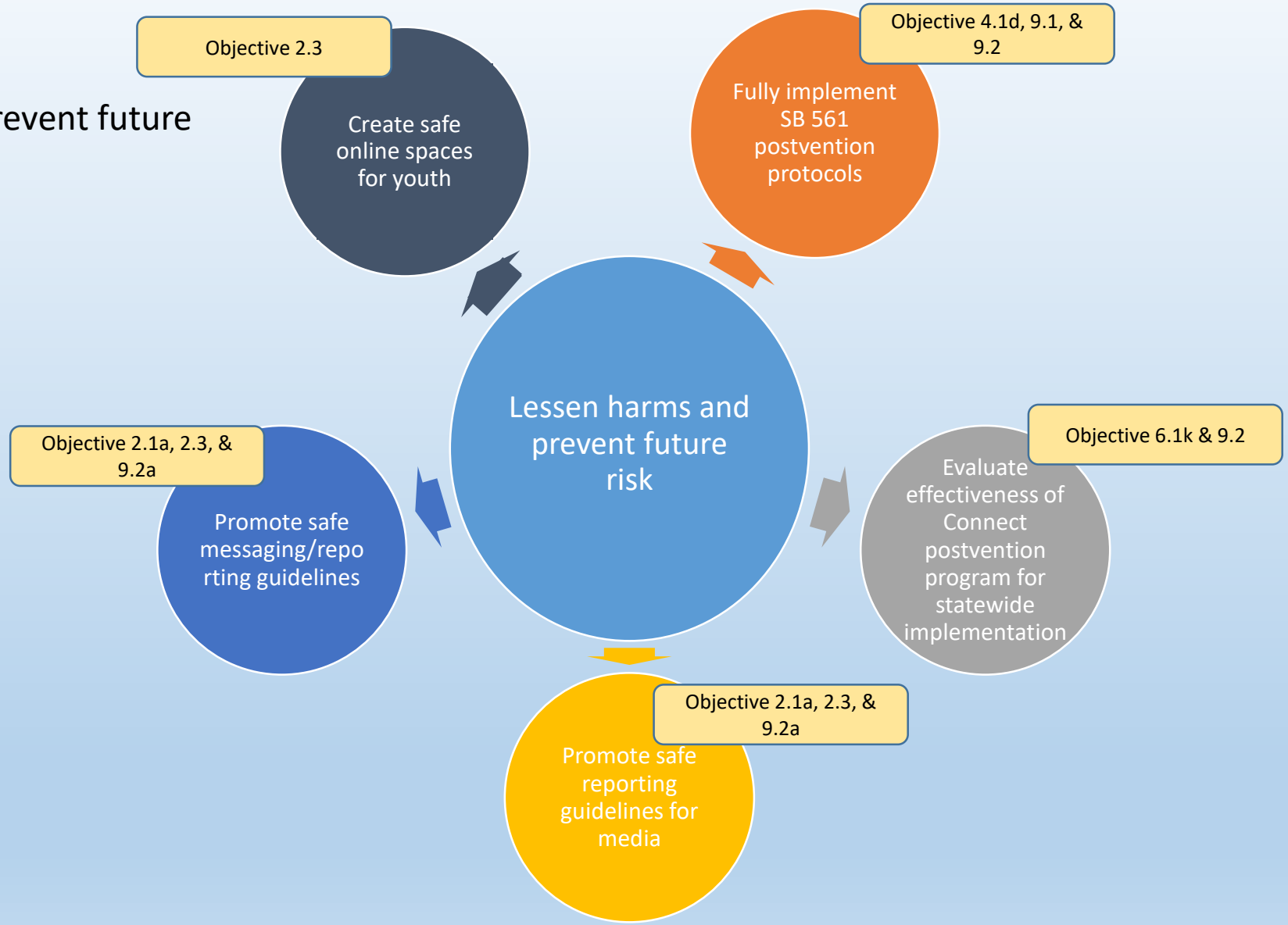
Identify and support people at risk



Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

Approach #7:

Lessen harms and prevent future risk



Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

Developing Comprehensive Suicide Protocols: A Toolkit for Oregon Schools

Liz Thorne, MPH
VP of Policy & Programs
Cairn Guidance

cairn
The path to healthy schools.

Impetus for the Toolkit

There are great resources out there BUT:

- Too long
- Not specific to Oregon
- I want examples/templates from a similar community
- Very limited or no dedicated staff capacity to develop protocols

Aim

Develop a Toolkit that:

- Draws from best practice resources and guidance.
- Is flexible.
- Provides modifiable samples, templates, language communities can take and modify. (No re-creating wheels).
- Highlights the great work happening in Oregon.

What's in the Toolkit?

Table of Contents

One story of success:
Strengthening partnerships between a school district and community mental health providers in Jackson Co.

Questions?

Thank you!

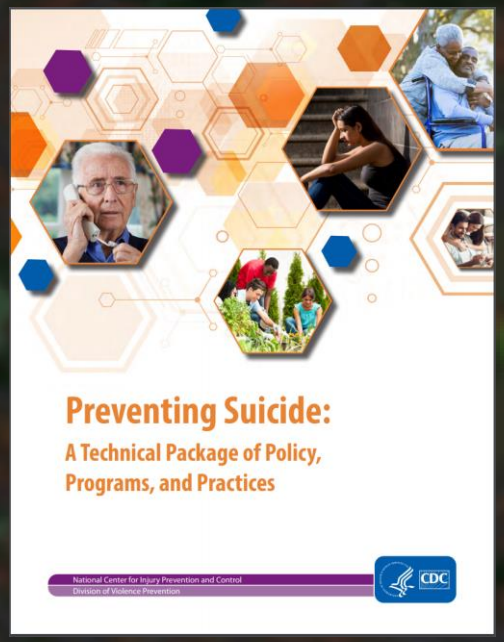
Liz Thorne, MPH
VP of Policy & Programs
Liz@cairnguidance.com
503.593.2840

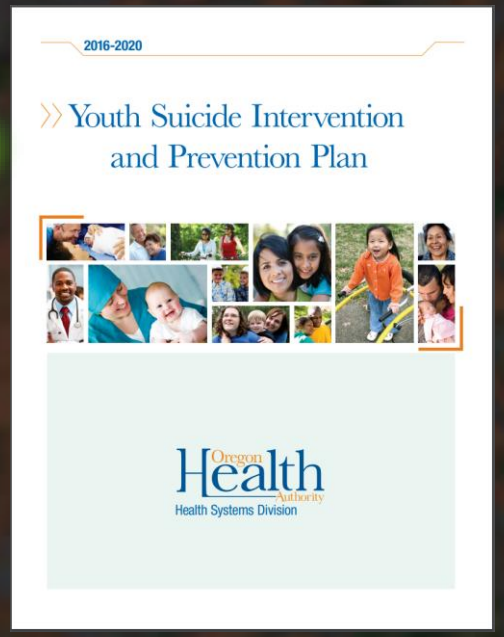
cairn
The path to healthy schools.

CDC Technical Approaches Map
&
Connect Postvention Evaluation

Evaluative Update by John Seeley and Jon Rochelle

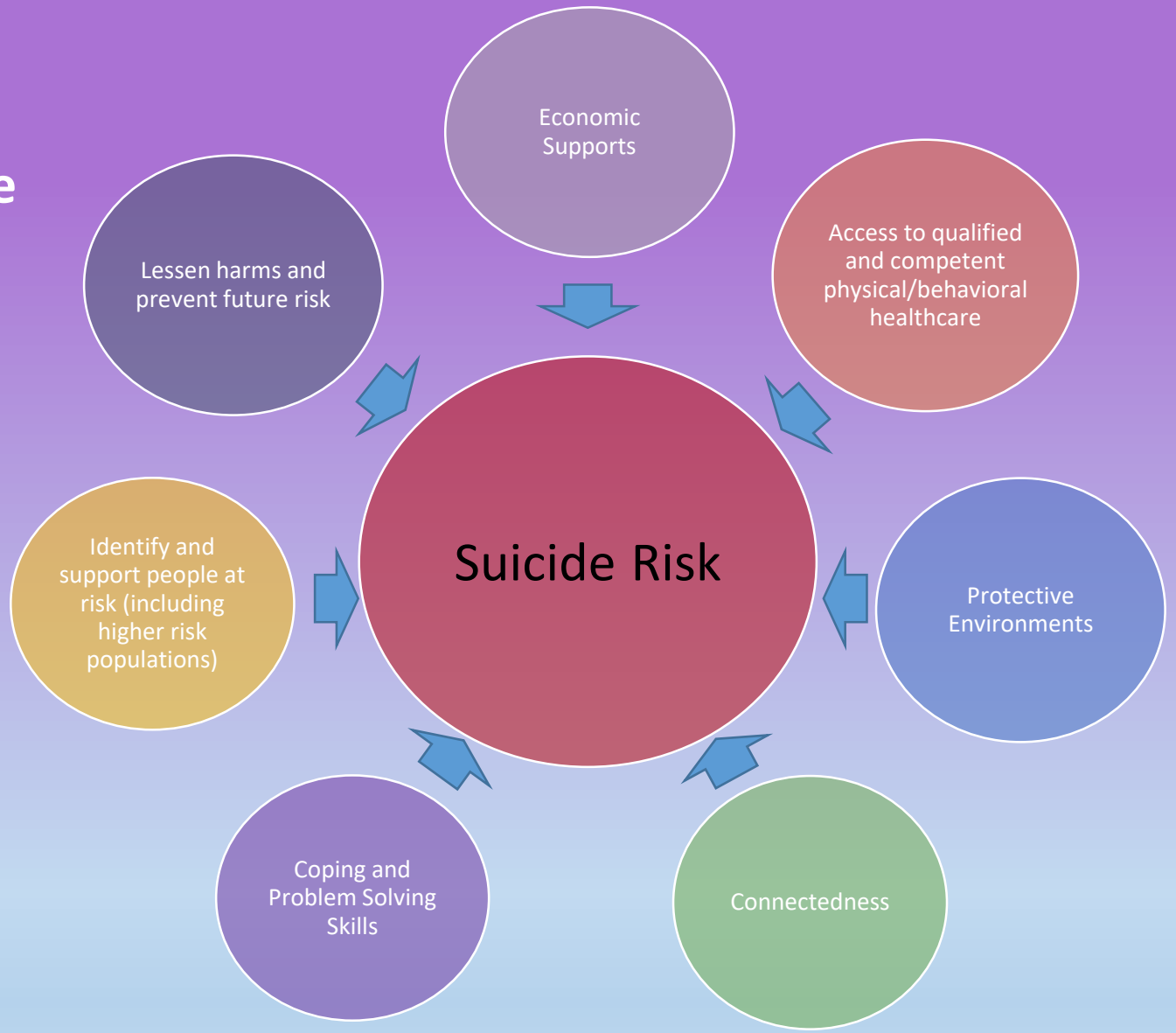
CDC Approaches and YSIPP Objectives





- Utilized the CDC Preventing Suicide Technical Package to link CDC evidence-based approaches and strategies to YSIPP objectives and action items.
- Sought to determine where each plan aligned and whether any concerning gaps existed.

Seven Key CDC Approaches for Attenuating Suicide Risk in Oregon Communities



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Strengthen access and delivery of physical/ behavioral health and suicide care

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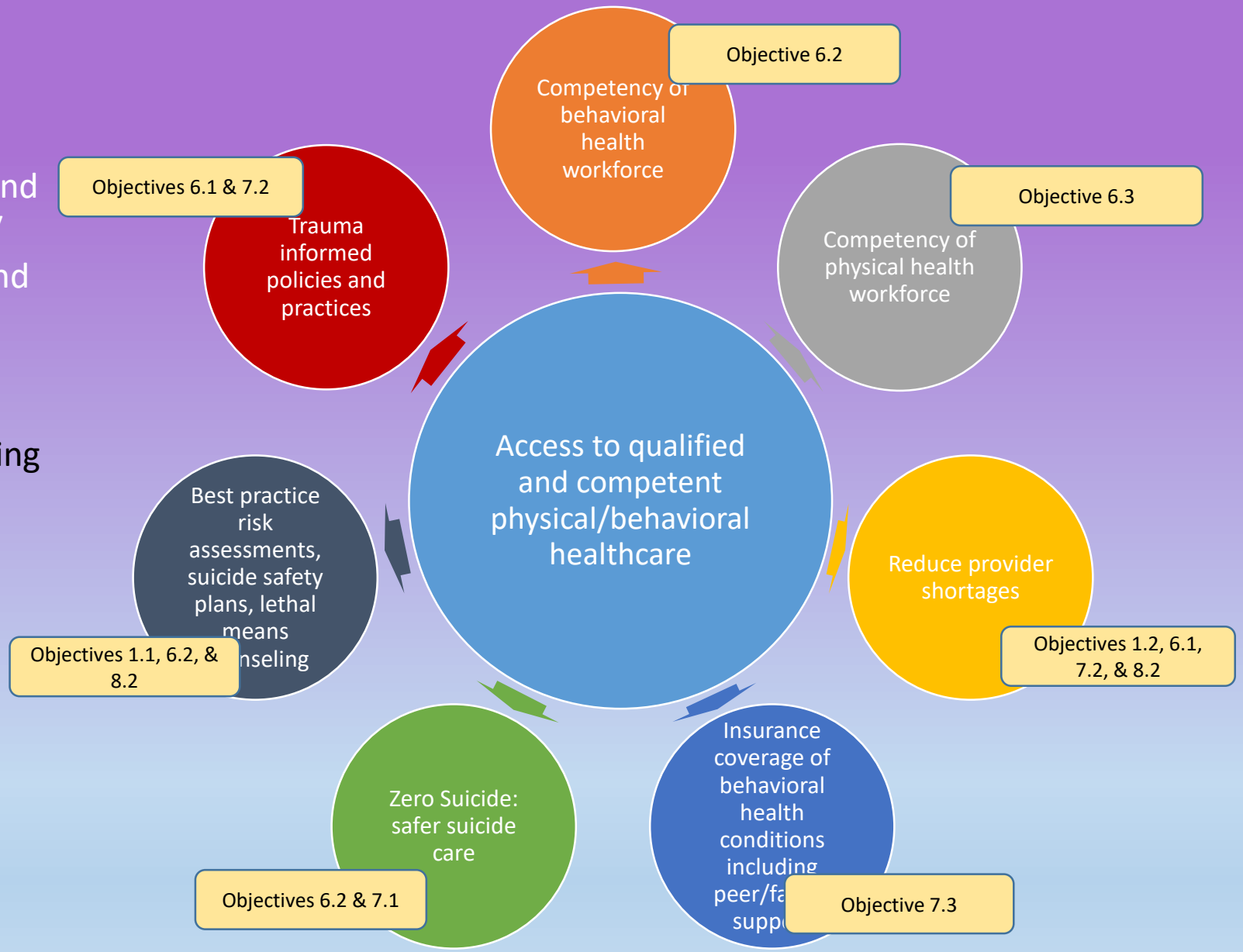


Adapted for Oregon from "Preventing Suicide: A Technical Package of Policy, Programs and Practices, Centers for Disease Control and Prevention, 2017.

YSIPP Data Collection Update

- Datasets currently received:
  - Oregon Healthy Teens
  - Vital Statistics
- Datasets ready to be received:
  - OR-NVDRS (expected in late October)
- Datasets that we have been unable to attain:
  - ESSENCE
  - Integrated Client Services (ICS) Data Warehouse

Connect Postvention Training

- **Postvention** training is a specific type of **gatekeeper** training program aimed at reducing the risk of contagion after a suicide takes place.
  - Coordinated response
  - Safe messaging about suicide
  - Identification of community resources
- **Design**: Community wide intervention that trains educators, emergency medical service providers, law enforcement, mental health providers, military personnel, and social service providers.
- **Structure**: Training takes place over four-days (can be modified for two days)

Pilot Rationale

- Previous research on the Connect program has found promising results.
- Baber and Bean (2009) and Bean and Baber (2011) demonstrated that participants had a significant increase in knowledge pertaining to suicide pre-test to post-test in a single group design.
- Best-Practice by American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC), both of which are under contract with the Substance Abuse Mental Health Services Administration (SAMHSA).
- However, is the program the right fit in Oregon?
  - Conduct an initial pilot summative evaluation at five separate Oregon sites

Evaluation Overview

- **Design**: Single group design with pre-test, post-test, and follow-up measures.
- **Sample**: Currently, n = 98 participants across four sites. (Yamhill data not received yet)
  - **Follow-Up Sample:** n = 33 participants from 2 sites (57% response rate)
- **Sites**: Malheur County, Umatilla County, Linn-Benton-Lincoln Counties, Madras City, (Yamhill County).
- **Measures**
  - Pre-test: Knowledge-based items and attitudes towards suicide
  - Post-test: Pre-test measures with additional satisfaction and postvention inventory items.
  - Follow-up: Pre-test measures with added implementation items.
- **Evaluation objective:** Evaluate the summative impact of the Connect Postvention training to determine whether the program is a viable option for statewide scale up.

Connect Training Participants

- Participation across sites: Malheur (n = 34), Linn-Benton-Lincoln (n = 32), Umatilla (n = 24), and Madras (n = 8).

- Demographics:
  - Collected in the train-the-trainer post survey (in process of obtaining from NAMI)
  - Demographics were not collected in postvention training pre-post survey.
- Suicide experience: 42% of participants had responded to a suicide at one point.

- Prior Connect Training: 14% of participants had attended a Connect Postvention training.

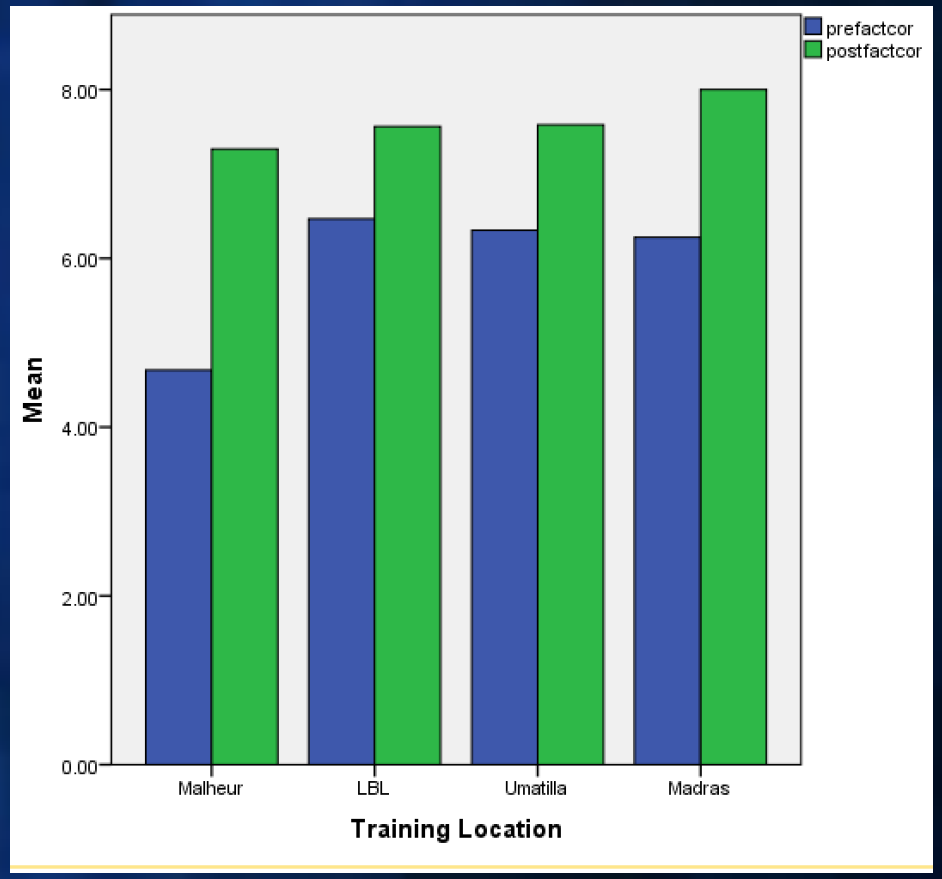
Results: Knowledge Scale Pre-Test to Post

- 8-item knowledge assessment (True/False/Unsure)
- All four sites showed statistically significant growth, both individually and combined.
- Cumulative across site growth was large in effect ($d = 0.97$, $p < .001$)
- Malheur's pre-test scores were significantly lower than the other three sites; however, this difference was no longer detectable upon post-test.

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	prefactcor	5.7959	98	1.75252	.17703
	postfactcor	7.5102	98	1.05757	.10683

Pre-Test to Post-Test Growth Across Sites



Results: Follow-Up (Malheur & Umatilla)

- Sample differences? Follow-up survey responders (n = 33) vs non-responders had no statistically significant differences on Pre- or Post-Test.
- Repeated measures ANOVA was used to determine that participants had maintained gains upon Follow-Up.

Pairwise Comparisons

Measure: Knowledge

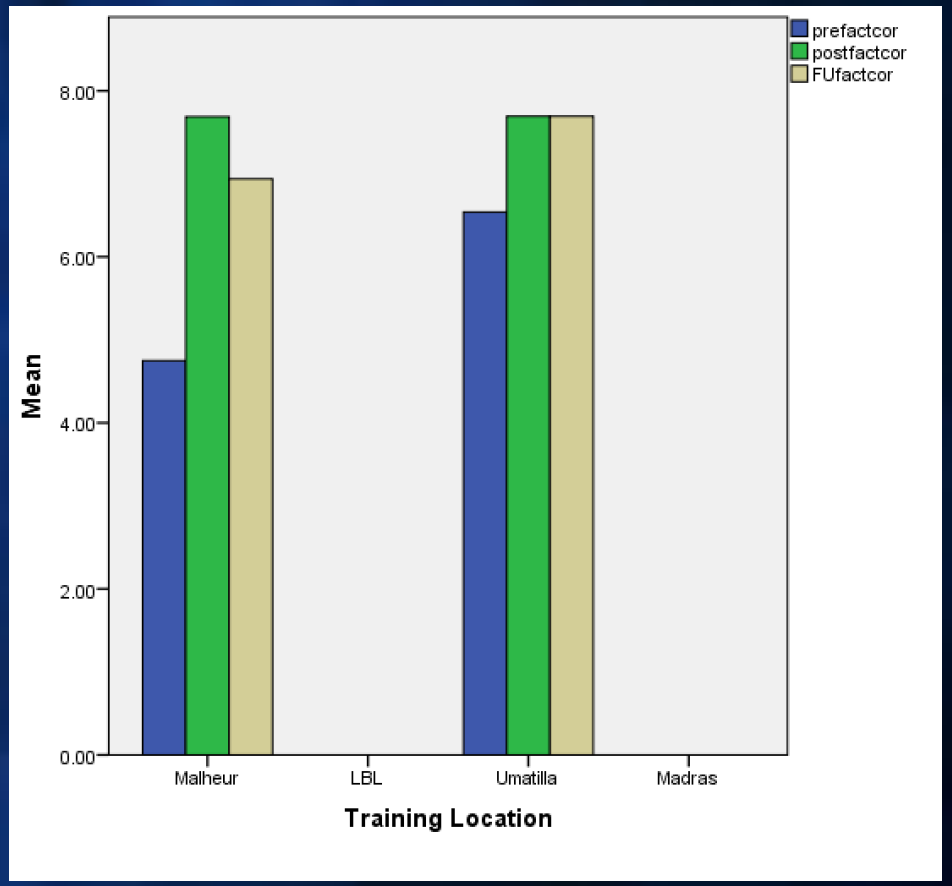
(I) Time	(J) Time	Mean Difference (I-J)	Std. Error	Sig.[b]	95% Confidence Interval for Difference[b]	
					Lower Bound	Upper Bound
1	2	-2.046*	.280	.000	-2.620	-1.472
	3	-1.671*	.356	.000	-2.401	-.940
2	1	2.046*	.280	.000	1.472	2.620
	3	.375	.193	.063	-.022	.772
3	1	1.671*	.356	.000	.940	2.401
	2	-.375	.193	.063	-.772	.022

Based on estimated marginal means

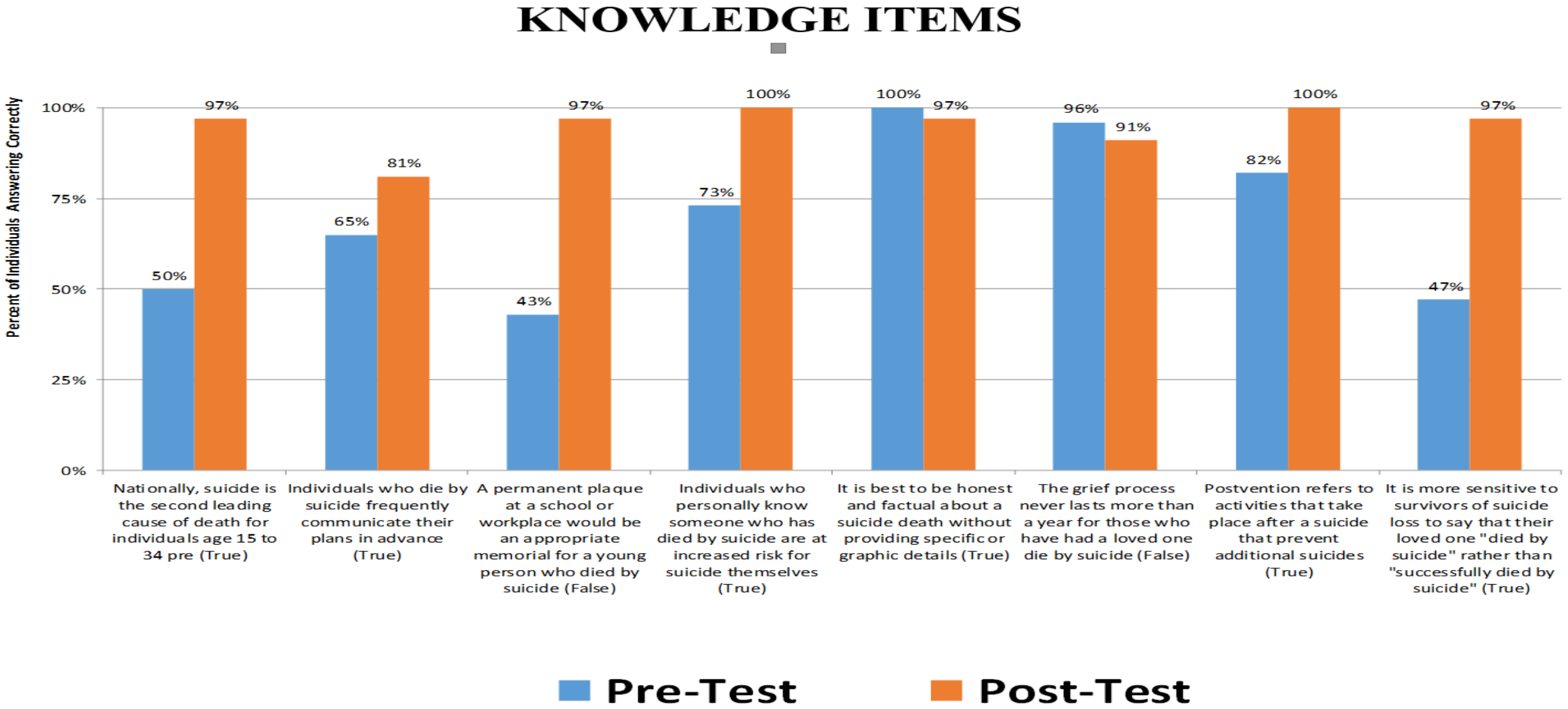
*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Knowledge Follow-Up



Individual Knowledge Questions (Malheur)



Results: Attitudes – Self-Efficacy

- Self-efficacy in response to suicide increased significantly (d = 1.34, p < .001) across all four sites pre- to post-test.

- At follow-up, Malheur and Umatilla responders still maintained statistically significant gains from Pre-Test.

Pairwise Comparisons

Measure: SelfEff

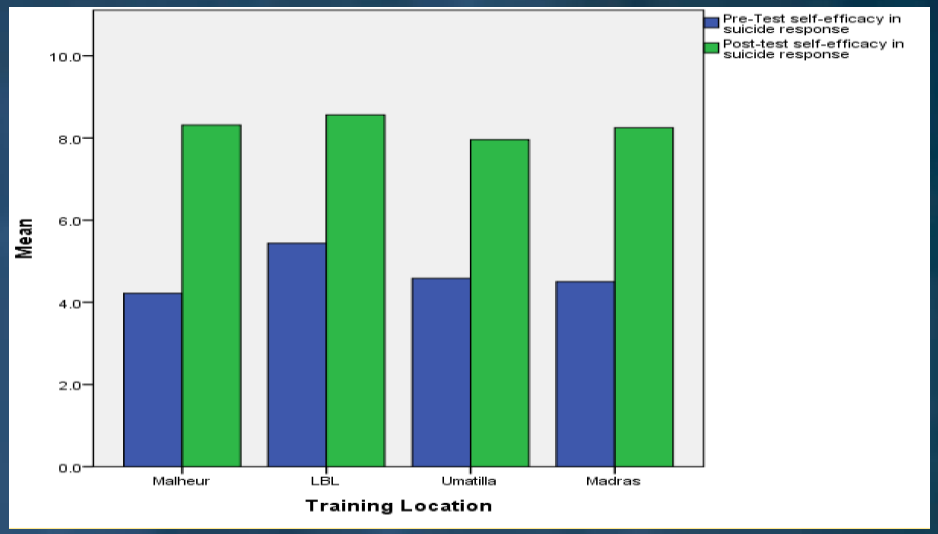
(I) Time	(J) Time	Mean Difference (I-J)	Std. Error	Sig.[b]	95% Confidence Interval for Difference[b]	
					Lower Bound	Upper Bound
1	2	-3.600*	.471	.000	-4.567	-2.633
	3	-3.059*	.440	.000	-3.963	-2.155
2	1	3.600*	.471	.000	2.633	4.567
	3	.541	.304	.087	-.083	1.165
3	1	3.059*	.440	.000	2.155	3.963
	2	-.541	.304	.087	-1.165	.083

Based on estimated marginal means

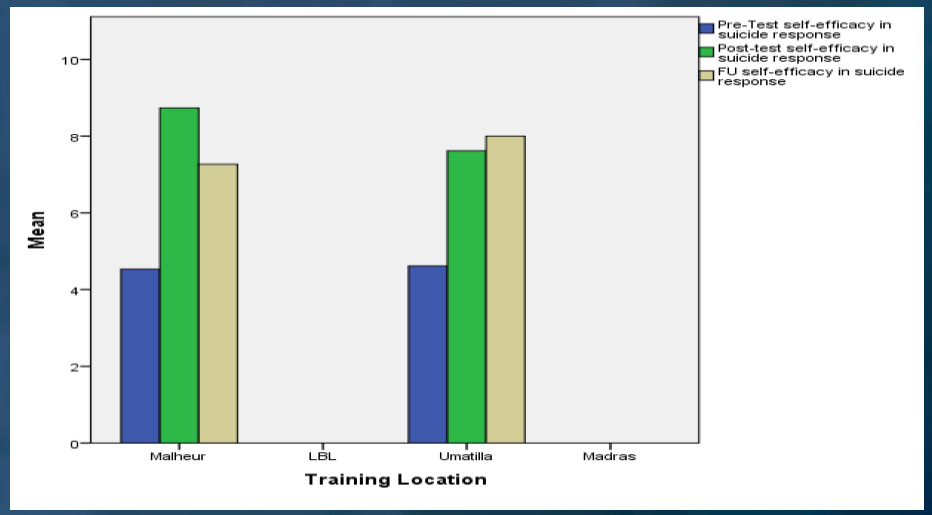
*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Least Significant Difference (equivalent to no adjustments).

Pre- to Post-



Follow-Up



Results: Postvention Inventory

Post-Training: Inventory of planned future activities by all participants **Follow-Up: Inventory of activities actually completed by follow-up responders**	Post-Training	Follow-Up
Formally publicize information about suicide prevention and mental health resources	43%	66%
Have informal conversations about suicide and suicide prevention/postvention with others	86%	93%
Identify individuals who might be at risk for suicide	66%	59%
Provide direct services to individuals at risk for suicide and/or their families	52%	35%
Train other staff members	51%	17%
Make referrals to mental health services for at risk individuals	70%	55%
Work with at-risk populations	62%	59%
Other	13%	7%
I have not used what I learned	0%	0%

Results: Training Satisfaction

- Satisfaction was measured on a 4-point Likert scale (1 = Strongly Disagree to 4 = Strongly Agree)
- Participants were most satisfied with the trainers' knowledge of the postvention topics.
- The overall satisfaction score for the training was 3.82.
- No significant site-to-site differences.

Across-Site Training Satisfaction

	N	Mean	SD
The trainers' knowledge of the training topics?	98	3.94	0.32
The trainers' presentation of the training topics?	98	3.85	0.39
The building where the training was held?	98	3.63	0.58
The location of the training?	98	3.57	0.59
Your overall training experience?	98	3.82	0.42

Results: Follow-Up Questions

- Prior gatekeeper training consisted mainly of ASSIST and QPR.
- No participants indicated that they had ever attended a Connect training.
- A high number (n = 15) of participants indicated that they did not create a postvention plan after the training.
- No significant site-to-site differences.

Prior Experience

	N	Yes	No	Unsure
Attended prior gatekeeper training	28	13	14	1
Already had postvention plan at organization	29	6	17	6

Postvention Planning

	N	Yes	No	Kept Prior Plan
Created a postvention plan after training	27	10	15	2

Results: Follow-Up Community Level Questions

- Scores were calculated on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree)
- Responses to community preparedness and knowledge both bordered the neutral category (3.38, 3.17) with relatively high variance (1.15, 1.20).
- Participants strongly agreed that the Connect training would be useful to communities statewide.

Community Preparedness

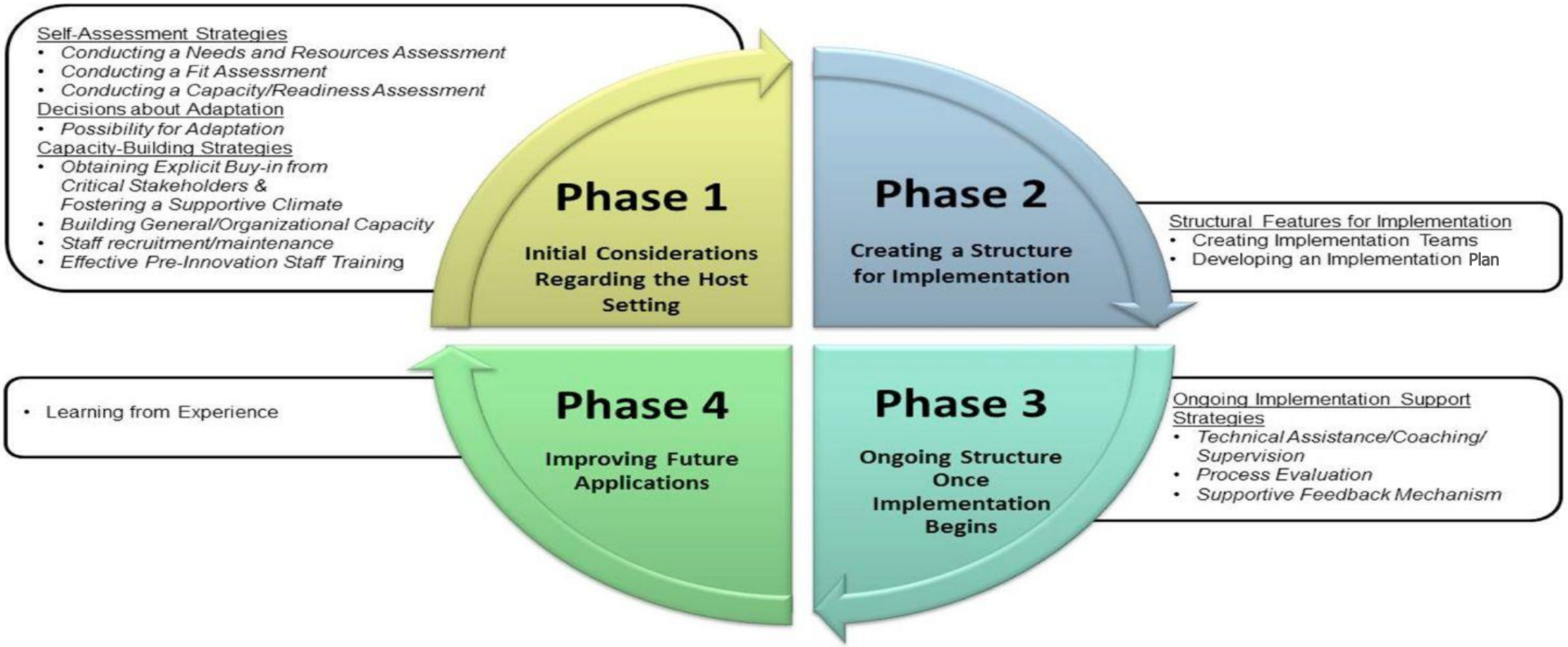
	N	Mean	SD
My community is prepared in the occurrence of an adolescent suicide.	29	3.38	1.15
Members of my community are informed on the issue of adolescent suicide	29	3.17	1.20
It would be useful to provide Connect training to other communities statewide.	29	4.83	0.60

Conclusions and Recommendations

- Connect training was effective in increasing suicide general knowledge and self-efficacy in suicide response.
- Participants were highly satisfied with the overall training and recommend that the training be scaled up to all counties in Oregon.

- The process of targeting and inviting key stakeholders to the Connect training should be prioritized.
  - Followed up with retrospective network analysis.
- An implementation science framework should be utilized to ensure postvention planning follow through (next slide).

Quality Implementation Framework

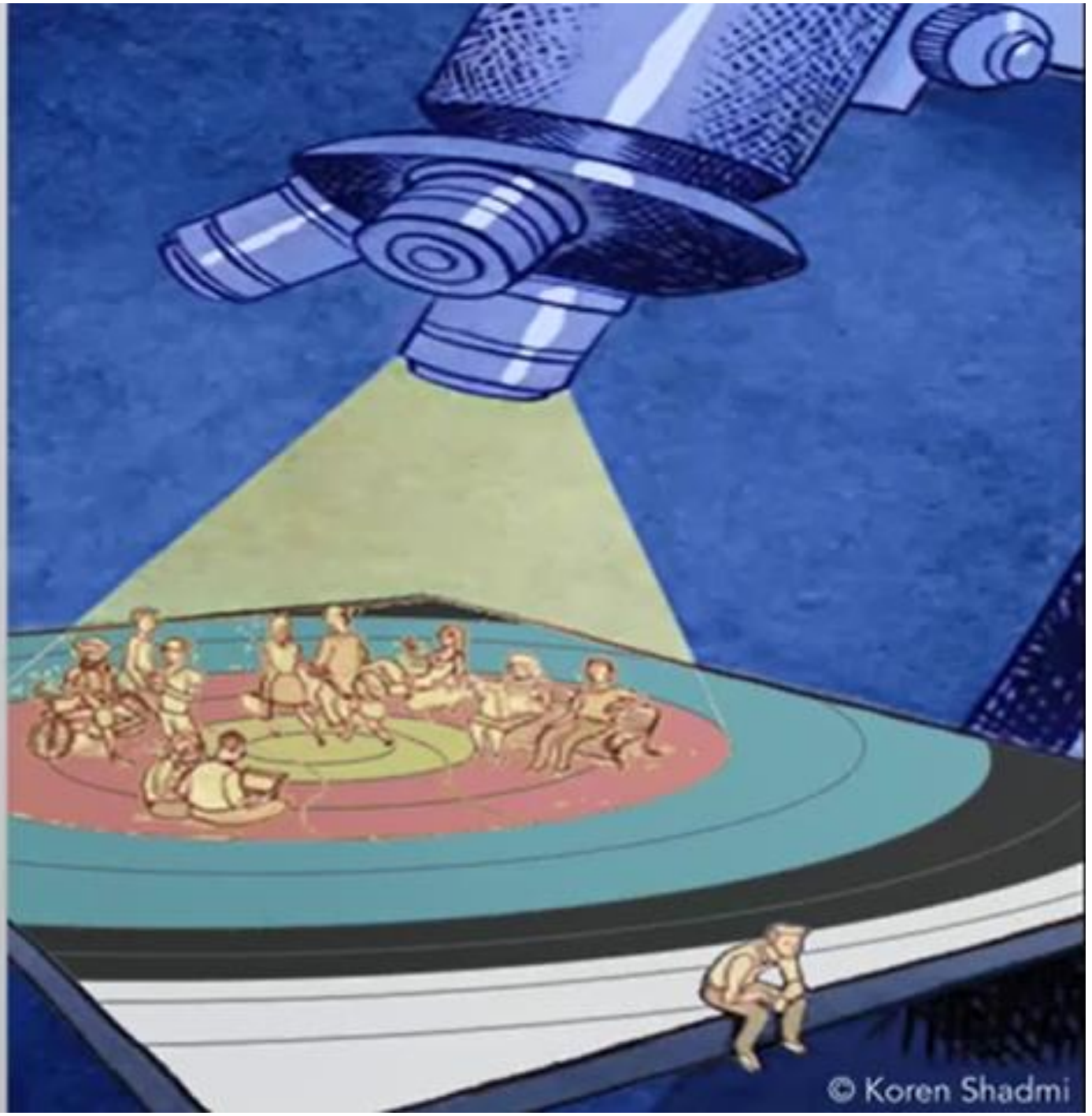


(Meyers, Durlak & Wandersman, 2012)

Zero Suicide and CALM

Meghan Crane, MPH
Zero Suicide Program Coordinator
Injury and Violence Prevention Section
Public Health Division
Oregon Health Authority
Suicide Prevention Alliance
October 5, 2017

Forbes Magazine 2010, "The Forgotten Patient" – Those at risk of suicide are pressed to the periphery of healthcare.




Thripp Photography


in suicide."
"Why no mention of firearms?"
"I have attempted suicide seriously once in my life."
"I never know what to say."
"Many can be prevented, some can't."
"If people are serious about it, they will complete it, no matter what is done for them."
"ALL health care providers should have training in suicide prevention."
"Love the Columbia scale"
"We need more education on this issue. No one wants to talk about it!"
"I don't know how to handle this topic, honestly."
"I think suicide is in our communities, but I do NOT think we should be spending tax dollars to do ANYTHING about it."
"My sister killed herself just yesterday"
"I think about suicide everyday."
"This survey is somewhat naive."
"The termi

It is time for healthcare leaders to aim for the bullseye on the challenge of suicide safer care.

"This really is an innovative approach, but I'm afraid we can't consider it. It's never been done before."

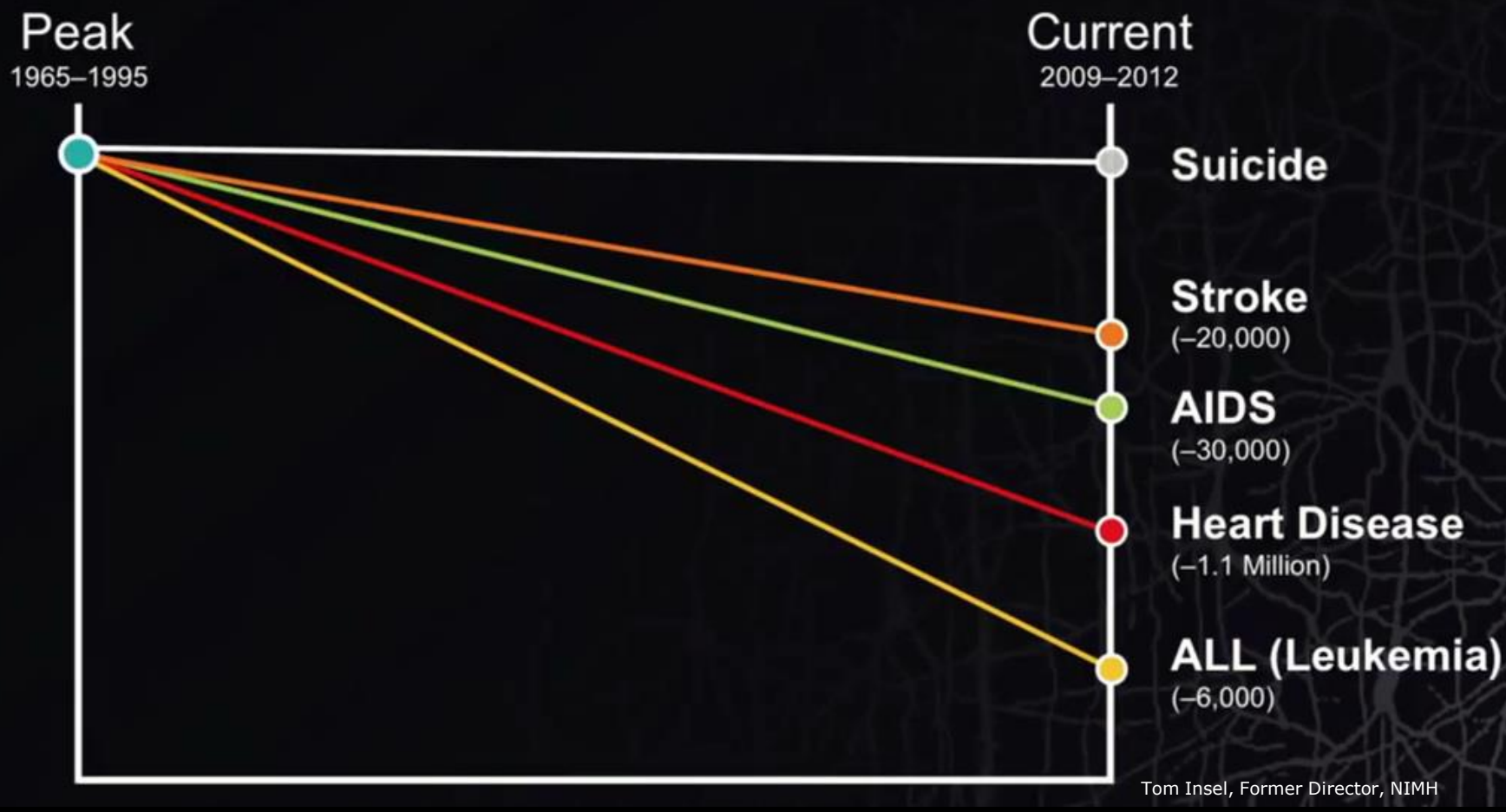
GETTING TO ZERO
SAN FRANCISCO

TARGET ZERO
Traffic Deaths
A goal we can all live with

ZERO
THE END OF PROSTATE CANCER

BELIEVE IN ZERO
22,000 CHILDREN DIE EVERY DAY FROM PREVENTABLE CAUSES. WE BELIEVE THAT NUMBER SHOULD BE ZERO.
unicef
united states fund

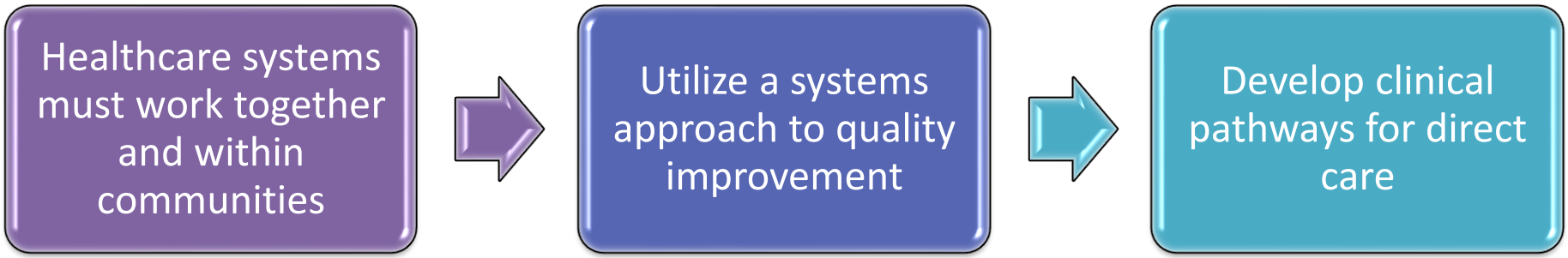
MORTALITY FROM MEDICAL CAUSES



Tom Insel, Former Director, NIMH


I've seen some weird stuff

Many, many more suicides can be prevented, but it will require….



Oregon Health Authority

2012 National Strategy for Suicide Prevention:

GOALS AND OBJECTIVES FOR ACTION

A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention

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

GOAL 9: Promote and implement effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors.

James Reason's "Swiss Cheese Model" of accidents

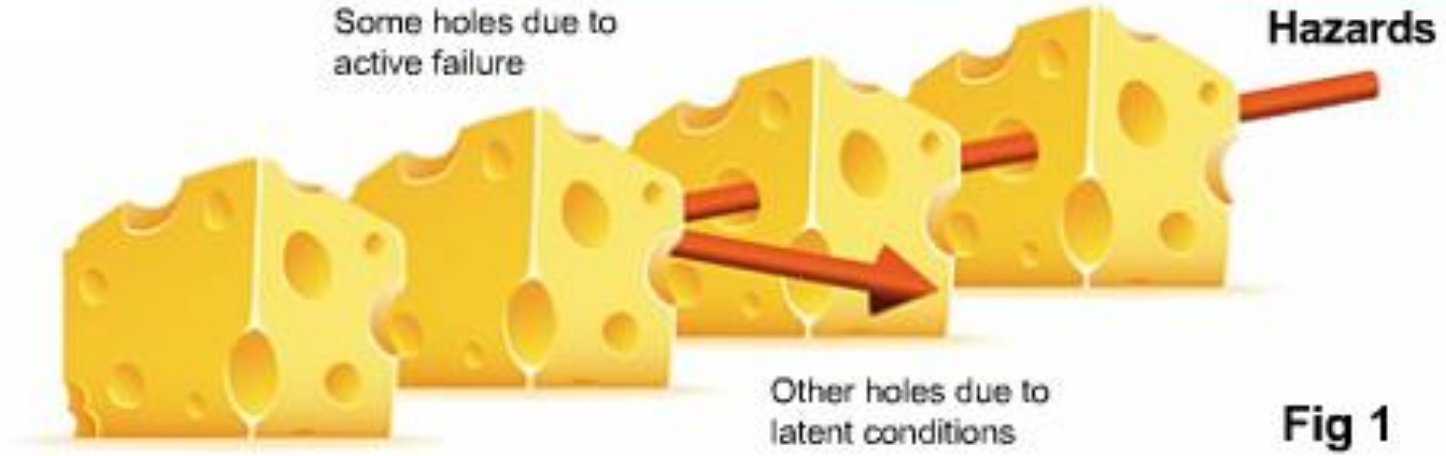


Fig 1

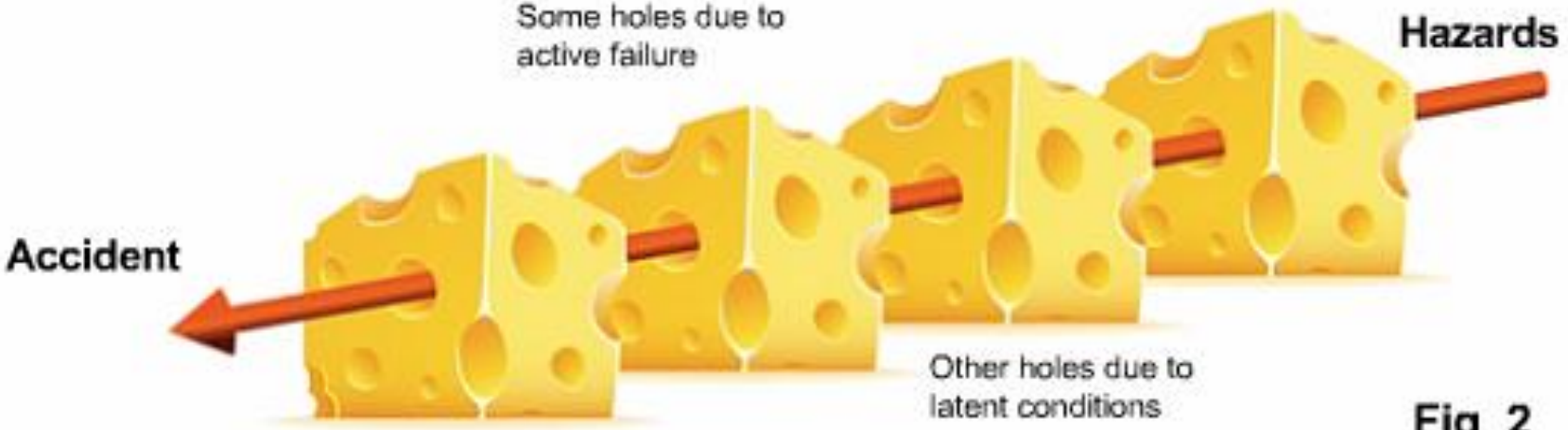
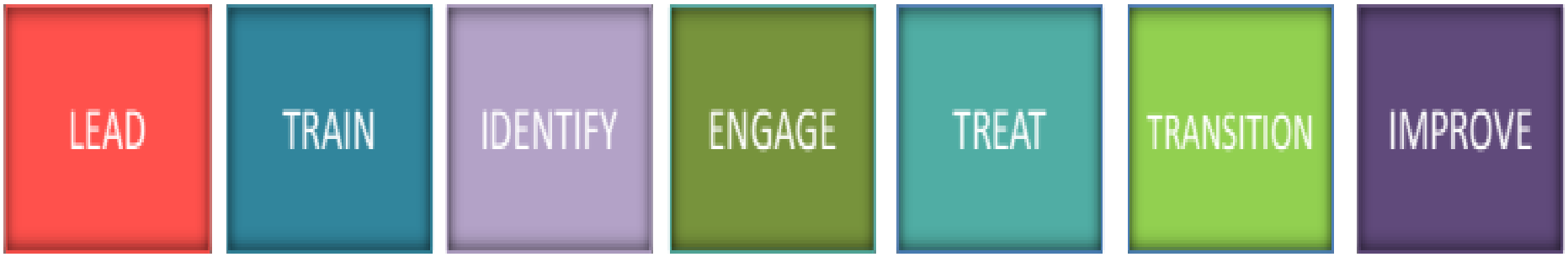


Fig 2

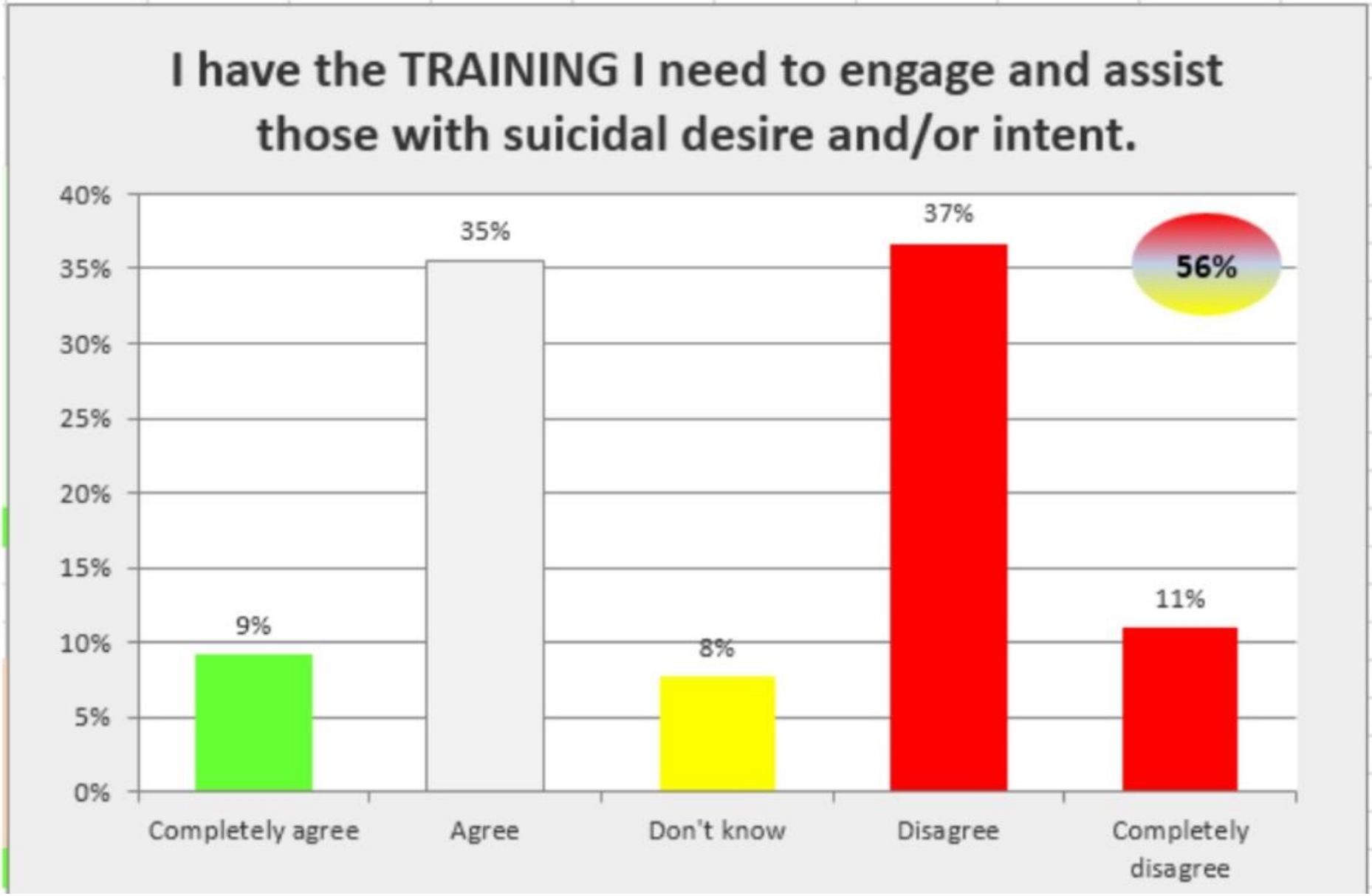
Systematic Suicide Care Plugs the Holes in Health Care

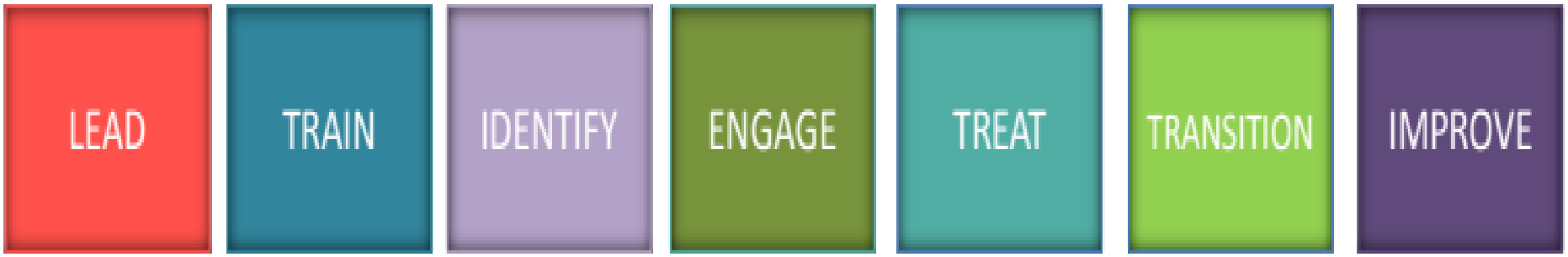
- Systematic Suicide Care



Oregon Health Authority

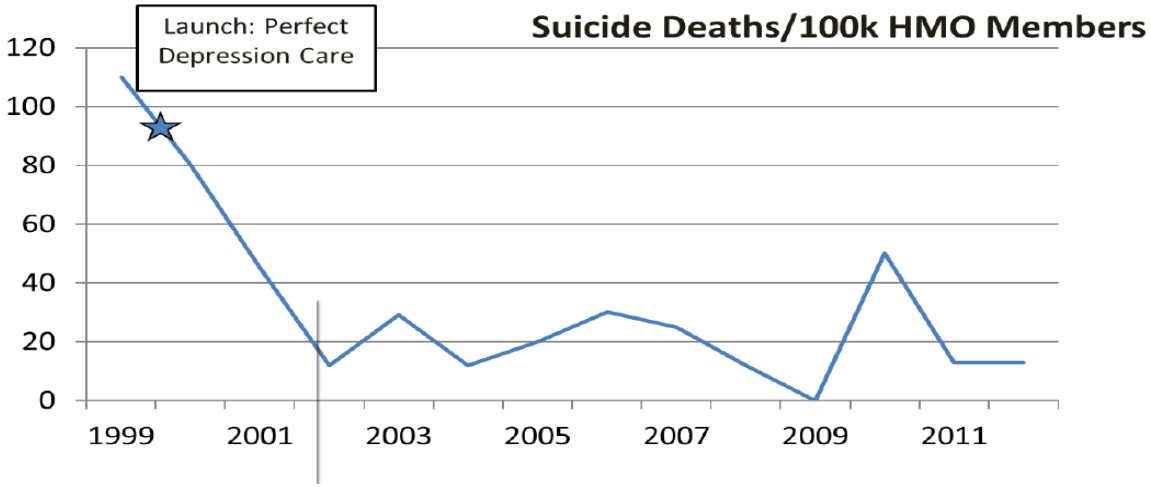
Question 13. TRAINING (Behavioral Health)



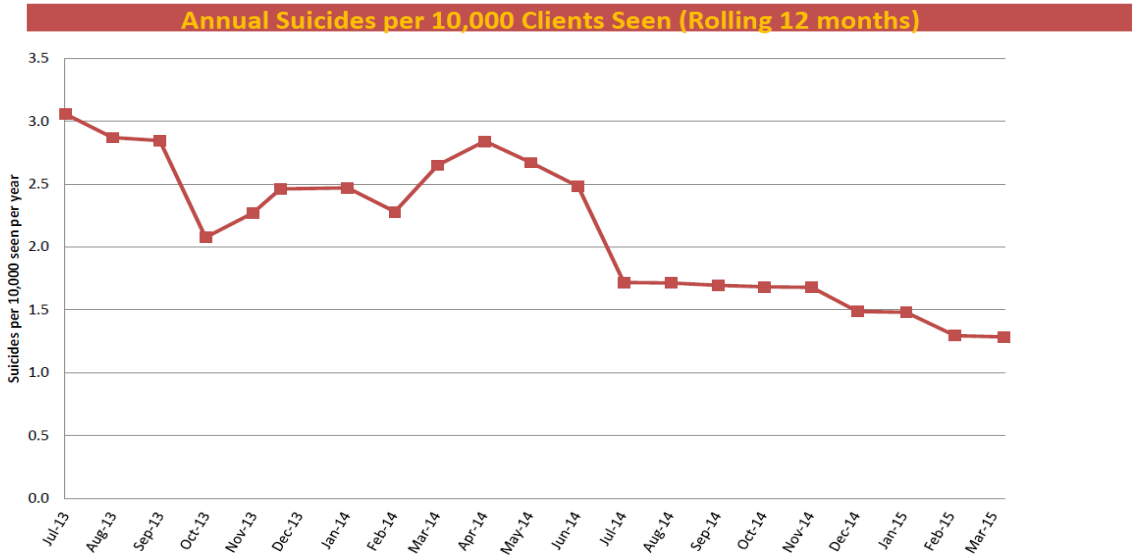


Oregon Health Authority

A System-Wide Approach for Health Care: Henry Ford Health System



Zero Suicide at Centerstone: Results



Zero Suicide Academy

2018

Oregon Health Authority

Counseling on Access to Lethal Means

Objectives:

- Increase knowledge about the association between access to lethal means and suicide, and the role of means reduction in preventing suicide.
- Increase skills and confidence to work with clients and their families to assess and reduce their access to lethal means

Putting time and distance between a person thinking about suicide and lethal means CAN save a life.

Counseling on Access to Lethal Means

- Fills a niche need to talk specifically about means reduction, focused on firearms

- What CALM is and isn't
  - Specific, effective PART of Suicide Prevention
  - Not suicide risk assessment
  - Can be effective in our personal lives as well
  - Not THE answer but should be included

Oregon Health Authority

Counseling on Access to Lethal Means

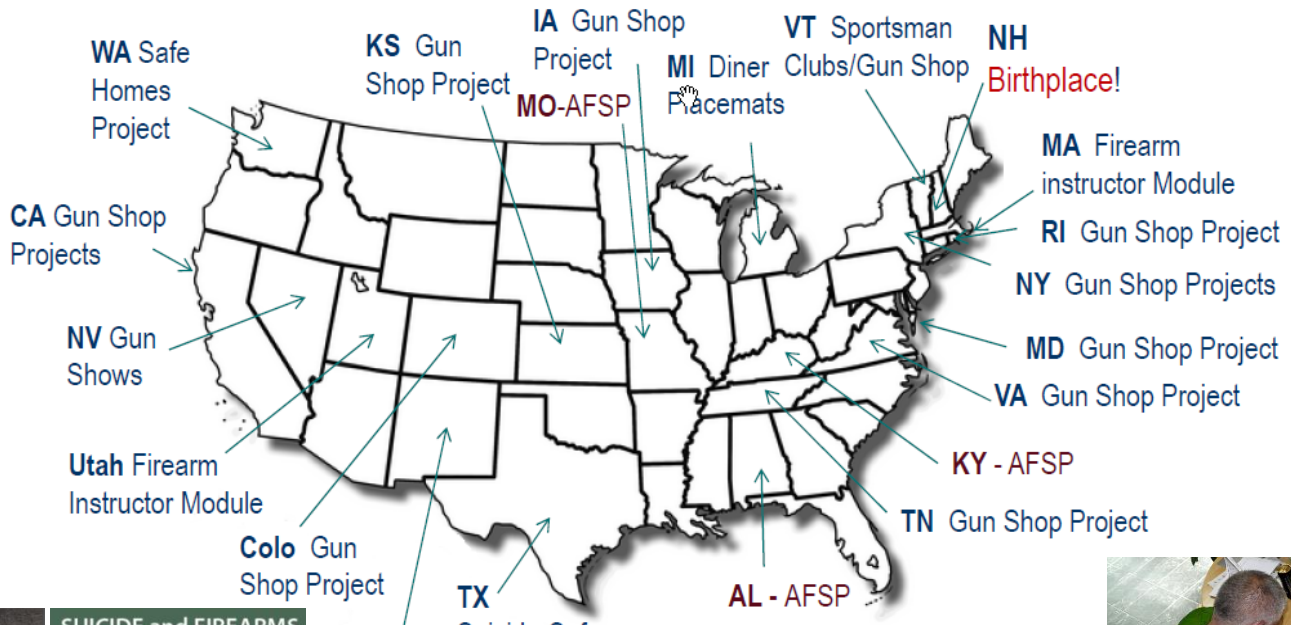
Training includes:

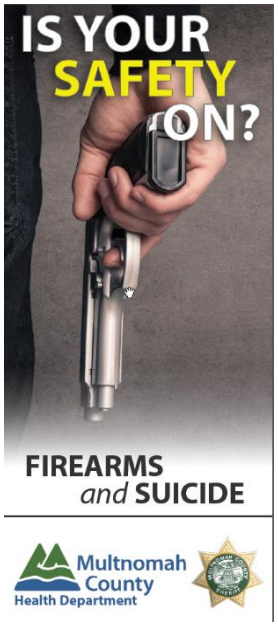
- The problem: suicide and access to lethal means
- Negotiation of means reduction (video presentation)
- Conducting a family firearms assessment
- Role plays (in-person training)

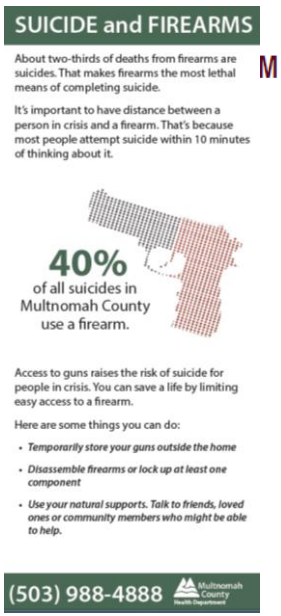
Access training through the SPRC website:
http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

Oregon Health Authority

Partnerships with Gun Owner Groups



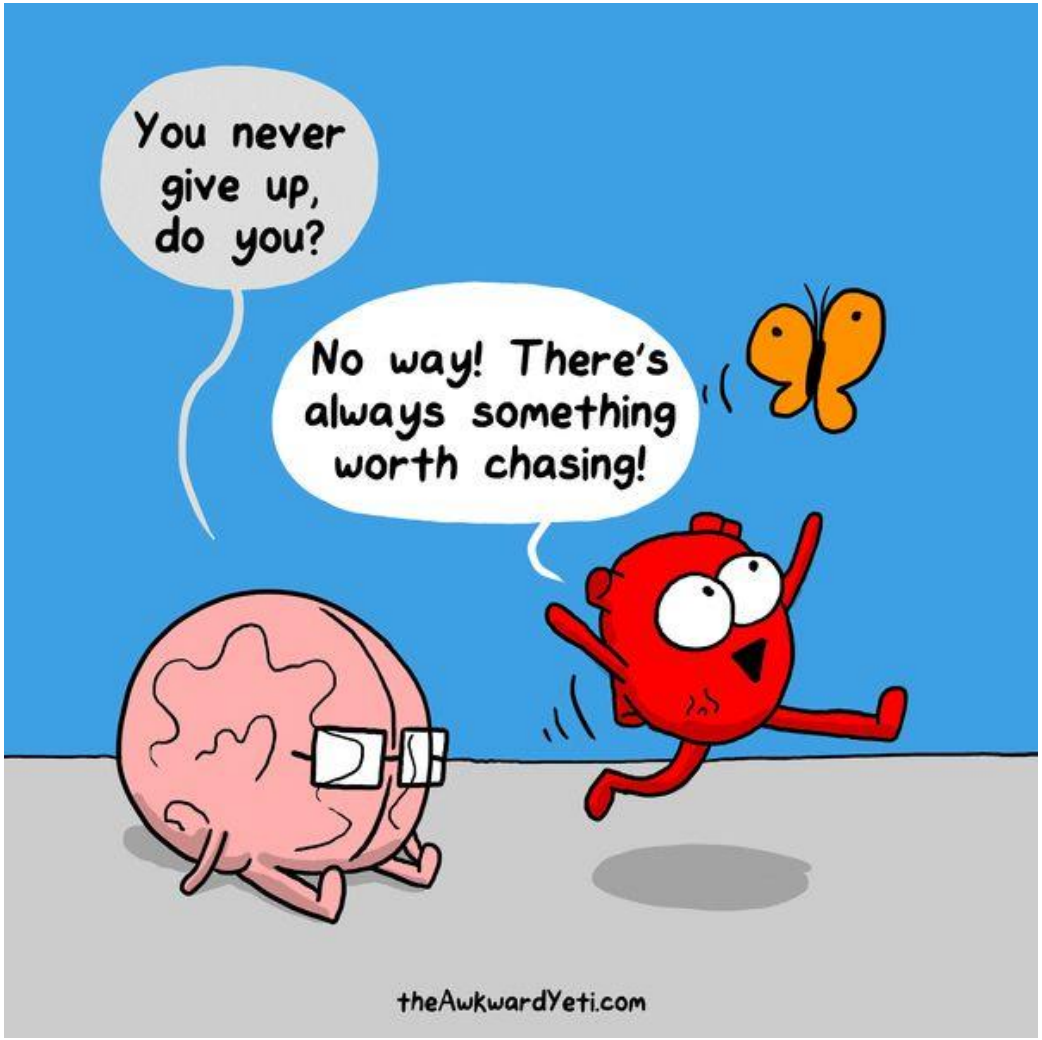




FIREARMS AND SUICIDE PREVENTION

AMERICAN FOUNDATION FOR Suicide Prevention

National SHOOTING SPORTS Foundation



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Oregon Health Authority

Suicide Prevention Alliance

Continuity of Care Workgroup

Action Plan Updates

10-5-2017

Members of the Workgroup:

Mitch Kruska

Julie Magers, Co-Chair

Amy Baker, Co-Chair

Gary McConahay

Galli Murray

Jerry Gabay

Kristi Nix

Tanya Pritt

Martin Rafferty

Julie Scholz

Stephanie Willard

Supported by Ann Kirkwood and Cherryl Ramirez

1. **Suggest EBPs (to ODE/ESDs/school districts) for mental health awareness and suicide prevention training programs for staff and students.**

    a. Punt to School Workgroup to get lists of EBPs info from Ann, Kairos, with support from Annette
    b. Ann states getting the collections of EBPs is related to SB 48 with timeline of list due to ( ) by Nov 1.
    c. Suggested to check with Meghan Crane and Liz Thorne to see what they have in the meantime.

2. **Send samples of MOUs concerning transitions from acute care back to school to the ESDs.**

    a. **Julie knows PPS MH has an agreement with Emanuel + PPS + families for ROI to enable safe transitions back to school; Mult ESD also has a ROI;**

As of last contact with Amy Ruona (PPS):

- Emanuel asks the family to sign a release for their school as part of the intake process. *this may have changed with Unity Center.
- Next, the MESD teachers (either Ben White or Angela Turner) contact the school counselor (or whomever the family identifies) to let them know that the student is hospitalized; they begin a plan for what will happen upon discharge.
- Once the school knows (and if the student is due to return to school), they hold a re-engagement meeting and go over the hospital "safety plan," which crosswalks nicely with PPS safety plan (although not every student returning has a PPS safety plan). That is also when the school talks about the family's opportunity to access a sped eval (if the student does not already have an IEP). The re-entry meeting is ideally a small group from the school, including the school counselor and/or social worker and school psychologist and/or anyone the family wants.

    b. **Kristi checked in with Youth Villages on their process for connecting to schools:**

- The first step before we contact schools or any additional contact/key players involved with the youth or their family is to get a release of information (ROI)

- Next, we reach out to the school they attend to send copies of the assessment and safety plan.
    - For youth who are in the Bend-Lapine school district we have one point of contact that then disseminates the information to School Psychologists, Counselors, teachers, etc. (Denise Sevigny at the school district offices).
    - For all other school districts, we reach out to each school individually.
- Contacting the school is a very important piece to what we do. We want to make sure that everyone has the same information and focuses on identified safety concerns in the most appropriate way. We also are able to attend IEP meetings, help families advocate for additional services needed and help to start and increase communication between parents, youth and the school.
- The intensity of involvement with the school system varies based on presenting issue of youth and need of the family but we definitely work to make contact and recognize the huge impact the school system plays in the life of the kids and families we work with.

Amy Gray MA, QMHP, Regional Supervisor, Youth Villages – Oregon
amy.gray@youthvillages.org | Office: 503-675-2250; Cell: 731-693-5609

c. Others?

- Corvallis SD (Benton Co) has an MOU with county mental health for information sharing. (contact Chris Hawkins at SD)
- Ann inquired about the PPS MOU and was told that at this point it's a bit tentative.
- Should check with Danette Killinger in Linn County and with Lane county, both of which have been doing school outreach for some time.
- Meghan Crane may be aware of what the GLS grantees are doing.

3. Review results of ED pilot projects through OHSU study findings after September and recommend best practices.

    a. OHSU has an outcomes study team working on a quality improvement initiative for the ED Diversion Pilots, Crisis and Transition Services programs (8 sites)
    b. Team is developing a proposed basic workflow to review with sites in order to create some uniform framework for the intervention
    c. Developing a Family Transition Inventory Tool to be used with family + program staff to help everyone participate in a shared process of the framework
    d. Study involves data collection and follow up calls to families (timeline is to go live with data tool by Jan 1)
    e. All sites coming together for face-to-face work session on Nov 1
    f. More news to follow

4. Recruit hospital to implement a Caring Contact intervention pilot in a non-ED pilot community.

    a. Needs to be further discussed.
    b. Is it feasible to do this? The thought is that we identify a community that does not have an ED pilot or a Connect post-vention, invite an ED to pilot a caring contacts short intervention, provide guidance from all we've researched on the practice (lines for life, Alliance, etc) to develop a project scope and tracking, and determine if a budget needs to be attached. With information about outcomes and impacts of this model alongside the other interventions that are still not universally available, we gather more information for decision-making.
    c. *note: CC is likely to be included in 3090 and or 3091 rules.

5. Alliance members will volunteer to participate in the RAC for HB 3090 and 3091 implementation.

    a. Jerry, Julie, Stephanie, Laura-Rose, Ajit, Ann, Cherryl, Galli are participating in one or both RACS **Anyone I missed, please be acknowledged

b. Cherryl/Julie/Ann will give an overview of process and highlights, cautions and concerns about ramifications of what is included and not included in rules, continued opportunities around implementation and tracking/reporting ongoing successes and barriers.

6. OHA/Suicide Prevention Alliance will schedule a meeting with the Hospital Association and representatives of some hospitals to outline and discuss requests for standards of care for people in behavioral health crisis who are discharged from hospitals and suicide risk assessments.

    a. What are hospitals' protocols re: 2023, 2948, 3378?
    b. What are hospitals' standards of care in-patient, emergency departments?
    c. What is the EDD/C&TS standard of care? – as presented above, this is in development as QI initiative and outcomes study; findings and progress will be shared
    d. Get hospital representation on Alliance, ask Danielle Meyers, ask members of the AKG workgroup