Purpose

The purpose of the Oregon Alliance to Prevent Suicide is to reduce youth suicides in the state of Oregon. Alliance members are appointed by the Oregon Health Authority to develop a public policy agenda for suicide intervention and prevention across agencies, systems and communities.

In 2014, the Oregon State Legislature mandated development of a 5-year plan to address Oregon's high rate of suicide among individuals age 10 through 24-years-old. The Oregon Youth Suicide Intervention and Prevention Plan was signed by the Oregon Health Authority and submitted to the Legislature in January 2016. The Alliance is charged with overseeing implementation of the plan and evaluating outcomes related to suicide prevention in Oregon

Embedded throughout the plan is a belief that it is crucial to support Oregon's youth and families by:

Promoting a sense of **hope** and highlighting resilience.
Normalizing **help**-seeking behaviors, and supporting individuals and systems to provide help
Engaging individuals and communities in the **healing** process after an attempt or suicide

Alliance Structure

Alliance members are appointed by the Oregon Health Authority and represent a broad range of subject matter experts including youth and young adults, suicide attempt survivors and loss survivors. The full Alliance meets quarterly and is staffed by the Association of Oregon Community Mental Health Programs. The Alliance has six standing committees and an advisory workgroup focused on supporting LGBTQ youth. Committees consist of Alliance members and invited colleagues and advocates.

Executive Summary
Youth Suicide Intervention and Prevention Communication Plan

Introduction

The purpose of the Oregon Alliance to Prevent Suicide is to reduce youth suicides in the state by supporting implementation of a five-year Youth Suicide Intervention and Prevention Plan. An element of the YSIPP is to develop a statewide approach for communicating and sharing information about suicide prevention, intervention and postvention.

The Alliance's Communication Plan is organized around a national framework and specific goals in the YSIPP. Embedded throughout is a belief that it is crucial to support Oregon's youth and families by:

- Promoting a sense of **hope** and highlighting resilience.
- Normalizing **help**-seeking behaviors, and supporting individuals and systems to provide help
- Engaging individuals and communities in the **healing** process after an attempt or suicide

Background

The Oregon Alliance to Prevent Suicide formed a Communications Workgroup to execute Strategic Direction 1, Goals 2 and 3 of YSIPP. Strategic Direction 1- Healthy and Empowered Individuals, Families and Communities - and Goals 2 and 3 promote general health and resilience to reduce the risk of suicidal behaviors. This approach is the basis for the Communication Plan.

The Communications Workgroup, with input from the field, established goals and action steps to increase continuity of messaging to promote resilience, hope and healing and to unify the youth suicide prevention and intervention field across Oregon. The call to action is centered on a coordinated and systematic communication strategy that connects youth suicide prevention and intervention efforts across the state.

The communication plan is informed by the National Action Alliance for Suicide Prevention's *Framework for Successful Messaging.*. It is a resource to help people messaging about suicide to develop content that is strategic, safe, positive, and makes use of relevant guidelines and best practices.

Planning Process

In addition to the Communication Workgroup, planning included discussions with U of O Suicide Prevention Lab; conferring with Alliance members; consultation with experts from the field; interviews with key contacts within public and private agencies; and, guidance from OHA Health Systems and Public Health divisions. Participants represented stakeholders from state agencies, county governments, private organizations, rural and urban communities, and non-profit organizations serving at-risk youth.

The participatory process identified four priority areas for action based on an analysis of challenges, needs, opportunities, and strengths. The four priority areas are:

1) Broader awareness of youth suicide prevention and intervention efforts being implemented in local communities across the state; and, a systematic communication process for sharing lessons learned, practice and communication resources, and subject matter expertise.

2) Increase dialogue across geographic areas and use suicide-related messaging to unify the field. Readily available communication materials such as talking points, fact sheets, one-page notes from the field (highlighting stories of hope, help and healing), promising practices and policy directions, and a resource list of subject matter experts all designed with Oregon communities in mind.

3) Design communication materials to support development of allies and champions at community, county and state levels. Materials should inform and engage decision and policy makers to promote public policy that aligns with best practice and potentially secures future funding.

4) Work with Oregon media to increase their understanding of and commitment to safe messaging. Develop relationships with media to support non-crisis driven coverage that promotes protective factors, de-stigmatizes help-seeking and highlights the preventable nature of suicide. Support development of innovative social media tools and work with youth to identify ways to meaningfully and appropriately engage and respond to struggling youth.

Goals

Four strategic communication goals, plus one goal to measure the impact of the action steps, were developed to address the priority action areas. The goals and highlights of the action steps are:

Goal A. Develop a communication strategy that fosters a more well-connected and effective youth suicide prevention and intervention field in Oregon.

Action Steps include scan of regional/local youth suicide prevention and intervention coalitions to develop communication hubs across the state; collaborate with state agencies on communication processes.

Goal B. Develop an online presence for the Oregon Alliance to Prevent Suicide.

Action Steps include: create a website to promote Alliance activities, facilitate communication among members and partners, and disseminate communication materials; collaborate with Public Health, Lines for Life and U of O to align efforts related to online dissemination of suicide prevention and intervention information; develop communication materials and messaging relevant to YSIPP priorities.

Goal C. Establish an approach to participate in national initiatives such as Suicide Prevention Month and to respond to emergent situations and crises.

Action Steps include: align communication materials with and support national and regional campaigns such as Suicide Prevention Walks and Mental Health Awareness month. Establish a communication response team to provide support and information during emergent or crisis situations.

Goal D. Support a nimble and effective communication strategy to respond to and promote policy change in alignment with the YSIPP.

Action Steps include: identifying types and recommending general content of communication materials to support Alliance work in the area of policy response and development.

Goal E. Measure utilization and impact of activities recommended by the Oregon Youth Suicide Prevention Communication Plan.

Action Steps include: U of O will coordinate with Outreach and Awareness and Data and Evaluation Committees to develop an evaluation strategy and submit to the Executive Committee for approval.

SUICIDE PREVENTION ALLIANCE COMMITTEE LIST

October 2018

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Youth Suicide Prevention and Intervention Communication Plan: Hope, Help and Healing

Oregon Alliance to Prevent Suicide
July 2018 – June 2019

Funded by Oregon Health Authority

Submitted for approval to Alliance: October 9, 2018

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Submitted for approval to Alliance: October 9, 2018

"Communication efforts, such as campaigns and social marketing interventions, can play an important role in changing knowledge, attitudes, and behaviors to promote suicide prevention. Safe and positive messages addressing mental illness, substance abuse, and suicide can help reduce prejudice and promote help seeking. These types of messages can help create a supportive environment in which someone who is experiencing problems feels comfortable seeking help, and where families and communities feel empowered to link a person in crisis with sources of care and assist the person in attaining or regaining a meaningful life."

– *National Strategy for Suicide Prevention*

Acknowledgements

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Introduction

Oregonians are seeing too many young people die by suicide, thinking about suicide and struggling with feelings of hopelessness and isolation. As a nation, Americans are working on better ways to communicate the urgency of these issues while also promoting a culture of hope, resilience, help-seeking and healing. This statewide youth suicide prevention and intervention Communication Plan for Oregon highlights ways that efforts to prevent and respond to suicide can be more effectively coordinated to create opportunities for more nimble responses to emerging situations, such as celebrity suicides and local or regional suicide clusters, as well as policy and funding threats and opportunities.

Oregon, like many Western states, has a significantly higher rate of youth suicide than the national average, despite the efforts of multiple organizations and stakeholders to implement programs and trainings to change this trend. One reason for this limited effectiveness may be that these local efforts often occur in isolation with limited opportunities for others elsewhere in the state to share information and learn from other communities' successes and challenges. Additionally, suicides continue to be inappropriately reported by news and social media in ways that have been shown to contribute to suicide contagion risk. At the same time, an unintended outcome of news media being warned that there is an "unsafe" way to cover suicide is reduced news coverage of suicides, leading to lower public perception of the prevalence of suicide in Oregon and nationwide.

In 2016, out of 50 states and the District of Columbia, Oregon had the 15th highest rate of youth suicides and 98 youth ages 10 to 24 died by suicide.

Youth Suicide Invention and Prevention Plan

2017 Annual Report

In 2015 the Oregon Health Authority (OHA) brought together experts in the field, youth, attempt survivors and people who lost a loved one to suicide to develop a statewide 5-year plan to reduce suicide in Oregon among individuals 10-24 years old. The resulting Youth Suicide Intervention and Prevention Plan (YSIPP) identified 117 different action items to address this issue in a comprehensive way. A key recommendation was development of a statewide communication plan to 1) support the plan's implementation through coordinated communication; 2) to promote a culture of resilience and hope in which help-seeking is seen as a strength; and, 3) to mobilize policy makers across the state to support the plan through innovation, legislation and resource investment. The Oregon Alliance to Prevent Suicide, created by the YSIPP (Appendix 1) and charged with facilitating its implementation, formed an ad hoc Communications Workgroup specifically to execute Strategic Direction 1, Goals 2 and 3 of YSIPP. Strategic Direction 1 – Healthy and Empowered Individuals,

Families and Communities – and Goals 2 and 3 (see below) promote general health and resilience to reduce the risk of suicidal behaviors. The youth suicide prevention, intervention and postvention approach described in the YSIPP is the foundation for this Communication Plan.

Goal 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors.

Goal 3. Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.

The Communications Workgroup, in conjunction with input from the field, established communication goals and objectives designed to increase statewide continuity of messaging that promotes resilience, hope and healing, and to unify the youth suicide prevention, intervention and postvention field across Oregon. This plan incorporates suicide prevention, intervention and post-suicide intervention (postvention; hereafter included in "suicide prevention and intervention") and its recommendations are a result of that workgroup's efforts. Once recommendations are formally adopted, the role of the Alliance in implementation of the Communication Plan will be:

- Leadership in tracking implementation progress and advising on adjustments to plan action steps as indicated
- Ongoing scans and identification of potential new partners
- Linkages and point of contact in response to emerging and crisis situations
- Facilitation of a shared responsibility of partners to unify the youth suicide prevention and intervention field through communication strategies
- Analysis of outcome measures and prioritization of future action steps
- Development of shared approach with other key thought-leaders to promote effective suicide prevention and intervention policy statewide

The Communication Workgroup call to action is based on the need for a coordinated and systematic communication strategy that connects youth suicide prevention and intervention efforts across the state. Fundamentally, this plan intended to promote community well-being and prevent suicide. As such, its actions are associated not only with those specifically tasked with outreach and communication, but applies broadly to the range of Alliance activities and groups working to facilitate implementation of the YSIPP.

Framework

The YSIPP Communication Plan is informed by the *Framework for Successful Messaging* created by the National Action Alliance for Suicide Prevention. A full discussion of the *Framework* is available at https://suicidepreventionmessaging.org/. The *Framework* is a resource to help programs and individuals messaging about suicide to develop content that is strategic, safe, positive, and makes use of relevant guidelines and best practices.

The *Framework* outlines four critical elements to consider when messaging about suicide. Oregon is aligning its suicide prevention and intervention communication action steps with the four elements. Below the definitions is a brief illustration of how this plan proposes to implement each element.

Framework for Successful Messaging
National Action alliance for Suicide Prevention

- ***Safety*** – avoiding content that increases risk for vulnerable individuals or is unhelpful by reinforcing problematic norms, conveying negative stereotypes or undermining prevention.

Links to a compendium of communication templates, tools, guides and resources will be based on safe messaging and research-informed best practices and disseminated using regional communication hubs enabled through a web based centralized dissemination point and a statewide distribution. The first priority is to ensure messaging promotes hope, help and healing and is available to all geographic areas of Oregon.

- **Positive Narrative** – promoting the positive in some form, such as sharing resources, telling positive real stories, describing action steps, and featuring program success.

Oregon specific briefs will be featured on the Alliance website, released to media, and shared with policy-makers to highlight individual and local stories of hope, help, and healing. This plan supports development of a cadre of speakers available to share personal experiences, de-stigmatize help-seeking behavior and promote the YSIPP. The Alliance and OHA will provide leadership to highlight and celebrate successes.

- **Guidelines** – use specific guidance or best practices that apply to messaging.

To increase understanding about best practices in messaging, the Communication Plan supports trainings like Connect that teach safe messaging protocols for both media and within communities and institutions. Messaging guidelines and best practices will be highlighted on the Alliance website, shared with a variety of other relevant sites and key stakeholders, and integrated into conferences and other education opportunities.

- **Strategy** – planning and focusing messages so they are as effective as possible. This includes integrating communications with other efforts, defining clear, achievable and measurable goals, understanding the audiences, identifying a "call to action" and providing resources for taking action.

This plan puts forth an actionable communication approach that includes: a) developing, adopting or adapting national materials, tools and resources for dissemination; b) Oregon-focused messaging around national initiatives such as Suicide Prevention Month, Zero Suicide and Weekend of Prayer for Suicide Prevention; c) use of culturally specific messaging; d) moving beyond the usual partnerships (health, behavior health, schools) to share information where youth and young adults spend their time, for example, in entry-level job settings, faith communities, sports events, etc; e) integrating efforts across Alliance committees and the broader field; and, f) measuring effectiveness of dissemination and messaging.

The Communication Plan was also informed by the work on postvention communication developed by the Connect program of NAMI New Hampshire. With OHA funding, Connect postvention trainings are currently being implemented in nine Oregon counties (Deschutes, Jackson, Jefferson, Lane, Linn, Benton, Lincoln, Malheur, Umatilla, and Yamhill).

Purpose

The goal of the YSIPP is to increase protective factors and decrease risk factors influencing the number of youth suicides by promoting "Healthy and Empowered Individuals, Families and Communities" (Strategic Direction 1, YSIPP). This Communication Plan focuses on incremental steps to increase knowledge and access to expertise with Oregon. It proposes actions to address fragmentation and promote unity of efforts across the state by integrating communication activities with other efforts. Action steps are designed to engage existing suicide prevention and intervention coalitions and promote new ones, actively advance wellness and recovery, align with research-

informed practices and support a more nimble response to emerging crisis situations. The Communication Plan proposes the development of communication hubs to achieve this and leverage local ownership and expertise.

Communication hubs, comprised of regional coalitions within identified geographic areas and collaborative groups within public agencies, will serve as the primary point for web-based dissemination of communication materials, tools, resources, and other featured items. The principle element of the communication hub design is to institute a systematic and consistent process of sharing suicide prevention and intervention information statewide. The long-term outcome of establishing communication hubs is to unify the suicide prevention and intervention field through a network of coalitions.

The Communication Plan is not an extensive Public Health messaging campaign. Rather it is a strategic communication undertaking intended to accurately target communications; map how to reach specific audience; make communication efforts efficient, effective, and lasting; and, track implement progress. On an ongoing basis, the Alliance Outreach and Awareness Committee will provide recommendations to modify Communication Plan activities based on findings of outcome measurements and shifts in the prevention field. While this plan is not a comprehensive public campaign approach, it is complementary to the larger statewide suicide prevention effort, Zero Suicide, and other prevention efforts with Oregon.

Audience

Implementation of the communication strategies is intended to increase awareness and understanding of the risk and protective factors related to suicide, including among behavioral and medical health providers, educators, local and regional suicide prevention coalitions, family, youth and policy makers. The Communication Plan includes an Alliance website. The website will facilitate the work of the Alliance by disseminating information about existing and emerging prevention coalitions and materials supportive of the prevention activities of local coalitions and other stakeholders as well a broadening public awareness of suicide prevention activities occurring in Oregon. The Communication Plan's long-term approach is intended to be aware of issues of language access and relevant to culturally specific audiences such as LGBTQ, faith based, military, Latinx , Native American and non-English speaking communities. Developing materials with the engagement of members of these communities will be an integral part of the implementation of each element of the Communication Plan.

Concurrently, the Public Health Division of OHA is developing an Oregon-focused website informed by the national Suicide Prevention Resource Center website, which will be directed to the public as a first-line suicide prevention resource. Shared planning and coordination and links between the Alliance website and Public Health websites are included as action steps in the Communication Plan.

Overview of Planning Process

Development of a Communication Plan began in Fall 2017 at the recommendation of the Alliance's Outreach and Awareness Committee. In addition to workgroup meetings, the participatory development process included discussions with the University of Oregon Suicide Prevention Lab; conferring with the Alliance Executive and Outreach and Awareness Committees; consultation with individuals and experts from the field; interviews with key contacts within public and private agencies; and, guidance from OHA Health Systems and Public Health divisions. The participants in this process represented stakeholders from state agencies, county governments, private organizations, rural and urban communities, and non-profits serving at-risk youth. The Alliance Schools Committee provided insight into the challenges and opportunities of working with partners within the educational system. That committee conducted a statewide survey of middle and high schools to determine what types, if any, suicide prevention curriculum, training and protocols were being implemented in their local communities. Survey results will be forthcoming and inform ongoing communication work.

Analysis of Current Situation

The following is a summary of the findings from the planning process

Challenges and Needs

- **Allies and Champions** – Prioritizing the case for suicide prevention and intervention requires allies and champions to obtain funding and promote effective practice and policy. Most importantly, it is key to instituting cultural and community norms, which promote hope, normalize help-seeking behaviors, and encourage engagement of communities in the healing process after an attempt or suicide. Alliance members and suicide prevention and intervention coalitions are well positioned to cultivate policy makers and practice influencers to establish these norms across the state.
- **Media** – While there are examples of exemplary reporting about suicide, often media outlets in Oregon do not report on suicide and, when they

do, reporting does not necessarily follow suicide safe messaging guidelines. Concerted efforts are needed to educate media about safe messaging and to motivate media to follow those guidelines. Media outreach also needs to consistently include messaging and safe practices designed for social media.

- **Messaging and Communication Efforts** – Suicide prevention messaging in Oregon needs to be tailored to urban, rural, and frontier audiences. There is a need to assemble a variety of communication tools that align with YSIPP guiding principles, are based in research-informed practices, and are easily accessed statewide. While some cross-county communication occurs through collaborative learning communities such as Garret Lee Smith program-funded counties and monthly calls among mental health Promotion and Prevention OHA grantees, an integrated and statewide approach to communication does not yet exist. Building a strong, stakeholder-oriented communication network across the state could address this gap. Additionally, communication materials need to be designed in response to emerging needs including the trend of increasing suicides among children in middle school and younger. The YSIPP address ages 10 through 24 year olds, however, feedback from the field indicates there is a need to expand prevention efforts to include young children who are experiencing hopelessness, as well as their families.

> **We need connections to resources in our communities. We need materials that our communities can relate to – images of people who look like they'd actually live in rural Oregon and language that speaks to them.**
>
> **Kimberlee Jones, Best Care Treatment Prevention Supervisor, Madras, OR**

- **Funding** – Although suicide prevention and intervention is a cross-disciplinary issue spanning health, behavioral health, public health, education, and child safety domains, staff and funding resources are often siloed. OHA has taken a leadership role in securing funds for suicide prevention and intervention, however, current grant funding is time-limited and secure state level funding is insufficient to accomplish a comprehensive approach unifying public agencies and community organizations. While challenging, there is a clear need to increase and diversify funding for Oregon's suicide prevention and intervention efforts by obtaining private and foundation resources.

- **Communication Mechanism** – A systematic and centralized communication mechanism is not in place, limiting the availability of materials, tools, messaging resources and lessons learned in the field across geographic areas. Often community supports are stretched to find staff time and expertise required to develop new or adapt existing safe

messaging resources. Having access to a centralized system would support public and private organizations of all sizes by facilitating the development of a compendium of communication resources accessible across the state.

Opportunities and Strengths

- **Collaboration** – The collaborative approach to networking greatly increases the potential for creating communication hubs for distribution of materials and unifying messaging. There is an opportunity to build on existing and emerging coalitions and collaborative groups among public agencies and non-profit organizations. In addition to broad dissemination, working with communication hubs is intended to improve our understanding of suicide prevention and intervention efforts statewide and the attending successes and challenges. Moreover, through collaborative efforts engaging multiple disciplines that address childhood trauma (e.g., child abuse, domestic violence, bullying) including mental health, substance abuse, youth development and education, suicide prevention can be further integrated into their work.

When regional coalitions become communication hubs for youth suicide prevention and intervention, there is greater potential to further efforts among partners, address broader issues and support collective actions.

Alliance Communication Workgroup

- **Shared Vision** – The YSIPP provides a shared vision for suicide prevention and intervention. Clear commitments and agreements between agencies, public and private, to prioritize suicide prevention and intervention communications using the *Framework for Successful Messaging* would help realize the goals of the YSIPP. Existing initiatives such as the School Safety Task Force, Trauma Informed Oregon, the Keny-Guyer Suicide Prevention Workgroup, American Foundation for Suicide Prevention and the Oregon College and University Suicide Prevention Project are sources for expertise and dissemination of communications, which can be further leveraged in communication efforts. For example, state agencies could agree to include audience-specific suicide prevention and intervention resources on their websites. The Oregon Department of Education is currently working towards that goal, and this effort could be implemented more broadly across other agencies and with greater coordination. Another example of the need for such coordination is the Public Health division's comprehensive suicide prevention website discussed above; close coordination with the Alliance is essential in order to avoid duplication of efforts while also aligning messaging and maximizing reach.

- **Youth and Families** – Another potential for collaborative communication action is to bring attention to suicide prevention activities of youth and families at the local level and communication about efforts statewide. Youth and families who have lived experience with family members with suicidal ideation and suicide attempt and bereavement survivors can be galvanized to be effective advocates in moving policy in Oregon. Collaborating with youth, families and the agencies serving youth is important on many levels, particularly in testing and refining messaging content. Their stories and perspectives are central to this Communication Plan.

- **New Partners** – Given that suicide prevention extends beyond traditional behavioral health systems, it would be helpful to broaden partnerships to include business, sport teams, and workforce education projects. Engaging these organizations in safe suicide messaging is key because they have reach and connection to young people that can be leveraged in suicide prevention campaigns and changing community norms.

- **The Alliance** – The Alliance is responsible for facilitating implementation of the YSIPP and leading development of the next five-year plan. The Alliance includes subject matter experts and leaders in the field, but is not yet well known statewide. Elevating awareness of the Alliance will increase its ability to influence policy and practice. One approach to achieving this broader awareness is to expand Alliance representation from across the state and develop more formal relationships with existing regional suicide prevention and intervention coalitions. Additionally, participating in and sponsoring relevant conferences and developing presentations that can be used by any Alliance member will contribute to increased awareness. For example the Health Systems Division funded the 2018 Suicide Prevention Conference and has set aside funding for 2019. Funding is requested for 2020 and 2021. The conferences feature Oregonians who have initiated local efforts, brings national experts to the state and promotes networking.

- **Leverage Existing Resources** – As mentioned in the Collaboration section, creating communication hubs via existing and emerging coalitions, including collaborative groups within public agencies, would open the opportunity for regional and statewide distribution of materials. The communication hubs will encourage sharing information and disseminating communication resources and experiences across geographic areas, particularly in response to emerging issues and events.

  Another resource to be leveraged is the YSIPP annual report published by OHA. This report has current data about suicide within Oregon and

progress on implementation of the YSIPP. When the 2018 report is released in February 2019, the Alliance and its partners should be prepared with press releases, editorials and briefing papers to further disseminate the most current information about suicide prevention and intervention in Oregon and to broaden awareness of the Alliance's role in supporting implementation of some of those activities.

- **Social Media** – An additional opportunity is to expand suicide prevention and intervention social media efforts designed to engage Oregon youth. OHA has identified funding to start a *by youth, for youth* project on social media to further reach youth and young adults. It must be a priority to identify additional funding sources to develop and ensure the future of the project.

Priority Areas for Action

Throughout the planning process four themes emerged:

1) The first theme is the need for broader awareness of the youth suicide prevention and intervention efforts being implemented in local communities across the state. Consequently, a systematic and centralized structure for gathering information and providing two-way communication among those implementing these activities and programs is needed. A systemic approach would facilitate sharing knowledge and practice resources across the state. Paired with this theme was the need for easily accessed communication resources (e.g, news releases) and expert knowledge to assist local communities to respond to high profile suicides and suicide clusters. For example, the OHA is currently developing a statewide postvention response team. The Alliance could support this effort and local communities by providing OHA with subject matter expertise and a diversity of perspectives to address emergent situations such as a high profile suicide.

When we faced a series of youth suicides, it put pressure on our local resources. It would be helpful to have messaging available to promote help-seeking, hope and healing. I'd like to be able to reach out to the State, in addition to my county, for support with sending out press and social media releases, and to have subject matter experts available to respond to interview requests.

Galli Murray, Suicide Prevention Coordinator, Clackamas County

To lay the foundation for the communication hubs, it is essential to clearly identify the key stakeholders. A scan of existing and emerging regional coalitions is proposed. This process will capture information about suicide

prevention and intervention efforts across the state and provide a means for sharing regional information with communities, integrating YSIPP communication materials with other efforts, and ensuring statewide distribution of communication materials and tools. The intent is to secure buy-in from state agencies and partners across the state to participate in a communication network with the goal of establishing a process for sharing information.

2) The second theme was unifying the field, particularly around suicide-related messaging. Although people often look to national resources, such as the American Foundation for Suicide Prevention or the Action Alliance to Prevent Suicide, in Oregon each agency, department, school district and community organization independently develops communication materials. Consequently, each entity determines if communications are based on safe messaging guidelines and appropriate for the identified audience. The Communication Workgroup recommended developing communication tools, such as succinct talking points for "elevator conversations", fact sheets with an Oregon focus, and one-page notes from the field highlighting individual and local stories of hope, help and healing, promising practices or policy directions and a resource list of subject matter experts in Oregon.

   To strengthen public support and advocacy of youth suicide prevention and intervention efforts, there is a need to increase opportunity for dialogue across geographic areas and also have readily available communication tools designed for a variety of Oregon communities, including rural, LGBTQ, Latinx, and Native American communities.

3) The third theme is developing allies and champions at the community, county and state level. The value of having decision makers and policy makers engaged in youth suicide prevention and intervention efforts helps secure the future of such activities, particularly when it comes to promoting public policy that aligns with best practice and secures funding for outreach, advocacy, and programs to prevent suicide.

4) The fourth theme is to continue to work with Oregon media to increase their understanding of and commitment to using suicide safe messaging. There is a need to develop relationships with media contacts to support ongoing non-crisis driven coverage that promotes protective factors, de-stigmatizes help-seeking and highlights the preventable nature of suicide. It is critical to be poised to respond when a crisis emerges.as demonstrated by the high level of media coverage after the recent release of a Centers for Disease Control and Prevention report showing significant increases in the rates of suicide among all age groups and across 44 U.S. states over the last two

decades (Stone et al., 2018[1]) and deaths of celebrities Anthony Bourdain and Kate Spade. While it is unknown whether these recent deaths will impact suicide rates, the World Health Organization has documented an increase in suicide after a celebrity death. In the first four months after Robin Williams death by suicide in August 2014 , there was a 9.8% increase in the number of suicides typically recorded during this time period. (Fink et al. 2018)[2]

At such times national media turn to such trusted sources as the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention. In Oregon, organizations such as Lines for Life and Youth ERA have taken a leadership role in responding to such crises. This plan proposes to build on their work through mechanisms for sharing information and resources (e.g., news releases) and improving access to subject matter experts across the state.

Finally, the Communication Plan acknowledges the value of sharing social media messaging, supporting development of innovative tools (such as smartphone applications), and working with youth to identify other ways to meaningfully and appropriately engage and respond to struggling youth.

Implementation Resource Needs

To fully implement the action steps of the Communication Plan, the Alliance and its partners will need to consider additional resources and funding options to support the following:

- **Website** – The University of Oregon is working closely with the Alliance to develop a website to house the materials, tools and messaging templates developed through the YSIPP and this Communication Plan. The centralized system will be used to encourage interactive dialogue among the communication hubs and YSIPP initiatives statewide. Resource allocation for the website must include staff, student or consultation time for ongoing dissemination of information, regular maintenance, posting of updated materials and ensuring the site accurately reflects the programmatic and organizational landscape of suicide prevention and intervention efforts across the state.

[1] Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Yuan, K., Holland, K. M., … Crosby, A. E. (2018). Vital Signs: Trends in state suicide rates — United States, 1999 – 2016 and circumstances contributing to suicide — 27 States, 2015. *Morbidity and Mortality Weekly Report*, *67*(22), 617–24.

[2] Fink DS, Santaella-Tenorio J, Keyes KM (2018) Increase in suicides the months after the death of Robin Williams in the US. PLoS ONE 13(2): e0191405. https://doi.org/10.1371/journal.pone.0191405

- **Consultation** – Additional consultation resources will be required for the 1) development and/or adaption of existing materials such as templates, messages, talking points, stories from the field, resource guides and manuals that are research-informed; 2) ongoing statewide coalition scan (administer, collate information and prepare information for posting on website); 3) identify opportunities to pool resources to amplify dissemination of information; and, 4) engage in ongoing communications with agencies, departments, and coalitions to facilitate consistent messaging and communication strategies across the state. Budgeting should also support engaging a graphic designer to develop layout for both digital and printed materials.

- **Measurement** – incorporate the development and implementation of an evaluation process into the state's existing YSIPP evaluation relationship with the University of Oregon, to determine effectiveness of messaging and success of action steps of the Communication Plan.

- **Culturally Responsive Expertise-** assess for needs of communities that speak languages other than English, communities at high risk of suicide and marginalized communities. Collaborate with community organizations, government entities and members of these communities to develop culturally responsive communication materials and strategies.

Recommendations

The following recommendations are intended for stakeholders including State agencies, the Alliance, regional coalitions, youth and families, and newly identified partners, with the goal of creating a more unified and effective statewide suicide prevention and intervention movement. By building on the recommended action steps of the Communication Plan, stakeholders can come together on practice, protocols, and future funding.

- Long term, the State may want to consider partnering with private funders to invest in a public health-type suicide prevention campaign such as those used for tobacco/smoking cessation, gambling and opioid abuse prevention.

- Develop a coordinated approach for cross-agency funding and staff resources that are devoted to youth suicide prevention and intervention. A coordinated effort across state agencies can make the best use of funds, ensuring funding goes to where the expertise is and meets emerging needs and avoiding duplication.

- Partner smartly. For example, working with organizations that regularly communicate with specific audiences like the National Guard, Northwest Portland Area Indian Health Board, Disability Rights Oregon and Basic Rights Oregon and many others is needed to reach culturally specific audiences.

- Although implementation of the Communication Plan requires participation from key stakeholders across the state and leadership from OHA, oversight of the Communication Plan should be the responsibility of the Alliance. This recommendation is based on continued funding for the Alliance.

- Use the annual suicide prevention conference as an opportunity to highlight local efforts, share local experience and insights, set locally-relevant priorities, host a media roundtable, and encourage coordination across the state including regional suicide prevention coalitions.

- It is recommended that state agencies integrate youth suicide prevention and intervention into their work as youth suicide prevention and intervention cuts across health, mental health, public health, education, poverty, housing insecurity, food insecurity, and violence domains. Beyond integration, improved coordination across state agencies and their collaboration on youth suicide prevention and intervention efforts would provide substantial support of the communication strategy for dissemination.

- It is recommended the Alliance Executive Committee identify, engage and get a commitment from external allies and champions who are positioned to a) influence political engagement and movement on policy issues; b) advocate for suicide prevention; and c) support the continued and expanded implementation of the YSIPP. Once the Executive Committee determines specific areas committed external community members are needed to move forward YSIPP prioritized items such as policy, practice, outreach, advocacy, and funding, communication materials should be developed to orient them to the burden of suicide in Oregon, impacted populations, the work and structure of Alliance, and provide an overview of YSIPP and priorities.

Strategic Communication Goals, Objectives and Action Steps

Goal A. Develop a communication strategy that fosters a more well-connected and effective youth suicide prevention and intervention field in Oregon.

Objective A.1. By July 1, 2019 complete a scan of regional and local youth suicide prevention and intervention coalitions to support development of communication hubs across the state.

Action Step A.1.a. By August 15, 2018 develop and administer a scan to identify regional and local suicide prevention and intervention coalitions. Scan to include an inquiry about existing youth suicide prevention and intervention communication approaches and plans; their recommendations on how to communicate with the Alliance; information about how they are meeting language access needs and reaching culturally diverse populations; and, who, if anybody, is the lead suicide prevention person for their county or region.

Action Step A.1.b. By September 30, 2018 Communication Outreach Committee develops a memorandum of understanding (MOU) template that identifies a structure for regular updates from regional coalitions to the Alliance and from the Alliance to them. Invite regional coalitions to sign and honor the MOU. As memorandum are signed, add coalition information to the Alliance website.

Action Step A.1.c. By November 1, 2018 distribute information to announce the launch of the Alliance website to entities participating in the scan, Alliance members, and coalition partners.

Action Step A.1.d. By January 31, 2019 begin to share regular updates of Alliance activities and quarterly highlights from regional communication hubs. Identify key state agencies serving children and families and a lead person within the agency to receive the updates.

Action Step A.1.e. By January 31, 2019 clarify a process for ongoing maintenance of website to ensure map of regional hubs and lead county contact information is current and updated annually.

Action Step A.1.f. Beginning July 1, 2019 conduct an annual update of coalition information by recirculating a survey and update coalition information on website.

Goal B. Develop an online presence for the Oregon Alliance to Prevent Suicide.

Objective B.1. By March 31, 2019 create and maintain an Alliance website in order to promote Alliance activities, facilitate communication among Alliance members and partners, and disseminate communication materials.

Action Step B.1.a. By July 1, 2018 outline a proposal with the University of Oregon (U of O) for the design and development of an Alliance website.

Action Step B.1.b. By July 15, 2018 share an outline of the website plan with Public Health and Lines for Life. Schedule a meeting to coordinate with Public Health, Lines for Life and U of O Suicide Prevention Lab to align efforts related to online dissemination of suicide prevention and intervention information.

Action Step B.1.c. By September 30, 2018 share draft format for the home page and website design with Outreach and Awareness Committee members, obtain their feedback and integrate feedback throughout design process.

Action Step B.1.d. By October 1, 2018 generate homepage content and design, obtain domain name, and launch website. Initial content on webpage to include background and role of Alliance members, highlights of current activities, the YSIPP, the national suicide prevention lifeline and other youth relevant and culturally specific suicide prevention lines such as the Trevor Project, annual reports and Communication Plan. Launch website.

Action Step B.1.e. By December 31, 2018 establish mechanism for ongoing posting of resources and materials to communication website and social media sites.

Action Step B.1.f. By March 31, 2019, begin quarterly updates for the website by adding newly identified resources to the compendium of materials, removing out-of-date materials and information, and updating information on Alliance.

Objective B.2: By March 31, 2019 develop, adapt or adopt materials and tools, including social media links and messaging relevant to YSIPP priorities and Oregon's needs.

Action Step B.2.a. By December 31, 2018 convene the Outreach and Awareness Committee to recommend priority areas and sequence development of safe messaging templates, talking points, stories from the field, and links to key

resources related to YSIPP. Seek input from other Alliance committees as indicated. Alliance staff is responsible for coordinating the development of these resources, seeking feedback from Committee members on content, and preparing items for posting.

Action Step B.2.b. By December 31, 2018 and quarterly thereafter post at least five priority materials on web-page as approved by Alliance staff.

Action Step B.2.c. By January 31, 2019 convene the Outreach and Awareness Committee, to Identify items for future postings.

Action Step B.2.d. By January 31, 2019, in conjunction with U of O Suicide Prevention Lab, complete a scan that identifies current youth-focused suicide prevention and intervention social media campaigns, apps and initiatives in use or in development in Oregon.

Action Step B.2.e. By February 28, 2019, in conjunction with the release of the annual YSIPP report, support OHA in the development of a press release to update the public on progress and develop a one page brief with same detail for Alliance members and post on website.

Action Step B.2.f. By March 31, 2019 convene a focus group including youth, families and youth-serving organizations to review and provide feedback on scan findings and make recommendations on next steps for social media engagement.

Goal C. Establish an approach to participate in national initiatives such as Suicide Prevention Month and to respond to emergent situations and crises.

Objective C.1. By June 30, 2019 support and align with national and regional youth suicide prevention and intervention campaigns.

Action Step C.1.a. By November 1, 2018 as Alliance develops materials, determine whether they align with national research and national messaging campaigns.

Action Step C.1.b. January 31, 2019 assess how Alliance members are engaged with communication campaigns in Oregon and at the national level that align with the YSIPP such as Suicide Prevention Walks and Mental Health Awareness month.

Action Step C.1.c. By January 31, 2019 access the regional communication hubs to gather information regarding Oregon participation in these types of activities.

Action Step C.1.d. By March 31, 2019 and quarterly thereafter identify a selection of these events and/or messages to post on the web site and social media—particularly if there is an Oregon specific or innovation element to it.

Objective C.2. By January 31, 2019 establish a communication response team whose members would be available to OHA and media during an emergent or crisis situation to provide subject matter expertise including stories of hope and resilience,

Action Step C.2.a. By August 31, 2018 attend OHA's listening session regarding postvention needs and collect information regarding recommendations for coordinated communication in response to emerging situations and crisis.

Action Step C.2.b. By December 31, 2018 complete a literature review and identify guidelines for responding to emerging situations and crisis. Adapt existing or develop new guidelines tailored to Oregon urban, rural and frontier communities and audiences.

Action Step C.2.c. By December 31, 2018, in conjunction with OHA's communication team, identify individuals who could serve as subject matter experts to include a psychiatrist, psychologist, healthcare professionals, educators, people with substance abuse expertise, young people, and individuals with lived experience to be available as a resource for emergent situations.

Action Step C.2.d. By January 31, 2019 convene the communication response team to develop and reach agreement on a protocol for activating a response and handling media inquiries. Establish lines of communication between OHA and the Alliance liaison regarding how to activate access.

Action Step C.2.e. By March 1, 2019 develop key contacts with regional media outlets to promote safe messaging, encourage them to provide information about sources of support and contact details of helplines when reporting mental health and suicide stories.

Action Step C.2.f. By April 1, 2019 in conjunction with statewide suicide prevention conference issue an announcement about the development of this team and release announcement to media outlets across the state.

Action Step C.2.g. By April1, 2019 provide regional media information to access subject matter experts. Provide information about accessing safe reporting guidelines through the Alliance website.

Action Step C.2.h. When annual YSIPP report is released, support OHA in the development of a press release to update the public on progress and develop a one page brief with same detail for Alliance members.

Goal D. Build a nimble and effective communication strategy to respond to and promote policy change in alignment with the YSIPP.

Objective D.1. By December 31, 2018 develop a structure for responding to changes in policy and promoting policy change that aligns with the YSIPP.

Action Step D.1.a. By October 1, 2018 the Alliance Executive Committee will outline policy priorities for 2019.

Action Step D.1.b. By December 31, 2018 Outreach and Awareness Committee will identify and develop materials to support Alliance work in the area of policy response and development.

Goal E. Measure impact and utilization of activities

Objective E.1. By September 30, 2019, submit an impact and utilization report to be developed by the University of Oregon evaluation group in coordination with the Alliance Outreach and Awareness and Data and Evaluation Committees.

Action Step E.1.a. By October 31, 2018 the University of Oregon evaluation group, in coordination with the Outreach and Awareness Committee and the Data and Evaluation Committee, will develop an evaluation strategy for activities. The proposed evaluation strategy will be submitted to the Executive Committee for approval.

Action Step E.1.b. By September 15, 2018 priority Communication Plan activities for evaluation (e.g., utilization of the Alliance website) will be outlined and key measures identified. Communication Plan activities will be implemented as funding and other resources become available; priority activities and measures will be added as needed.

Action Step E.1.c. By April 31, 2019 initial Alliance website (launched September 2018) utilization data will be collected summarized by the University of Oregon evaluation group. Data will include public site traffic and reach metrics for public information-oriented sections of the website for the first two quarters the site will have been active (October-December 2018 and January-March 2019). Additionally, utilization data for the resource hub sections of the site (used by Alliance members and stakeholders) will be reported for the first quarter of 2019.

Action Step E .2.d. By September 30, 2019 write an impact and utilization report. It will summarize all available measures related to activities implemented to date. These measures are anticipated to include those pertaining to Alliance Website utilization (e.g., site traffic, number of stakeholders/allies identified and engaged), and policy and advocacy efforts (e.g., number of white papers, policy briefs, and press releases developed). The annual report will be submitted to the Alliance and OHA.

Appendix 1

The Oregon Alliance to Prevent Suicide

In 2014, the Oregon State Legislature mandated development of a 5-year plan to address Oregon's high rate of suicide among individuals age 10-24. The Oregon Youth Suicide Intervention and Prevention Plan (YSIPP) was signed by the Oregon Health Authority Director and submitted to the Legislature in January 2016. The plan calls for the creation of the Oregon Alliance to Prevent Suicide to develop a public policy agenda for suicide intervention and prevention across agencies, systems and communities. The Alliance is charged with overseeing implementation of the YSIPP, evaluating outcomes related to suicide prevention and monitoring risk factors, and advancing a public policy agenda for suicide prevention across the state. The multi-disciplinary Alliance includes:

- Legislators
- Parents
- Youth
- Clergy
- Law Enforcement
- Health Systems
- Military
- Insurers and CCOs
- Consumers and advocates
- Community mental health and substance use providers
- Prevention Specialists
- Educators
- Child Welfare
- School-based health center staff
- Representatives of groups at disproportionate risk of suicide from across Oregon

There are six committees within the Alliance, each committee is tasked with assisting the Alliance Liaison to ensure goals are met and deliverables are completed. The committees are:

- Executive
- Continuity of Care
- Outreach and Awareness, includes the Communication Workgroup
- Schools
- Workforce
- Evaluation & Data

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Strategic Communication Plan

OUTREACH AND AWARENESS COMMITTEE

OCTOBER 9, 2018

The Communications Plan Should….

- Be based on both best practices and innovation
- Recommend to adopt, adapt or develop messaging tailored for Oregon
- Describe how a rollout would be implemented over time
- Identify types of media to be used including electronic and social media
- Identify costs for elements for future implementation funding
- Leverage groups to assist with planning and implementation

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Organizing Frameworks

Youth Suicide Intervention Prevention Plan

Strategic Direction 1 – Healthy and Empowered Individuals, Families and Communities

Goal 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors.

Goal 3. Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.

Framework for Successful Messaging – National Action Alliance for Suicide Prevention

A resource for messaging about suicide to develop content that is strategic, safe, positive, and makes use of relevant guidelines and best practices

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Key Take Away Points

Connect	Build	Disseminate	Show
High need for field to be more well-connected; Plan activities to support existing efforts and to increase understanding of activities and coordination.	Build allies and champions to secure future of suicide prevention movement.	Need a systematic dissemination of information and a pool of resources to facilitate consistent messaging specific to Oregon communities.	Show how our work is connected to our suicide prevention strategic vision.

Overview of Communication Plan

Embedded throughout is a belief that it is crucial to support youth and families by:

- Promoting a sense of hope and highlighting resilience.
- Normalizing help-seeking behaviors, and supporting individuals and systems to provide help.
- Engaging individuals and communities in the healing process after an attempt or suicide

It is an ambitious one-year plan that identifies challenges, needs, opportunities and strengths and outlines clear goals, objectives and actions.

It includes recommendations and budgeting considerations but is not a broad public health messaging campaign.

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Role of Outreach and Awareness Committee

- Track Implementation
- Identify New Partners
- Respond To Emerging and Crisis Situations
- Build Connections to Unify Youth Suicide Prevention Field
- Analyze Outcome Measures, Prioritize Future Action Steps
- Promote Effective Suicide Prevention and Intervention Policy Statewide

Goals and Action Items

Five goals including one on measurement to:

- **Strengthen the youth suicide prevention and intervention field in Oregon**
- **Enhance connectedness of field within state to establish an online information resource**
- **Meet Goals 2 & 3 of YSIPP**
- **Provide foundation for future communication efforts related to youth suicide prevention and intervention**

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Goal A - Develop a communication strategy that fosters a more well-connected and effective youth suicide prevention and intervention field in Oregon.

Action Steps

- Administer a scan of regional and local youth suicide prevention and intervention coalitions to develop communication hubs
- Develop MOU between the Alliance and Coalitions
- Collaborate with state agencies to explore options for state agency communication processes.

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Communication Hubs

Do we have your local contact?

Are you willing to talk with them about the MOU?

Goal B- Develop an online presence for the Oregon Alliance to Prevent Suicide

ACTION STEPS

- Create website to promote Alliance activities, facilitate communication among members and partners, and disseminate communication materials
- Collaborate with Public Health, Lines for Life and U of O to align efforts related to online dissemination of suicide prevention and intervention information
- Develop communication materials and messaging relevant to YSIPP priorities

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Goal C –

Establish an approach to participate in national initiatives such as Suicide Prevention Month and to respond to emergent situations and crises.

ACTION STEPS

- Align communication materials with and support national and regional campaigns such as Suicide Prevention Walks and Mental Health Awareness month.

- Establish a communication response team to provide support and information during emergent or crisis situations.

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Talking to the Media

Are you interested in being part of a team that will be available to speak with journalists about suicide?

What type of support would you want to prepare for this?

Goal D –
Build a nimble and effective communication strategy to respond to and promote policy change in alignment with the YSIPP.

ACTION STEPS

- Alliance Executive Committee will outline policy priorities for 2019

- Outreach and Awareness Committee will identify and develop materials to support Alliance work in the area of policy response and development.

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Policy Priorities

- Strengthen Senate Bill 48
- Strengthen school involvement in postvention reporting—SB 561
- Adult Suicide Prevention and Intervention Plan
- Support OHA's POP
- Write Alliance into statute

Goal E. Measure Impact and Utilization

ACTION STEPS

- Develop evaluation strategy for activities of communication plan with UO lab and Evaluation and Data Committee
- Collect and summarize utilization data for website
- Write and submit an impact and utilization report to Alliance members and OHA

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Next Steps

- Forward to executive committee for approval - September
- Present to Alliance for acceptance - October
- Implement, implement
- Review quarterly with Outreach and Awareness Committee to monitor and adjust if needed

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AOCMHP
Funded by Oregon Health Authority

DRAFT

Basic Rights Oregon Youth Suicide Prevention 2019 Legislation

Problem statement:

- Suicide is the second leading cause of death for youth and young adults 10 to 24 years of age[1]
- Youth suicide is on the rise in Oregon, with the number of youth dying by suicide nearly doubling since 2016
- According to Oregon Health Authority's (OHA) 2017 Healthy Teens Survey, 30% Oregon eighth and eleventh graders reported having a period of two weeks or more during which they felt so sad that they missed some of their regular activities[2].

According to the OHA survey, nearly half of all 8th graders identifying as lesbian, gay or bisexual contemplated suicide and almost a quarter have attempted suicide in the last year. Reports for transgender youth are even worse, with nearly a third of transgender 8th graders attempting suicide.

- As children and teens spend a significant amount of their young lives in school, the personnel who interact with them on a daily basis are in a prime position to recognize the warning signs of suicide and make the appropriate referrals for help.
- In a national survey conducted by the Jason Foundation[3], the number one person whom a pupil would turn to for helping a friend who might be suicidal was a teacher. It is imperative that when a young person comes to a teacher for help, the teacher has the knowledge, tools, and resources to respond.
- According to the Family Acceptance Project[4], research has found that, for an LGBTQ youth, having at least one supportive adult can reduce the youth's risk of suicide.
- Oregon is one of only 3 states that do not have suicide prevention regulations for schools in statute[5]

[1] *Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports* in 2016

[2] https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Documents/2017/2017_OHT_State_Report.pdf

[3] https://www.google.com/url?q=https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2019/YRBS_questionnaire_content_1991-2019.pdf&sa=D&ust=1533748977146000&usg=AFQjCNG-tSV6nso70Y4bbEWuuMTLHTdVTQ

[4] https://familyproject.sfsu.edu/sites/default/files/FAP_English%20Booklet_pst.pdf

[5] https://afsp.org/wp-content/uploads/2016/04/Suicide-Prevention-Statutes-Schools-1.pdf

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Proposed legislation:

Basic Rights Oregon is advocating for passing standalone youth suicide prevention legislation that reflects national bests practices for suicide prevention in schools, mirrors California law (House Bill 2246 from 2015-2016), and builds off of Oregon's Safe Schools Act of 2009 that requires an anti-bullying policies in K-12 schools (see Appendix for the language of both bills). The bill would:

- Provide all school districts in Oregon with a model suicide prevention policy, based on national best practices. The Oregon Department of Education would work with suicide experts and schools to develop the policy. *The Model School District Policy on Suicide Prevention* from the The National Association of School Psychologists, The American School Counselor Association, American Foundation for Suicide Prevention, and The Trevor Project provides a best practices model for ODE and schools: https://www.thetrevorproject.org/wp-content/uploads/2017/09/District-Policy.pdf
- Require school districts to have a suicide prevention policy including procedures relating to suicide prevention, intervention, and postvention. The policy must also address populations at higher risk for youth suicide (defined below), as recommended by *The Model School District Policy on Suicide Prevention.*

Supporting other youth suicide prevention efforts: In addition to running this standalone legislation to provide all schools in Oregon with a model suicide prevention policy, Basic Rights Oregon will advocate for additional legislative efforts for youth suicide prevention to ensure schools get the resources and personnel necessary to support children and address mental health crisis.

Basic Rights Oregon has been working with partners like Lines for Life, the Alliance to Prevent Suicide, and the ACLU of Oregon and has reached out to organizations like the School Based Health Alliance, the Confederation of School Administrators, the Oregon School Board Association, the Oregon Education Association, the School Safety Task Force, the Oregon School Counselors Association, the Oregon School Psychologists Association, county mental health providers, and community-based LGBTQ organizations to learn more about, and support, additional efforts to address this dire issue and prevent youth suicide.

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DRAFT text of proposed bill:

Note that the following language is directly pulled from 2 sources: California's law and Oregon's Safe Schools Act, which can be found in the Appendix.

Relating to suicide prevention policies in K-12 school districts… amending ORS 339… (creating new section after bullying statutes; new ORS 339.365)

Section (1) Each school districts shall, before the beginning of the 2020–2021 school year, have a policy on pupil suicide prevention in grades K to 12, inclusive. School districts are encouraged to develop the policy after consultation with the Alliance to Prevent Suicide, the Oregon Department of Education, school-based mental health professionals, parents, guardians, school employees, students, and administrators.

Section (2) At a minimum, the policy should address:

A) procedures relating to suicide prevention, intervention, and postvention, including the job title of the school officials responsible for the policy and handling reports of suicidal risk.

B) a procedure by which a person may request a school district to review the actions of a school in responding to suicidal risk

(C) the needs of high-risk groups, including, but not limited to, all of the following:

(i) Youth bereaved by suicide.

(ii) Youth with disabilities, mental illness, or substance use disorders.

(iii) Youth experiencing homelessness or in out-of-home settings, such as foster care.

(iv) Lesbian, gay, bisexual, transgender, or questioning youth.

D) a statement of how the policy is to be publicized within the district. At a minimum, a school district shall make the policy:

(i) Annually available to parents, guardians, school employees and students in a student and employee handbook; and

(ii) Readily available to parents, guardians, school employees, volunteers, students, administrators and community representatives at each school office

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or at the school district office and, if available, on the website for a school or the school district

Section (3) The policy shall also address any training to be provided to school employees on suicide awareness and prevention.

(A) Materials approved by the school district for training shall include how to identify appropriate mental health services, both at the school site and within the larger community, and when and how to refer youth and their families to those services.

(B) Materials approved for training may also include programs that can be completed through self-review of suitable suicide prevention materials.

Section (4) The policy shall be written to ensure that a school employee acts only within the authorization and scope of the employee's credential or license. Nothing in this section shall be construed as authorizing or encouraging a school employee to diagnose or treat mental illness unless the employee is specifically licensed and employed to do so.

Section (5) To assist school districts in developing policies for pupil suicide the Oregon Department of Education shall develop and maintain a model policy in accordance with sections 1-4 to serve as a guide for school districts. The Department is encouraged to coordinate with the Alliance to Prevent Suicide, suicide experts, school based mental health providers such as school psychologists and school counselors, and use national models for local school districts in the creation of a model policy for districts. The Department shall disseminate the model policy to school districts.

Section (6) A school district that does not comply with the requirements of this section is considered nonstandard under ORS 327.103

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Appendix:

National model school district policy

from **The American Foundation for Suicide Prevention, the American School Counselor Association**, **the National Association of School Psychologists**, and **The Trevor Project**:

https://www.thetrevorproject.org/education/model-school-policy/#sm.0001sudf61qp2f9jz762g74t1wyx2

California Law:

AB-2246 Pupil suicide prevention policies (2015-2016)
https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2246

Passed 64-11-4 in House and 38-0-1 in Senate

SECTION 1.

The Legislature finds and declares all of the following:

(a) According to the latest 2013 data from the federal Centers for Disease Control and Prevention, suicide is the second leading cause of death for youth and young adults 10 to 24 years of age, inclusive.

(b) As children and teens spend a significant amount of their young lives in school, the personnel who interact with them on a daily basis are in a prime position to recognize the warning signs of suicide and make the appropriate referrals for help.

(c) In a national survey conducted by the Jason Foundation, the number one person whom a pupil would turn to for helping a friend who might be suicidal was a teacher. It is imperative that when a young person comes to a teacher for help, the teacher has the knowledge, tools, and resources to respond.

(d) There are national hotlines available to help adults and lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth experiencing suicidal ideation, including the National Suicide Prevention Lifeline and the Trevor Project, respectively.

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(e) According to the Family Acceptance Project, research has found that, for an LGBTQ youth, having at least one supportive adult can reduce the youth's risk of suicide.

(f) A model policy on suicide prevention created in consultation with suicide prevention experts and other stakeholders is available through the Trevor Project for adoption or adaptation, or both, by the State Department of Education and local educational agencies.

SEC. 2.

Article 2.5 (commencing with Section 215) is added to Chapter 2 of Part 1 of Division 1 of Title 1 of the Education Code, to read:

Article 2.5. Pupil Suicide Prevention Policies
215.

(a) (1) The governing board or body of a local educational agency that serves pupils in grades 7 to 12, inclusive, shall, before the beginning of the 2017–18 school year, adopt, at a regularly scheduled meeting, a policy on pupil suicide prevention in grades 7 to 12, inclusive. The policy shall be developed in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts and shall, at a minimum, address procedures relating to suicide prevention, intervention, and postvention.

(2) The policy shall specifically address the needs of high-risk groups, including, but not limited to, all of the following:

(A) Youth bereaved by suicide.

(B) Youth with disabilities, mental illness, or substance use disorders.

(C) Youth experiencing homelessness or in out-of-home settings, such as foster care.

(D) Lesbian, gay, bisexual, transgender, or questioning youth.

(3) (A) The policy shall also address any training to be provided to teachers of pupils in grades 7 to 12, inclusive, on suicide awareness and prevention.

(B) Materials approved by a local educational agency for training shall include how to identify appropriate mental health services, both at the schoolsite and within the larger community, and when and how to refer youth and their families to those services.

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(C) Materials approved for training may also include programs that can be completed through self-review of suitable suicide prevention materials.

(4) The policy shall be written to ensure that a school employee acts only within the authorization and scope of the employee's credential or license. Nothing in this section shall be construed as authorizing or encouraging a school employee to diagnose or treat mental illness unless the employee is specifically licensed and employed to do so.

(5) To assist local educational agencies in developing policies for pupil suicide prevention, the department shall develop and maintain a model policy in accordance with this section to serve as a guide for local educational agencies.

(b) For purposes of this section, "local educational agency" means a county office of education, school district, state special school, or charter school.

Oregon's Safe Schools Act (HB 2599 from 2009):

https://olis.leg.state.or.us/liz/2009R1/Downloads/MeasureDocument/HB2599/Enrolled

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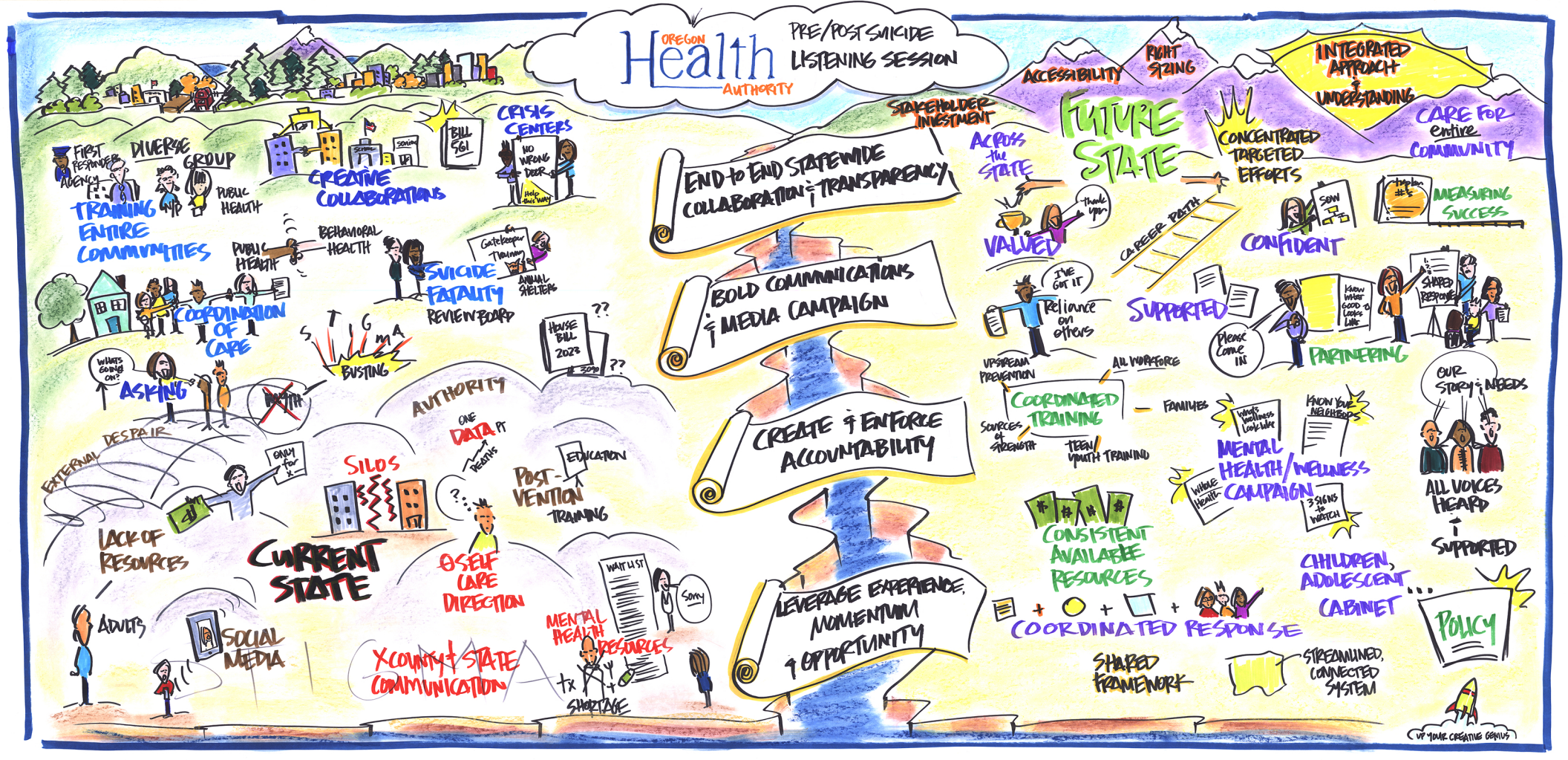
Oregon Health Authority
PRE/POST SUICIDE LISTENING SESSION
CURRENT STATE
FUTURE STATE
STAKEHOLDER INVESTMENT
END-to-END STATEWIDE COLLABORATION & TRANSPARENCY
BOLD COMMUNICATIONS & MEDIA CAMPAIGN
CREATE & ENFORCE ACCOUNTABILITY
LEVERAGE EXPERIENCE, MOMENTUM & OPPORTUNITY
ACCESSIBILITY
RIGHT SIZING
INTEGRATED APPROACH & UNDERSTANDING
CARE FOR entire COMMUNITY
CONCENTRATED TARGETED EFFORTS
ACROSS the STATE
VALUED
CONFIDENT
MEASURING SUCCESS
SUPPORTED
PARTNERING
CAREER PATH
Reliance on others
I'VE GOT IT
Please Come IN
SHARED RESPONSE
Know what GOOD looks LIKE
UPSTREAM PREVENTION
ALL WORKFORCE
COORDINATED TRAINING
FAMILIES
SOURCES of STRENGTH
TEEN/YOUTH TRAINING
MENTAL HEALTH/WELLNESS CAMPAIGN
WHOLE HEALTH
3 SIGNS to WATCH
KNOW YOUR NEIGHBORS
CONSISTENT AVAILABLE RESOURCES
CHILDREN, ADOLESCENT CABINET
COORDINATED RESPONSE
SHARED FRAMEWORK
STREAMLINED, CONNECTED SYSTEM
OUR STORY & NEEDS
ALL VOICES HEARD & SUPPORTED
POLICY
UP YOUR CREATIVE GENIUS
FIRST RESPONDER AGENCY
DIVERSE GROUP
PUBLIC HEALTH
TRAINING ENTIRE COMMUNITIES
CREATIVE COLLABORATIONS
BILL 561
CRISIS CENTERS
NO WRONG DOOR
Help this way
PUBLIC HEALTH
BEHAVIORAL HEALTH
COORDINATION OF CARE
SUICIDE FATALITY REVIEW BOARD
Gatekeeper Training
ANNUAL SHELTERS
WHAT'S GOING ON?
ASKING
STIGMA BUSTING
HOUSE BILL 2023
EXTERNAL DESPAIR
ONLY for X
LACK OF RESOURCES
SILOS
AUTHORITY
ONE DATA PT
DEATHS
POST-VENTION TRAINING
EDUCATION
SELF CARE DIRECTION
ADULTS
SOCIAL MEDIA
X COUNTY & STATE COMMUNICATION
MENTAL HEALTH RESOURCES
WAIT LIST
SORRY
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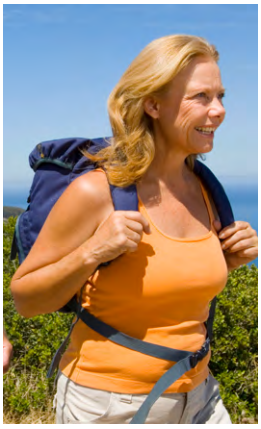
SHORTAGE

September 2018

Suicide-related training for medical and behavioral health providers

Data report to the Legislature per SB 48








Oregon Health Authority
HEALTH SYSTEMS DIVISION

Contents

Executive summary

The rate of suicide in Oregon has been increasing since 2011. There were about 772 suicides in Oregon in 2016. Oregon's rate of suicide deaths is 17.8 per 100,000 people, while the national rate is 13.5. Suicide is the second leading cause of death for Oregonians between the ages of 15 and 34. Over 2,000 state residents are seen in the hospital for suicidal behaviors each year. In 2015, 16 percent of 11th graders reported seriously considering suicide in the past 12 months. (1)

The Oregon Health Authority (OHA) uses a multifaceted approach to address suicide. As part of this effort, OHA proposed a bill in 2017 to require physical and behavioral health professionals to take continuing education in suicide assessment, treatment and management. Workforce development is a major initiative of the Oregon Alliance to Prevent Suicide (Alliance). Members of the Alliance testified in favor of the bill. However, the final bill makes continuing education optional and instructs OHA to report on results in August of each even-numbered year.

Over 80 percent of Americans who die by suicide see a medical or behavioral health professional in the year before death. Many of them see a professional in the month before death. To bring down Oregon's high suicide rate, it is crucial that medical and behavioral health professionals are confident and competent in assessing suicide risk and treating suicidal individuals. Currently, these professionals largely do not receive training in suicide assessment, treatment and management in their advanced degree programs. Thus, they need continuing education to ensure care to the public focuses on suicide safety.

"Health care organizations have a unique opportunity to help prevent suicide. People at risk of suicide are often seen in health care settings; in a study within large health systems, over 80 percent of those who died by suicide had been seen by a professional in the prior year; most did not have a mental health diagnosis. Almost 40 percent of those who died by suicide had an emergency department visit without a mental health diagnosis (Ahmedani et al., 2014). In another review (Luoma, Martin, & Pearson, 2002) reported that close to one-half of those who died by suicide visited a primary care provider in the month before their death. In response, and due to advances in research and the development of new tools to assist in addressing suicide, health care organizations have begun to prioritize suicide prevention." (2)

The following report details the history of Senate Bill 48, the implementation and the initial data OHA has collected from medical doctors and naturopathic physicians.

Based on results of initial surveys given to those licensed by the Oregon Medical Board and Oregon Board of Naturopathic Medicine, a minority of all licensees reported taking courses specified in SB 48. According to Oregon Medical Board data only 22.7 percent of the 18,261 responding (MD, DO, physician assistants and others licensed by the board) took a course relevant to SB 48. Among the 1,021 naturopaths responding, only 16.2 percent took such a course. On follow-up, those who took courses found them:

- Beneficial
- Relevant to their work and
- Contributing to improving their skills in identifying suicidal individuals.

OHA looks forward to seeing increased participation in suicide assessment training. All types of providers could play a pivotal role in saving lives.

Introduction

Over 80 percent of Americans who die by suicide see a medical or behavioral health professional in the year before death. Many of them see a professional in the month before death.

OHA proposed a bill in 2017 to require physical and behavioral health professionals to take continuing education in suicide assessment, treatment and management. Workforce development is a major initiative of the Oregon Alliance to Prevent Suicide (Alliance). Members of the Alliance testified in favor of the bill. However, the final bill makes continuing education optional and instructs OHA to report on results in August of each even-numbered year.

This report is legislatively mandated. The report tells what work has been done to carry out Senate Bill (SB) 48 in the first year (2017). Data collected for this 2018 biennial report includes providers licensed by the:

- Board of Medicine and
- Board of Naturopathic Physicians.

Other licensing boards specified in legislation will start gathering information in 2018.

Background

To address the rising rate of suicide across the nation, training in suicide prevention and treatment for physical and behavioral health providers and school personnel is encouraged by the:

- U.S. Surgeon General
- National Action Alliance for Suicide Prevention (Action Alliance)
- National Strategy for Suicide Prevention (the National Strategy) — A joint effort by the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention
- American Association of Suicidology
- American Foundation for Suicide Prevention and
- It is an objective of the Oregon Youth Suicide Intervention and Prevention Plan.

In 2017, OHA addressed this national consensus. OHA asked for legislation in Oregon to require physical and behavioral health professionals and school counselors to complete continuing education (CE) in suicide:

- Assessment
- Treatment and
- Management.

The legislature revised the bill to encourage licensed providers to take such training, but not require it. If providers take these optional courses, licensees must report it to their licensing boards at license renewal. Licensing boards are required to report a summary of aggregate data to OHA by March 1 of each year. Based on OHA research, Oregon is the only state to adopt voluntary basis CE to address provider education. Other states require certain professionals to take the courses.

Professions and boards addressed in SB 48

Physicians	Oregon Medical Board
Physician assistants	Oregon Medical Board
Nurses and nurse practitioners	Oregon State Board of Nursing
Naturopathic physicians	Oregon Board of Naturopathic Medicine
Social workers	Oregon Board of Licensed Social Workers
School counselors	Teacher Standards and Practices Commission
Licensed counselors	Oregon Board of Licensed Professional Counselors and Therapists
Occupational therapists	Occupational Therapy Licensing Board
Physical therapists	Physical Therapist Licensing Board
Chiropractic physicians	Oregon Board of Chiropractic Examiners
Psychologists	Oregon Board of Psychologist Examiners

Findings and conclusions

Based on results of initial surveys given to those licensed by the Oregon Medical Board and Oregon Board of Naturopathic Medicine, a minority of all licensees reported taking courses specified in SB 48. According to Oregon Medical Board data only 22.7 percent of the 18,261 responding (MD, DO, physician assistants and others licensed by the board) took a course relevant to SB 48. Among the 1,021 naturopaths responding, only 16.2 percent took such a course. On follow-up, those who took courses found them:

- Beneficial
- Relevant to their work and
- Contributing to improving their skills in identifying suicidal individuals.

It is doubtful that courses taken were uniformly best practices in suicide assessment, treatment and management. Many classes were reported as short and delivered at conferences. Available best practice trainings are generally several hours or more.

Note that this is an initial sample and a starting point. The bill didn't go into effect for reporting for physicians and naturopaths before November 2017. Other licensing boards will begin reporting data in 2018.

Course offerings

SB 48 requires OHA to develop a list of suggested courses that address suicide assessment, treatment and management. OHA posted the list on the OHA website on Nov. 2, 2017. OHA plans to make annual updates. The 2017-2018 list is available at: https://tinyurl.com/y96gnxf6

Additionally, under its contract with the Oregon Pediatric Society (OPS), OHA funded development and implementation of training about suicide risk, treatment and management. In January 2018, OPS began delivering the suicide prevention module to:

- Family practice physicians
- Family practice physicians' clinic staff and
- School-based health centers.

Continuing medical education (CME) units are provided by OPS.

OHA also funded a low-cost offering of the best practice Question, Persuade, Refer-Triage (QPRT-T) course at the March 2018 Oregon Suicide Prevention Conference in Portland. The course addresses assessment and treatment issues. CE credits were available. OHA asked licensing boards to promote this training to their licensees. Four nurses and 12 behavioral health professionals attended the training.

Senate Bill 48 does not require dental professionals to report CE at license renewal. Yet, the Oregon Board of Dentistry promoted trainings to their licensees. In December 2017, the Oregon Board of Dentistry newsletter promoted information on the SB 48 initiative. The article told of:

- Practice changes for suicide prevention and intervention
- Courses that meet the outline of SB 48 and
- Workplace wellness programs to address the high rate of suicide among dentists.

Data collection

The implementation date for SB 48 was Jan. 1, 2018. Only licensees of the medical and naturopathic boards were surveyed in 2017. Data on additional groups of licensees will be reported to OHA in March 2019. That data will be available for the next legislative report scheduled for August 2020. Results for the two licensing boards' licensees are below.

OHA, at request of the licensing boards, distributed survey questions to all licensees for which OHA collects data at license renewal. Licensees up for license renewal in 2017 (naturopathic physicians) were surveyed. Additional data collection among other remaining groups of licenses through these OHA surveys are planned in 2018-2020 and beyond.

The Teachers Standards and Practices Commission, which licenses school counselors, began distributing surveys on Jan. 1, 2018.

Physicians are not routinely surveyed at license renewal by OHA; the Oregon Medical Board surveyed them. Those results are below.

Physicians

Twenty-seven percent of physicians (MD and DO, physician assistants and others licensed by the Oregon Medical Board) reporting (4,894 out of 18,261) said they took a course in suicide assessment, treatment or management. (Table 1 and 2)

Table 1. Total physicians reporting at 2017 license renewal and percentage of those reporting continuing education in suicide assessment, treatment or management.

Percentage	Count	Self-report suicide CME
48%	8674	No
26%	4693	Unsure
27%	4894	Yes
100%	**18,261**	**Total**

Table 2. Report by county of physicians receiving continuing education in suicide assessment, treatment or management.

County	Count
Harney	2
Hood River	45
Jackson	212
Jefferson	15
Josephine	45
Klamath	63
Lake	4
Lane	306
Lincoln	40
Linn	75
Malheur	54
Marion	277
Morrow	3
Multnomah	1931
Polk	37
Sherman	1
Tillamook	21
Umatilla	53
Union	17
Wallowa	12
Wasco	36
Washington	452
Yamhill	77
Total	**4894**

Naturopathic physicians

Data collected during 2017 license renewal period (primarily Nov-Dec 2017)

Active licensees as of Dec. 30, 2017	1030
Number of licensees who completed the workforce survey*	1012
Number of survey takers who completed any CE described in SB 48	164
Percent of survey takers who completed any CE described in SB 48*	16%

*Non-survey takers are primarily new licensees

About 43 percent of naturopathic physicians reported that their training occurred at a conference (Table 3). Stand-alone courses were taken about 38 percent of the time.

Table 3. Naturopathic physician training types

Training type	Count	Percent
Conference	72	44%
Stand-alone course	63	38%
Other	29	18%
Grand total	**164**	**100%**

More than three-quarters of trainings taken lasted two hours or less. (Table 4) Most best practice trainings in suicide assessment, treatment and management last a day or more.

Table 4. Naturopathic physician training duration

Course length	Count	Percent
0-2 hours	125	76%
3-6 hours	24	15%
7 hours or more	7	4%
I don't remember	8	5%
Grand Total	**164**	**100%**

Naturopathic physicians from 15 counties reported taking trainings in assessment, treatment or management.

Table 5. Naturopath trainees by county

County	Count	Percent
Did not list	23	14%
Benton	1	1%
Clackamas	17	10%
Clatsop	2	1%
Columbia	1	1%
Coos	1	1%
Deschutes	4	2%
Jackson	4	2%
Josephine	2	1%
Lane	4	2%
Linn	1	1%
Marion	5	3%
Multnomah	77	47%
Wasco	2	1%
Washington	17	10%
Yamhill	3	2%
Grand Total	**164**	**99%**

Surveys on course content and satisfaction

Boards and OHA sent surveys to licensees up for license renewal in 2017. Licensees were asked if they would be willing to share with OHA the content and knowledge gained because of courses taken. The Medical Board provided spreadsheets to OHA showing those willing to share input. OHA prepared a short online questionnaire for licensees. It was distributed to 4,894 physicians and 164 naturopathic physicians by the University of Oregon. The University of Oregon analyzed the results and reported them in detail. University of Oregon data reports are in Appendix I (medical board licensees) and Appendix II (naturopathic physicians).

Conclusion

This report is presented to the legislature in compliance with SB 48. It reports data for the medical and naturopathic boards on licensees who reported at license renewal in 2017 they took a course in suicide assessment, treatment or management in the previous period of licensure. Data for additional licensees referenced in the legislation will be reported as required in August 2020.

Report Overview

In alignment with the efforts of Senate Bill 48, the University of Oregon (UO) and the Oregon Health Authority (OHA) distributed an informative survey to medical practitioners who had participated in a suicide-related training as part of their relicensure process. The survey aimed to determine what type of suicide training medical professionals were participating in and whether these courses were deemed useful. Of the 2,740 practitioners who indicated they would be willing to provide training feedback, 378 individuals (D.O. = 6.6%, D.P.M. = 0.5%, M.D. = 83.3%, Volunteer M.D. = 0.3%, P.A. = 9 %) responded to at least part of the survey and 323 practitioners completed the entire survey. The response rate (13.8%) may be due to several contextual factors. Roughly 30 practitioners responded to the survey that they either had not been trained or were unsure of what training they participated in. Additionally, because responses were voluntary, practitioners may not have seen participation as necessary.

Training Content and Impact

An overarching aim of the survey was to ascertain what type of suicide-related content was being presented during trainings and whether or not that information was useful for practitioners. Research on professional development and training has demonstrated that measuring outcomes related to how participants received a training helps determine if information learned will impact daily practice. Thus, several survey questions were designed to assess the appropriateness, utility, and acceptability of the suicide-related training that practitioners received. Additionally, practitioners were questioned on what content their training covered and what topics they are interested in learning more about.

Training Topics

Many of the suicide-related trainings covered multiple topics that were limited to eight major domains. The four most frequently covered topics included *suicide warning signs* (16.2%), *suicide-risk assessment* (16.2%), *risk and protective factors* (15.3%), and *safety planning* (13.2%). The remaining topics included *treatment strategies for suicidal patients* (11.9%), *managing suicidal patients* (11.7%), *provider self-care* (7.0%) and *lethal means counseling*

(6.8%). Less than 2% of practitioners took a training that covered a topic outside of these eight topics. Additionally, the frequent selection of multiple topics may denote a pattern of trainings being concentrated on broad overviews rather than more specialized content.

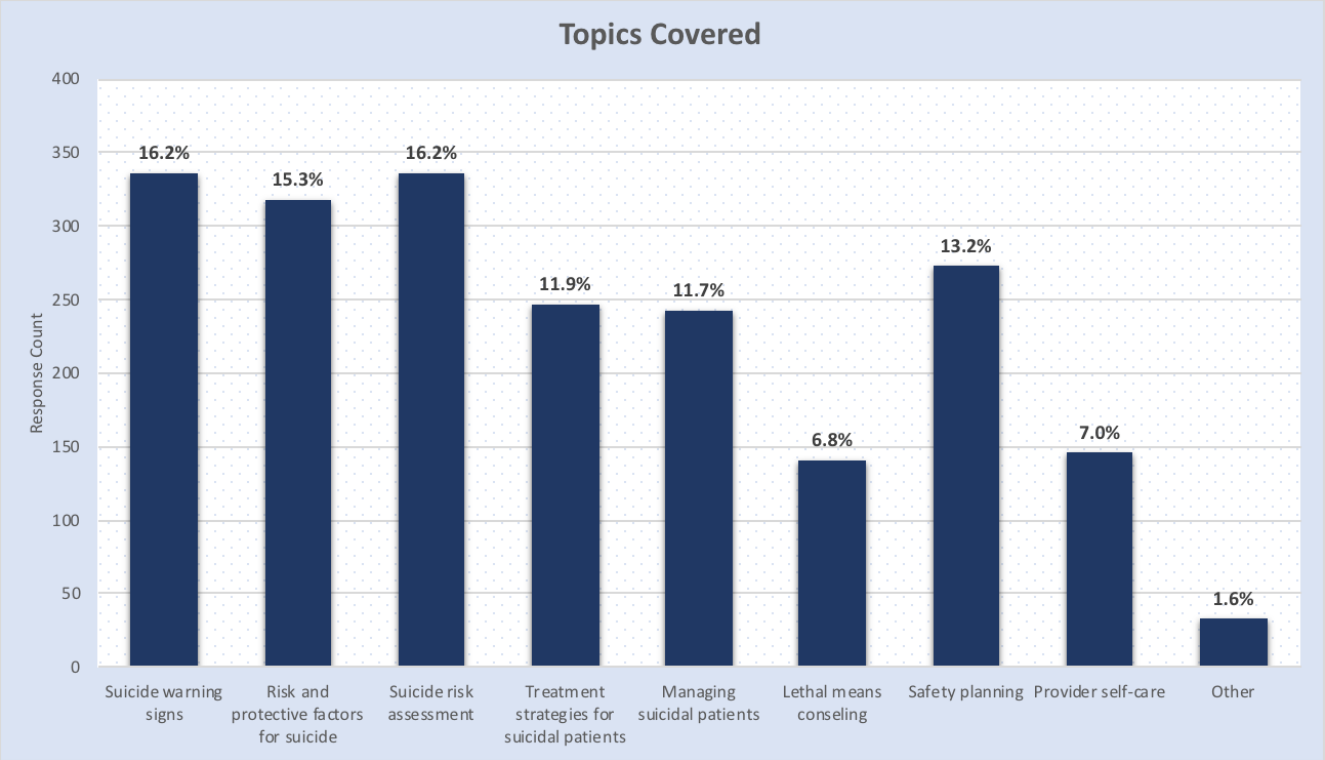


Figure 1. Summary of topics covered during trainings

As was the case with topics covered, most practitioners were interested in pursuing future trainings in multiple content domains. The highest interest was in t*alking to patients and families about suicide* (13.7%), *treatment strategies for suicidal patients* (13.4%), *managing suicidal patients* (13.1%), and *provider self-care* (12.8%). The high interest in self-care contrasts against the low percentage of trainings that covered that topic, which indicates a possible shortage in the trainings available on a subject area identified as highly valuable to practitioners.

Figure 2. Summary of additional topics of interest

Impact of Training

Practitioners found the majority of trainings to be effective, useful, appropriate to their practice, and overall satisfactory. For gains in knowledge and skills, most practitioners either agreed (50.2%) or somewhat agreed (44.0%) that the training was effective. The same was true for increased ability to identify patients at-risk of suicide, where over 93% of practitioners agreed or somewhat agreed to their ability being increased. Additionally, five survey questions were designed to measure outcomes related specifically to how the training would translate into actual practice. Across all five of these measures, practitioners overwhelming agreed that the training had a positive impact. Participants agreed or somewhat agreed most with the statements that the training was satisfactory (95.3%) and that the content was well-suited for the topic covered (98%). For all questions related to training impact, please refer to Table 1. Furthermore, a summary of all responses across the seven training impact questions is presented in Figure 3.

Table 1. Overall impact of training on practitioners

	Percent Endorsed (%)				
	Disagree (1)	Somewhat Disagree (2)	Somewhat Agree (3)	Agree (4)	Average Score
Knowledge was gained	1.6	4.1	44	50.3	3.43
Increased ability to identify at-risk patients	1.9	4.6	42.5	51	3.43
Content was useful to practice	3.6	5.5	32.1	58.9	3.46
Training was relevant to client population	3.3	4.4	25.7	66.7	3.56
Content helped with suicide safer changes to practice	4.9	9.3	42.6	43.2	3.24
Format and content was suited to topic covered	0.6	1.4	32.2	65.8	3.63
Training was satisfactory	1.1	3.6	27.1	68.2	3.62

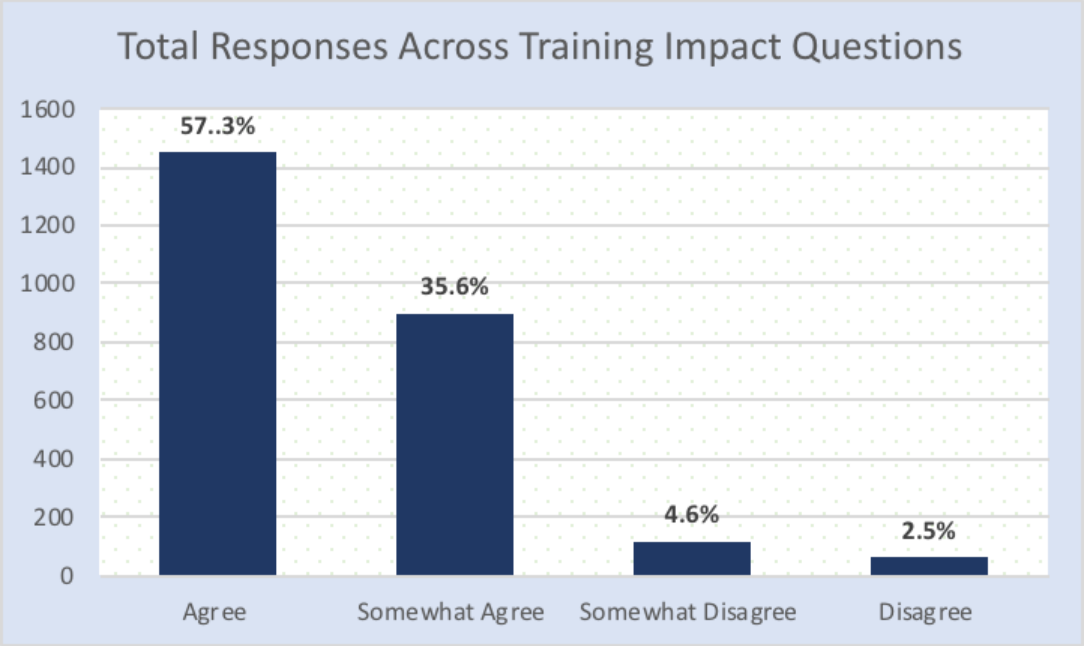


Figure 3. Summary of responses across training impact questions

Training Context and Logistics

Prior to survey dissemination, little was known regarding how medical practitioners received suicide-related training. Thus, a section of the survey was dedicated to collecting logistical data on (a) how trainings were delivered, (b) training cost, (c) who provided the training, (d) whether Continuing Medical Education (CMEs) credits or Continuing Education Units (CEUs) were provided, and (e) training duration.

Format and Cost

Trainings were mainly delivered through the *online* (52.6%) or *conference format* (30.1%), with the remainder occurring either *in-person* (7.6%), both *online and in-person* (3.1%), or *other* (6.7%). The majority of participants that selected "other" for training delivery used some form of information readings as the main training input. For training cost, most trainings were *free* (71.3%) or *below $50* (7.8%); however, a small percentage of trainings were *over $300* (8.8%).

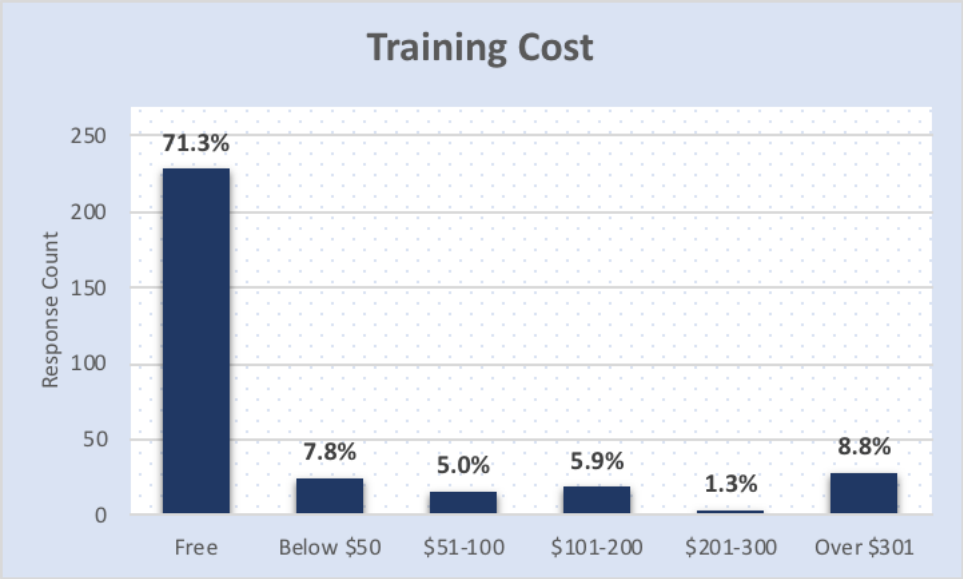


Figure 4. Summary of training costs

Training Provider

Professional associations (e.g., American Psychological Association, Kaiser Permanente) provided 38.4% of the trainings. The second most frequent provider was "Other" at 27.2%. The remainder of participants took courses provided by the *licensing board* (6.8%), *course developer* (16.5%), *university* (7.8%), or a *behavioral health agency* (3.2%). An analysis of provider names found five agencies that were listed most frequently: (a) Kaiser Permanente Continuing Medical Education, (b) OHA, (c) OHSU, (d) VA, and (e) Washington State Psychiatric Association.

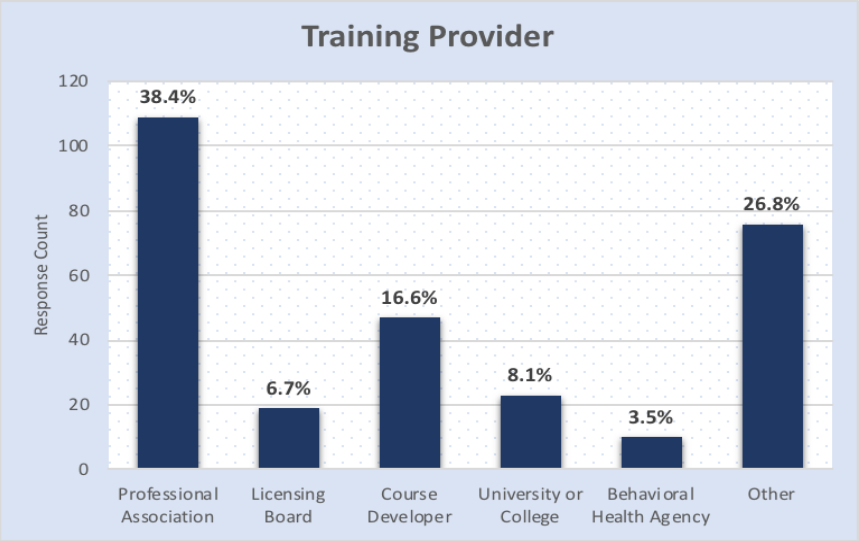


Figure 5. Breakdown of providers for trainings

CMEs and CEUs

Participants were mostly *unsure* (53.5%) whether CEUs were provided at the training. Roughly a quarter of participants (28.2%) believed CEUs were *not* provided and 18.4% stated that CEUs were provided. There was higher clarity regarding CMEs. Of the 323 responses, 63% of practitioners stated that trainings offered CMEs and 37% believed they were not offered. Additionally, participants were asked how important CMEs or CEUs were in their decision to attend the training. A majority of practitioners stated that CMEs or CEUs were either *very important* (22.9%), *important* (34.5%), or *somewhat important* (31.3%). Only a small percentage of participants stated that CMEs or CEUs were *not important* (11.0%).

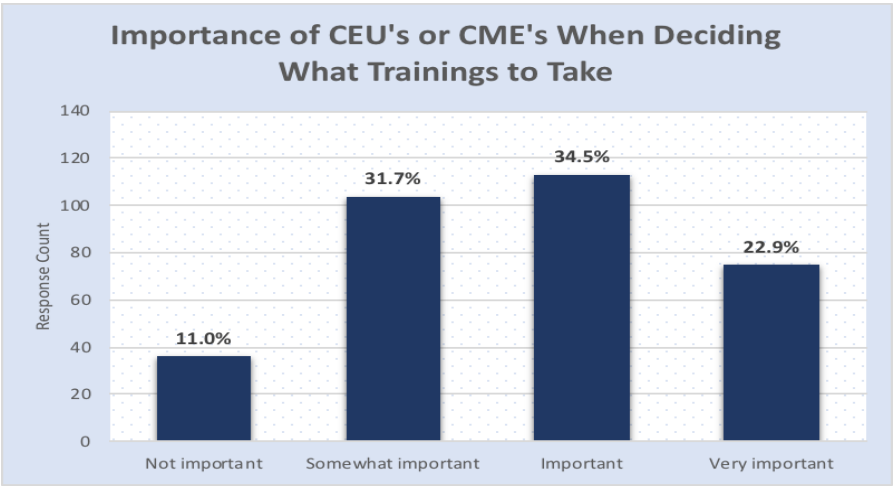


Figure 6. Summary of CEU or CME importance

Duration

Overall, trainings tended to be relatively short in length with over half (55.3%) being under 2-hours. However, there was a subsection of practitioners who participated in a training lasting six or more hours (22.5%).

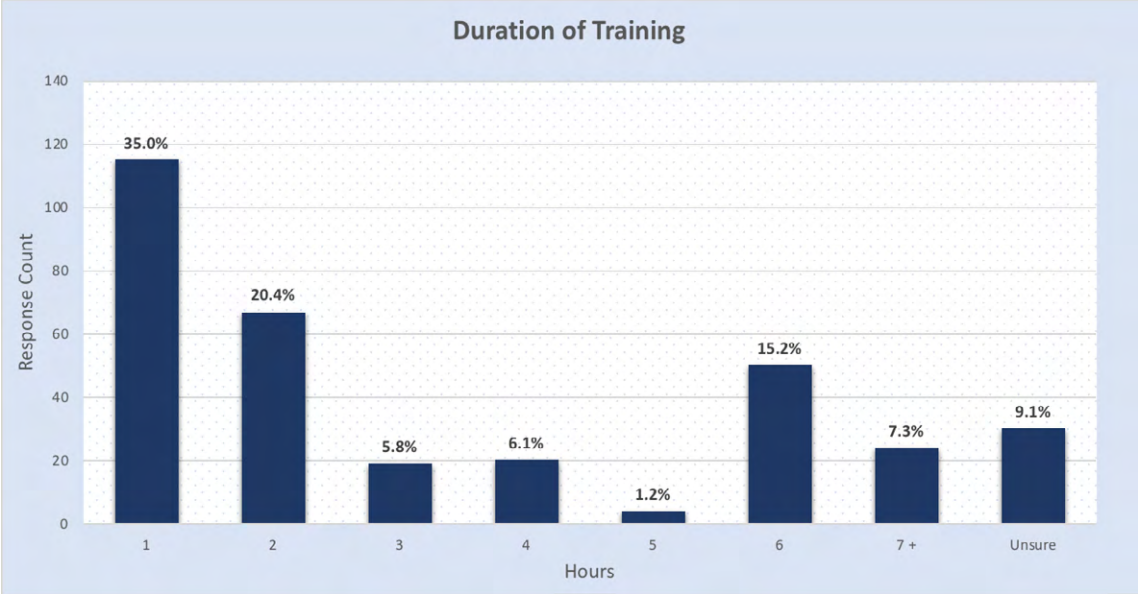


Figure 7. Breakdown of duration for trainings

Summary

The medical practitioner survey resulted in a better understanding of what type of suicide-related trainings practitioners are participating in as part of their relicensure process. Trainings tended to be relatively short, free of charge, and delivered either online or during a conference. Most courses covered multiple topics; however, the subject of provider self-care was the least frequently covered subject even though practitioners were highly interested in learning more about the topic. Overall, practitioners seemed to be receptive to the trainings and agreed that the courses were appropriate, useful, and effective in increasing knowledge and skills.

Provided by the University of Oregon
Prevention Science Lab

Report Overview

In order to support the efforts of Senate Bill 48, the University of Oregon (UO) and the Oregon Health Authority (OHA) distributed an informative survey to naturopathic practitioners who had participated in a suicide-related training as part of their relicensure process. The aim of the survey was to determine what type of suicide training that naturopathic professionals were participating in and whether those courses were deemed useful. Of the 22 practitioners who indicated they would be willing to provide training feedback, there were five individuals (N.D. = 100%) who responded to the survey. The response rate (22.7%) may be due to several contextual factors. Two practitioners responded to the survey that they either had not been trained or were unsure of what training they participated in. Additionally, because responses were voluntary, practitioners may not have seen participation as necessary.

Training Content and Impact

An overarching aim of the survey was to ascertain what type of suicide-related content was being presented during trainings and whether or not that information was useful for practitioners. Research on professional development and training has demonstrated that measuring outcomes related to how a training is received by participants helps determine if information learned will impact daily practice. Thus, several survey questions were designed to assess the appropriateness, utility, and acceptability of the suicide-related training that practitioners received. Additionally, practitioners were questioned on what content their training covered and what topics they are interested in learning more about.

Training Topics

Many of the suicide-related trainings covered multiple topics that were limited to eight major domains. The five most frequently covered topics included suicide warning signs (18.5%), suicide-risk assessment (18.5%), risk and protective factors (14.8%), safety planning (14.8%),

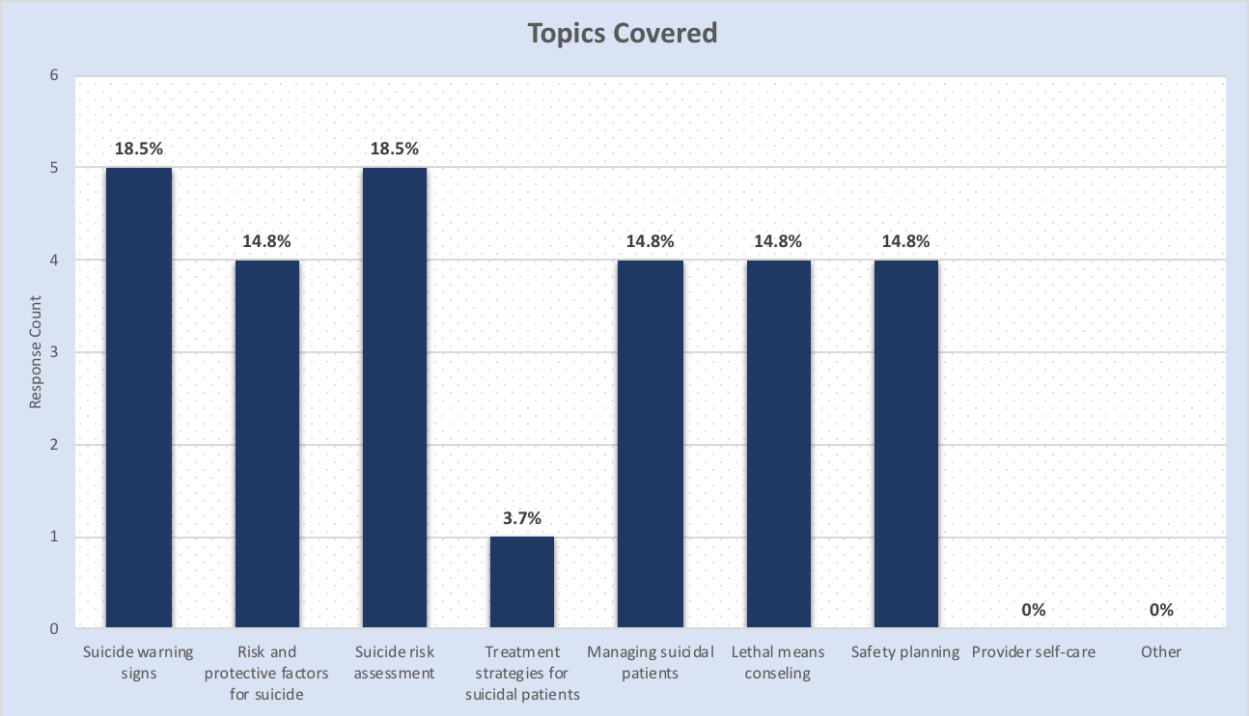


Figure 1. Summary of topics covered during trainings

As was the case with topics covered, most practitioners were interested in pursuing future trainings on multiple content domains. The highest interest was in managing suicidal patients (25%) and provider self-care (25%). The high interest in self-care contrasts against the low percentage of trainings that covered that topic, which indicates a possible shortage in the trainings available on a subject area identified as highly valuable to practitioners.

Impact of Training

Practitioners found the majority of trainings to be effective, useful, appropriate to their practice, and overall satisfactory. For gains in knowledge and skills, all practitioners either *agreed* (n = 3) or *somewhat agreed* (n = 2) that the training was effective. The same was true for increased ability to identify patients at-risk of suicide, where 100% of practitioners agreed or somewhat agreed to their ability being increased. Additionally, five survey questions were designed to measure outcomes related specifically to how the training would translate into actual practice. Across all five of these measures, practitioners overwhelming agreed that the training had a positive impact. Participants agreed most with the statements that the training was satisfactory (100%) and that the content was well-suited for the topic covered (100%). For all questions related to training impact, please refer to Table 1.

Table 1. Overall impact of training on practitioners

	Participant Count				
	Disagree (1)	Somewhat Disagree (2)	Somewhat Agree (3)	Agree (4)	Average Score
Knowledge was gained	0	0	2	3	3.60
Increased ability to identify at-risk patients	0	0	2	3	3.60
Content was useful to practice	0	0	0	5	4.00
Training was relevant to client population	0	0	1	4	3.80
Content helped with suicide safer changes to practice	0	0	2	3	3.60
Format and content was suited to topic covered	0	0	0	5	4.00
Training was satisfactory	0	0	0	5	4.00

Training Context and Logistics

Prior to survey dissemination, little was known regarding how medical practitioners received suicide-related training. Thus, a section of the survey was dedicated to collecting logistical data on (a) how trainings were delivered, (b) training cost, (c) who provided the training, (d) whether Continuing Medical Education (CMEs) credits or Continuing Education Units (CEUs) were provided, and (e) training duration.

Format and Cost

Trainings were mainly delivered through the online (n = 2) or conference format (n = 2) with the remaining practitioners taking a course in-person. For training cost, 4 participants received a free training and 1 participant took a course below $50.

Training Provider

Professional associations (i.e., NetCE, Oregon Pediatrics Society, and Philadelphia Transgender Health Conference) provided 3 of the trainings. ZOOM Care and the Kaiser Foundation provided training for the other two practitioners.

CMEs and CEUs

Two participants were unsure whether CEUs were provided at the training and 2 participants believed CEUs were provided. There was higher clarity regarding CMEs, where all 5 practitioners stated CMEs were provided. Additionally, the survey asked participants how

important CMEs or CEUs were in their decision to attend the training. For this question, practitioners responded evenly across the choice categories with 1 participant selecting “Not Important,” 1 selecting “Somewhat Important,” 1 selecting “Important,” and 2 selecting “Very Important.”

Duration

Overall, trainings tended to be either relatively short in length or significantly longer in duration. Two participants took a 1-hour training, while the remaining three participated in a 6-hour or longer training.

Summary

The naturopathic practitioner survey resulted in a better understanding of what type of suicide-related trainings practitioners are participating in as part of their relicensure process. Trainings tended to be relatively short, free of charge, and delivered either online or during a conference. Overall, practitioners seemed to be receptive to the trainings and agreed that the courses were appropriate, useful, and effective in increasing knowledge and skills.

Provided by the University of Oregon
Prevention Science Lab

Endnotes

1. National Center for Health Statistics [Internet]. Centers for Disease Control and Prevention; 2018 [cited 2018 Aug 3]. Available from: https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.

2. Transforming Health Systems Initiative Work Group Washington, DC: Education Development Center, Inc. Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe. National Action Alliance for Suicide Prevention [Internet] 2018. [cited 2018 Aug 3] Available from: http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Action%20Alliance%20Recommended%20Standard%20Care%20FINAL.pdf

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