Alliance Executive Committee
Meeting Materials
November 2020

Attachment 1:

The Alliance Policy Agenda
State Fiscal Year 2020-21

Legislative Policy

Lead

Amend current legislation on youth suicide to expand the age range from 10 to 24, to include all school age children (5-24). **(Executive Committee)**

Require behavioral health workforce to receive continuing education on suicide prevention, intervention, and management **(Workforce Committee)**

Collaborate

Legislative concept requiring medical examiners to report youth suicide deaths to local mental health authorities including specific reporting timelines. **(OHA – lead; Data and Evaluation Committee)**

Explore

Explore collaborations and priorities for protecting behavioral health budgets for essential services for children, youth and young adults. **(Executive Committee)**

Explore legislative concept asking Oregon Health Authority to develop a suicide prevention and intervention plan for adults that incorporates clear connections with the YSIPP. **(Executive Committee)**

Advocacy Related to Programs, OARS and Practice

Lead

Continue to lead efforts to ensure implementation HB 3090, 3091, and 2023. **(Transitions of Care)**

Require organizations that serve our most vulnerable youth and young adults such as Child Welfare, Residential Treatment, Juvenile Justice to build LGBTQ affirming organizational cultures by training staff, developing LGBTQ supportive policies and programs to increase protective factors and reduce risk of suicide. **(LGBTQ Advisory Group)**

Increase the number of health professionals who receive regular, evidence-informed education and training in suicide assessment, treatment, and management. (With the view of working towards legislation in the future.) **(Workforce Committee; coordinate with Transitions of Care)**

Coordinate efforts with coalitions to support workplace policies and programs that promote mental health and prevent suicidal behavior among employees. Emphasis on 24 years and younger. **(Workforce Committee)**

Promote adding a CCO incentive / performance measure around suicide screening and referral. **(Transitions of Care)**

Diversify Alliance membership to better reflect people of color and other marginalized groups; and, elevate their voices and perspective in policy advocacy and YSIPP plan development. **(Executive Committee; other?)**

Collaborate

Ensure that appropriate cross-system communication occurs in order to prevent death by suicide. Address the need for hospitals to develop MOUs or other protocols for communication with schools and colleges after a behavioral health crisis. **(Transitions of Care Committee Lead; Schools Committee)**

Support comprehensive K-12 school suicide prevention legislation and policies, including mandated training for school personnel and mandated policies on suicide prevention, intervention, and postvention. **(Schools Committee)**

Support development of an adult suicide prevention plan. **(Who and How?)**

Advocate for more social workers and counselors in schools and that all school social workers and counselors are trained to screen for suicidality and make appropriate referrals. **(Schools Committee)**

Advocate for youth-serving organizations, in particular social service, residential care and judicial system, to actively develop LGBTQ+ affirming cultures and practice in order to promote protective factors and prevent suicide. **(LGBTQ Advisory Committee and YYEA)**

Support and promote suicide prevention skill building directed towards parents and caregivers of children. **(Who?)**

Collaborate to support implementation of the strategic plan developed by the Alliance Lethal Means Advisory Group. **(Lethal Means Advisory Group; Executive Committee)**

Explore

Explore replicating Washington County's Suicide Fatality Review process across Oregon. **(Who? Data and Evaluation Committee?)**

Ensure the linkage between substance abuse and suicide is addressed in all aspects of policy work. Push for greater integration of substance abuse treatment and suicide prevention and intervention. **(Who?)**

Alliance Executive Committee
Meeting Materials
November 2020

Attachment 2:

SMART GOALS

STRATEGIC PRIORITY: The Alliance will develop a plan to foster and sustain statewide policy development and leadership in suicide prevention.

DEADLINE	TASK #	ACTION STEP
Ongoing through 6.30.21	Task 1	Track progress on legislative priorities for 2021 legislative session through monthly reports from committee chairs or staff
1.01.21	Task 2	Meet with key behavioral health advocates to coordinate support for funding of safety net services most relevant to suicide prevention and intervention
1.01.21	Task 3	Make recommendations regarding policy areas to address in YSIPP 2.0 based on committee recommendations and input from September Quarterly Meeting
11.15.20	Task 4	Assign a workgroup to identify long-term policy agenda for the Alliance

STRATEGIC PRIORITY: Integrate and coordinate suicide prevention activities across multiple sectors and settings

DEADLINE	TASK #	ACTION STEP
Quarterly	Task 1	Develop agendas for quarterly Alliance meetings and provide updates to membership on progress.
11.15.20	Task 2	Annually review Alliance member satisfaction survey and make quality improvement recommendations if needed
2.28.21	Task 3	Review and approve or modify recommendations from the Outreach and Awareness Committee regarding recruiting and appointing new members to reflect Oregon's BIPOC
Monthly	Task 4	Provide feedback, support or advice to OHA based on monthly updates about ongoing activities or key areas of data from the SPIPP team.

Health Systems Division
Children and Families Behavioral Health, Suicide Prevention
Kate Brown, Governor

To: Alliance to Prevent Suicide
Executive Committee

From: Jill Baker, Youth Suicide
Prevention Policy Coordinator
(on behalf of the OHA - HB 3090 workgroup)

Re: Response to the letter dated Feb 18, 2020

Date: October 27, 2020

Dear Executive Committee:

This letter is in response to your request for information regarding ORS 441.053 dated Feb 18, 2020 and request for an update in September 2020. We want to acknowledge that this response was delayed, and to affirm that this work is important to us. Thank you for patience and for being willing to keep this on the forefront during these unprecedented times. The delay in response was largely due to the directive from Pat Allen to cease any work that required time from key stakeholders as Oregon moved into the pandemic response. After your letter in Feb 2020, the OHA HB 3090 workgroup has met several times, begun to draft survey questions, confirmed key stakeholder list, engaged with the Oregon Hospital Association, and gotten permission to resume this work from OHA leadership.

Our intended timeline to re-survey hospitals is as follows:

November 2020	Complete draft survey questions and analysis goals internally
December 2020	Send draft survey questions to Key Stakeholder list for review
January 2021	Convene a meeting with Key Stakeholders to gather feedback on survey questions, methodology, and analysis goals.
February 2021	Finalize survey
March/April 2021	Disseminate survey, follow up as needed
May 2021	Analyze results – Send to Publications
June 15, 2021	Release report of 2nd survey

In addition to responding to your direct questions (below), we wanted to clarify a few things as we move forward with a second survey:

- Some of the answers to your questions are unknown. In those cases, we are not collecting metrics referenced, and to date the only analysis was the single survey performed previously and the complaints that have been received by OHA.
- There was not funding attached to this legislation to have compliance be monitored in any other way than complaint-driven. There are not adequate resources currently to have comprehensive compliance measures for this legislation.
- OHA will use the hospitals' answers to assess implementation and identify barriers to implementation of this legislation. OHA is not completing the second survey for the purpose of assessing compliance with the legislation nor do we anticipate punitive measures being a direct outcome of this survey.
- We hope to work collaboratively with the Alliance to Prevent Suicide and other stakeholders to strengthen these policies and therefore increase the protective factor of a caring contact for people experiencing behavioral health crises.

Please direct any questions or comments about this letter of response to Jill Baker. Thank you for your tireless work in this important field.

Sincerely,

Jill Baker
Youth Suicide Prevention Policy Coordinator
(503) 339-6264
Jill.baker@dhsoha.state.or.us

Alliance to Prevent Suicide Questions with OHA responses (in blue):

1) Have all hospitals provided OHA information on adoption of policies required by 333-520-0070 (Emergency Department Services) 333-505-0055 (Hospital Discharge Planning)?

- For yes:
  - How are these policies being made available to patients and their lay caregivers?
  - Do adopted policies sufficiently meet the requirements in rules?
  - Are policies being incorporated into the hospital practices?
- For no:
  - Why not?
  - What barriers are being reported as preventing this requirement from being fulfilled?
  - What is OHA doing about those not in compliance?

OAR 333-505-0055(2)(b) requires a hospital to "adopt, maintain and follow written policies on discharge planning and termination of services in accordance with these rules and 42 CFR 482.43." The rule at subsection (2)(b) specifies the elements necessary in a policy for patients hospitalized for mental health treatment.
OAR 333-520-0070 requires a hospital to "adopt, maintain and follow written policies that pertain to the release of a patient from the emergency department who is being seen for a behavioral health." The rule further specifies elements necessary in the policy.
Neither of these rules require the hospitals to submit their policies to the Authority for review. This is a complaint driven process, whereby, when the Authority receives a complaint about a hospital's alleged failure to comply with discharge planning, it will review the complaint and conduct a complaint investigation to determine whether the necessary policies are in place and whether the hospital followed the policy. HCRQI presented to the OAHHS Behavioral Health Compliance Group to help hospitals work to design and implement compliant policies and procedures.
The PHD does not have information that reflects the level of compliance across the state. We've had fewer than 5 complaints and 1 finding of non-compliance has been issued as of August 20, 2020. Hospitals cited for non-compliance are required to submit a Plan of Correction which identifies the hospital's plan to correct each cited deficiency and return to compliance. Plans are reviewed for sufficiency of:

- The plan & procedure to correct the deficiency;
- The monitoring to ensure that the deficiency has been abated; and
- The title of the person responsible for implementing the corrective action.

The HPA program does not have additional information based on responses received from the survey which they distributed.

Are barriers to implementing required policies (other than those identified in #2b above) being reported to OHA by hospitals?
There is nothing further to report back on here.

Are hospitals utilizing OAHHS guidelines on ORS 441.196 (inpatient discharge) and ORS 192.567 (HIPAA clarifications)?
Public Health and the Health Policy and Analytics does not have enough information to give a conclusion answer to this question.

How are lay caregivers engaged in patient evaluation, risk assessment and discharge/release processes and how are they being informed of elements required in rules?
Public Health and the Health Policy and Analytics does not have enough information to give a conclusion answer to this question.

What information is available related to how hospitals are implementing behavioral health assessments, suicide risk evaluations, safety planning, lethal means counseling, caring contacts, scheduled follow up appointments, care coordination and case management?

Public Health and the Health Policy and Analytics does not have enough information to give a conclusion answer to this question.

For what percentage of patients is a follow up appointment successfully scheduled to take place within seven days following release from the ED? What barriers have been identified as preventing this from happening?
Public Health and the Health Policy and Analytics does not have enough information to give a conclusion answer to this question.

Finally, please inform us of the following regarding OHA actions:

Other than upon receiving a complaint, is OHA going to regularly check to see if the laws are being followed using objective methodology? This includes auditing patient records to see if the policies adopted are in fact being implemented.
No. The legislation did not direct the Authority to perform regular checks or fund such activity. The measurement used in the complaint process looks at actual patient records, which is a measure of both policies and how implementation impacted individuals in crisis. This complaint driven work is crucial in determining not just whether hospitals have appropriate policies, but how those policies are used by front line staff working with real patients.

What potential penalties are available to OHA to impose upon a hospital found in substantial non-compliance?
ORS 441.030 allows the Authority to assess a civil penalty against a health care facility for substantial failure to comply with ORS 441.015 to 441.087 or the rules adopted.

YOUTH ERA

Oregon Youth Advocates Mentoring Program Pilot

OVERVIEW

The Oregon Youth Advocates Mentoring Program pairs young adult mentees and adult ally mentors to amplify youth voice and create equity within Behavioral Health Councils. Through these unique partnerships, we ensure that youth voice is present and integral in decision-making, policy creation, and service delivery, resulting in services more relevant to youth and young adults' needs.

ELIGIBILITY

- Regular attendance and active participation in one of the following State Councils; the Children System Advisory Council (CSAC), the Oregon Alliance to Prevent Suicide, or the Healthy Transitions Statewide Steering Committee
- Commitment to serving as a mentor/mentee for six months (March - August 2021)
- Willingness to spend time and regularly communicate with the mentor/mentee to grow a meaningful, supportive, and mutually beneficial relationship
- Willingness to communicate with and accept guidance from Mentoring Program Coordinators to get the most out of the program

INTERESTED IN APPLYING

Please email expressions of interest to your council's assigned program coordinator by **February 15, 2021**.

The Program Coordinator for CSAC and the Oregon Alliance to Prevent Suicide is Emily Morrissey (emorrissey@youthera.org until November 30th when her maternity leave replacement will step in). The Healthy Transitions Statewide Steering Committee Program Coordinator is Emilie Lamson- Siu (emiliel@pdx.edu). Interested parties will receive Youth Era's "Oregon Youth Advocates Mentoring Program Guide" with additional details about the program. All mentors and mentees will then complete an online pairing questionnaire to match participants with compatible interests and lived experience. This pilot program launches on March 1, 2021. Participants will receive monthly emails and tip sheets to aid in their success over the six months term. As this is a pilot program, we will require feedback throughout this project to make necessary adjustments. You will have an opportunity to submit feedback via brief midpoint and end-point surveys.

Thank you for your commitment to creating a better world for youth and young adults by supporting positive youth development and youth voice!

YSIPP 2.0 Progress Report

November 2, 2020

Overview

1. Check-in with YSIPP 2.0 Timeline and Tasks
2. Progress with strategic planning: Information gathering
3. Focus groups highlights (YYEA, EMSC, Schools)
4. Completed work and next steps

1. YSIPP 2.0 Timeline and Tasks

Timeline

Task	2020							2021					
	Jun	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
(1) YSIPP 2016-2020 activity report	⇨	✔	✔	✔	✔								
(2) SPRC state plan review	✔	✔	✔	✔	✔								
(3) Solicit input from key stakeholder groups		⇨	✔	✔	✔								
(4) Conduct research for Section 2 updates	✔	✔	✔	✔	✔								

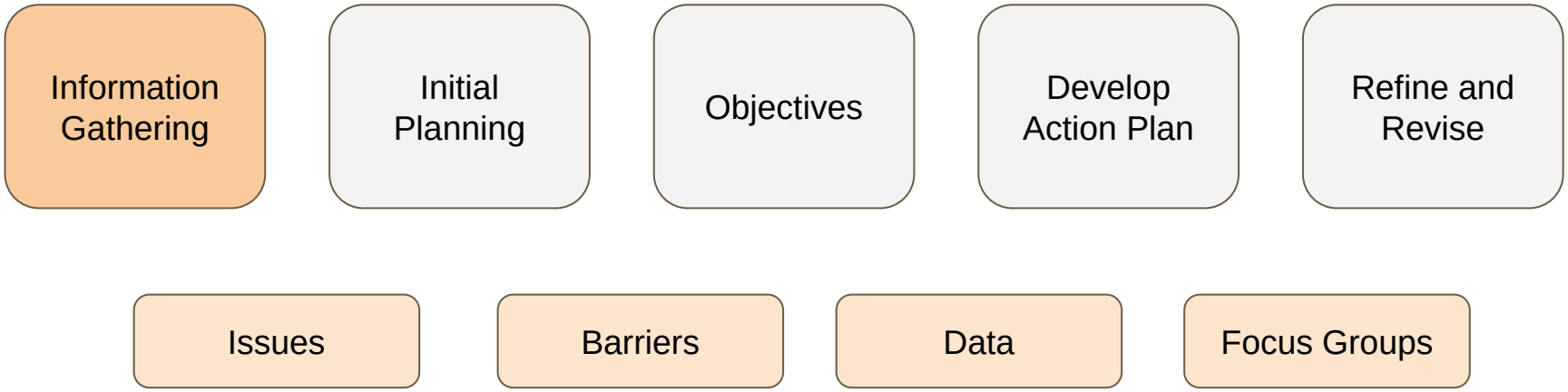
Timeline Cont.

Task	2020							2021					
	Jun	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
(5) Summarize needs and gap analysis for review					⇨								
(6) Draft YSIPP 2.0													
(7) Circulate draft for input													
(8) Incorporate feedback and finalize draft													
(9) Final draft to Publication Division													

2. Strategic Planning Framework

Information Gathering

Strategic Planning Framework



Initial Information Gathering

Focus Groups

Three discussion sessions were facilitated during October:

- YYEA focus groups (with follow up survey)
- Alliance School Committee focus group
- OHA: EMSC Advisory Committee discussion

Expanding reach with surveys in November

- Collaborating with LGBTQ work group and Lived Experiences committee to survey their respective members

Formative Interviews: Digging Deeper

Transitioning to focus on interviewing key informants.

Interviews will begin with Alliance groups, then extend to other key groups throughout the state.

- ***Alliance Committees and Workgroups***
  - Lethal Means workgroup
  - Outreach and Awareness committee
  - Transitions of Care committee
  - Data and Evaluation committee
- ***Other Key Stakeholders***
  - OHA departments and program
  - Local coalition coordinators

3. Focus Group Highlights

Snippets of from discussions with
YYEA, EMSC, and Schools

Youth Era, YYEA Focus Groups

- **~20 members of YYEA**
  - Non-students
  - High school students
  - College students
- **Topics addressed related to mental health and suicide prevention:**
  - YYEA current work and priorities
  - Services and activities in schools and communities
  - Role of social media
  - Effects of COVID-19
  - Incorporating the “youth voice”
- **Follow up survey sent out**

YYEA Focus Groups: Major Themes

- **Ambivalence towards mental health services**
  - Youth expressed positive engagement with Youthline supervisors and activities
  - Referring to a crisis line: “If I’m in crisis do I really want to talk to a stranger?”
- **School services are improving but need more follow-through**
  - “My school is doing a lot better, we have a mental health club now… ”
  - “I got suspended because suicidal thoughts were having an effect on the other students”
- **Perceived relatability with people their age**
  - “I think it has become easier to talk to our peers about mental health.”
  - “… Because [peers] know you’re going through the same thing, it’s easier for them to talk to you about it.”

YYEA Focus Groups: Major Themes

- **Stigma prevents talking directly to youth about suicide**
  - “I never hear anything come up. Sometimes teachers indirectly say we should reach out if we are struggling... they never say ‘suicide’.”
  - “My community of faith does not talk about suicide and suicidality”, with “poor ideas surrounding mental health, in general.”
- **Feeling devalued and unheard**
  - Observed “tokenization”, “manipulation”, and “asking for input but not using it”
  - “Not feeling respected as equal contributors or trusting [youth] to be able to contribute”
  - “When I was in the youth system, I had no say in what issues I focused on, DHS had control over my treatment. Youth having real confidentiality, not just what HIPAA says.”

OHA: EMSC Advisory Committee

- **Telehealth implementation amidst COVID-19**
  - Transition and integration of telehealth has allowed for stronger connectivity and ease of access when interacting with patients
  - “...youth have expressed wanting more mental health support and resources in school. I have also spoken to school nurses who feel ill equipped to complete suicide risk assessments or respond to self-harm actions, and I don't know what we can do during the pandemic with these asks.”
  - “...our Mental Health Public Dept. is not seeing children in person only online..our kids don’t do well with this..counseling wise.”

OHA: EMSC Advisory Committee

- **Access to suicide prevention education and services**
  - Many individuals unsure about what the resources are and how to access them
  - Would like to see information provided in the public media
  - Members expressed that trainings should be required in current education for practicioners, however, “There isn’t a mandate for suicide prevention screening, assessment, or treatment.”
- **HB-3090**
  - Many individuals were not familiar with the bill or did not know it was required
  - “We have that…I just didn’t know it was required by law.”

Alliance Schools Committee

- **Resources must be appropriate to student identity, culture, context**
  - For example, curriculum addressing LGBTQ issues being implemented in spaces that are negative toward LGBTQ population
  - Culturally responsive strategies: making sure that these don't just "check a box", but engage population being served and are implemented well
- **Implementation barriers and successes**
  - A need for more "boots on the ground" in schools for successful implementation and shifting school culture around seeking and referring help
  - Need to build infrastructure that "addresses issues related to leadership and engagement" to support truly inclusive implementation
  - Disconnected systems limits school bandwidth

Alliance Schools Committee

- **Youth voice**
  - “One thing that I think would be important for this committee to focus on is working on projects where youth can really feel like they are taking part in a change in their own schools.”
  - Working with YYEA to engage more POC members
- **Committee membership and representation**
  - “I think continuing to expand the membership to mirror the populations that we are trying to impact and uplift with this work.”
  - Uplift voices from POC individuals to inform on policies that directly affect these individuals
- **Committee support of information-sharing**
  - Schools committee has been a hub of resources, information, allowing for connectivity

4. Completed Work and Next Steps

Summary: Completed Output and Products

- YSIPP 1.0 Report on Activities
- Quarterly meeting break out discussions and summary report
- YYEA focus groups, follow-up survey, and summary report
- Schools focus group and summary report

Summary: In Progress

- State plan reviews based on SPRC framework/guidelines
- Lived Experiences and LGBTQ surveys
- Perform formative interviews with key members from Alliance committee and workgroups
- Identify key informants from OHA and local coalitions for formative interviews

October 2020

Suicide-related training for medical and behavioral health providers

Data report to the Legislature







Oregon Health Authority
PUBLIC HEALTH DIVISION

Contents

Executive summary

Suicide is one of Oregon's most persistent, yet largely preventable public health problems. The rate of suicide in Oregon has increased annually since 2011. In 2018, there were 844 suicides in Oregon. Oregon also had the 11th highest youth suicide rate in the country that year. Oregon's age-adjusted rate of suicide deaths is 19.02 per 100,000 people, while the national rate is 14.21. **Suicide is now the leading cause of death for Oregonians ages 10-24**. (1)

In 2019, 18% of 11th graders and 20% of 8th graders reported seriously considering suicide in the past 12 months. (2) The percentage of students that have seriously considered suicide has risen every year since 2015.

People do not always seek professional help from behavioral health providers who:

- Experience suicidal thoughts
- Intend to harm themselves, and
- Have suicidal actions.

For example, 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 about large health systems, over 80% 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% of those who died by suicide had an emergency department visit without a mental health diagnosis (3).

The Oregon Health Authority (OHA) uses a multilayered approach to address suicide across the lifespan. Key components to an effective suicide prevention strategy:

- Equip a broad workforce to recognize signs of suicide

Oregon's medical and behavioral health professionals generally do not receive training in suicide assessment, treatment and management in their advanced degree programs. Thus, these professionals need continuing education (CE) to ensure care to the public focuses on suicide safety. In 2017. as part of this effort, OHA proposed a bill 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 (the Alliance). Members of the Alliance testified in favor of the bill. However, the final bill made continuing education optional. The bill instructs OHA to report on results in September of each even-numbered year.

- Know where to refer a person at-risk for suicide, and
- Ensure behavioral and physical health providers feel confident and competent to treat suicidality with best practices.

The following report details the history of Senate Bill (SB) 48 (2017). It also details data from licensing boards self-reported continuing education for suicide prevention data from licensing boards. Data are shown by licensing board and by county. This information was mostly unavailable for the September 2018 report, which only had data from medical doctors and naturopathic physicians.

OHA continues to recommend a legislative mandate requiring CE and continuing medical education in suicide prevention best practices for re-licensure. Currently, this is optional. Many other states have these requirements in law. With these requirements, all types of providers could play a key role to save lives.

Introduction

Suicide continues to be a largely preventable cause of death. Suicide is an incredibly difficult experience for Oregon communities. A well-trained workforce is a key component of Oregon's strategy to reduce suicide deaths. OHA's suicide prevention team and the Oregon Alliance to Prevent Suicide have increased access and availability to best practices in suicide prevention training. However, this need continues to represent a gaping hole in suicide prevention for Oregon.

OHA proposed a bill in 2017, supported by the Oregon Alliance to Prevent Suicide. The proposal was to require physical and behavioral health professionals to take continuing education (CE) in suicide assessment, treatment and management. The final version of the bill made continuing education optional. The bill instructed OHA to report on results in September of each even-numbered year.

The first biennial report in 2018 included limited data. It includes data from providers licensed by the:

- Board of Medicine, and
- Board of Naturopathic Physicians.

This report is legislatively mandated. It includes all the licensing boards listed in Senate Bill 48 (2017).

Background

The strategy of a well-trained workforce is recommended widely. It includes support from:

- U.S. Surgeon General
- National Action Alliance for Suicide Prevention (Action Alliance)
- National Strategy for Suicide Prevention (National Strategy) — A joint effort by the Office of the U.S. Surgeon General and the Action Alliance.
- American Association of Suicidology
- American Foundation for Suicide Prevention (AFSP)
- Youth Suicide Intervention and Prevention Plan (YSIPP), and
- Oregon Alliance to Prevent Suicide.

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 in suicide:

- Assessment
- Treatment, and
- Management.

The legislature revised the bill to encourage licensed providers to take such training. However, they did not require it. If providers take these optional courses, licensees self-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 each year. Based on OHA research, Oregon remains the only state to adopt a voluntary basis CE to address provider education. Many other states require certain professionals to take courses in suicide prevention. This approach is supported by national suicide prevention organizations and experts.

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	Oregon Board of Physical Therapy
Chiropractic physicians	Oregon Board of Chiropractic Examiners
Psychologists	Board of Psychology

Findings overview

Based on the surveys to the professions and boards addressed in SB 48, 33% of all reporting licensing boards' licensees (38,060 out of 114,748) reported they took a course in suicide assessment, treatment or management (see Figure 1).

Figure 1: Total reported continued education in suicide assessment, treatment or management by all licensing boards' licensees.

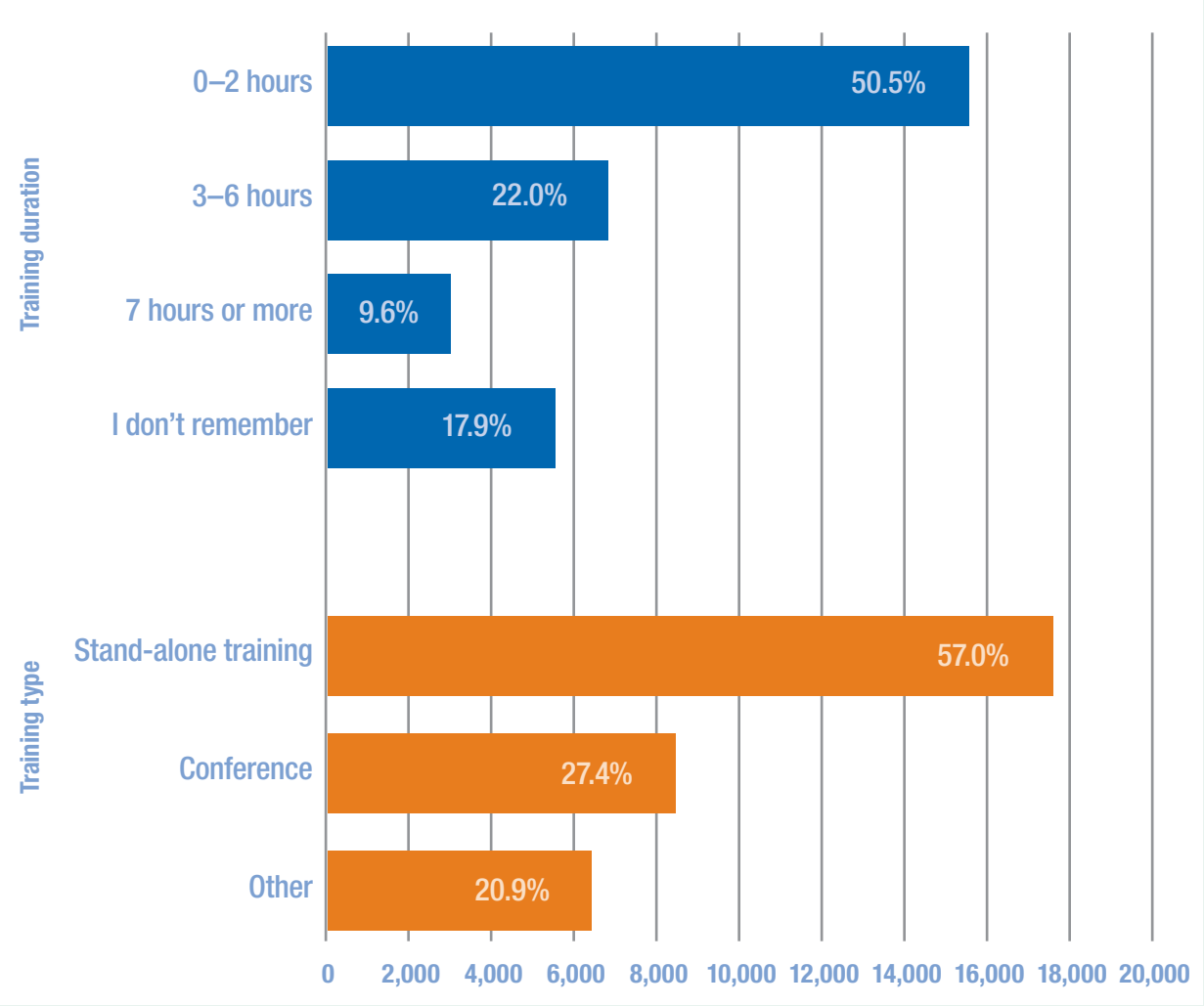
The Teacher Standards and Practices Commission (TSPC) and Oregon Medical Board gathered and submitted their data to OHA in 2020. These data were not included in the collection of data during the 2018 and 2019 license renewal periods by the Health Care Workforce Reporting Program (HCWRP). The professions and boards included in HCWRP data are:

- Chiropractic Examiners (DC)
- Counselors and Therapists (COU)
- Naturopathic Medicine (ND)
- Nursing (CNA, CNS, CRNA, LPN, NP and RN)
- Occupational Therapy (OT and OTA)
- Physical Therapy (PT and PTA)
- Psychology (PSY), and
- Social Work (CSWA, LCSW, and NonCl_SW).

Among the licensing boards reporting to HCWRP, approximately:

- 57% of all trainings were reported as stand-alone training, and
- 50% of all trainings were less than two hours long (see Figure 2).

Figure 2: Total reported training type and duration by licensing boards' licensees to Health Care Workforce Reporting Program.



As shown in Figure 3, TSPC had the highest percentage of licensees completing continuing education on suicide risk assessment, treatment and management. The chiropractic examiner board reported having the least percentage of licensees having taken a relevant course.

Figure 3: Percentage of licensees reporting completion of continued education in suicide assessment, treatment or management by licensing boards.

Teachers Standards and Practices Commission (TSPC) School counselors

Approximately 75% of TSPC reporting (697 out of 931) said they had taken a relevant course in suicide risk training (see Figure 4).

Figure 4: Total Teachers Standards and Practices Commission licensees reporting continuing education on suicide risk assessment, treatment and management.

TSPC from 36 counties reported taking trainings in assessment, treatment or management (see Table 1).

Table 1. Teachers Standards and Practices Commission trainees by county.

County	Count
Baker	4
Benton	16
Clackamas	69
Clatsop	5
Columbia	7
Coos	8
Crook	3
Curry	3

County	Count
Deschutes	28
Douglas	10
Gilliam	0
Grant	1
Harney	0
Hood River	5
Jackson	8
Jefferson	7
Josephine	1
Klamath	4
Lake	2
Lane	39
Lincoln	5
Linn	21
Malheur	4
Marion	65
Morrow	1
Multnomah	115
Polk	14
Sherman	0
Tillamook	7
Umatilla	11
Union	4
Wallowa	0
Wasco	3
Washington	122
Wheeler	0
Yamhill	13
N/A	52

County	Count
Out of state	20
Virtual – more than two counties	8
Foreign	9
Total	**694**

Physicians

Approximately 33% of physicians (MD and DO, physician assistants and others licensed by the Oregon Medical Board) reporting (6,470 out of 19,353) said they took a course in suicide assessment, treatment or management (see Figure 5).

Figure 5: Total physicians at 2019 license renewal reporting continuing education in suicide assessment, treatment or management.

Physicians from 35 counties reported taking trainings in assessment, treatment or management (see Table 2).

Table 2. Physician trainees by county.

County	Count
Baker	27
Benton	177

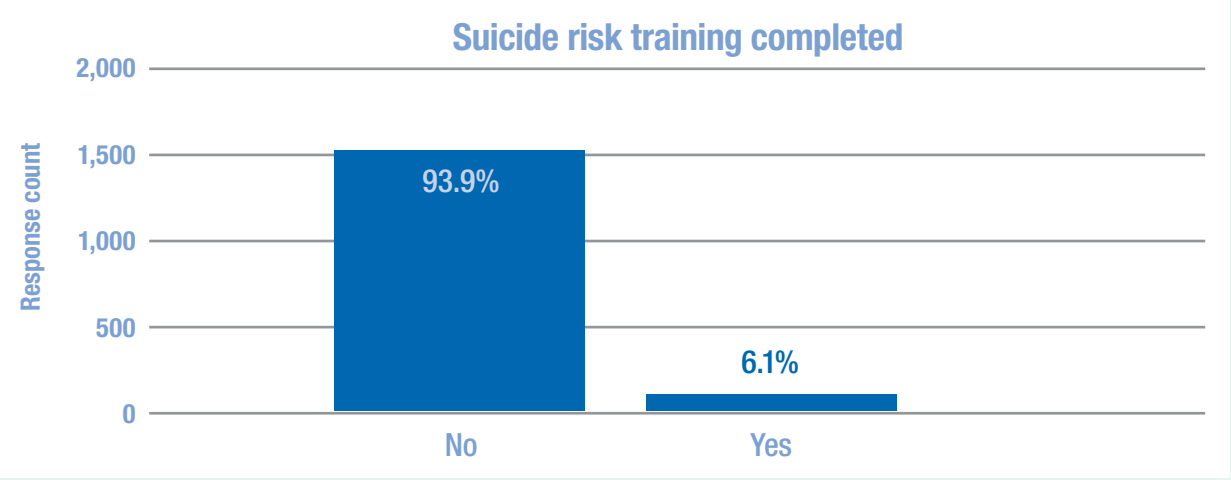
County	Count
Clackamas	475
Clatsop	39
Columbia	24
Coos	54
Crook	10
Curry	33
Deschutes	324
Douglas	108
Grant	7
Harney	4
Hood River	50
Jackson	247
Jefferson	33
Josephine	57
Klamath	50
Lake	18
Lane	378
Lincoln	50
Linn	101
Malheur	69
Marion	340
Morrow	4
Multnomah	2110
Not Applicable - do not practice in Oregon	861
Polk	34
Sherman	1
Tillamook	21
Umatilla	66
Union	18

County	Count
Wallowa	6
Wasco	31
Washington	562
Wheeler	1
Yamhill	80
Total	**6470**

Chiropractic physicians

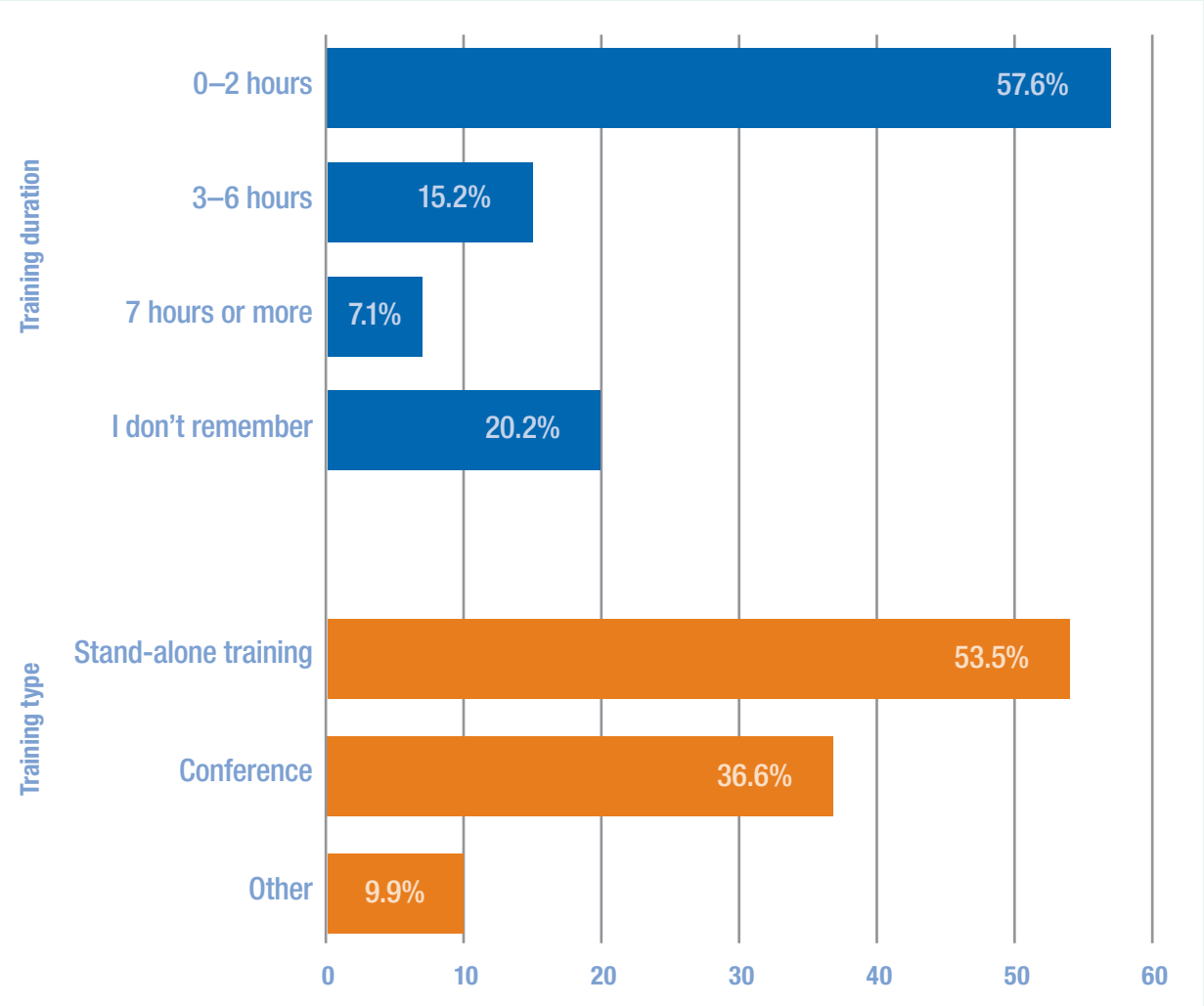
Six percent of chiropractic physicians reporting (99 out of 1,626) said they took a course in suicide assessment, treatment or management (see Figure 6).

Figure 6: Total chiropractic physicians reporting continuing education on suicide risk assessment, treatment and management.



About 54% of chiropractic physicians reported their trainings were stand-alone training. Fifty-eight percent reported the trainings they had taken lasted two hours or less (see Figure 7). Trainings were taken at conferences about 37% of the time.

Figure 7: Chiropractic physician training type and duration.



Chiropractic physicians from 17 counties reported taking trainings in assessment, treatment or management (see Table 3).

Table 3. Chiropractic physician trainees by county.

County	Count
Benton	3
Clackamas	9

County	Count
Columbia	1
Curry	2
Deschutes	4
Douglas	1
Hood River	1
Jackson	5
Josephine	1
Lane	7
Lincoln	2
Marion	2
Multnomah	27
Tillamook	1
Wasco	1
Washington	16
Yamhill	2
(blank)	14
Total	**99**

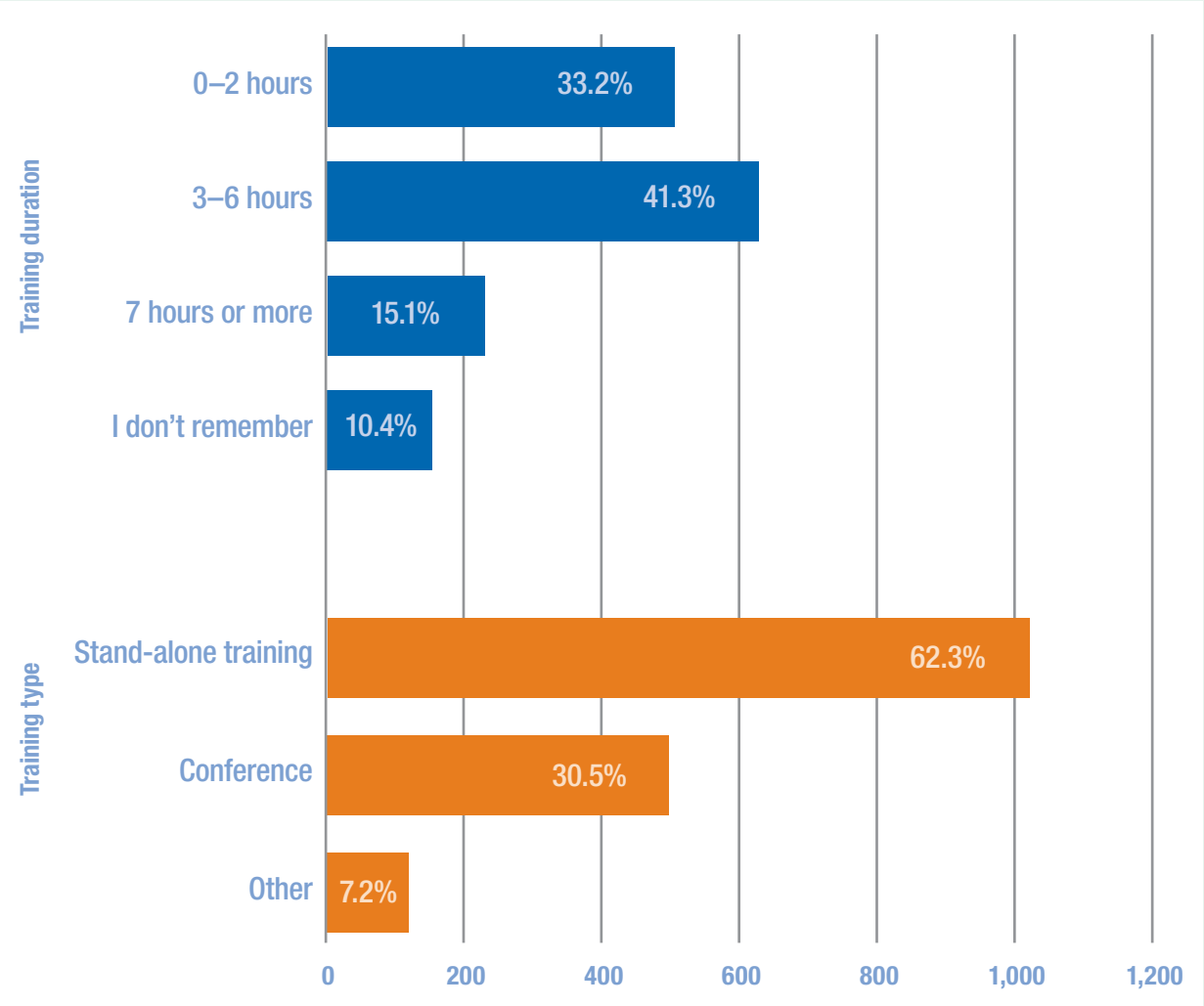
Counselors and therapists

Thirty-seven percent of counselors and therapists reporting (1532 out of 4100) said they took a course in suicide assessment, treatment or management (see Figure 8).

Figure 8: Total counselors and therapists reporting continuing education regarding suicide risk assessment, treatment, and management.

About 62% of counselor and therapists reported their trainings were stand-alone training. Forty-one percent reported the trainings they had taken lasted three to six hours (see Figure 9). Trainings were taken at conferences about 30% of the time.

Figure 9: Counselor and therapist training type and duration.



Counselor and therapists from 32 counties reported taking trainings in assessment, treatment or management (see Table 4).

Table 4. Counselor and therapist trainees by county.

County	Count
Baker	5
Benton	25
Clackamas	131
Clatsop	13
Columbia	7

County	Count
Coos	14
Crook	5
Curry	4
Deschutes	96
Douglas	8
Grant	2
Harney	3
Hood River	1
Jackson	80
Jefferson	6
Josephine	31
Klamath	14
Lake	2
Lane	114
Lincoln	17
Lincoln	19
Malheur	7
Marion	121
Multnomah	366
Polk	20
Tillamook	4
Umatilla	8
Union	3
Wallowa	2
Wasco	7
Washington	177
Yamhill	27
(blank)	193
Total	**1532**

Naturopathic physicians

About 26% of naturopathic physicians reporting (279 out of 1,080) said they took a course in suicide assessment, treatment or management (see Figure 10).

Figure 10: Total naturopathic physicians reporting continuing education on suicide risk assessment, treatment and management.

About 49% of naturopathic physicians reported their trainings were stand-alone training. Seventy-seven percent reported the trainings they had taken lasted two hours or less (see Figure 11). Trainings were taken at conferences about 32% of the time.

Naturopathic physicians from 17 counties reported taking trainings in assessment, treatment or management (see Table 5).

Figure 11: Naturopathic physician training type and duration.

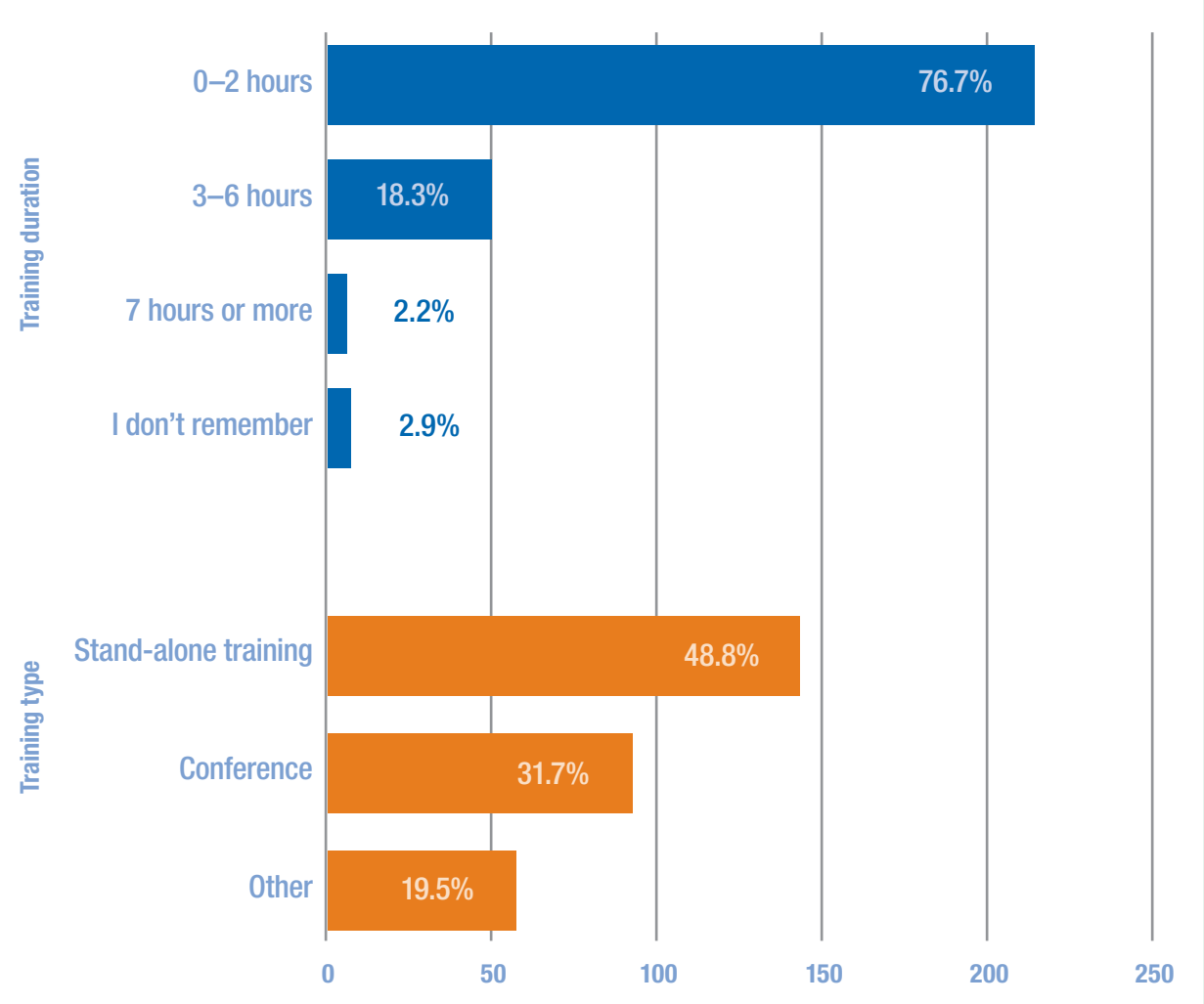


Table 5. Naturopathic physician trainees by county.

County	Count
Benton	1
Clackamas	23
Clatsop	2
Deschutes	12
Douglas	1
Hood River	1
Jackson	6

County	Count
Josephine	1
Lane	9
Lincoln	1
Linn	1
Marion	4
Multnomah	132
Umatilla	1
Wasco	1
Washington	35
Yamhill	4
(blank)	44
Total	**279**

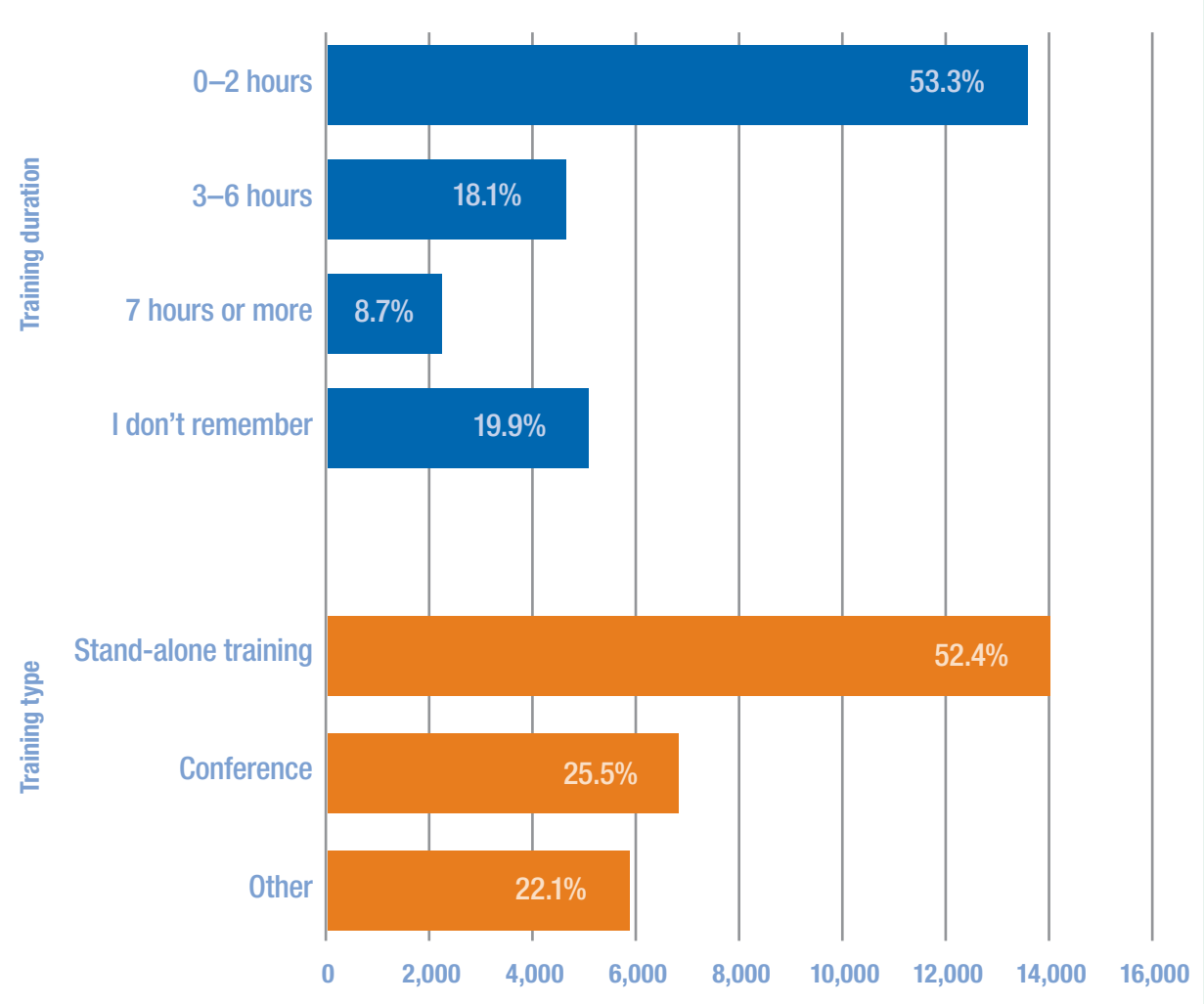
Nursing

About 35% of nursing licensees reporting (25,345 out of 73,496) said they took a course in suicide assessment, treatment or management (see Figure 12).

Figure 12: Total nursing licensees reporting continuing education regarding suicide risk assessment, treatment, and management.

About 52% of nursing licensees reported their trainings were stand-alone training. Fifty-three percent reported the trainings they had taken lasted two hours or less (see Figure 13). Trainings were taken at conferences about 26% of the time.

Figure 13: Nursing training type and duration.



Nursing licensees from 35 counties reported taking trainings in assessment, treatment or management (see Table 6).

Table 6. Nursing trainees by county.

County	Count
Baker	70
Benton	473
Clackamas	1409
Clatsop	147
Columbia	37

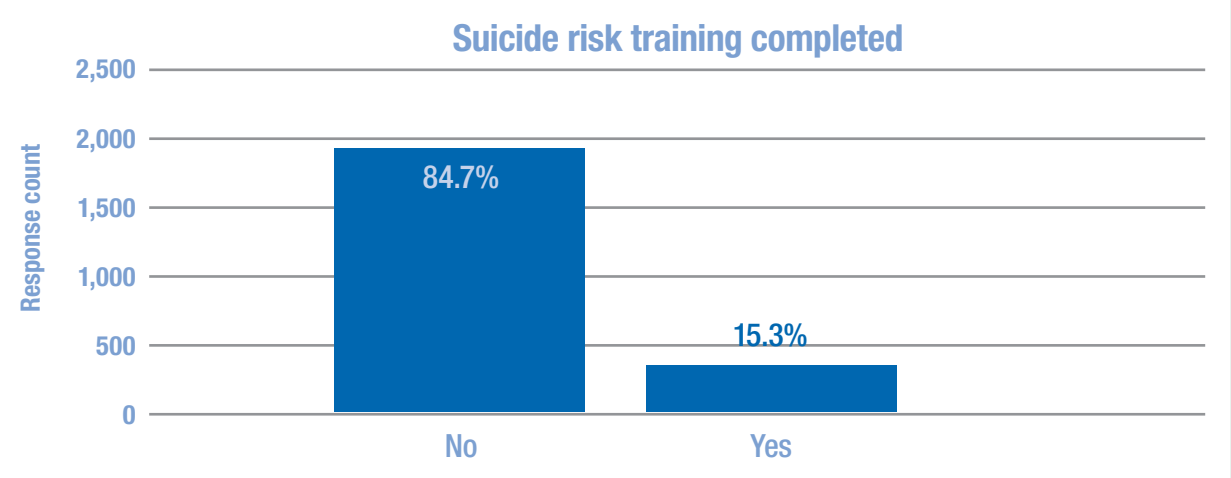
County	Count
Coos	312
Crook	52
Curry	52
Deschutes	1076
Douglas	519
Gilliam	1
Grant	26
Harney	23
Hood River	128
Jackson	1218
Jefferson	72
Josephine	303
Klamath	186
Lake	29
Lane	1464
Lincoln	163
Linn	361
Malheur	112
Marion	2052
Morrow	14
Multnomah	5632
Polk	145
Tillamook	71
Umatilla	292
Union	73
Wallowa	17
Wasco	145
Washington	2309
Wheeler	3

County	Count
Yamhill	350
(blank)	6009
Total	**25345**

Occupational therapists

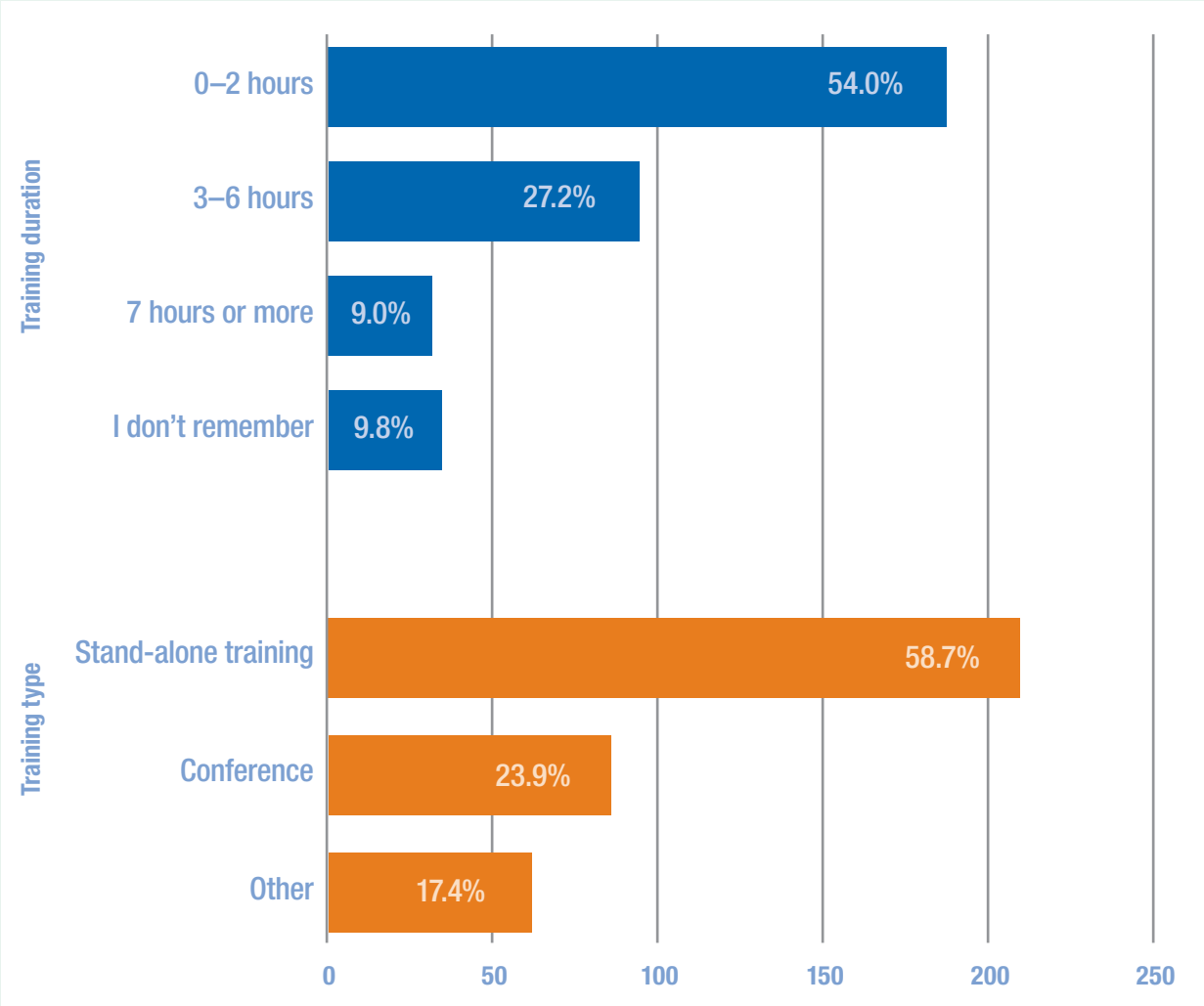
Fifteen percent of occupational therapists reporting (346 out of 2260) said they took a course in suicide assessment, treatment or management (see Figure 14).

Figure 14: Total occupational therapists reporting continuing education regarding suicide risk assessment, treatment, and management.



About 59% of occupational therapists reported their trainings were stand-alone training. Fifty-four percent reported the trainings they had taken lasted two hours or less (see Figure 15). Trainings were taken at conferences about 24% of the time.

Figure 15: Occupational therapist training type and duration.



Occupational therapists from 21 counties reported taking trainings in assessment, treatment or management (see Table 7).

Table 7. Occupational therapist trainees by county.

County	Count
Baker	1
Clackamas	12
Clatsop	5
Columbia	1
Coos	2

County	Count
Deschutes	15
Douglas	6
Hood River	1
Jackson	9
Josephine	2
Lane	10
Lincoln	1
Linn	5
Marion	40
Multnomah	63
Polk	2
Tillamook	2
Umatilla	2
Wasco	5
Washington	38
Yamhill	4
(blank)	120
Total	**346**

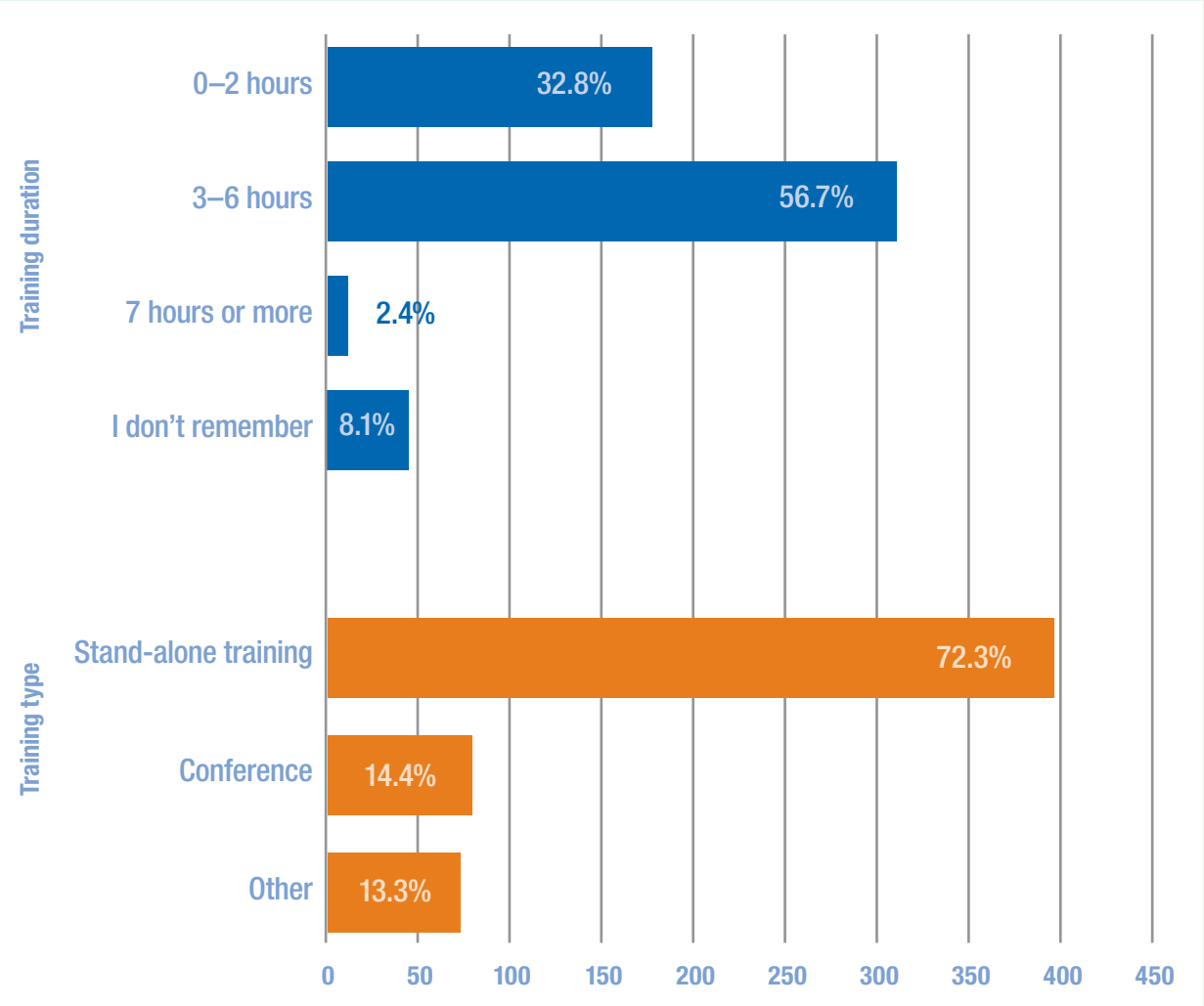
Physical therapists

About 10% of physical therapists reporting (543 out of 5535) said they took a course in suicide assessment, treatment or management (see Figure 16).

Figure 16: Total physical therapists reporting continuing education regarding suicide risk assessment, treatment, and management.

About 72% of physical therapists reported their trainings were stand-alone training and 57% reported the trainings they had taken lasted three to six hours (see Figure 17). Trainings were taken at conferences about 14% of the time.

Figure 17: Physical therapist training type and duration.



Physical therapists from 26 counties reported taking trainings in assessment, treatment or management (see Table 8).

Table 8. Physical therapist trainees by county.

County	Count
Baker	1
Benton	4
Clackamas	32
Clatsop	3
Coos	1

County	Count
Crook	1
Curry	1
Deschutes	15
Douglas	5
Grant	1
Hood River	5
Jackson	7
Josephine	1
Klamath	2
Lane	7
Lincoln	7
Linn	4
Malheur	2
Marion	15
Multnomah	96
Polk	2
Tillamook	3
Umatilla	8
Wasco	12
Washington	32
Yamhill	8
(blank)	268
Total	**543**

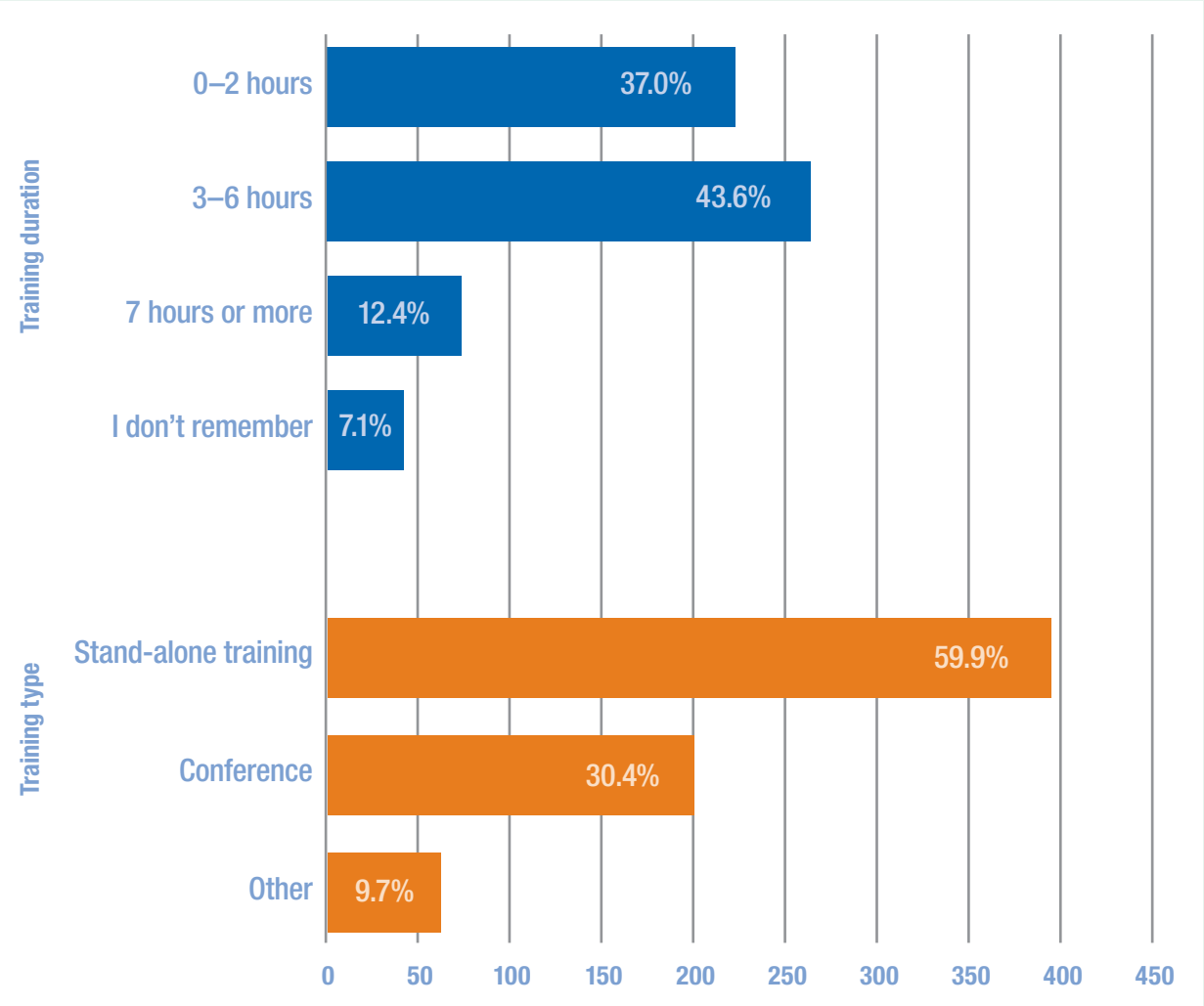
Psychologists

About 34% of psychologists reporting (606 out of 1794) said they took a course in suicide assessment, treatment or management (see Figure 18).

Figure 18: Total psychologists reporting continuing education on suicide risk assessment, treatment and management.

About 60% of chiropractic physicians reported their trainings were stand-alone training. Forty-four percent reported the trainings they had taken lasted three to six hours (see Figure 19). Trainings were taken at conferences about 30% of the time.

Figure 19: Psychologist training type and duration.



Psychologists from 21 counties reported taking trainings in assessment, treatment or management (see Table 9).

Table 9. Psychologist trainees by county.

County	Count
Benton	17
Clackamas	43
Columbia	1
Coos	2
Crook	1

County	Count
Curry	1
Deschutes	19
Douglas	2
Hood River	2
Jackson	19
Jefferson	1
Josephine	3
Lane	68
Lincoln	2
Linn	3
Marion	50
Multnomah	196
Polk	4
Union	2
Washington	78
Yamhill	14
(blank)	78
Total	**606**

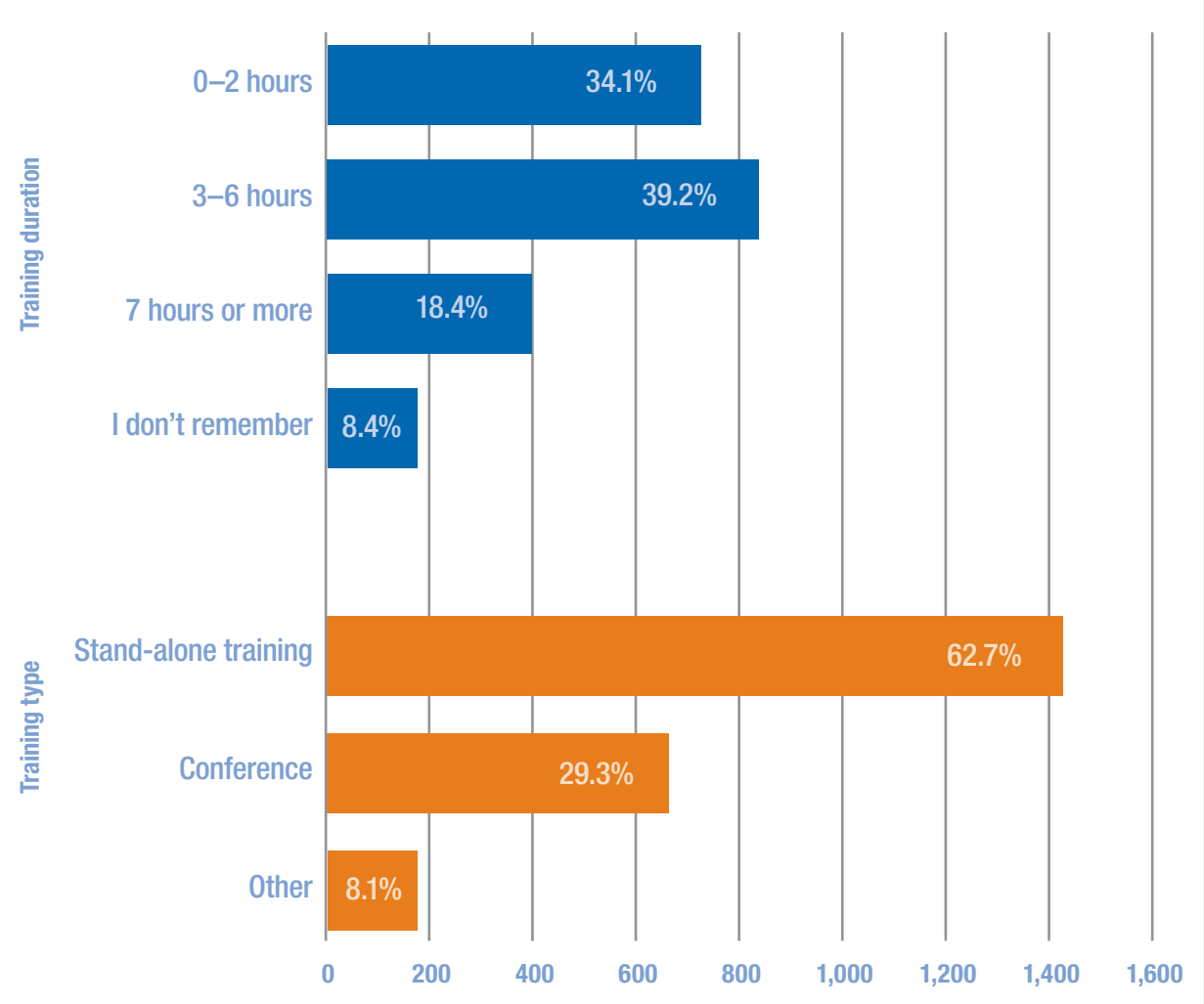
Social workers

About 47% of social workers reporting (2,143 out of 4,573) said they took a course in suicide assessment, treatment or management (see Figure 20).

Figure 20: Total social workers reporting continuing education regarding suicide risk assessment, treatment, and management.

About 63% of social workers reported their trainings were stand-alone training and 39% reported the trainings they had taken lasted three to six hours (see Figure 21). Trainings were taken at conferences about 29% of the time.

Figure 21: Social worker training type and duration.



Social workers from 32 counties reported taking trainings in assessment, treatment or management (see Table 10).

Table 10. Social worker trainees by county.

County	Count
Baker	7
Benton	38
Clackamas	146
Clatsop	12
Columbia	7

County	Count
Coos	15
Curry	2
Deschutes	106
Douglas	31
Grant	2
Harney	3
Hood River	11
Jackson	84
Jefferson	2
Josephine	21
Klamath	19
Lake	1
Lane	161
Lincoln	13
Linn	30
Malheur	8
Marion	126
Morrow	3
Multnomah	669
Polk	15
Tillamook	10
Umatilla	22
Union	10
Wallowa	3
Wasco	9
Washington	192
Yamhill	22
(blank)	343
Total	**2143**

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 makes annual updates. The 2019-2020 list is available here.

OHA has current contracts for statewide access to the Big Six Programs best-practices trainings for suicide prevention, intervention and postvention (response after a suicide death). These trainings include:

- **Sources of Strength** – a peer-led upstream prevention program for middle school, high school and college campus populations.
- **Mental Health First Aid** – A broad overview training to teach skills to recognize the early signs of mental illness, mental health problems and substance use.
- **Question, Persuade, Refer** – A 1.5 hour online or in-person training program for ages 16+ that teaches three easy steps to identify signs someone is thinking about suicide and how to connect them with help.
- **safeTALK** – A half-day in-person training program that teaches ages 15+ how to recognize and engage individuals who might be having thoughts of suicide and how to connect them with community resources.
- **Applied Suicide Intervention Skills Training (ASIST)** – A two-day workshop designed for anyone 16+ to learn to provide skilled intervention and safety planning with someone having suicidal thoughts.
- **Connect: Postvention** – This course teaches adult service providers the best practices to respond in a coordinated and comprehensive way in the aftermath of a suicide.

Through grant dollars, OHA is currently able to offer the below courses. These courses have limited availability and are free to behavioral health providers:

- **Collaborative Assessment and Management of Suicidality (CAMS)** – An evidence based, suicide-focused treatment framework backed by 30 years of clinical research and 5 randomized controlled trials.
- **Assessing and Managing Suicide Risk (AMSR)** – A training that teaches best practices recommended by the nation's leading experts in the research and delivery of suicide care.

Additionally, under its contract with the Oregon Pediatric Society (OPS), OHA funded development and implementation of:

- Training about suicide risk, treatment and management, and

- Technical assistance for quality improvement processes.

Since 2018, OPS has been delivering the suicide prevention module to:

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

CME units are provided by OPS.

Conclusion

This report is presented to the legislature in compliance with SB 48 (2017). It reports data for all boards listed in SB 48 on licensees who self-reported at license renewal that they took a course in suicide assessment, treatment or management in the previous period of licensure.

Physical and behavioral health providers that are confident, competent and equipped to provide the best care to those who experience suicide ideation is an essential part of Oregon's suicide prevention strategy. To ensure Oregon's workforce is meeting the needs of people most at-risk, the law should require suicide prevention education in professional training programs and continuing education for key professions.

Endnotes

1. Broker Version 9.4 (Build 1366) [Internet]. Webappa.cdc.gov. 2020 [cited 9 October 2020]. Available from: https://webappa.cdc.gov/cgi-bin/broker.exe
2. Oregon Health Authority Healthy Teens Survey, 2019 [Internet]. Oregon Health Authority [cited 9 October 2020]. Available from: https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Documents/2019/2019%20State%20of%20Oregon%20Profile%20Report.pdf
3. Ahmedani et al. Health Care Contacts in the Year Before Suicide Death., 2014. [cited 9 October 2020]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4026491/
4. 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.
5. 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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OHA 2889 (10/2020)

Dear (Insert OHA Name – Send to Jill to forward on, is there someone else appropriate) and Legislative Committee That Receives the Report:

We are writing on behalf of the Oregon Alliance to Prevent Suicide to support and amplify the conclusion that health and behavioral health professionals should be required to receive education on suicide assessment, intervention and management in the Oregon Health Authority's October 2020 report to the Legislature, *Suicide-related training for media and behavioral health* providers. [1]' This letter focuses on results for the behavioral health workforce.

Last year suicide was the leading cause of death for Oregonians between ages 10 to 24 and Oregon's suicide rates have continued to rise across the lifespan. We know that well-trained counselors, peer providers, therapists and social workers are able to identify the signs of suicidality *and* support people through a suicidal crisis and build the skills to live a full life, yet

The core recommendation of the report is: "Physical and behavioral health providers that are confident, competent and equipped to provide the best care to those who experience suicide ideation is an essential part of Oregon's suicide prevention strategy. To ensure Oregon's workforce is meeting the needs of people most at-risk, the law should require suicide prevention education in professional training programs and continuing education for key professions."

Unfortunately, assessment and treatment for suicidality is not a standard part of either undergraduate or post-graduate training for therapists, social workers and counselors. OHA's 2020 legislative report indicates that without a mandate many behavioral health providers received no recent training in suicide risk assessment or management. Only 33.8% of psychologists, 46.9% of social workers and 37.4% of counselors and therapists reported receiving any training. The Teachers Standards and Practices Commission which licenses school counselors had the highest rate of completed trainings at 74.9%. While this is an excellent start, the reality is that school counselors generally will be assessing suicidal students and count on being able to refer students to well-trained therapists or social workers. The fact that more than half of most behavioral health professionals in Oregon received no training means that even when referred to treatment, individuals.

The 2020 t report is a requirement of Senate Bill (SB) 48 (2017), which requires the licensing boards for physical and behavioral health providers to submit a summary of aggregate data to OHA annually on March 1st, SB48 was introduced in 2017 by members of the Alliance and OHA with the intention of requiring continuing education on suicide assessment, intervention and management; however, opposition, especially from the health sector, led to a compromise bill that simply required licensing board to document how many of their licensees were taking relevant courses, for OHA to publish the results and for OHA to post a list of available trainings.

The Alliance is re-introducing legislation in 2021 to require that Oregon's behavioral health workforce receive just such training at least once every six years. In future years, working closely with health professionals who traditionally are opposed to most new continuing education mandates, to ensure that health providers also are required to receive such training.

We look forward to ongoing work in partnership with OHA to ensure that our professionals have the skills to support those at risk.

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[1] Oregon Health Authority, Public Health Division, Suicide-related training for medical and behavioral health providers: Data report to the Legislature. October 2020.