

>> Youth Suicide Intervention and Prevention Plan Annual Report



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Executive summary

The impact of youth suicides can rattle entire communities. In addition to the devastation for family and friends, the loss of a young person upsets community stability and shocks residents. Suicide risk is present for all economic and demographic groups and impacts the future economic viability of a community as the youth do not live into a productive adulthood. In the most recent yearly data reported to the Oregon Health Authority (2017), there were 107 suicides by youths age 24 and younger.

The Oregon Health Authority's implementation of the Youth Suicide Intervention and Prevention Plan for 2016-2020 continued to progress in 2018. The plan focuses on bolstering protective factors and reducing risk factors by promoting youth connection and belonging to families, peers and adults in their communities. The plan approaches prevention and intervention on these levels:

- Building human connections
- Increasing resiliency and positive decision-making
- Upstream prevention
- Increasing access to competent and confident behavioral and physical health care providers.
- Providing rapid and effective response to suicides to reduce contagion risk
- Eliminating gaps between types of services.

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

- OHA launched a new Rapid Response system to provide post suicide intervention (postvention) supports to under-resourced communities experiencing suicides. The purpose of the program is to guard against contagion risk, which is particularly high among youth, and help communities grieve. The first services were dispatched to the Salem community in November 2018, where one school had experienced three suicides in eight months. Services include grief support, classroom and parent presentations, community listening sessions, peer support to parents and youth peer support. Funding is available through June 2019 and a request has been submitted for continued funding in the next biennium.
- A Postvention Listening Session was held by OHA for county and school staff who respond to suicides in their communities. The purpose was for OHA to learn what services and supports would be helpful to aid communities in their postvention efforts. Counties attending included several that have experienced multiple suicides in the past

three years, including clusters in some areas. Partners in planning the session were Benton County, Corvallis School District and Youth ERA (formerly Youth Move). Follow-up activities are being planned for 2019.

- An ongoing collaboration with the University of Oregon continues to:
 - » Evaluate effectiveness of:
 - » Prevention
 - » Intervention
 - » Post-suicide response programs
 - » Monitor influences that have implications for suicide, including the following:
 - » Child abuse
 - » Homelessness
 - » Trauma
 - » Domestic violence
 - » Poverty
 - » Parental unemployment
 - » Review a cross-section of OHA data pertaining to suicide to identify trends and risk and protective factors.
- Work of the Oregon Alliance to Prevent Suicide, formed by OHA in response to the Youth Suicide Intervention and Prevention Plan (YSIPP) for 2016-2020, continued to expand.
 - » Initiated activities relating to:
 - » Continuity of care
 - » Legislation
 - » Outreach and awareness
 - » Data and evaluation
 - » Workforce development
 - » Suicide loss and attempt survivors
 - » Schools
 - » LGBTQ initiatives
 - » Policy
 - » Communication between and among suicide prevention programs statewide.

The following is a summary of some of the actions OHA and partners took in 2018. These actions meet goals of the legislatively mandated Youth Suicide Intervention and Prevention Plan for 2016-2020:

- **Assessment of medical and behavioral workforce competency:** OHA collected data to determine how many medical professionals took continuing education in suicide assessment, intervention and treatment in compliance with Senate Bill 48 (2017). The first licensing boards to report were the Board of Naturopathic Medicine and the Oregon Medical Board. Additional providers are expected to report in 2019.

Of the 18,261 physicians, physician assistants and others licensed by the Board of Medicine reporting, 22.7 percent reported taking such courses. Sixteen percent of the 1,021 naturopaths reporting took such classes. A reduced-cost best-practice training was offered by OHA at the March 2018 Suicide Prevention Conference, with four nurses attending and the remainder behavioral health providers. Other courses are available online at reduced cost.

- **Policymaking support:** OHA provided technical support to advisory committees formed to develop rules to implement House Bill (HB) 3090 and HB 3091. These bills require risk-reduction strategies when individuals in behavioral health or suicide crises are released from emergency departments and provisions for public and private insurance in paying for those services. Rules were adopted in 2018.
- **Spreading best practices for community providers:** OHA continued rollout of the CONNECT suicide postvention program to additional counties and launched a train the trainer program for the Sources of Strength, youth-led resiliency program for middle and high schools. Some communities also are using OHA prevention funding to implement the PAX Good Behavior Game in elementary schools to promote pro-social development. CONNECT training on best practices in postvention have been offered in the following counties:

- » Malheur
- » Umatilla
- » Linn
- » Benton
- » Lincoln
- » Deschutes
- » Jackson
- » Lane
- » Jefferson
- » Yamhill

In 2019, additional courses have been funded by OHA for the following counties:

- » Clackamas
- » Columbia
- » Coos
- » Curry
- » Klamath
- » Marion

- **Education for families:** The Children’s System Advisory Council completed a handbook for parents with children seen in emergency departments. Work began in 2018 to create another for youth. In addition, work was underway in 2019 on a set of policies to guide peer support to youth and families experiencing a suicide crisis.
- **Trauma Informed Oregon (TIO):** TIO continued incorporating trauma impacts on suicide risk into its statewide trainings and materials offered to various personnel in these fields in Oregon, including the following:
 - » Behavioral
 - » Medical
 - » School
 - » Emergency response
- **Training for pediatricians and family practice providers:** The Oregon Pediatric Society expanded its training for primary care and school-based providers and others to include suicide assessment, lethal means counseling and safety planning.
- **Fostering safe online spaces:** OHA entered into a contract with Lines for Life and Youth ERA (formerly Youth Move) to implement a strategic plan developed by youth to guide electronic communication by and for youth. The initial project is expected to be completed in 2019 when one-time funding is expended. A request has been submitted for funds to continue the project in 2019-2021.

- **Post-suicide interventions and death reporting under SB 561 (2015):** The Association of Oregon Community Mental Health Programs conducted outreach to Community Mental Health Programs (CMHPs) statewide to identify lead staff for reporting suicide deaths under SB 561 and better coordinate across counties. A roster of 18 local or regional suicide prevention coalitions also was compiled to foster communication across counties statewide.

Sixty-five deaths of individuals age 24 and younger were reported to OHA by CMHPs under SB 561 in 2018. OHA expects final death certificate data for 2018, when available, to reflect more suicides. SB 561 reporting is still not uniform statewide and some populations, including Tribes, are not required to report. OHA has no legal authority to mandate death reports.

- **Communication:** The Alliance to Prevent Suicide adopted an outreach communication plan created by an ad hoc group of communication professionals. As a first step in implementing the Communication Plan, the Alliance launched its website in 2018. The website url is: www.oregonalliancetopreventsuicide.org.
- **Clergy Outreach and Education:** The Alliance to Prevent Suicide held a pilot community meeting and education session for multiple denominations of clergy in Benton, Linn and Lane counties in 2018. The goal is to bring local clergy together to learn about suicide prevention and risk and protective factors to allow them to better respond to the needs of their congregations. Based on the success of the pilot hosted by Alliance members, additional sessions in other interested communities are expected in 2019.
- **LGBTQ Work Group:** The Alliance formed an LGBTQ work group to address the high suicide rate among this population. Initial plans are to bring the Family Acceptance Project for a presentation at the Oregon Suicide Prevention Conference in 2019. This project offers education and support to families of LGBTQ youth who are experiencing suicidal ideation in order to encourage support and connection with families. Research indicates that LGBTQ youth with strong family connections have a lower suicide rate than peers who do not have those connections.
- **Survivor Support:** The American Foundation for Suicide Prevention (AFSP) is working to bring a training program to Oregon for providers of suicide loss support groups. The AFSP Facilitator Training Program offers suicide prevention organizers a way to create and facilitate a community support group for suicide loss survivors in the aftermath of a suicide. Courses are offered as two-day trainings, of up to 36 attendees, and include lecture, interactive discussion, and role-playing. They are led by experts in the field of suicide bereavement. The AFSP Oregon Chapter is considering bringing this 2-day training to Oregon to help create an environment where Oregonians from across the state have the ability to attend a suicide bereavement group and to equip those who want to facilitate a group with the evidence-based information they need to be successful.

Introduction and background

Background

Suicide is an important public health problem in Oregon. The national suicide rate has been continuing to increase since 2000. The Oregon suicide rate parallels the national trend, but has been higher than the national average. Since 2011, youth (10-24 years of age) suicide deaths and rates have seen significant increases. Refer to data section on page 33 for more information.

Concerned by this increasing rate, the Oregon Legislature in 2014 passed HB 4124. This bill mandated a five-year Youth Suicide Intervention and Prevention Plan (YSIPP). It also created the position of youth suicide intervention and prevention coordinator in the Oregon Health Authority's Health Systems Division. This report fulfills the requirement that OHA present an annual progress report to the Legislature. Specifically, this report focuses on data from 2017 and activities related to the plan in 2018.

In 2017, out of 50 states and the District of Columbia, Oregon ranked number 17 for suicide among youth aged 10 to 24 years. Oregon was number 15 in 2016.

Youth Suicide Intervention and Prevention Plan

One-hundred experts in suicide prevention, intervention and children's behavioral health developed the Oregon Youth Suicide Intervention and Prevention Plan (YSIPP) in 2015. The plan fulfills the mandate of HB 4124 (ORS 418.704). The group modeled the plan after the National Strategy for Suicide Prevention (NSSP) but addressed issues specific to Oregon. The plan is based on Thomas Joiner's interpersonal theory of suicide. It emphasizes the need to increase a sense of belonging and connectedness of youth to their families, peers and adults in their communities. The plan approaches prevention and intervention on these levels:

- Building human connections
- Increasing resiliency and positive decision-making
- Upstream prevention for all youth
- Increasing access to competent and confident behavioral and physical health care providers
- Addressing post-suicide intervention to reduce the risk of contagion

Participants in writing the YSIPP included the following:

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

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

- LGBTQ Oregonians
- People who have attempted suicide
- People who have lost a loved one to suicide
- American Indians/Alaska Natives
- Military members, veterans and their families

The YSIPP calls on Oregonians to work toward “Zero Suicide”. This aspirational goal can be achieved through collective action among health and behavioral health systems, schools, communities, parents and other systems that touch the lives of youth. The Youth Suicide Intervention and Prevention Plan is available at [YSIPP](#).

In 2018, three years into implementation, OHA and stakeholders have achieved many objectives of the plan. Work is underway on many others.

Oregon Alliance to Prevent Suicide

Formed in 2016 as required by the YSIPP, the Oregon Alliance to Prevent Suicide is responsible for the following:

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

The multi-disciplinary Alliance includes the following:

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

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

- Education and schools
- Workforce development
- Continuity of care across systems
- Outreach and awareness
- Data and evaluation

OHA Director Patrick Allen appointed new Alliance members in 2018. They are expected to serve through 2020, the life of the Plan. Work will begin in 2019 to begin framing of the next 5-year plan mandated by legislation.

The Alliance has developed infrastructure to guide its work, including by-laws and an executive committee. This ensures continuity in Alliance leadership and a format for self-governance. The Alliance submitted requests to legislators for four legislative concepts for the 2019 legislative session. HB 2813 pertains to mandatory continuing education for health providers, SB 707 would establish the Alliance, and its responsibility in statute to ensure its ongoing viability, HB 2667 would focus on the development of a suicide prevention plan for adults, and SB 485 would add schools as mandated reporters when suicides occur under SB 561. All of these bills have been introduced during the 2019 legislative session and are being considered for passage.

Implementing SB 48 (2017) for continuing education

Behavioral health and medical professional licensing boards and the Teachers Standards and Practices Commission (regulating school counselors) are collecting data pertinent to SB 48. Licensees report suicide assessment, treatment and management courses they take at license renewal. OHA submitted its first legislative report in September 2018 to outline the data collected in 2017 by the board of medicine and naturopath board. Other boards will begin reporting in 2019. SB 48 addresses continuing education for these identified professions:

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

SB 48 requires licensing boards to report any suicide assessment, treatment and management continuing education courses licensees take and report at re-licensure. OHA staff administers a survey to licensees for most behavioral and medical providers. OHA has added questions to that survey, relevant to SB 48, at the request of the boards. The Oregon Board of Medicine and the Teachers Standards and Practices Commission are handling their own surveys.

As required by law, the Legislature will receive a data report from OHA in even number years. The report was submitted in September 2018 and will be submitted again in 2020. Data will help to find out how many licensees are taking training to improve their competency and confidence in suicide assessment, treatment and management.

Implementing SB 561 (2015) to address grief and contagion

Contagion occurs when a suicide influences the suicidal behaviors of others. Research shows contagion risk is higher among youth than for older individuals. SB 561 was passed in 2015 to address this issue. SB 561, sponsored by state Senator Sara Gelser, mandated each Local Mental Health Authority (LMHA) in Oregon develop postvention plans. Schools and colleges may participate voluntarily. There has been a gap in reporting from K-12 schools and colleges. House Bill 2813 has been introduced during the 2019 legislative session to require schools and colleges to report deaths and participate in community postvention to address this gap.

Thirty-three community mental health programs (CMHPs) implement community mental health on behalf of the LMHAs. As of December 2018, 22 CMHPs had submitted their postvention plans to OHA. These plans include protocols for sharing information among local partners and for managing postvention response, when needed. Annual updates to the plans are required. CMHPs also are responsible for reporting suspected suicides among individuals aged 24 and younger to OHA within seven days of death. OHA received reports of 65 suicides, in this age group, in 2018. OHA has no enforcement authority that all CMHPs create plans or report deaths. To encourage CHMPs to do so, OHA:

- Held a Listening Session including SB 561 county staff to refine direction on how to encourage CMHP involvement
- Asked AOCMHP to work with CMHP directors to identify staff specifically responsible to implement SB 561
- Offered technical assistance to counties
- Reviewed the protocols submitted, offering comments and suggestions for best practices.
- Provided the best practice CONNECT training and technical assistance to counties on suicide postvention
- Worked with the Alliance Schools Committee to address privacy statutes that are barriers to information sharing between schools/colleges and mental health providers.

Cultural relevance

The Youth Suicide and Intervention Plan has identified the need to focus work on specific population groups at greater risk of suicide. For example, around fifty percent of LGBTQ youth report that they have seriously considered suicide (Healthy Teens Survey 2017). The Alliance Executive Committee created a special project to address unique suicide prevention and intervention needs of the LGBTQ population. This population experiences an extremely high rate of suicide and suicide attempts. The work group is addressing the need for family support for at-risk LGBTQ youth by bringing the Family Acceptance Project to the State of Oregon. This project educates and supports families in addressing the suicidality of their LGBTQ children.

The Alliance also expects to create special project work groups in the future to address the needs of other groups at disproportionate risk of suicide. These groups include the following:

- Military members, veterans and their families
- American Indians/Alaska Natives and other minority populations
- People with mental illnesses
- People with chronic medical conditions
- People bereaved by the loss of a loved one

In 2019, Alliance members also intend to address the needs of people who previously attempted or seriously thought about suicide.

OHA also is working with the tribes to identify suicide prevention needs. In addition, OHA is working with the Oregon Department of Veterans Affairs to develop and offer training in 2019 to medical and behavioral health providers on suicide assessment, lethal means counseling and safety planning specifically for veterans and military members.

In 2018, the Oregon Pediatric Society continued delivering culturally appropriate Screening Tools and Referral Training (START) for providers. These trainings on depression, suicide prevention, substance abuse and trauma-informed care included providers in American Indian/Alaska Native communities. OPS is expected to present the training at the Oregon Suicide Prevention Conference in 2019.

As of December 2018, the tentative agenda for the March 2019 Oregon Suicide Prevention Conference includes presentations by national suicide bereavement and attempt survivors.

Evaluation plan

The University of Oregon (UO) evaluation team, with the guidance of Oregon Health Authority and in collaboration with the Oregon Alliance to Prevent Suicide, made noticeable strides during the 2018-19 contract year to support and evaluate the implementation efforts of the YSIPP. Progress was made on all four strategic areas outlined by the YSIPP, all of which are agreed upon as essential components for reducing the incidence of youth suicide in the state of Oregon. Key accomplishments and recommendations from the University of Oregon are outlined below as they relate to the strategic directions of the YSIPP.

YSIPP Strategic Direction 1: Healthy and empowered individuals, families and communities

- Evaluation Key 2018 Accomplishments:
 - » Supported development of the Alliance Communications Plan
 - » Developed Oregon Alliance to Prevent Suicide website
 - » Completed Oregon Suicide Prevention Conference outcomes report
 - » Collaboration between the University and Warm Springs Tribe to facilitate suicide prevention
- Summary and University Recommendations: The development of the communications plan, website, and suicide prevention conference have helped to achieve the Alliance's goals to establish and continuously improve internal and external community-wide communication. By improving the quality and reach of suicide prevention-related communications, Oregon moves closer to providing individuals, families, and communities with the resources they need to be healthy and empowered. Working directly with the Warm Springs Tribe to assess community readiness and provide

direction for the provision of services, the University has obtained information on opportunities in the future for providing recommendations and guidance on programming for local American Indian/Alaska Native communities at their request.

YSIPP Strategic Direction 2: Clinical and community preventative services

- Key 2018 Accomplishments:
 - » Conducted CONNECT postvention training evaluation and scale-up
 - » Planned Alliance-coordinated LGBTQ working group
 - » Completed scan of local and regional suicide prevention coalitions across the state
 - » Completed scan of suicide prevention-related school programming
 - » Completed survey of school athletic staff on school-based suicide prevention needs
- Summary and University Recommendations: CONNECT postvention activities, the LGBTQ initiative, and the completion of three regional scans provided information about the current statewide and local efforts related to suicide prevention. Based on the information gathered, the following five recommendations have emerged:
 - » providing additional support for CONNECT Postvention implementation,
 - » advancing the LGBTQ initiative,
 - » increasing involvement in the Alliance from regional coalitions,
 - » creating a database for state practitioners and researchers to obtain support and exchange ideas, and
 - » providing support for schools who indicated a need for assistance in prevention efforts.
- The UO evaluation team has already begun developing implementation supports for CONNECT postvention training, creating a database for practitioners and researchers to share information and support postvention efforts.

YSIPP Strategic Direction 3: Treatment and support services

- Key University Accomplishments:
 - » Surveyed physicians and naturopaths about continuing education courses taken pertinent to State Bill 48
 - » Began scan of suicide prevention efforts at drug and alcohol treatment centers
- Summary and University Recommendations: The survey of Senate Bill 48 professionals was completed and the survey on drug and alcohol treatment center efforts began in 2018. Both of these efforts are in line with goals of diffusion of suicide prevention into existing systems. The University recommended that, based on the results of its analysis, medical practitioners should be mandated for professionals to complete suicide-related training. Of physicians and naturopaths reporting in 2018, only about 20 percent reported completion of such trainings. Many courses that were reported had a duration

of less than two hours, however best practice trainings in assessment, treatment and management of suicidal patients customarily are 1- or 2-day courses. Of those taking the courses, many reported the trainings were valuable and resulted in changes to their practice.

YSIPP Strategic Direction 4: Surveillance, research and evaluation

- **Key University Accomplishments:**
 - » Oregon Healthy Teens secondary data analysis
 - » Access to Oregon Electronic Surveillance System for the Early Notification of Community-Based epidemics (ESSENCE) dataset
 - » Access to ORVDRS (Oregon Violent Death Reporting System) dataset
- **Summary and University Recommendations:** Results from the Oregon Healthy Teens survey suggests that youth at risk for suicide are more likely than low-risk youth and youth who engage in substance use to have been maltreated. Efforts to disseminate these findings have begun by conducting analyses specific to local counties and sharing data with local practitioners for diffusion into the community. Access to the ESSENCE healthcare data will provide insight into the frequency of youth suicide attempts.

Suicide and trauma training

Significant progress was made in addressing trauma as it pertains to suicide and training of medical providers in suicide risk assessment, lethal means counseling and safety planning. Trauma Informed Oregon continued incorporating suicide issues into its programming under a contract with OHA. Below are those accomplishments:

Trainings:

- In 2018, Trauma Informed Oregon (TIO) continued to update all training presentation materials to include Oregon State and national trauma and suicide data slides, reports and protocols. TIO also developed [online training modules](#) with the same information. Additionally all trainings addressed the impact of adverse childhood experiences as well as current or historical trauma. During the 2018 calendar year, 3 TIO Trainers trained 4,538 providers, from a wide variety of systems, communities, and people with lived experience throughout Oregon.
- A Peer Support/Wellness Training on trauma informed strategies and tools was developed in 2017 and vetted with adult and youth peers in 2018. It was presented in TIO's fall 2018 newsletter posted online.
- TIO collaborated with Oregon Foster Youth Connection, FosterClub and Oregon Trauma Advocates Coalition (OTAC) to develop a youth workshop by youth for youth on foundations of trauma informed care. The workshop was vetted at two youth conferences and is now offered by FosterClub and on the TIO [website](#).

Website:

- TIO developed a Community Page and Discussion Forums on the website to connect others doing TIC work and share suicide prevention and postvention plans.
- TIO continues to add resources in the web resource folder on TIO website called “Suicide Prevention” with available resources for providers, youth, families, and survivors of trauma.

Newsletters and Blogs:

- The September TIO Newsletter, which focused on Suicide Prevention with dissemination of blogs, resources, and tools, was released and uploaded to website resource page. This newsletter has 1,631 subscribers.
- TIO formed a youth-led trauma advocacy coalition (OTAC) with a focus on expanding and enhancing TIO resources and supports that explicitly address the needs of young people affected by trauma. OTAC has drafted two tools for Youth Crisis in Schools: one for staff providing services to youth in crisis, and the other for youth experiencing a crisis to advocate for themselves in the school, which will be in vetting form in 2019.

Other:

- TIO continued in 2018 to collaborate with early childhood agencies, schools, and other stakeholders to identify and document best-practice education programs and services addressing the relationship between early childhood trauma and suicide risk.
- TIO Leadership Team provided expertise and resources available on suicide prevention to meet deliverables of the Youth Suicide Intervention and Prevention Plan. Gaps have been identified and resources shared.
- Met with Adolescent Health Project Manager about the suicide prevention module OPS/START is developing.
- Two OTAC Young Adult members are to be participants with CSAC and OHA in the development of a youth emergency department guidebook that will be distributed throughout hospitals across the state in 2019-2020.

The Oregon Pediatric Society convened an expert panel on suicide prevention to identify components for best practice training for pediatricians and other health care providers. Starting in 2018, OPS courses included instruction in suicide risk assessment, lethal means counseling and safety planning, primarily for adolescents. Based on research by the expert panel, those courses recommend use of the Ask Suicide-Screening Questions (AsQ) suicide risk assessment tool developed by the National Institute of Mental Health specifically for pediatric populations.

This included reviewing best practice for providers in these areas:

- Youth suicide risk assessment
- Lethal means counseling

- Safety planning.
- Research-informed tools
- Protocols and referral processes.

Members of the OPS expert panel represented various perspectives and clinical practices:

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

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

Policy highlights

SB 48, initiated by OHA and reviewed by the Alliance to Prevent Suicide, was passed by the Legislature in 2017 and initial data were available in 2018. The bill requires licensing boards of certain behavioral and physical health providers and school counselors to gather data at re-licensure about any continuing education licensees have taken on suicide assessment, treatment and management. OHA, at the request of most of the licensing boards, is distributing a survey at re-licensure to gather data. The Oregon Medical Board is distributing separate surveys to physicians. The Teachers Standards and Practices Commission is sending separate surveys to school counselors. The OHA electronic survey asks licensees to report if they have taken any continuing education courses in suicide assessment, treatment and management. Licensees provide a yes or no answer and the duration of any class. If licensees are willing to discuss the course with the OHA suicide intervention and prevention coordinator, they are asked to provide their contact information and are sent a follow-up survey. Per legislation, OHA developed a list of suggested classes. OHA began distribution of the list to licensing boards in November 2017 and updated in [2018](#). The Board of Dentistry also is promoting training, although it is not required to do so.

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 (under 2 hours) and delivered at conferences. Available best practice trainings are generally several hours or more. Note that 2018 data are an initial sample and additional data is being collected. The bill didn't go into effect for reporting for physicians and naturopaths before November 2017. Other licensing boards began collecting 2018 data and will report to OHA in March 2019.

SB 561 (2015), which mandates post-suicide information sharing and response activities in all Oregon counties, is being implemented. OHA received reports of 65 suspected suicides of individuals aged 24 and younger within seven days of death, as required by law.

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

As the program continued in 2018, OHA identified in real time the communities with disproportionate suicide rates. OHA also provided technical assistance, including funding for peer support and school programs.

In addition, OHA funded a Sources of Strength train the trainer course to school personnel. Sources of Strength is a best practice program that trains adult mentors and youth leaders to establish resilience-building programs in their middle and high schools. The train the trainer program is a pilot that can be expanded if OHA's budget request is authorized in 2019-2021.

Utilizing one-time funding, OHA identified counties for the CONNECT suicide postvention train the trainer program:

- | | |
|-------------|-------------|
| » Linn | » Jackson |
| » Benton | » Jefferson |
| » Lincoln | » Yamhill |
| » Umatilla | » Malheur |
| » Deschutes | » Clackamas |
| » Lane | » Columbia |

- » Coos
- » Curry

- » Klamath
- » Marion

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

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

The University of Oregon is evaluating CONNECT to find out if on-the-ground practices change because of the program. Initial analysis indicated the pilots were successful and the evaluators have recommended statewide implementation. Evaluators also recommended that trainers be offered technical assistance. As a result, quarterly learning collaborative calls continue. An online system also was created for counties to record trainings, participants, and follow up activities. Plans are for six more CONNECT train-the-trainer sessions in 2019 for Clackamas, Columbia, Coos, Curry, Klamath, and Marion counties. Additional funds have been requested to continue in 2019-2021.

While OHA was neutral on the legislation, OHA is watching implementation of SB 719 (2017). SB 719 allows for extreme risk protective orders for individuals at risk to self or others. The legislation allows household members or police to seek a court order to remove, for 12 months, a firearm from the home of someone who is a threat to self or others. Initial Oregon data indicate most of the removal orders in the first year were done to address suicidality, not threat to others.

The Alliance adopted a legislative agenda for 2019 with four pieces of legislation:

- Establish the Alliance and its responsibility in statute to ensure its ongoing viability
- Adopt a suicide prevention plan for individuals 25 and older to reflect a lifespan approach that addresses high suicide rates among adults.
- Add schools and colleges to entities that report deaths and adopt suicide postvention protocols
- Mandate continuing education in suicide assessment, treatment and management for behavioral health providers.

The coordinator provided technical assistance to rules advisory committees implementing HB 3090 and HB 3091 advanced by state Representative Alissa Keny-Guyer. HB 3090 specifies services to be provided at release from hospital emergency departments (EDs) to

individuals in behavioral health crisis. HB 3091 sets up a payment mechanism for those services and case management supports. As of December 2018, rules included provision of “caring contacts” at ED release to assist individuals and designated caregivers with the transition to outpatient care. Rules include provisions of safety planning and lethal means counseling, as well as provision of peer and family support. Additional rule clarification may be needed in the future.

Grant-funded activities

The Oregon Health Authority Public Health Division (OHA PHD) manages Garrett Lee Smith Memorial Act (GLSMA) youth suicide prevention funding. Funding comes from the Substance Abuse and Mental Health Services Administration (SAMHSA). The grant ends in September 2019. SAMHSA issued a new funding announcement with the application due in March 2019. OHA PHD will submit an application to receive this funding. During development of the YSIPP, objectives and activities underway as part of this GLSMA funding were included in the YSIPP. This was in order to maintain alignment among the grant efforts underway and efforts proposed as part of the emerging state plan in 2015. GLSMA activities include gatekeeper training, clinical training and improved continuity of care for youth discharged from health care systems. Activities also include implementation of the Zero Suicide initiative, promotion of the National Suicide Prevention Lifeline and project evaluation. Details about grant-funded efforts underway are in Appendix I.

Report on OHA activities in 2017

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

Section 1

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

Status: Completed

Progress: Completed

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

Status: Ongoing

Progress:

The Alliance to Prevent Suicide and Association of Oregon County Mental Health Programs, in collaboration with OHA, launched a special project to bring the Family Acceptance Project to Oregon. Working with a committee of LGBTQ individuals and their families, those collaborating on the project began scoping dates for presentations designed to help professionals working with parents, to promote their acceptance of their LGBTQ youth. The committee is planning additional work in 2019. The Family Acceptance Project is scheduled to be on the agenda for the Oregon Suicide Prevention Conference in March 2019.

OHA also continues to collaborate with other groups at disproportionate risk of suicide. Members of the Alliance include these representatives:

- The Oregon National Guard
- Oregon Department of Veteran Affairs (ODVA)
- Suicide bereavement survivors
- Individuals who attempted suicide
- LGBTQ Oregonians
- Native Americans
- People with behavioral health conditions

OHA is working with ODVA to launch a training program for medical and behavioral health practitioners on suicide risk assessment, lethal means counseling and safety planning for veterans and military members. These trainings are expected to begin in 2019. Additionally, the Alliance will be initiating services to suicide bereavement and attempt survivors in 2019. The American Foundation for Suicide Prevention Oregon Chapter also is pursuing training for survivor support group facilitators. The tribal liaison for the OHA Child and Family Behavioral Health Unit was hired in 2018 and will be serving on the Alliance.

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

Status: Ongoing

Progress:

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

This includes:

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

OHA worked with providers and stakeholders on rules for services to individuals in behavioral health crisis at release from emergency departments (HB 3090 and 3091). HB 3090 rules were finalized in 2018, including best practices in suicide risk assessment, lethal means counseling, safety planning, caring contacts and peer and family support services. HB 3091 set up a payment infrastructure for HB 3090's new aspect of case management services. Work is needed to monitor implementation of the laws and rules.

- Crisis and Acute Transition Services Project (CATS).

Funding for the Emergency Department Diversion Project, currently called CATS, originally rolled out in late 2014/early 2015 to four sites, expanding to 11 sites by 2018. CATS is designed to address the needs of youth discharged from emergency departments, and their families, in an effort to reduce re-hospitalizations at a later date. Early data collected indicates that CATS is effective in diverting youth from emergency department stays. Families receive quick response and are connected to needed supports. Approximately 65 percent of youth seen in the program presented at the emergency department with suicidal ideation or after a suicide attempt. From January – June 2018, 286 youth were served. Only 4.5 percent of youth returned to the emergency department while being served by CATS. In 2018, services were available in: Benton, Clackamas, Deschutes, Jackson, Klamath, Linn, Malheur, Marion, Multnomah, Umatilla and Washington counties. Oregon Health & Science University (OHSU) is conducting an evaluation. OHSU will make recommendations on outcomes and promising practices. There will be a statement of results in future reports.

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

Licensing boards began reporting data to OHA under SB 48 in 2018. The Oregon Board of Medicine and Naturopathic Board reported data to OHA while other licensing boards began implementing the law in 2018 and will report data by March 2019. Data are being collected through two surveys administered to behavioral and medical professionals annually: 1) An OHA administered survey done at the request of licensing boards, and 2) surveys administered by the Board of Medicine and Teachers Practices and Standards Commission (school counselors). The first OHA report on the training outcomes was reported to the Legislature in September 2018. (https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/SUICIDEPREVENTION/Documents/oha2889_sb48_report.pdf)

Approximately 20 percent of physicians and others licensed by the Board of Medicine and naturopaths reported they had taken continuing education in suicide assessment, treatment and management. Most courses lasted 1-3 hours, however, far fewer hours than best practice assessment, treatment and management courses available in the United States, indicating the likelihood that the courses taken did not cover a full array of issues intended in the legislation. As required by legislation, OHA prepared a list of available courses and distributed it in 2017 (<https://www.oregon.gov/oha/HSD/AMH/Documents/SB%2048%20Continuing%20Education%20Courses.pdf>) and updated it in 2018. A comprehensive course that meets Washington State’s mandated continuing education was offered by OHA at a reduced charge at the Oregon Suicide Prevention Conference in 2018. Approximately 24 people took the class, most of them behavioral health providers.

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

The Oregon Pediatric Society and Trauma Informed Oregon designed suicide prevention, intervention and postvention practice interventions and now include them in their training curricula for physical and behavioral health providers. Their trainings involve primary care and clinic staff, behavioral health clinicians, school based health clinics, tribal providers and social service workers.

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

The Children’s System Advisory Council (CSAC) completed and began distributing a guide for families of youth seen in emergency departments for behavioral health crises. A final version will be printed in 2019.

CSAC also is collaborating with stakeholders to prepare a proposed statewide protocol for family and youth support services. Family and peer support providers will use this protocol in responding to families and youth in outpatient care.

- Suicide Risk Assessment Tools

At the request of the Behavioral Health Collaborative and the Alliance, OHA began work to identify suicide risk assessments that could be recommended for use by medical and behavioral health providers in Oregon. Based on research completed in 2018, internal and external work groups are being created to review recommendations on adoption of recommended standardized screening and risk assessment tools.

Section 1 (2)(d): Technical assistance

Status: Ongoing

Progress:

As required by ORS 418.704, The Health Systems Division (HSD) youth suicide intervention and prevention coordinator provides technical assistance in suicide prevention, intervention and postvention. The OHA PHD Zero Suicide Program Coordinator provides technical assistance to hospitals and health systems that are implementing the Zero Suicide initiative. Groups or programs receiving technical assistance include:

- State boards and commissions
- Schools and Education Service Districts
- K-12 athletic directors, coaches and trainers
- Community Mental Health Programs
- Hospitals and health systems
- Outpatient behavioral health providers,
- Parents and groups representing interests of youth
- Suicide prevention staff and advocates
- Coordinated Care Organizations and private
- Organizations representing groups at disproportionate risk of suicide

The coordinator also provides additional technical assistance to OHA staff, including school based health programs, Health Policy and Analytics and Adult Behavioral Health.

The Zero Suicide Coordinator in OHA PHD moderates a suicide prevention listserv that reaches more than 300 individuals across Oregon. The listserv offers technical assistance and access to the latest information on suicide prevention, intervention and postvention.

Section 2

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

Status: Ongoing

Progress:

The coordinator in 2018 emphasized infrastructure development for long-term sustainability of suicide prevention in Oregon. Rules for HB 3090 and 3091 (2017) were finalized. HB 3090 outlines the activities emergency departments must undertake when a person who is suicidal or has attempted suicide at release. The rules include best practices in suicide risk assessment, lethal means counseling, safety planning and caring contacts. These will ensure smooth transitions to outpatient care.

Additionally, infrastructure investments included:

- Continued implementation of SB 561 and the associated postvention intervention training called CONNECT. CONNECT trainers can ensure best practices in suicide postvention across communities to reduce the risk of contagion.
- OHA awarded a contract for providing rapid postvention response to schools and communities after a suicide. Services are deployed quickly to address contagion risk among youth. Services available include classroom activities, community listening sessions, youth peer support, family peer support, grief processing, interventions for staff and parent programs. One-time funding is available through June 2019. OHA has requested funds to continue rapid response in 2019-2021.
- Availability of clinical and family support services to youth seen in emergency departments in a behavioral health crisis. The CATS program is being evaluated by OHSU at pilot sites in Oregon. Funds will be needed for statewide implementation.
- OHA PHD Zero Suicide Program Coordinator hosted a Zero Suicide Academy in September 2018 for sixteen hospitals and health systems to support implementation safer suicide care and quality improvement. OHA PHD is facilitating a Community of Practice with 10 of the participating organizations to help move efforts forward.

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

Status: Ongoing

Progress:

- OHA and the Alliance saw much momentum forming on use of critical aspects of suicide intervention and treatment, including use of caring contacts to bridge the gap

between emergency department release and outpatient care. In addition, progress was made to encourage widespread use of research-based suicide risk assessments, lethal means counseling and safety planning as recommended in the Joint Commission's [Sentinel Alert 56: Detecting and treating suicide ideation in all settings](#) as well as reevaluation of the [National Patient Safety Goal for suicide prevention](#).

- One time funding for 2017-2019 also allowed OHA to issue a grant to AOCMHP to provide administrative support to the Alliance. AOCMHP employed a suicide prevention liaison. This level of service allowed the Alliance to take additional strides in initiating communication statewide among suicide prevention coalitions and prevention specialists, as well as SB 561 reporters. The Liaison in collaboration with the University of Oregon also established an Alliance website to foster partnerships statewide. The Liaison also assisted the Alliance in advancing legislative initiatives pertaining to workforce competence, continuity of care and suicide prevention across the lifespan. The Alliance also initiated a concept for legislation to place the requirement for an Alliance into state law.
- A listening session held by OHA in 2018 brought together individuals in communities responsible for responding to youth suicides, including public health and behavioral health programs. Several SB 561 reporters who attended discussed barriers to information sharing among systems and programs, including between counties and schools/colleges. In learning of this barrier, the Alliance asked legislators to add schools as reporters under SB 561 during the 2019 session. OHA will follow up on recommendations made at the listening session during 2019.
- An OHA budget request for 2019-2021 also was submitted to provide more in-school behavioral health services in order to increase access to care, including for youth at risk of suicide. The budget request also includes funding for multidimensional suicide prevention, intervention and postvention advances.

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

Status: Ongoing

Progress:

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

The OPS initiative has trained 471 primary care and school-based providers since its initiation in 2013. In 2018, with the addition of the suicide prevention module, 207 providers

were trained in risk assessment, lethal means counseling and safety planning. Additional modules addressed adverse childhood experiences, trauma, depression and substance abuse. Evaluation included measures of practice changes as a result of the trainings. OPS conducts learning community follow-up training and learning calls to support implementation. Suicide prevention trainee surveys in 2018 showed that

1. 97 percent agreed their awareness of suicide risk increased
2. 99% said training increased awareness of need for lethal means counseling and safety planning,
3. 99% said training increased confidence in addressing suicide risk in their practice,
4. 75% said their use of lethal means counseling for at-risk patients will increase,
5. 75% said they were very committed to making a change in their adolescent suicide risk screening practices.

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

Status: Ongoing

Progress:

- Lines for Life, Youth MOVE (now called Youth ERA), and youth received one-time funding in 2017-2019 to pilot social media strategies to create safe online spaces for youth. That project will be completed in 2019. OHA has requested funding to continue the initiative in 2019-2021.
- With leadership from the Alliance Outreach and Awareness Committee a communication action plan was developed in 2018. This included development of an Alliance website and fostering more communication among suicide prevention specialists and local coalitions statewide. Participants at the OHA Listening Session also requested development of a statewide media campaign. Funding would be needed for such a campaign.

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

Status: Ongoing

Progress:

- A contract was issued by OHA in 2018 to launch a rapid response system to deploy postvention services to communities experiencing youth suicides. The first response occurred in the fall of 2018 to Sprague High School in Marion County, which had

experienced three suicides in eight months. Effectiveness of these innovative services will be evaluated. The system had one-time funding through June 2019. A funding request has been submitted by OHA for 2019-2021. OHA will be presenting the program to stakeholders in 2019 to ensure communities are aware of available services.

- OHA also is seeking funds to train and certify all Oregon medical examiners in best practices in conducting psychological autopsies. They are designed to explore the social-psychological circumstances youth were experiencing prior to death. Information gathered will allow communities to better understand conditions surrounding suicides and ensure that suicides are identified when they occur. Better data will allow for prevention, intervention and postvention to be customized for local circumstances.

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

Status: Completed

Progress:

- A comparison of Oregon's youth suicide rates and prevention strategies with other states is in the plan, as required. Rankings for 2017 are included in the statistics provided in Appendix II of this report.

Section 2 Action items requiring additional resources to complete

Status: Underway

Progress:

- OHA prepared a budget proposal for \$13 million 2019-2021 to address gaps in services and prevention activities across multiple risk factors. They were advanced by OHA, approved by the Governor and will be presented to the Legislature in 2019. The budget request included funds to increase availability of behavioral health services in schools and the following request pertaining to suicide prevention. The list is organized by the Strategic Directions of the YSIPP:
 - » **YSIPP Strategic Direction 1: Healthy and empowered individuals, families and communities**
 1. **Youth engagement and leadership.** Fund services to meaningfully engage youth with OHA, Oregon Alliance to Prevent Suicide and the Children's System Advisory Committee in suicide prevention, intervention and postvention. Recent experience indicates that a specific entity is needed to coordinate youth engagement and lead groups of youth stakeholders/experts to provide crucial youth and young adult input on suicide planning and activities.

2. **Develop second mandated 5-year Youth Suicide Intervention and Prevention Plan.** Involve the Alliance and broad array of stakeholders and youth in developing the legislatively mandated plan update for 2021-2026.
- » **YSIPP Strategic Direction 2: Clinical and community preventive services**
1. **Support communities in crisis.** Fund immediate post-suicide rapid response in communities experiencing multiple suicides or attempts. This addresses the high rate of contagion among youth. Funds will be distributed to communities that have been stressed beyond their capacity.
 2. **Train communities to develop suicide response plans to reduce contagion risk.** SB 561 requires all counties to work with partners to develop and implement post-suicide response plans. This training, called CONNECT, would be offered to community members to provide knowledge and skills in postvention and increase an Oregon cadre of suicide response experts.
 3. **Psychological autopsy certification.** This will allow for collaboration between medical examiners and OHA suicide prevention staff to ensure that psychological autopsies are conducted for suicide deaths. A psychological autopsy allows medical examiners to better ascertain circumstances around the suicide and improve data reporting and surveillance to better monitor the psychosocial circumstances that contributed to the suicide.
- » **YSIPP Strategic Direction 3: Treatment and support services**
1. **Youth-led development of online resources for youth.** This will involve youth and suicide prevention experts working with youth to develop or identify safe online practices on social media platforms. Includes a Youth Summit to develop teams of youth to serve as prevention leaders across the state. This will encourage healthy peer relationships.
 2. **Oregon suicide prevention hotline.** This will fully fund Lines for Life and YouthLine crisis response services for Oregon youth and families. The hotline currently is operating at a deficit due to drastic increases in call volume. YouthLine has never been funded by the state. Oregonians rely on this phone, chat and text service as a critical component on the continuum to prevent and intervene to de-escalate crises and guide people to the support they need.
 3. **Resilience building in schools.** This will provide funding to:
 - a. Implement the best practice Sources of Strength youth-led resiliency program in middle and high schools.
 - b. Work with preschools and elementary schools to support pro-social development through the best-practice PAX Good Behavior Game.

- c. Provide mini-grants to pilot schools to identify or develop customized protocols and strategies to prevent suicide and provide best practice post-suicide response.

» **YSIPP Strategic Direction 4: Surveillance, research and evaluation**

1. **Evaluation on progress implementing the YSIPP.** This will continue an intergovernmental agreement between OHA and the University of Oregon to collect, evaluate and analyze data to gauge the success of programs implemented to meet the goals and objectives of YSIPP. This analysis increases the ability to determine cost/benefit of certain interventions and guide future investments.
2. **Data collection from hospitals and health systems.** This will provide supports to Oregon hospitals and medical or behavioral healthcare systems to deliver suicide-safer care. Those hospitals and medical/behavioral health systems participating also will be required to collect and submit data about their needs, challenges and program innovations they are implementing under the best practice comprehensive Zero Suicide initiative.

» **Infrastructure: Support for implementation**

1. Hire an OHA staff person to coordinate and implement prevention and post-suicide intervention activities called for in the 117 action items in the YSIPP and the widening scope of youth suicide prevention activities in Oregon since 2014. The rate of youth suicides in Oregon has been increasing since 2011, with 107 recorded deaths in 2017.
2. Funding to support adults with behavioral health disorders with suicide risk and their at-risk children. Hire an OHA staff person to coordinate and implement activities to prevent suicide among adults over age 25. This would include developing a complementary suicide prevention plan to extend the reach to individuals 25 and older. This will ensure youth receive support at the high-risk time when they move into the workforce and address the dramatically increasing suicide rate across the lifespan. Approximately 670 adult suicides are reported in Oregon each year.
3. Hold a state suicide prevention summit and training annually. This will encourage collaboration among communities, promote best practices, and share innovative practices from all corners of the state.

» **Populations at disproportionately high risk of suicide as identified in YSIPP**

1. **LGBTQ supports.** This will expand suicide prevention efforts to the extremely high-risk LGBTQ youth in Oregon. LGBTQ individuals are at extremely high risk of suicide. Some report that approximately 40% of transgender individuals attempt suicide.
2. **Tribal mini grants.** Oregon tribes do not have state funding for suicide prevention, intervention and postvention. They are in acute need of support for such programs.

This funding would allow for tribes to select projects that would respond to their high suicide rate. In 2000–2010, Native American males aged 15–24 years experienced a 51.93 per 100,000 suicide death rate vs. 16.9 among all U.S. males in that age group. Among females aged 15–24 years, the rate for Native Americans was 16.74 per 100,000 compared with 3.89 for the total female population.

3. **Suicide attempt and bereavement survivors.** This would fund online and other easily accessible tools to reduce suicide risk among people who previously attempted suicide and loved ones left behind after a death. These groups are an elevated risk of suicide.

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

Status: Ongoing

Progress:

- OHA has submitted a budget request for 2019-2021 to increase availability of school-based behavioral health services. Having behavioral health clinicians in schools improves access to services, a critical component to reducing suicide risk.
- The Alliance Schools Committee is examining confidentiality requirements for the following:
 - » Schools
 - » Behavioral health providers
 - » Substance use providers
 - » Hospitals and health systems

This will help to identify barriers for information exchange across systems and methods to overcome them, thus ensuring continuity of care.

- The committee also expects to examine procedures followed in some communities to encourage parents to sign information releases across education and healthcare systems. This would enable schools, hospitals and behavioral health providers to share certain information to aid student success.
- There is an expectation that overcoming legal barriers to information exchange — e.g. HIPAA and the Family Educational Rights and Privacy Act (FERPA) — will take time and require legal review.

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

Status: Ongoing

Progress:

- At the request of the Behavioral Health Collaborative, OHA staff began research on standardized risk assessments during 2018. Types of risk assessments and screenings and their research base were explored and presented to a variety of stakeholders, including the Alliance. Internal and external work groups will be formed for 2019 to guide implementation. An inventory is needed to determine what screening and assessments are currently being used in emergency, inpatient and outpatient settings.
- The Alliance Schools Committee and University of Oregon researchers need to complete an assessment of which schools and colleges have adopted suicide prevention and postvention protocols. Adding schools and colleges to entities covered by SB 561 would remedy this issue.
- In initial data gathering among physicians and naturopaths, about 20 percent reported taking courses in suicide assessment, treatment and management. Most courses were 2 hours or less, indicating that the courses were likely not full best practice trainings in assessment, treatment and management. SB 48 currently does not require physical or behavioral health providers to take trainings, but to report them to their licensing boards if they do take them. The Alliance is seeking legislation in 2019 to mandate continuing education for behavioral health providers only. To increase the number of physical and behavioral health providers taking courses to increase their confidence and skills in dealing with suicidal patients, the courses likely will need to be mandated in the future. Additional data on voluntary completion of courses from across the spectrum of providers will be reported to the Legislature in 2020.
- OHA's budget request for 2019-2021 needs to be approved to implement the YSIPP. The YSIPP is mandated in statute but has not been fully funded.

Section 3

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

Status: Ongoing

Progress:

The following data analysis addresses Section 1 (3)(a-g) of HB 4124. Included in the data below are the number of youth and youth adults aged 10 to 24 years who die by suicide, those hospitalized due to self-inflicted injury, and youth suicidal ideation and behaviors.

Basic facts

Suicide was the second leading cause of death among youth aged 10 to 24 years in Oregon in 2017.(1)

Overall, Oregon suicide deaths and rates among youth aged 10 to 24 years have increased significantly since 2011. Oregon suicide rates were higher than the U.S. rates in the past decade. From 2014 to 2017, adolescent (10 to 17 years old) suicides have increased from 20 deaths a year to 31 deaths in 2017 (Figure 1).(2)

In 2017, the Oregon rate of suicide among youth aged 10 to 24 years is ranked 17 among all U.S. states.(Appendix II) It was the 15th highest state rate reported in 2016 and 16th highest state rate reported in 2015.(2)

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

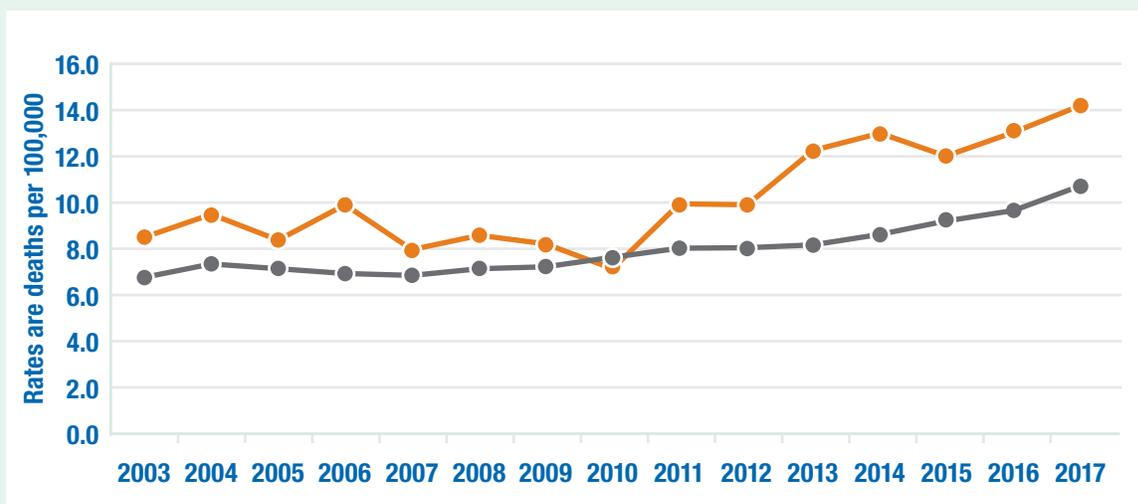
Suicide rates increased with age. The rate increased from approximately 3.1 per 100,000 among youth aged 10 to 14 years to 14.1 per 100,000 among youth aged 15 to 19 years, and up to 20.2 per 100,000 among youth aged 20 to 24 years (Figure 2).(3)

The suicide rate among veterans were higher than non-veterans.(3)

During 2013 to 2016, seven youth suicides were identified as among LGBTQ Oregonians. This accounts for 1.9 percent of Oregon youth suicide deaths.

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

Figure 1: Suicide rates among youth aged 10 to 24 years, U.S. and Oregon, 2003-2017



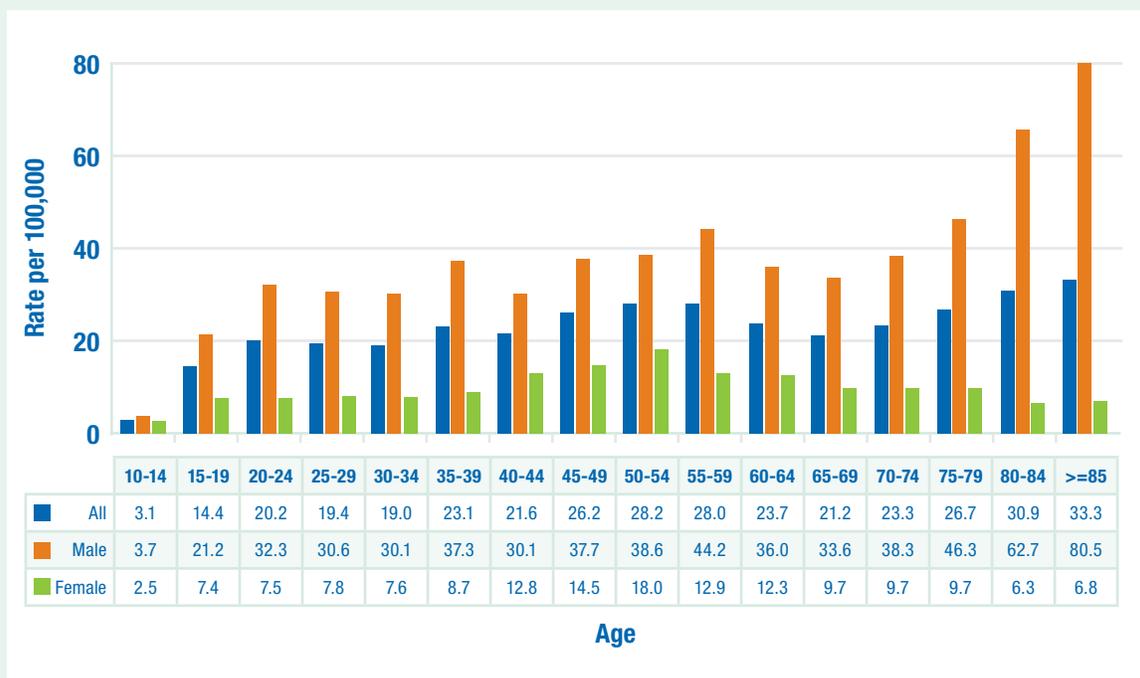
Source: CDC WISQARS and OPHAT

Table 1. Comparison of suicide completion rates per 100,000, among youth aged 10 to 24 years in Oregon and the U.S., 2003-2017(1)(2)*

Year	Oregon	U.S.
2003	8.4	6.7
2004	9.4	7.3
2005	8.3	7.0
2006	9.9	6.9
2007	7.9	6.8
2008	8.5	7.0
2009	8.1	7.2
2010	7.2	7.6
2011	9.8	7.9
2012	9.8	8.0
2013	12.2	8.2
2014	12.9	8.5
2015	12.0	9.2
2016	13.0	9.6
2017	14.1	10.6

Source: CDC WISQARS and OPHAT

Figure 2: Suicide rates by age group, Oregon, 2003-2017



Source: CDC WISQARS and OPHAT

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

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

Table 2. Common circumstances surrounding suicide incidents by age group, Oregon, 2013-2016

Circumstance	Aged 10-17 (n=100)		Aged 18-24 (n=261)		Aged 10-24 (n=361)	
	Count	%	Count	%	Count	%
Mental health status						
Mentioned mental health problems*	66	66	190	73	256	71
Diagnosed mental disorder	35	35	109	42	144	40
Problem with alcohol	2	2	32	12	34	9
Problem with other substance	10	10	57	22	67	19
Current depressed mood	51	51	121	46	172	48
Current treatment for mental health problem**	26	26	66	25	92	25
Interpersonal relationship problems						
Broken up with boy/girlfriend, Intimate partner problem	19	19	81	31	100	28
Suicide of family member or friend within past five years	1	1	8	3	9	2
Death of family member or friend within past five years	4	4	11	4	15	4
Family stressor(s)	31	31	35	13	66	18
History of abuse as a child	5	5	10	4	15	4
Life stressors						
A crisis in the past two weeks	18	18	49	19	67	19
Physical health problems	1	1	12	5	13	4
Job / financial Problem	0	0	29	11	29	8
Recent criminal legal problem	3	3	30	11	33	9
School problem	19	19	6	2	25	7
Suicidal behaviors						
History of expressed suicidal thought or plan	28	28	71	27	99	27

Recently disclosed intent to die by suicide	28	28	72	28	100	28
Left a suicide note	33	33	79	30	112	31
History of suicide attempt	17	17	69	26	86	24

* Include diagnosed mental disorder, problem with alcohol and/or other substance, and/or depressed mood.

** Include treatment for problems with alcohol and/or other substance

Source: Oregon Violent Death Reporting System

In 2017

- Final data reported 107 suicides occurred among Oregon youth aged 10 to 24 years. Most suicides occurred among males (80 percent), White (87 percent) and those aged 20 to 24 years (54 percent).
- Thirty-four of the deaths were among middle school and high school students.(3)
- In 2017, these were the most frequently observed mechanisms of injury in suicide deaths among youth(3):
 - » Firearms (47 percent)
 - » Suffocation or hanging (37 percent)
 - » Poisoning (9 percent)

Table 3. The characteristics of youth suicides, Oregon 2017

		Deaths*	% of total
Age	10-14	10	10%
	15-19	37	36%
	20-24	56	54%
Sex	Male	82	80%
	Female	21	20%
Race**/ethnicity	White	90	87%
	African American	5	5%
	American Indian/Native Alaskan	6	6%
	Asian/Pacific Islander	5	5%
	Multiple race	5	5%
	Other/Unknown	3	3%
	Hispanic	9	9%
Student status	Middle School	6	6%
	High School	28	27%

Mechanism of death	Firearm	48	47%
	Hanging/Suffocation	38	37%
	Poisoning	9	9%
	Other	8	8%
Other	Veteran	7	7%

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

**Includes any race (one or more, any mention) and ethnicity mention. Race categories will not sum to the total since multiple race selections could be made for each decedent.

Source: Oregon Violent Death Reporting System

Note: According to the center for health statistics, OHA, there were 107 suicides aged 10 to 24 in 2017.

Suicide attempts*

- More than 750 Oregon youth ages 10 to 24 years are hospitalized for self-inflicted injury or attempted suicide in 2017 (Table 4).
- Females were far more likely to be hospitalized for suicide attempts than males.

Table 4. Numbers of self-harm hospitalizations and suicides among youth aged 10 to 24 years by county, Oregon, 2017

County	Hospitalizations*		Deaths**	
	Count	% of total	Count	% of total
Baker	0.0	0.0	2	1.9
Benton	9.0	1.2	1	0.9
Clackamas	58.0	7.7	7	6.5
Clatsop	5.0	0.7	1	0.9
Columbia	13.0	1.7	2	1.9
Coos	21.0	2.8	2	1.9
Crook	6.0	0.8	0	0.0
Curry	3.0	0.4	2	1.9
Deschutes	29.0	3.8	9	8.4
Douglas	20.0	2.6	3	2.8
Gilliam	0.0	0.0	0	0.0
Grant	3.0	0.4	0	0.0
Harney	5.0	0.7	2	1.9
Hood River	2.0	0.3	1	0.9
Jackson	49.0	6.5	3	2.8
Jefferson	2.0	0.3	1	0.9
Josephine	26.0	3.4	3	2.8
Klamath	17.0	2.2	6	5.6
Lake	0.0	0.0	0	0.0

Lane	77.0	10.2	11	10.3
Lincoln	4.0	0.5	1	0.9
Linn	19.0	2.5	3	2.8
Malheur	7.0	0.9	0	0.0
Marion	69.0	9.1	10	9.3
Morrow	2.0	0.3	0	0.0
Multnomah	140.0	18.5	18	16.8
Polk	26.0	3.4	1	0.9
Sherman	0.0	0.0	0	0.0
Tillamook	5.0	0.7	1	0.9
Umatilla	4.0	0.5	5	4.7
Union	2.0	0.3	0	0.0
Wallowa	0.0	0.0	0	0.0
Wasco	4.0	0.5	2	1.9
Washington	108.0	14.2	7	6.5
Wheeler	0.0	0.0	0	0.0
Yamhill	23.0	3.0	3	2.8
State	758	N/A	107	100.0

* Oregon Public Health Division, Injury and Violence Prevention Program, 2016, OPHAT

** Oregon Hospital Discharge Index

Suicidal ideation: Oregon Healthy Teens Survey

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

Limitations of data used for suicide surveillance

Suicide is one of the leading causes of death in Oregon and an important public health issue nationally. Oregon Health Authority has set suicide prevention as one of its top priority areas. Suicide is a complex behavior and associated with a lot of factors—mental health,

substance use, physical health, relationships, life events, isolation, and other environmental and societal conditions. Oregon uses various existing administrative data sets, surveys and active surveillance efforts to monitor and track suicide as well as some risk and protective factors that lead to or prevent suicide.

Administrative data sets are used to track outcomes such as deaths from suicide and medical outcomes such as inpatient hospitalizations and emergency department (ED) visits for attempted suicide or self-harm. These data sources include death certificates collected by the Center for Health Statistics (CHS) at the Oregon Public Health Division (PHD) and hospitalization discharge data (HDD) from the Oregon Association of Hospitals and Health Systems (OAHHS).

Obtaining a standardized emergency department (ED) discharge data set has been an objective of the State Health Improvement Plan and a high priority for OHA. PHD currently has access to 2017 ED discharge data from OAHHS, although the data use agreement between OHA and OAHHS does not currently permit use of the data beyond evaluation of the data itself (i.e. does not permit public release). ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics) provides real-time syndromic surveillance data for public health and hospitals to monitor health events (ED visits) in emergency departments across the state and was designed primarily to quickly identify emerging infectious disease events such as bioterrorism attacks. ESSENCE data are “passively” collected by PHD through direct reporting by hospitals. ESSENCE data are available for tracking ED visits for suicide or self-harm. However, ESSENCE data are not part of a standardized administrative data set, and the type of data reported can vary by hospital. Reporting data to ESSENCE (by hospitals) is not a requirement or mandated by statute, and although most hospital EDs report data, missing and incomplete data is a known system issue. Although some standardized, coded data are available in ESSENCE, the system is based on free-text chief complaint data, which is not standardized and cannot consistently distinguish suicide attempts from other forms of self-harm.

Administrative data sets typically capture data at the population level (e.g. all instances of deaths within Oregon, or all hospital inpatient visits for suicide attempt), but include limited or no information on factors among individuals that

Report on OHA activities in 2017 | Youth Suicide Intervention and Prevention 42 Plan Annual Report may have led to suicide (e.g. untreated depression, life stressors, etc.).

Survey data can capture information on the factors associated with suicide (e.g. depression, etc.), but are based on population samples, and do not link risk and protective factors for suicide to specific individuals. Survey data come, in part, from the following:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Oregon Healthy Teens Survey (OHT)
- Student Wellness Survey (SWS)

- National Survey on Drug Use and Health (NSDUH)
- American Community Survey (ACS)

These surveys are both state administered and nationally administered. Questions about suicidality or mental health issues are periodically included in some of these surveys, but often depend on funding from individual programs (e.g. BRFSS, OHT) to continue data collection for specific questions year-to-year.

Some active surveillance data sources and surveillance systems link outcomes to individual risk factors. The Oregon Violent Death Reporting System (ORVDRS) and the Oregon Child Fatality Review (CFR) data collect active surveillance data from multiple sources to provide a more complete picture, such as detailed demographics, mechanism of death, and circumstances surrounding suicide incidents. Due to lack of standardized questionnaires and investigations on each death, some data elements in ORVDRS are not mandated to collect across agencies (e.g. LGBTQ status among people who died by suicide). In addition, limited witnesses and contacts with a person who died by suicide could result in incomplete information surrounding the incidents. Therefore, the data from the system may underestimate some given circumstances/risk factors. The CFR data only covers those ages under 18 years old, and some deaths were not reviewed by county teams.

These data sets, surveys and surveillance activities include data elements of interest to policy makers. However, these data sources may fall short in other areas of interest. Standard administrative data used to track outcomes (i.e. death certificates, hospitalizations, ED visits) do not typically additionally collect data on risk and protective factors for suicide (e.g. depression), past medical and behavioral histories (e.g. treatment episodes), or other data elements that can tie individual risk and protective factors directly to suicidal behaviors or outcomes among individuals (for example, the number of previous suicide attempts among individual decedents). The following complete data are not available for individual youth who died by suicide:

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

Generation of missing data described above would involve many components:

- Additional resources, position authority and planning
- Linkage of several large administrative data sets

- In-person case interviews
- Requirements for law enforcement agencies and health care providers to release individual information
- Additional personnel for data entry and database management
- Statute that would require hospitals to report some types of data, such as ED data, and specify the manner in which data are reported

Implementation of SB 561 is still a work in progress. The Alliance is currently working on a legislative concept that would require schools, colleges, and universities to report youth suicides that occur within their student population. This additional reporting requirement would hopefully accomplish two important steps: 1) Allow for greater collaboration between schools, colleges, universities and the local LMHPs and 2) Allow for LMHPs to provide more accurate and reliable information in their suicide death reports to OHA.

Appendix I

Public Health Division: 2018 Garrett Lee Smith grant activities

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

- **Gatekeeper training** to increase by 30% the number of individuals in youth-serving organizations trained to identify and refer youth at risk by these activities:
 - » Hosting quarterly Applied Suicide Intervention Skills Trainings (ASIST), Question, Persuade and Refer (QPR) and/or safeTALK trainings to community members. Over 6,750 gatekeepers have been trained.
 - » Establishing Response in 50% of the high schools in one CMHP catchment area
 - » Providing Kognito *At Risk for High School Educators and Kognito Step In! Speak Up!* LGBTQ module training to 20,000 educators and school staff. Over 470 staff from 50 Oregon schools completed Kognito.
- **Clinical training** to increase health, mental health and substance abuse clinicians trained to assess, manage and treat youth at risk for suicide by these activities:
 - » Hosting 11 trainings in Assessing and Managing Suicide Risk (AMSR) for 550 behavioral health clinicians. Eleven trainings attended by 415 clinicians have been completed.
 - » Implementing Kognito *At-Risk for Primary Care* training for staff at all 76 School-Based Health Centers (SBHCs), and to pediatricians. Over 60 staff members from SBHCs and pediatricians have completed the training.
 - » Implementing Kognito *At-Risk for EDs* for Emergency Department staff around the state. Over 20 staff from at least 8 Emergency Departments have completed the training.

- **Improving continuity of care for:**
 - » Youth discharged from emergency departments and inpatient psychiatric units.
 - » Veterans and military families receiving care in the community.
 - » Establishing full wrap around services within updated county crisis response plans.
- **Comprehensive implementation of goals 8 and 9 of National Strategy for Suicide Prevention:**
 - » Focus on the Zero Suicide Initiative approach to improve suicide care in healthcare settings. The Zero Suicide Academy supported implementation across the state.
- **Promotion of the National Suicide Prevention Lifeline (NSPL) and Project Evaluation** with all partners:
 - » Ongoing promotion of the NSPL in multiple venues and events around the state.
 - » Continued data collection from OCCI grantees and reporting on outcomes

Year four grant activities

The following section describes activities completed in year four (October 2017 – September 2018) of the five-year SAMHSA Oregon Caring Connections Initiative. Sections correspond with the Strategic Directions and Objectives in the Youth Suicide Intervention and Prevention Plan.

1. Gatekeeper Training

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

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

Gatekeeper trainings are best-practice or evidence-based means to prepare lay people and professionals to identify and refer persons at risk for suicide to appropriate care. This activity is an objective in the national suicide prevention plan and Objective 6.1 under Strategic Direction 2 in Oregon’s youth suicide intervention and prevention plan. Funded counties exceeded the target of implementing one gatekeeper training per quarter (Table 5) in year four.

Table 5. Completed QPR, ASIST and safeTALK Trainings and participants trained during the OCCI grant, by grant year

Year	QPR	ASIST	safeTALK	Total
Year 4 Total	71 trainings (1,745 people)	13 training (301 people)	—	84 trainings (2,046 people)
Year 3 Total	66 trainings (1,758 people)	13 trainings (313 people)	—	79 trainings (2,071 people)
Year 2 Total	42 trainings (1,300 people)	21 trainings (492 people)	1 training (17 people)	64 trainings (1,809 people)
Year 1 Total	10 trainings (274 people)	21 trainings (567 people)	—	31 trainings (841 people)
Cumulative	118 trainings 3,332 people	55 trainings 1,372 people	1 training 17 people	258 trainings 6,767 people

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

Counties have trained a variety of community members and professionals. These groups include: city staff, foster grandparents, sobering center staff, juvenile justice staff, local newspaper staff, hospital chaplains, Boys and Girls Club staff, Veteran Affairs staff, Community and Shelter Assistance staff, and police.

In addition to the above trainings, county sites facilitated or conducted additional best-practice or evidence-based suicide prevention/intervention trainings. In year 4, trainings in C-SSRS, Counseling on Access to Lethal Means (CALM), Connect Suicide Postvention program, Response high school suicide prevention curriculum, Signs of Suicide (SOS) middle school and high school suicide prevention program and Suicide to Hope (mental health profession training) resulted in an additional 2,249 people trained.

The Response high school suicide prevention curriculum revision continued in year 4, advised by a stakeholder group of suicide prevention experts and those well versed in school health standards. The curriculum has been updated to reflect current pedagogy, health standards, and highlight activities to engage students. Final editing started in fall 2018 and will be completed by spring 2019.

2. Clinical Training

Through the grant, OHA, PHD provides an opportunity for professionals to use a web-based gatekeeper training. Individuals working in schools, emergency departments, in primary care, and in school-based health centers can complete their training online. The name of this training is Kognito. Table 6 provides data on the settings, number of locations and users who completed Kognito training.

Table 6. Implementation and completion of Kognito gatekeeper training by setting, year 1 through year 4

Type of setting	Locations	Users completed training
Schools*	50	472
Emergency departments**	8+	21
Primary care providers/school-based health centers†	26+	63
Total	84+	556

* Access to module for schools ended in January 2018.

** Promotion of these Kognito programs stated in year two.

† Participants grouped in the “Other” category could not be identified by location. Therefore, the exact number of locations is unknown.

The Oregon Health Authority, PHD Injury and Violence Prevention Program continued to work with the School-Based Health Center (SBHC) program to promote Kognito for Primary Care. Based on requests from the SBHC coordinators, the Public Health Division arranged several learning opportunities for SBHC staff with the creator of the Columbia Suicide Severity Rating Scale (C-SSRS) on various aspects of suicide intervention. The webinars included:

- March 2018: Identification, Triage and Monitoring Using the C-SSRS: Increasing Precision, Improving Care Delivery and Redirecting Scarce Resources
- April 2018: The Stanley/Brown Safety Planning Intervention: A First Contact Treatment of Those At-Risk of Suicide
- August 2018: Using the C-SSRS: Implementation Q&A

The recorded webinars are available on the OHA School-Based Health Centers Training and Presentations webpage. Webinars provide, an overview of the Kognito training and give instructions for free staff could access to the program. The webinars and Kognito training have also been made available to Oregon school nurses.

The Kognito training for primary care and emergency departments were also promoted at the Oregon Zero Suicide Academy (see below). The healthcare organizations that attended the Zero Suicide Academy are exploring potential use of these trainings as part of their Zero Suicide implementation efforts.

The OCCI required funded counties to implement a clinical training designed for mental health service providers known as Assessing and Managing for Suicide Risk. Table 7 includes information that documents the county level implementation of AMSR training. In 2018, the grant was on target to reach this goal.

Table 7. Total AMSR trainings completed year 1 – year 4 (Target: Complete 11 trainings and train 550 participants by Dec. 29, 2019)

Training Date	Training Location	Clinicians Trained
2/27/2015	Washington	49
Year 1 total	1	49
10/30/2015	Jackson	42
03/30/2016	Josephine	41
07/12/2016	Deschutes	49
08/05/2016	Malheur	47
09/16/2016	Lane/Douglas	51
09/22/2016	Multnomah	46
Year 2 total	6	276
09/01/2017	Umatilla	17
09/22/2017	Jackson	20
Year 3 total	2	37
04/27/2018	Jackson	19
05/03/2018	Josephine	34
Year 4 total	2	53
Total to date	11	415
Total remaining to train	0	135

Two AMSR trainings were held in year 4 bringing the total number of AMSR trainings to 11. The objective on the number of trainings for the grant has been met. The original goal of 550 trained during 11 AMSR trainings assumed a 100% enrollment rate of 50 participants per training, which was unrealistic given the rural nature of some of the OCCI funded counties. However, additional training curricula are being used to train clinicians and mental health professionals. These trainings include ASIST and Collaborative Assessment and Management of Suicidality (CAMS).

The brochure for firearm owners and a tip sheet for Primary Care Providers (PCPs) continued to be shared in year 4 via hard copy and the web, thanks to OCCI funding. Along with promotion through the OCCI funded counties, this work has been promoted through outreach events, training events, webinars and conference presentations. These include:

- Oregon Rural Health Symposium, Pendleton, OR
- Oregon Suicide Prevention Conference, Clackamas, OR
- Oregon Health Sciences University Early Psychosis and the Early Assessment and Support Alliance (EASA)
- Through the Oregon Pediatric Society suicide prevention training offered to pediatric primary care teams around the state

In year 4, over 2,480 physical firearm safety brochures for firearm owners and over 580 firearm tip sheets for providers were distributed in Oregon. The electronic links to these materials were also distributed at many events and through multiple listservs.

As a next phase to this work, four brief videos for providers and clinicians on how to address firearm safety with a patient at risk of suicide have been filmed and are currently in final editing. Four videos will be created based on the research emphasizing appropriate language to use with a patient at risk of suicide: The videos demonstrate how to:

- discuss firearms with a patient at risk of suicide (Video 1);
- develop a safety plan focused on firearm safety (Video 2);
- engage the patient who becomes defensive when the subject of firearms is addressed (Video 3); and
- respond when a high-risk patient becomes angry when a provider brings up the topic of firearm safety and leaves the office (Video 4).

The final videos will be distributed in early 2019 and will also be made available online to healthcare providers.

3. Zero Suicide initiative promotion and implementation

The Oregon Health Authority, PHD, Injury and Violence Prevention Program continues to work with Oregon healthcare organizations on Zero Suicide Initiative implementation. The Zero Suicide initiative is a commitment to suicide prevention in health and behavioral health care systems. It is also a specific set of tools and strategies. Its core propositions are that suicide deaths for people under care are preventable, and the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept and work toward. The approach aims to improve care and outcomes for individuals at risk of suicide in health care systems.

The OHA, PHD hosted a two-day Zero Suicide Academy in Oregon in September 2018. This required an extensive recruitment process to garner interest among Oregon healthcare organizations. As part of these efforts, national Zero Suicide faculty and staff attended the 2018 Oregon Suicide Prevention Conference and participated in a variety of events. These events included:

- Healthcare leader luncheon: Oregon healthcare leaders were invited to attend a luncheon for an introduction to the Zero Suicide Initiative, learn about the Zero Suicide Academy, and hear from national faculty on their role as a leader in implementing Zero Suicide within their organization. Approximately 45 individuals attended the luncheon from healthcare organizations around the state.
- A 30-minute plenary providing an overview on the Zero Suicide Initiative. Conference participants from a variety of backgrounds heard about the Zero Suicide Initiative and gained context for how it is being implemented in Oregon.

- A breakout session providing a more in-depth presentation by national faculty on how they developed and implemented policies and procedures in line with Zero Suicide.

An additional breakout session at the conference featured three local healthcare organizations already engaged in Zero Suicide implementation. The session enabled local healthcare leaders to see examples of implementation at the local level. All these Zero Suicide events helped build understanding and support for the initiative among healthcare leadership, staff and general conference attendees.

The application for the Oregon Zero Suicide Academy was released in March 2018 and shared widely with healthcare leaders through a variety of venues and partners. Nineteen healthcare organizations applied. Given that only 16 organizations could attend the event due to limits set by the national event facilitator, an extensive review process was undertaken to identify the 16 invited organizations. All these agencies accepted the invitation to the Zero Suicide Academy which took place September 18-19, 2018 in Portland, OR. These healthcare organizations represent a geographically diverse group as well as a variety of system types including hospitals, youth serving organizations, Tribal entities, county services, behavioral health focused organizations, and primary care. Additional state and county stakeholders participated as table facilitators for the event. All 16 healthcare organizations produced a 90-day work plan to move their Zero Suicide efforts forward following the Academy. The OHA, PHD Injury and Violence Prevention Program received copies of those plans and is working with these systems to support implementation. Key findings from the Oregon Zero Suicide Evaluation survey were:

- All respondents were at least somewhat satisfied with the Academy with more than three-quarters (75.7%) being very satisfied, and 83.8% finding it very useful to have access to the national Zero Suicide faculty.
- Respondents were either very confident (70.3%) or somewhat confident (29.7%) about their ability to implement the 90-day plan developed at the Academy.
- 95% of respondents reported that they would recommend this process for implementing Zero Suicide to other healthcare organizations in Oregon.

As a follow-up to the Oregon Zero Suicide Academy, a Community of Practice (CoP) for Better Suicide Care with 10 of the organizations who attended the Zero Suicide Academy is being facilitated by the OHA, PHD Injury and Violence Prevention Program. The benefits of the CoP include connecting Oregon healthcare organizations implementing better suicide care practices and hearing from experts on their experiences implementing better suicide care practices. Participating organizations will also gain knowledge and ideas to address on-the-ground challenges and have opportunities to share expertise from their implementation efforts. Additional support and follow-up with Oregon Zero Suicide Academy attendees, as well as broadening Zero Suicide implementation to other Oregon healthcare organizations, will take place in 2019.

Appendix II

Table 8: Suicide rates among youth aged 10 to 24 years by state, U.S. 2017

State	Deaths	Crude Rate*
Alaska	47	31.1
South Dakota	45	25.6
Wyoming	27	23.9
Montana	47	23.5
New Mexico	99	23.4
North Dakota	32	20.2
Utah	135	17.8
Colorado	192	17.5
Oklahoma	138	17.1
New Hampshire	42	16.6
Idaho	59	16.3
Kansas	99	16.1
Arkansas	96	16.0
Missouri	182	15.2
Washington	207	15.0
Nevada	80	14.4
Oregon	107	14.1
Hawaii	35	13.8
Nebraska	53	13.2
Arizona	179	12.6
Iowa	79	12.1
Indiana	165	12.0
Ohio	268	11.8
Vermont	14	11.5
Alabama	109	11.4
Minnesota	123	11.3

State	Deaths	Crude Rate*
Pennsylvania	268	11.2
South Carolina	108	11.1
Wisconsin	126	11.0
Tennessee	142	10.9
Texas	662	10.9
Michigan	212	10.7
Louisiana	98	10.6
Kentucky	92	10.5
Maine	24	10.5
Virginia	170	10.3
West Virginia	33	10.1
Mississippi	62	10.0
Georgia	213	9.8
North Carolina	200	9.8
Illinois	235	9.3
Rhode Island	18	8.5
Florida	310	8.5
Delaware	14	7.9
Connecticut	56	7.9
Maryland	85	7.4
California	561	7.1
Massachusetts	86	6.4
New Jersey	108	6.3
New York	218	5.9
District of Columbia	<10	Not calculated

*Rates are deaths per 100,000

Source: CDC WISQARS

Appendix III

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Endnotes

1. Deaths and Perinatal Deaths Data [Internet]. Oregon Health Authority: Deaths and Perinatal Deaths Data: Annual Report Volume 2: State of Oregon. [cited 2018 Dec 14]. Available from: <http://www.oregon.gov/oha/PH/BirthDeathCertificates/VitalStatistics/annualreports/Volume2>
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