Quarterly Meeting - DRAFT

Date: Friday, December 11, 2020 Time 9:30 a.m. – 12:30 p.m. Orientation 8:45 a.m.
Join the meeting from your computer, tablet or smartphone.

Join Zoom Meeting
Meeting ID: 810 114 8442
https://uoregon.zoom.us/j/8101148442

Call In information: 253.215.8782; Access Code: 8101148442#

Time	Topic/What	Notes/Attachments
8:45 – 9:15	**Orientation** Annette Marcus, Suicide Prevention Policy Manager	**Optional:** Newcomers Encouraged to Attend All Welcome
9:30 - 9:45	**Welcome, Introductions and Agenda Overview** Annette Marcus, Policy Manager, Alliance Galli Murray, Chair of the Alliance, Suicide Prevention Coordinator in Clackamas County Ryan Price, Co-Chair of the Alliance, AFSP Area Director for Oregon and Idaho	**Big View, Review and Preview**
9:45 – 10:15	**Alliance Business** Annette Marcus, Suicide Prevention Policy Manager Laura Rose Misaras, Lived Experience Advisory Chair TBD Wren Fulner, LGBTQ+ Advisory Group Co-Chair Elissa Adair, Lethal Means Workgroup Member	Goal: highlight progress, challenges, and needs Possible report from a couple of committees • Update on CEU legislation • Update on lived experience advisory • Overview of Transitions of Care root cause analysis and next steps • LGBTQ+ Mini-Grants • Lethal Means Workgroup
10:15 – 10:25	**YYEA Update** Karli Read, YYEA Representative on Executive Committee Maya Bryant, YYEA Representative on Executive Committee	Mentoring program – Request for mentors

	Olivia Nilsson, YYEA Representative on Executive Committee	
10:25 – 10:45	**Understanding the Role of Community Mental Health Programs in Crisis Response, Suicide Prevention, Intervention, and Postvention** Kimberlee Lindsay, Stan Gilbert,	See attached PowerPoint
10:45 – 10:55	**Break**	
Time TBD	**Alliance Staff Update** Annette Marcus, Suicide Prevention Policy Manager, Alliance	Update on anti-racism and radical inclusion consultants
Time TBD	**YSIPP 2.0 Update** John Seeley, University of Oregon Suicide Prevention Lab	Update on progress and share themes and recommendations to date, receive feedback from Alliance on these themes
Time TBD	**OHA Update** Jill Baker, OHA, Youth Suicide Prevention Coordinator Meghan Crane, OHA, Zero Suicide Program Coordinator Shanda Hochstetler, OHA, Youth Suicide Prevention Coordinator	• Overview of available data for people to use •
Time TBD	**Public Comment(s) and Adjourn**	

December Committee Updates for Executive Committee

Name of Committee: Data & Evaluation Committee

Chair(s): John Seeley

Committee Members *(italicized members are either youth or young adult members)***:** Chris Sorvari, Debra Darmata, Elissa Adair, Jill Baker, John Seeley, Jon Rochelle, *Joseph Stepanenko*, Karen Cellarius, Roger Brubaker, Sandy Bumpus, Sarah Spafford, Shanda Hochstetler, Spencer Delbridge

List Committee's Strategic Priority(ies) FY20-21:

- Committee is currently working to build up its infrastructure and specific priorities going forward. Their current focus is on advising and supporting the process of developing the next YSIPP and naming gaps in data. These are the current priorities listed on their SMART Goals:
    - Healthy and empowered individuals, families, and communities
    - Clinical and community preventive services
    - Surveillance, Research, and Evaluation

Highlights and/or Progress on Priorities (include data if available):

- Committee is working to understand what data is available from OHA, and creating written recommendations to OHA for data requests and exploring how to best use the data to inform ongoing work of the Alliance. OHA will gave an hour presentation at the Dec. 3rd Data/Eval committee meeting and the committee is scheduled to explore how best to share information with appropriate committees and link data with YSIPP.

Challenges/Obstacles:

- This group came together over the summer and spent some time "norming" and determining priorities.

Request for Feedback from Executive Committee: Yes ☐No ☒

If yes, what type of feedback is needed? N/A

Discussion or Presentation Needed at Quarterly: Yes ☒ No ☐

Topic: John Seeley will provide a presentation on YSIPP 2.0 development.

Name of Committee: Executive Committee

Chair(s): Galli Murray & Ryan Price

Committee Members *(italicized members are either youth or young adult members)***:** Dan Foster, Deb Darmata, Don Erickson, Galli Murray, Gordon Clay, Jill Baker, John Seeley, *Karli Read*, Kimberlee Jones, Kirk Wolfe, Laura Rose Misaras, Leslie Golden, Lon Staub, *Maya Bryant*, Meghan Crane, *Olivia Nilsson*, Ryan Price, Shanda Hochstetler

List Committee's Strategic Priority(ies) FY20-21:

- Develop a plan to foster and sustain statewide policy development and leadership in suicide prevention.
- Integrate and coordinate suicide prevention activities across multiple sectors and settings

Highlights and/or Progress on Priorities (include data if available):

- Members of this committee participated in the first ASIPP meeting
- Executive members worked together to complete a written response to OHA on their SB 48 report and attended meetings with legislators to support Behavioral Health CEU legislation.

Challenges/Obstacles:

- There have not been any challenges or obstacles listed

Request for Feedback from Executive Committee: Yes ☒No ☐

If yes, what type of feedback is needed? Vote needed on SB 48 report.

Discussion or Presentation Needed at Quarterly: Yes ☐ No ☒

Name of Committee: Outreach & Awareness Committee

Chair(s): Ryan Price & Laura Rose Misaras

Committee Members *(italicized members are either youth or young adult members)***:** Andrea Childreth, Angie Butler, Jill Baker, Laura Rose Misaras, Leslie Golden, Liz Thorne, Sarah Rea, Mark Hammond, Meghan Crane, Nicholas Clark, Ryan Price, Shanda Hochstetler, Tia Barnes

List Committee's Strategic Priority(ies) FY20-21:

- Connect and collaborate with regional coalitions
- Develop sample press releases based on hope, help, and healing framework, and a panel of subject matter experts to respond to legislative, media, and other requests about suicide intervention / prevention
- Support, recruit and retain Alliance membership to align with SB707 and represent BIPOC and frontier communities

Highlights and/or Progress on Priorities (include data if available):

- Alliance staff conducted two Regional Suicide Prevention Coalition Webinars this quarter.
- Ryan Price reached out to AFSP and found a potential trainer to review how to interact with the media so subject matter experts and leadership in the Alliance can be trained in this area
- Press Materials developed. Hope, Help, and Healing stories with young people underway with support from Youth ERA. Media distribution list obtained.
- The plan is to work with the Anti-Racism/Inclusion consultants on membership recruitment and engagement.

Challenges/Obstacles:

- There have not been any challenges or obstacles listed

Request for Feedback from Executive Committee: Yes ☒No ☐

If yes, what type of feedback is needed? A vote on which equity consultant to move forward with

Discussion or Presentation Needed at Quarterly: Yes ☐ No ☒

Topic: N/A

Name of Committee: Schools Committee

Chair(s): Kimberlee Jones

Committee Members *(italicized members are either youth or young adult members)***:** Amy Ruona, Caitlin Wentz, Chris Hawkins, Emily Moser, Emilie Spalding, Fran Pearson, Gabi Colton, Jill Baker, Jim Hanson, John Seeley, Jon Rochelle, Justin Potts, Kahae Rikeman, Kimberlee Jones, Liz Thorne, Lon Staub, Maya Bryant, Mila Rodriguez-Adair, Olivia Nilsson, Parker Sczepanik, Shanda Hochstetler, Spencer Delbridge, Spencer Lewis, Sydney Stringer, Tony Martins

List Committee's Strategic Priority(ies) FY20-21:

- SMART Goals are currently under review by committee members and have not been finalized yet

Highlights and/or Progress on Priorities (include data if available):

- Committee members have reviewed and made edits to SMART Goals for fiscal year
- A small group met to do a deep dive into Adi's Act documents and policy plans from OHA and ODE. This group provided extensive feedback to OHA and ODE on guidance documents for schools.

Challenges/Obstacles:

- There have not been any challenges or obstacles listed

Request for Feedback from Executive Committee: Yes ☐No ☒

If yes, what type of feedback is needed? N/A

Discussion or Presentation Needed at Quarterly: Yes ☐ No ☒

Topic: N/A

Name of Committee: Transitions of Care Committee

Chair(s): Galli Murray & Julie Magers

Committee Members *(italicized members are either youth or young adult members)***:** Anders Kass, Charlette Lumby, Galli Murray, Jill Baker, John Seeley, Jonathan Rochelle, Julie Magers, *Joseph Stepanenko*, Kaliq Fulton-Mathis, Lon Staub, Rachel Ford, Rebecca Marshall, Shanda Hochstetler, Tanya Pritt

List Committee's Strategic Priority(ies) FY20-21:

- Build up group roster and find new chairs for this committee
- Continue work on HB 2023 / 3090 / 3091

Highlights and/or Progress on Priorities (include data if available):

- An orientation was held for new members
- The committee had their first meeting in November

Challenges/Obstacles:

--We are seeking a new chair for this committee (potential candidate identified.) Julie Magers would like to transition off by the end of the year and Galli is fully occupied as the chair of the Alliance. Key legislative champion, Rep. Alissa Keny-Guyer is retiring. We will need to find traction with another legislator.

Request for Feedback from Executive Committee: Yes ☐No ☒

If yes, what type of feedback is needed? N/A

Discussion or Presentation Needed at Quarterly: Yes ☒ No ☐

Topic: N/A

Name of Committee: Workforce Committee

Chair(s): Don Erickson & Julie Scholz

Committee Members *(italicized members are either youth or young adult members)***:** Don Erickson, Amber Ziring, Fran Pearson, Jill Baker, John Seeley, Julie Scholz, Kirk Wolfe, Liz Thorne, Sarah Spafford, Shanda Hochstetler, Stephanie Willard, Tanya Pritt

List Committee's Strategic Priority(ies) FY20-21:

- 2021 Legislation to require behavioral health workforce to take suicide prevention related CEUs
- By the end of June 2021, get legislation passed requiring the behavioral health workforce to take continuing education units on suicide assessment, intervention, and management

Highlights and/or Progress on Priorities (include data if available):

- Alliance staff and committee members continue to meet with legislators to review proposed legislation and seek out any support. Youth and young adults have actively participated in legislative meetings.
- Committee members are planning to present on legislation at December Legislative Days

Challenges/Obstacles:

- There have not been any challenges or obstacles listed

Request for Feedback from Executive Committee: Yes ☐No ☒

If yes, what type of feedback is needed? N/A

Discussion or Presentation Needed at Quarterly: Yes ☐ No ☒

Topic: N/A

Name of Committee: LGBTQ+ Advisory Group

Chair(s): Khanya Msibi & Wren Fulner

Committee Members *(italicized members are either youth or young adult members)***:**

List Committee's Strategic Priority(ies) FY20-21:

- Promote LGBTQ affirming policies and practice in youth serving organizations to promote resilience and decrease rejection
- Reduce the harm of family rejection by promoting the strategies of the Family Acceptance Project
- Provide survey to LGBTQ+ community for YSIPP 2.0 feedback

Highlights and/or Progress on Priorities (include data if available):

- Advisory group is completing a survey they will distribute to members of the LGBTQ+ community for feedback on what should go in YSIPP 2.0
- Group is developing a model for LGBTQ+ intervention which ranges from harm reduction to liberation and will provide recommendation that it is included in the next YSIPP.
- Worked closely with OHA to develop LGBTQ+ mini-grant low-barrier application. Received 81 applications, funded 18 grants. Mini-grant applications also served as informal needs assessment and will be used to disseminate LGBTQ+ Survey.

Challenges/Obstacles:

- There have not been any challenges or obstacles listed

Request for Feedback from Executive Committee: Yes ☐No ☒

If yes, what type of feedback is needed? N/A

Discussion or Presentation Needed at Quarterly: Yes ☐ No ☒

Topic: N/A

Name of Committee: Lived Experience Advisory Group

Chair(s): Laura Rose Misaras

Committee Members *(italicized members are either youth or young adult members)***:** Dan Foster, Elliott Hinkle, *Emilie Spalding*, Laura Rose Misaras, *Nicholas Rogers, Noah Rogers*, Jennifer Fraga, *Shane Roberts*

List Committee's Strategic Priority(ies) FY20-21:

- Provide input on YSIPP 2.0

Highlights and/or Progress on Priorities (include data if available):

- Advisory group has created a survey to send to folks with lived experience as defined by a youth or young adult with personal experience or parents to youth / young adults with lived experience. This survey should be ready to send out to folks early January 2021.
- There is strong youth participation in this advisory group.

Challenges/Obstacles:

- The group has focused on getting to know one another and on developing the survey. It would be helpful to have a clearer sense of what type of advisory role the executive would like the committee to play.

Request for Feedback from Executive Committee: Yes ☒No ☐

If yes, what type of feedback is needed? N/A

Discussion or Presentation Needed at Quarterly: Yes ☐ No ☒

Topic: N/A

Name of Committee: Lethal Means and Firearm Safety Workgroup

Chair(s): Jonathan Hankins

Committee Members *(italicized members are either youth or young adult members)***:** Debra Darmata, Elissa Adair, Emily Watson, John Seeley, Jonathan Hankins, Kathleen Carlson, Meghan Crane, Pamela Pearce, Ryan Price, Stephanie Willard, Sunshine Mason, Zev Braun

List Committee's Strategic Priority(ies) FY20-21:

- Restructure committee for fiscal year – decide if it should be one group to focus on both firearms and opioids or split to two groups. Work closely with the Gun Owners Suicide Prevention Coalition (hosted by Lines for Life) to identify areas of focus.

Highlights and/or Progress on Priorities (include data if available):

- There will be a presentation on opioids and suicide prevention during the next workgroup meeting.
- Report developed by Lines for Life with this committee on gun owners views re: gun safety and suicide is on website.

Challenges/Obstacles:

- There have not been any challenges or obstacles listed

Request for Feedback from Executive Committee: Yes ☐No ☒

If yes, what type of feedback is needed? N/A

Discussion or Presentation Needed at Quarterly: Yes ☐ No ☒

Topic: N/A

LC 1370
2021 Regular Session
10/12/20 (LAS/ps)

D R A F T

SUMMARY

Modifies laws relating to youth suicide intervention and prevention to include children under 10 years of age.

A BILL FOR AN ACT

Relating to youth suicide; amending ORS 418.726 and 418.731.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 418.726 is amended to read:

418.726. (1) There is created a Youth Suicide Intervention and Prevention Advisory Committee to advise the Oregon Health Authority on the development and administration of strategies to address suicide intervention and prevention for children and youth [*10 through*] **who are** 24 years of age **or younger**. The Director of the Oregon Health Authority shall appoint members of the advisory committee and members shall serve at the pleasure of the director. The authority shall provide staffing for the advisory committee.

(2) The director shall ensure that advisory committee membership reflects the cultural, linguistic, geographic and economic diversity of this state. The members of the advisory committee must include, but need not be limited to:

(a) Individuals who have survived suicide attempts;

(b) Individuals who have lost friends or family members to suicide;

(c) Individuals who have not attained 21 years of age;

(d) Representatives of state agencies, including but not limited to the Department of Human Services, the Oregon Health Authority and the Department of Education, who provide services to individuals who have not attained 21 years of age;

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(e) Representatives of Oregon Indian tribes;

(f) Representatives of colleges and universities;

(g) Medical and behavioral treatment providers;

(h) Representatives of hospitals and health systems;

(i) Representatives of coordinated care organizations and private insurers;

(j) Suicide prevention specialists; and

(k) Representatives of members of the military and their families.

(3) Members of the advisory committee other than members employed in full-time public service may be compensated for their services and may be reimbursed by the authority for the member's actual and necessary expenses incurred in the performance of the member's duties. Members of the advisory committee who are employed in full-time public service may be reimbursed by the member's employing agency for the member's actual and necessary expenses incurred in the performance of the member's duties. Reimbursements under this subsection are subject to the provisions of ORS 292.210 to 292.288.

(4) The advisory committee shall meet no less than once every three months.

(5) The advisory committee may recommend potential members for appointment to the advisory committee.

(6) The advisory committee shall consult with the Youth Suicide Intervention and Prevention Coordinator on updates to the Youth Suicide Intervention and Prevention Plan under ORS 418.733.

SECTION 2. ORS 418.731 is amended to read:

418.731. (1) As used in this section and ORS 418.733:

(a) "Youth" means a person [*10 through*] **who is** 24 years of age **or younger**.

(b) "Youth suicide" means a completed or attempted suicide by a person [*10 through*] **who is** 24 years of age **or younger**.

(2) There is established a Youth Suicide Intervention and Prevention Coordinator within that part of the Oregon Health Authority that works with

mental health and addiction issues. The coordinator shall:

(a) Facilitate the development of a statewide strategic Youth Suicide Intervention and Prevention Plan to address youth suicide and youth self-inflicted injury, and develop strategies for intervention with suicidal, depressed and at-risk youth;

(b) Improve outreach to special populations of youth that are at risk for suicide and self-inflicted injury;

(c) Identify barriers to accessing intervention services for suicidal, depressed and at-risk youth; and

(d) Provide technical assistance to state and local partners and coordinate interagency efforts to establish youth suicide and youth self-inflicted injury prevention and intervention strategies.

(3) The coordinator shall review data and prepare an annual report to interim and regular committees of the Legislative Assembly with subject matter jurisdiction over child welfare, mental health and addiction issues, and to the Oregon Health Authority, regarding:

(a) The number of emergency room admissions for completed and attempted youth suicides and incidents of youth self-inflicted injury;

(b) The manner and method of completed and attempted youth suicides and incidents of youth self-inflicted injury;

(c) The counties in which the completed and attempted suicides and self-injury incidents occurred;

(d) The number of middle schools and high schools with completed youth suicides among the student body;

(e) The number of completed youth suicides where the youth had previously been admitted to a hospital or emergency room for treatment of attempted youth suicide or self-inflicted injury or had been the subject of a request for intervention services related to depression, suicidal ideation or self-injury within the prior 12 months;

(f) Demographic information regarding youth who completed or attempted youth suicide or who had self-injury incidents, including but not limited to:

(A) Age;

(B) Gender;

(C) Race;

(D) Primary spoken language;

(E) Sexual orientation;

(F) The existence of any physical, mental, intellectual or emotional disability; and

(G) Foster care status; and

(g) Recommendations for administrative and legislative changes to address service gaps in youth suicide prevention, intervention and post-suicide activities, developed in consultation with the Youth Suicide Intervention and Prevention Advisory Committee established in ORS 418.726.

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

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

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

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

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

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

The Alliance is re-introducing legislation in 2021 to require that Oregon's behavioral health workforce receive training in suicide assessment, intervention, and treatment at least once every six years. We have looked to our neighboring state, Washington, for a model for developing this type of mandate. Our long-term goal is to also ensure that suicide prevention training is widely available and utilized by primary care and other health professionals. Further SB48 reports will help us to assess whether the current voluntary approach is achieving this goal. However, our assessment is that we are a few years

Commented [JF1]: Kirk commented "would recommend eliminating reference to future training for primary care, taking this one step at a time. You may get unexpected resistance to the bill by including primary care- let's focus on our current efforts with the behavioral health workforce, and get this necessary legislation passed."

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

away from being able to move that forward by addressing and overcoming opposition from various medical licensing entities and professional organizations. This is understandable as doctors and nurses have numerous continuing education requirements, many of which do indeed address life and death matters. However, in the case of the behavioral health workforce, they are the designated "experts" to whom those who are experiencing suicidal ideation are referred. We would go so far as to say that it is unethical that counselors, therapists, social workers, and peer support specialists, who regularly interact with highly suicidal individuals often do not have a strong understanding of how to assess risk of suicide effectively , and how to engage with people through times of suicidal ideation. They also need to understand and convey to their clients that many people live full, productive lives despite living with chronic suicidal thoughts and to help their clients develop the skills to do so.

Preparing this workforce to meet these needs is essential. Requiring continuing education is the least we could do as a start. We look forward to ongoing work in partnership with OHA to ensure that our professionals have the skills to identify suicide risk and help save lives.

JenJennifer Fraga

From: JenJennifer Fraga
Sent: Monday, December 14, 2020 12:58 PM
To: JenJennifer Fraga
Subject: Alliance Exec OHA report
Attachments: OAR FORM 309-027-0010 final.docx; OAR FORM 309-027-0020 final.docx; OAR FORM 309-027-0030 final.docx; OAR form 309-027-0040 final.docx; OAR form 309-027-0060 final.docx

OHA Written Report

309-027 Rules update:

The revised rules for OAR 309-027 incorporating SB918 (2019) and SB485 (2019) have been submitted to the OHA Rules Coordinator. The submitted rules are attached to this email. The rulemaking forms include:

1. The Notice of Proposed Rulemaking Hearing
2. The Statement of Need and Fiscal Impact
3. The Proposed Rule

Nprm-027-changes-122120.pdf	309-027 - Youth Suicide Communication and Post-Intervention Plan

You can view these and other recent rulemaking notices at www.oregon.gov/OHA/HSD/OHP/Pages/Rule-Notices.aspx.

How to comment:
You may comment by attending a hearing on the proposed rules (if one is being held), or by sending written comments to:

HSD Behavioral Health Rules Coordinator
Oregon Health Authority, Health Systems Division
500 Summer St. NE
Salem, OR 97301
bhrulemaking@dhsoha.state.or.us

HB 3090 project work update:

The internal OHA team continues to be on track with the work plan for HB 3090, pursuant to the letter that I submitted to the Alliance to Prevent Suicide in November. The stakeholder meeting to gather input on survey questions and methodology has been calendared for Jan 15, 2021 from 10AM-12PM and written feedback will be accepted prior to that. We are scheduled to send out sample questions to stakeholders prior to Dec 15, 2020.

In addition to the re-survey project, the OHA SPIP team is working on amplifying and supporting Caring Contacts work. We have interviewed several key hospitals, a representative from the Hospital Association and the staff in charge of the Caring Contacts team at Lines for Life, which contracts with several hospitals to do this work.

Big Seven suicide prevention trainings update:

QPR, Mental Health First Aid, Source of Strength, and Connect: Postvention continue to be offered virtually, and continue to grow. ASIST and safeTALK are still not being offered due to COVID-19 and no virtual options have been approved by LivingWorks. We recently got word that and ASIST Tune Up is now available virtually, and Tim Glassock at AOCMHP is the coordinator for this program. OHA redirected funds from ASIST and safeTALK to develop Youth Suicide Assessment in Virtual Environments (Youth SAVE) in partnership with AOCMHP and the Oregon Pediatric Society. This training is most appropriate for school counselors or other mental health professionals with a base knowledge of mental health and suicide. Two highly successful trainings were held in November, and we have added capacity throughout the spring due to high demand.

YSIPP 2.0 update:

Dr. Seely and OHA continue to meet weekly to align the goals and stakeholder lists for feedback on the YSIPP. We are on track to complete the stakeholder feedback sessions in December, and then will move into synthesizing the feedback, developing a first draft of the measurable action items for YSIPP 2.0 and writing the YSIPP 2.0. We believe we are on track for our revised deadline of June 2021 for the publication/release date.

Jill Baker, LSC
she/her/hers
Youth Suicide Prevention
Oregon Health Authority
503-339-6264

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

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

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

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

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

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

The Alliance is re-introducing legislation in 2021 to require that Oregon's behavioral health workforce receive training in suicide assessment, intervention, and treatment at least once every six years. We have looked to our neighboring state, Washington, for a model for developing this type of mandate. Our long-term goal is to also ensure that suicide prevention training is widely available and utilized by

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

primary care and other health professionals. Further SB48 reports will help us to assess whether the current voluntary approach is achieving this goal. However, our assessment is that we are a few years away from being able to move that forward by addressing and overcoming opposition from various medical licensing entities and professional organizations. This is understandable as doctors and nurses have numerous continuing education requirements, many of which do indeed address life and death matters. However, in the case of the behavioral health workforce, they are the designated "experts" to whom those who are experiencing suicidal ideation are referred. We would go so far as to say that it is unethical that counselors, therapists, social workers, and peer support specialists, who regularly interact with highly suicidal individuals often do not have a strong understanding of how to assess risk of suicide effectively , and how to engage with people through times of suicidal ideation. They also need to understand and convey to their clients that many people live full, productive lives despite living with chronic suicidal thoughts and to help their clients develop the skills to do so.

Preparing this workforce to meet these needs is essential. Requiring continuing education is the least we could do as a start. We look forward to ongoing work in partnership with OHA to ensure that our professionals have the skills to identify suicide risk and help save lives.

Oregon Administrative Rule
Action

See Rules Coordinator for new rule numbers (Adopted or Renumbered rules).
One rule per form. All fields required.

Action: ☐Adopt ☒Amend ☐Repeal ☐Suspend ☐Renumber ☐Amend & Renumber
(Choose one for this rule)

Rule Number: OAR 309-027-010

Rule Title: Purpose and Scope

Statutory Authority: ORS 413.042, 430.630, 430.640

Statues Implemented: ORS 418.735

Rule Summary: This rule defines the Purpose and Scope of the Youth Suicide Communication and Postvention Plan in the case of a known suicide death of a youth (age 24 or younger) in Oregon. The revision adds language from 2019 legislation SB 485 and SB 918.

Rule Text:

(1) ~~These rules~~Oregon Administrative Rules (OAR) ~~309-027-0010 through 309-027-0060~~ implement Senate Bill (SB) 561 from Oregon's 2015 Regular Session~~, and Senate Bill (SB)~~SB 485 ~~from Oregon's 2019 Regular Session, and Senate Bill (BS)~~SB 918 from Oregon's 2019 Regular Session.

(2) These administrative rules ~~identify:~~

(a) Identify Local Mental Health Authorities (LMHAs) as the entities responsible for initiating and coordinating the community response to each case of suicide which meets the criteria established in SB 561 (2015)~~.~~;

(b) ~~identify w~~Identify what information shall be communicated to tribes, youth-serving entities, and individuals after a suspected youth suicide death by the LMHA~~'s~~'s~~.~~; and

(c) ~~d~~Describe~~s~~ the information ~~that~~ public school districts, public universities listed in ORS 352.002, or private post-secondary institutions of education~~out~~ are required to report to LMHA~~'s~~'s after a suspected youth suicide death.

(3) There~~ are three~~ four purposes ~~for~~of these administrative rules are:

(~~a~~2a) ~~The rules~~To establish minimum standards for the communication protocol and post-intervention protocol to ~~address~~ suspected youth suicide between LMHA's, Oregon Health Authority, and youth-serving entities;~~.~~

(~~b~~3b) ~~The rules aim t~~To reduce the risk of contagion among individuals 24 years of age or younger after a suspected youth suicide by establishing overall guidelines for communication and post-~~inter~~vention response protocols for effective communication and response by local agencies, groups, or individuals~~.~~;

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(c4c) ~~The rules~~To establish the process for LMHAs to report suspected youth suicides to the Oregon Health Authority within seven ~~(7)~~ days of the death.; and

(d) ~~The rules~~To establish the process for public school districts, public universities listed in ORS 352.002 or private ~~post-~~secondary institutions of education are required to report suspected youth suicides to the Oregon Health Authority through LMHAs within seven ~~(7)~~ days of the death.

(24) The Oregon Health Authority shall provide technical assistance to LMHAs in developing and implementing the protocols and reporting of suspected youth suicides.

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Oregon Administrative Rule
Action

See Rules Coordinator for new rule numbers (Adopted or Renumbered rules).
One rule per form. All fields required.

Action: ☐Adopt ☒Amend ☐Repeal ☐Suspend ☐Renumber ☐Amend & Renumber
(Choose one for this rule)

Rule Number: OAR 309-027-020

Rule Title: Definitions

Statutory Authority: ORS 413.042, 430.630, 430.640

Statues Implemented: ORS 418.735

Rule Summary: These rules detail the definitions for the communication protocol for postvention response in the case of a known suicide death of a youth (age 24 or younger) in Oregon. The revision add language from 2019 legislation SB 485 and SB 918.

Rule Text:

(1) "Authority" means the Oregon Health Authority (OHA).

(2) "Authority's Plan" means the Authority's Youth Suicide Communication and Postvention Plan developed to implement SB 561 codified as ORS 418.735.

(32) "Communication Protocol" means the plan identifying information-sharing pathways to improve notifications and information-sharing regarding a suspected youth suicide between the LMHA and community partners, and the individuals within those entities to communicate or receive communications.

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(43) "Community partners" includes local individuals, entities, and organizations including medical examiners, public school districts, public universities, private post-secondary institutions of education, or any facility or organization that provides services or resources to runaway or homeless youth.

(54) "Coordinator" means the Authority's Youth Suicide ~~Intervention and~~ Prevention Policy Coordinator or ~~his or her~~their designee.

(6) "Decedent" means an individual 24 years of age or younger reported by a medical examiner or designee that is no longer living.

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(57) "LMHA" means a Local Mental Health Authority as defined in ORS 430.630.

(86) “Medical examiner” has the same meaning given that term in ORS 146.003(10) or a physician appointed as provided by ORS 146.003 to 146.189 to investigate and certify the cause and manner of deaths requiring investigation, including the State Medical Examiner.

~~(7) “Authority’s Plan” means the Authority’s Youth Suicide Communication and Post-Intervention Plan developed to implement SB 561 codified as ORS 418.735.~~

(98) “Post-Intervention” or “Postvention” means the activities implemented after a suspected youth suicide, including support for the bereaved family, friends, professionals, peers and those with geographic, social or social media ties to the ~~deceased~~decedent. “Post-intervention and “postvention” are used interchangeably. In order to meet the needs of those bereaved by a suicide, and to reduce the risk of suicide contagion “post-~~inter~~vention” includes:

(a) Immediate postvention response implemented in the immediate days and weeks after a suspected youth suicide;

(b) Intermediate postvention response implemented in the several months after a suspected youth suicide; and

(c) Long-term postvention response implemented up to a year after the suspected youth suicide.

(109) “Primary LMHA” means the LMHA serving the county where the suspected youth suicide occurred.

(110) “Response Protocol” means the plan identifying the roles, responsibilities and actions of the LMHA and community partners that are activated in response to a suspected youth suicide.

(121) “Suicide Contagion” means the exposure to the suicide or suicidal behavior of one or more ~~persons~~ individuals that influences others to engage in suicidal behavior, including to attempt or complete suicide.

(132) “Suspected Youth Suicide” means a death of an individual 24 years of age or younger reported by a medical examiner or designee that is believed to have been caused by self-directed injurious behavior with an intent to die as a result of the behavior.

(143) “Traumatic Death” means a death that is sudden, unanticipated, violent, mutilating or destructive, random and/or preventable, involves multiple deaths, or one in which the mourner has a personal encounter with death. It may be caused by an accident, homicide, suicide or death in war.

(154) “Youth-serving entity” refers to any public school district, public university listed in ORS 352.002, private post-secondary institution of education, any facility that provides services or resources to runaway or homeless youth, the juvenile department, Oregon Youth Authority, community developmental disabilities programs, local child welfare and self-sufficiency agencies, local substance use disorder programs, organizations serving transitional-aged youth or any other organization or ~~person~~individual identified by the local mental health authority as necessary to receive notice to preserve public health.

(16) “Designated Reporter” means the individual designated by the primary LMHA to report a suspected youth suicide to the Oregon Health Authority.

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Oregon Administrative Rule
Action

See Rules Coordinator for new rule numbers (Adopted or Renumbered rules).
One rule per form. All fields required.

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Rule Number: OAR 309-027-0030

Rule Title: Communication Protocol

Statutory Authority: ORS 413.042, 430.630, 430.640

Statues Implemented: ORS 418.735

Rule Summary: This rule details the communication protocol for postvention response in the case of a known suicide death of a youth (age 24 or younger) in Oregon. The revision adds language from 2019 legislation SB 485 and SB 918.

Rule Text:

(1) Each LMHA, in collaboration with tribes and community partners, shall identify local pathways for information-sharing and shall establish a Communication Protocol to communicate across and within the LMHA and community partners, including tribes, to inform and mobilize postvention response. This includes both a protocol from the LMHA to youth-serving entities and from any public school district, public university listed in ORS 352.002, and private post-secondary institution of education to the LMHA in the event of a suspected youth suicide death.

(2) Communication Protocols from the LMHA to youth-serving entities shall, at the minimum:

(a) Identify the tribes, community partners, and youth-serving entities involved in developing and implementing the protocol;

(b) Identify the specific roles and responsibilities of the LMHA, community partners, and youth-serving entities for implementing the protocol;

(c) Identify how a Communication Lead will be identified for responding to each suspected youth suicide. The Communication Lead may vary among incidents, depending on the nature of the death, location of the death, age of the decedent, or other factors. The Communication Lead may be an individual designated by a tribe, school district or university, the LMHA, another facility, or another community partner. The Communication Lead is responsible for centralizing information-sharing activities in the event of a suspected youth suicide;

(d) Detail the communication-sharing process among community partners, including tribes; and

(e) Identify the process for determining the specific information and data that will be communicated from the LMHA via the Communication Lead to all relevant youth-serving entities or individuals. This may vary based on the specific circumstances of the youth suicide death, but must include:

(A) The name of the decedent;

(B) The birthdate of the decedent;

(C) The date of death of the decedent;

(D) Any other information that the local mental health authority determines is necessary to preserve the public health and that is not otherwise protected from public disclosure by state or federal law.

(3) The LMHA shall document the completed Communication Protocol in writing and submit to the Coordinator within 120 days of the effective date of these rules, and annually on or before December 15th.

(4) At least annually on or before December 15th, each LMHA, in collaboration with community partners, shall review the Communication Protocol and evaluate the protocol's effectiveness over the past year, and provide a rationale for all revisions to the Coordinator. The Communication Protocol shall be updated and provided to the Coordinator within two weeks of a change of LMHA staff named in the protocol.

(5) The Coordinator shall:

(a) Review the communication protocols submitted by the LMHAs;

(b) Review any revisions to the communication protocols as submitted annually; and

(c) Provide feedback to the LMHA, including information on best practices, and offer technical assistance for preparation and implementation of the protocols.

(6) Communication Protocols from any public school district, public university listed in ORS 352.002, or private post-secondary institution of education to LMHAs shall, at the minimum:

(a) Identify the staff member responsible for notifying the LMHA of a suspected suicide death;

(b) Include the following information in the notification:

(A) The date of the death, or approximate date if not known;

(B) That the suspected manner of death is suicide; and

(C) A name, phone number, and email address for the school representative.

(c) No requirement of this section requires disclosure of information that is protected by state or federal public disclosure laws.

Oregon Administrative Rule
Action

See Rules Coordinator for new rule numbers (Adopted or Renumbered rules).
One rule per form. All fields required.

Action: ☐Adopt ☒Amend ☐Repeal ☐Suspend ☐Renumber ☐Amend & Renumber
(Choose one for this rule)

Rule Number: OAR 309-027-0040

Rule Title: Response Protocol

Statutory Authority: ORS 413.042, 430.630, 430.640

Statues Implemented: ORS 418.735

Rule Summary: This rule details the response protocol for postvention response in the case of a known suicide death of a youth (age 24 or younger) in Oregon. The revision add language from 2019 legislation SB 485 and SB 918.

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(1) Each LMHA, in collaboration with community partners, shall develop a Response Protocol identifying tribes, community partners, programs, individuals and others within the community that may be notified of a suspected youth suicide or mobilized to provide post-intervention response to a suspected youth suicide.

(2) At minimum, the Response Protocol shall:

(a) Identify the community partners and youth-serving entities, which shall be involved in developing and implementing the Response Protocol;

(b) Identify the roles, responsibilities, services, and available resources of each community partner involved in implementing the Response Protocol including the immediate, intermediate and long-term postvention response;

(c) Identify the process for notification to local systems that had contact with the decedent individual in the event of a suspected youth suicide. This may include:

(i) Sample scripts for communication of death notification to local youth-serving entities;

(ii) A description of the process to determine what information should be included in each notification.

(d) Identify how a Postvention Response Lead shall be identified for responding to each suspected youth suicide. The Postvention Response Lead may vary, depending on the circumstances and may be an individual designated by a tribe, school district or university, the LMHA, or another community partner. The Postvention Response Lead is responsible for coordinating postvention response and the notification process to local systems that had contact with the decedent in the event of a suspected youth suicide. The Postvention Response Lead for the Response Protocol also may be the Communication Lead;

(e) Establish and disseminate the postvention notification and response process among community partners and youth-serving entities or individuals connected to the decedent, including outreach to families, families of choice, and tribes, if applicable; and

(f) Identify the evaluation process used by community partners to debrief and assess the effectiveness of each suspected youth suicide response and the mechanism to adjust processes, as indicated, in the future. The evaluation process shall include an assessment of the effectiveness of meeting the needs of grieving families and families of choice; friends or others with relationships with the decedent; and the wider network of community members impacted by the suspected youth suicide;

(g) Identify how the Primary LMHA will notify other LMHAs linked to the decedent through residency, employment, school attendance, or significant family or social ties.

(3) The LMHA shall document the completed Response Protocol in writing and submit to the Coordinator.

(4) At least annually on or before December 15th, each LMHA in collaboration with community partners shall review the Response Protocol to debrief and evaluate the protocol's effectiveness in the past year, and provide a rationale for all revisions to the Coordinator.

(5) For the purposes of Response Protocols, the Coordinator shall:

(a) Review the response protocols submitted by the LMHAs;

(b) Review any revisions to the response protocols submitted annually; and

(c) Provide feedback to the LMHA and offer technical assistance on best practices for development and implementation of the protocols.

Oregon Administrative Rule
Action

See Rules Coordinator for new rule numbers (Adopted or Renumbered rules).
One rule per form. All fields required.

Action: ☐Adopt ☒Amend ☐Repeal ☐Suspend ☐Renumber ☐Amend & Renumber
(Choose one for this rule)

Rule Number: OAR 309-027-0060

Rule Title: Reporting to the Coordinator

Statutory Authority: ORS 413.042, 430.630, 430.634 & 430.

Statues Implemented: ORS 418.735

Rule Summary: This rule outlines requirements for reporting to the Coordinator for postvention response in the case of a known suicide death of a youth (age 24 or younger) in Oregon. The revision adds language from 2019 legislation SB 485 and SB 918.

Rule Text

(1) Each LMHA shall designate a Designated Reporter assigned to timely report suspected youth suicides and postvention activities to the Coordinator. Each LMHA shall provide the name and all contact information (including email address and phone number) for the Designated Reporter. The LMHA shall also designate a backup Designated Reporter to assume those responsibilities in the event of the Designated Reporter's absence. The LMHA shall maintain updated contact information of the Designated Reporter and backup with the Coordinator.

(2) Within seven days of a suspected or confirmed youth suicide the primary LMHA shall report to the Coordinator as follows or to the extent allowed by law.

(3) The LMHA in the county where the death occurred shall report the death to the Coordinator. The Primary LMHA and each impacted LMHA shall report their respective postvention activities. At a minimum, the reports to OHA shall include:

(a) Date of report;

(b) The author's name, affiliated LMHA, email address and phone number;

(c) The date of the suspected youth suicide and the city and county in which the suspected youth suicide occurred;

(d) Age of the decedent;

(e) If a student, the name of the school, public or private university or college, or private post-secondary institution of education attended by the decedent.

(f) A narrative discussing the postvention activities completed or to be completed by the Primary LMHA, other impacted LMHAs, if available, and community partners. The narrative must include activities completed or planned for:

(A) The immediate postvention response;

(B) The intermediate postvention response; and

(C) The long-term postvention response, including how the interventions may change due to the end of a school year, at graduation, and at the anniversary of the death;

(g) If the LMHA has not determined intermediate or long-term postvention response activities at the time of the seven- day report, the LMHA shall provide the narrative described in subsection (f) to the Coordinator within 45 days of the date of the initial report.

(h) A request or decline of technical assistance from OHA.

(i) If assistance is requested, the LMHA shall make the request by phone or secure email and include as much of the following as is possible:

(A) The decedent's age; race and/or ethnicity; gender; gender identity; and sexual orientation;

(B) Identify the agency with custody of the decedent, if applicable;

(C) Identify organizations or individuals that provided services or resources to the decedent if the decedent was a runaway or homeless youth at the time of death;

(D) Location of the suspected youth suicide (such as a public place or private residence);

(E) Any evidence of bullying (cyber or in person);

(F) The manner in which, if at all, social media were involved;

(G) Whether, within the previous year, the decedent's family experienced another suicide;

(H) A description of all other traumatic deaths within the community, if known within the previous year;

(I) Whether the decedent was receiving mental or behavioral health services at or close to the time of death;

(J) Whether substance use or abuse was a factor in the death, if known; and,

(K) Any other information that the LMHAs deems necessary for the Coordinator to have in order to provide assistance.

(4) LMHAs shall notify the Coordinator if a death reported as a suspected youth suicide is later determined by the medical examiner or designee to not be a suicide.

(5) OHA shall provide LMHAs with a form for reporting the required information via e-mail to the Coordinator.

(6) Annually by December 15th, each LMHA shall report to the Coordinator an assessment of the effectiveness of the: communication and response protocols; post-intervention services provided, and procedures for reporting deaths to OHA. The LMHA may also include an estimate of the costs to the LMHA in implementing these rules that year.

(7) As part of the Authority's Plan to improve communication and response to suspected youth suicides, the Coordinator shall use the information compiled from the LMHA annual reports to aid its efforts to serve as a resource to the LMHAs.

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

We are writing on behalf of the Oregon Alliance to Prevent Suicide (Alliance) to support and amplify the conclusions of the Oregon Health Authority's October 2020 report to the Legislature, *Suicide-related training for medical and behavioral health* providers. [1'] This letter focuses on the need for behavioral health professionals to be required to receive continuing education on suicide assessment, intervention and management.

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

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

Unfortunately, assessment and treatment for suicidality is not a standard part of either undergraduate or post-graduate training for behavioral health therapists, social workers, and counselors. OHA's 2020 legislative report indicates that without a mandate many behavioral healthcare providers received no recent training in suicide risk assessment or management. Only 33.8% of psychologists, 46.9% of social workers and 37.4% of counselors and therapists reported receiving any training. The Teachers Standards and Practices Commission which licenses school counselors had the highest rate of completed trainings at 74.9%. While this is an excellent start, the reality is that school counselors generally only assess suicidal students and count on being able to refer students to well-trained therapists or social workers. In short, most of Oregon's behavioral health workforce is unprepared to respond to a suicidal client. This means that, when an at-risk individual is referred to counseling, they may not get the help they need.

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

The Alliance is re-introducing legislation in 2021 to require that Oregon's behavioral health workforce receive continuing education units in suicide assessment, intervention, and treatment. We have looked to our neighboring state, Washington, for a model for developing this type of mandate.

We believe it is more important than ever that Oregon move forward with requiring continuing education on suicide prevention for behavioral healthcare providers, as people across Oregon navigate

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

this traumatic time. Given the COVID-19 Pandemic and the multiple stressors on physical healthcare providers, this is not the right time to address the need for physical healthcare providers to receive continuing education. Further SB48 reports will help us to assess whether the current voluntary approach is achieving this goal.

On the other hand, behavioral healthcare workers are the designated “experts” to whom those who are experiencing suicidal ideation are referred. We would go so far as to say that it is unethical that counselors, therapists, social workers, and peer support specialists, who regularly interact with highly suicidal individuals often do not have a strong understanding of how to assess risk of suicide effectively, and how to engage with people through times of suicidal ideation. They also need to understand and convey to their clients that many people live full, productive lives despite living with chronic suicidal thoughts and to help their clients develop the skills to do so.

Preparing this workforce to meet these needs is essential. Requiring continuing education is the least we could do as a start. We look forward to ongoing work in partnership with OHA to ensure that our professionals have the skills to identify suicide risk and help save lives.