Alliance March 11, 2022 Quarterly Meeting Optional Orientation: 8:45 AM – 9:15 AM
Meeting: 9:30 AM – 12:30 PM

Join over Zoom:
https://us02web.zoom.us/j/82324465888?pwd=d0pSUGhKalBVa25ZYmN1T2IxWE42QT09

Meeting ID: 823 2446 5888
Passcode: 294424
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Minutes

Meeting agenda, materials and minutes are posted on the Alliance website.
https://oregonalliancetopreventsuicide.org/

Our Vision

In Oregon all young people have hope, feel safe asking for help, can find access to the right help at the right time to prevent suicide, and live in communities that foster healing, connection, and wellness.

Mission

The Alliance advocates and works to inform and strengthen Oregon's suicide prevention, intervention and postvention policies, services and supports to prevent youth and young adults from dying by suicide.

8:45 – 9:15 **Orientation**
Annette Marcus, Suicide Prevention Policy Manager, AOCMHP

9 :30 - 9 :45 **Welcome, Introductions, Draft Equity Statement Alliance Mission and Vision, Agenda Overview**
Galli Murray, Chair of Alliance

Galli welcomed attendees and thanked everyone for their commitment to suicide prevention and supporting the work of the Alliance. She reminded attendees to take care of each other and to reach out to staff through the chat feature if having a tough time and need to talk with someone. She also requested attendees to sign-in via the chat feature.

Galli acknowledged the tremendous level of the work, activities and events happening around the state. She asked if anyone had an announcement they would like to share.

Jenn announced that May is Mental Health Awareness month and the Suicide Prevention Coalition leaders asked her to poll Alliance members to help select a focus of the upcoming statewide campaign. Two coalition representatives provided brief description of the two proposals:

Gordon Clay: Develop short (15 seconds) You Tube spots that would feature people on the street demonstrating how to ask, "Are you are ok?"

Abby Warren: Building on the successful 2021 Signs of Hope campaign, host a 2022 Signs of Hope campaign with a focus on how to ask ,"Are you ok?".

Attendees participated in a rapid poll and the results were so close it was decided that the two approaches will be combined and the theme will center on asking, "Are you ok?"

Laura Rose announced that the Peer Galaxy website posts events on their calendar page, see for more information: https://www.peergalaxy.com/calendar/

Ryan Price announced a recent publication, A Blueprint for Youth Suicide Prevention, a collaborative effort between AFSP and the American Academy of Pediatrics. https://afsp.org/story/pediatric-and-suicide-prevention-experts-partner-to-create-blueprint and https://www.aap.org/suicideprevention

Mandy Kubish read the Alliance vision statement and Laura Rose Misaras read the mission statement.

Galli reported that the Alliance now has an Equity Statement which was approved by the executive committee. She thanked everyone who worked on it and asked Michelle Bagan from the Equity Committee read the statement:

Equity Statement
To achieve our vision, we acknowledge the impact of white supremacy, institutionalized racism, and all forms of oppression. The Alliance endeavors to make Oregon a place where suicide reduction and prevention is achieved for people of all ages, races, ethnicities, abilities, gender identities, sexual orientations, socioeconomic status, nationalities and geographic locations.

Big View, Review, and Preview

Staff and committees worked hard to put together several POP (Policy Option Package) ideas and sent them forward to OHA. This legislative session there were no specific suicide prevention bills passed, however, the bills that passed related to housing and behavior health treatment support prevention strategies. Looking forward to the full legislative session next year, we are going to put together a timeline for when and how the Alliance moves legislation forward. For example, when we passed HB 2315, the Alliance neglected to include school psychologist in the list of behavioral health professionals required to complete suicide prevention, intervention and treatment training. In the next session, we may move an amendment forward to add school psychologist. At the June 2022 quarterly meeting will talk more about the timeline and how the Alliance will propose and/or support new legislation. Staff has created a **form** and encourages you to submit your ideas through the Alliance website. For example, Galli shared the idea of standardizing medical examiner reports across the state.

We have only two items today that require a vote: approval of the December quarterly meeting minutes and approval of the updates to the Alliance by-laws.

Before calling for the votes, Galli reviewed the agenda. She also reminded attendees that the Alliance is recruiting members and asked all to help with nominations. Please forward nominations to Annette and Jenn.

Galli called for a motion to accept the December quarterly meeting minutes as presented. Pam Pierce motioned to accept the minutes; Ryan Price, seconded. Motion passed; no abstentions; no nays

Before the vote on the by-laws, Galli reminded attendees the Executive Committee approved the minor changes. Galli called for discussion on the changes and hearing none, she called for a motion to approve. John Seeley, moved to approve the changes; Julie Majors, seconded. The motion passed; no abstentions; no nays.

Changes to by-laws:

Page 1: addition of 2021 legislation
Page 2: reordering of language
Page 2-3: SB707 requirements added
Page 5: Executive Committee approvals
Page 5: committee and advisory group information added
Page 6: voting membership information clarified
Page 6: information about voting over email removed

9:59 – 10:30 **OHA Public Health Suicide Data Presentation**
Meghan Crane, Zero Suicide in Health Systems Coordinator, OHA

Galli introduced Meghan and asked attendees to think about the data in the context of committee work you may be involved in.

Meghan shared that the report is currently being finalized for publication. The lag time in reporting data is due to CDC's release of state rankings which is important to partners and legislators. Today's data is on finalized 2020 death data and preliminary 2021 death data. This data is only one aspect of the picture in suicide and does not highlight other data sources such as the Student Health Survey, qualitative and focus group data, Big River programming data and the amazing work being done around the state by each of you in terms of training programs, awareness activities, and suicide prevention work. Some of this data may be challenging to hear. Please step away if that is the case for you.

The PowerPoint slides are included in meeting materials posted on the Alliance website https://oregonalliancetopreventsuicide.org/ . Meghan provided a very detailed report and this summary:

What We Know About 2021

- Preliminary data in Oregon indicates a decreasing trend in youth suicide for youth aged 17 and younger and are similar to previous years for youth 18-24 in 2021. There is decreasing trend in youth suicide (24 and younger) in Oregon.
- While the number of statewide suicides of youth 17 and under decreased and are similar to previous years for youth aged 18-24 in 2021, the number of youth suicides for some counties did not decrease.
- Preliminary data indicate an increase in the number of suicides in 2021 compared to 2020 across the lifespan.
- While the continued decrease or similarity in Oregon's youth suicide number is 2021 is positive news, it must be considered in the context that Oregon started this three-year trend with a youth suicide rate higher than the national average. Far too

many Oregon families and community experienced the devastating loss of a loved one to suicide in 2021.

- OHA's suicide prevention team remains focused on working to prevent and reduce risk factors and increase protective factors for youth and their families and caregivers.

Note: 2021 data are preliminary data and may change as data is finalized.

Meghan said that OHA is open to feedback on the data presentation, email her at meghan.crane@state.or.us She encouraged all to remain hopeful and help those who are struggling and read this quote:

Hope is that thing inside us that insists, despite all the evidence to the contrary, that something better awaits us if we have the courage to reach for it and to work it and to fight for it. Barack Obama

10:15 – 10:30 **Data Presentation – Discussion, Questions and Answers**
Alliance Members and Affiliates

Galli asked if there were questions?
Q: Are there any school based strategies statewide to prevent suicide K-12?
A: Adi's act requires all schools to have plans, see the Alliance website for more information https://oregonalliancetopreventsuicide.org/sb-52/

The Big River trainings are offered statewide; see the YSIPP for details
https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/SUICIDEPREVENTION/Documents/21-25-youth-suicide-prevention-plan.pdf

Q: Which other 6 states had a decrease 2019 – 2020 like Oregon?
A: States with statistically significant declines were California, Connecticut, Florida, New Jersey, Ohio, Oregon, and Pennsylvania.

Before the YSIPP Update, Galli asked Roxanne to introduce our special guest. Roxanne introduced Alyssa and Brayden, youth from 5CA. Roxanne thanked them for joining us to see what the Alliance is all about. Galli also thanked Alyssa and Brayden and asked them to join us again.

10:33 – 10:50 **YSIPP Annual Update and Alliance Next Steps**
Jill Baker, Youth Suicide Prevention Coordinator, OHA
Galli Murray, Alliance Chair

Jill thanked Meghan for her thoughtful and thorough presentation. Jill shared that she thought it was important for OHA to begin with data to see our improved outcomes; there is more work to be done but we're moving in right direction. Jill provided a preview of annual YSIPP report which will be released by the end of March. The PowerPoint presentation is included in the meeting materials, https://oregonalliancetopreventsuicide.org/ Highlights from Jill's presentation include:

- The YSIPP 2021-25 is aligned with national recommendations for suicide prevention and intervention; the San Diego model and input from many throughout Oregon informed our plan; and, today reviewing the framework is to deepen our understanding.
- The ASIPP is built on the same framework and will look the same and will look the same in terms strategic goals, strategic pathways and initiatives. The foundation and centering lenses will also remain the same: policy, funding, data and evaluation, equity, trauma informed practice, lived experience voice and collective impact, and collaboration.
- Finding your work in the framework: example - **Local Initiative**: You Matter to Klamath: video contest; **YSIPP Goal**: Media and Communication **Pathway:** All Oregonian receive safe messaging about suicide. This example is related to Strategic Pillar 1, green on diagram)
- The annual report will indicate the status of initiatives: on track with deadlines; meeting most, but not all deadlines; some or all tasks are overdue.
- During fall 2022, 23 YSIPP initiatives will be collaboratively choosen.

10:55 – 11:00 **BREAK**

11:00 – 11:25 **Centering Lived Experience Voice – Breakout Rooms/Discussion**
Laura Rose Misaras, Alliance Member

Laura Rose shared information on how the Live Experience Advisory contributed to YSIPP development and the ongoing input they provide on YSIPP implementation and suicide prevention statewide. She also shared examples of lived experience input on implementation of initiatives, here are a few of those examples:

- Lived experience should be active in the review and input of messaging as well as distribution of materials and media
- Look at more than just coping/getting by – what do people need to thrive and live
- Lived experience needed for roll out of 988 and the mobile response system services (MRSS); ideally team will include staff and people with lived experience

- Include people with lived experience and equity perspective in the creation and review of toolkits and trainings prior to publication and distribution.

Laura Rose introduced the breakout session and asked that all groups discuss the same question: What does centering the voice of people with lived experience look like in our shared work to support the YSIPP? There will not be a report session, however, responses will be recorded on jamboards and used to:

- Schedule a follow-up gathering (Doodle Poll) to share & discuss input
- Draft a proposed Vison, Principles, and Action Plan for Centering the Voices of Lived Experience
- Guide how we monitor and advise on YSIPP work as we continue to develop our Lived Experience Advisory and Equity work
- Share back at a future quarterly meeting

At the close of the breakout session, Annette thanked Laura Rose for today and all her work with the Alliance. Annette also acknowledged the valuable work that Laura Rose does around the state. Annette thanked members for bringing so much to our work by keeping lived experience at our center.

11:25 – 12:20 **988 and MRSS Presentation and Discussion**
Beth Holliman, Intensive Community Based Services Coordinator
Rusha Grinstead, Behavorial Health Crisis System & 988 Lead
Cherryl Ramirez, AOCMHP)
Chelsea Holcomb, Child and Family Behavioral Health Director
Brian Pitkin, Children's 988/Mobile Response and Mobilization Services Coordinator
David Westbrook, COO, Lines for Life

Rusha provided background on National Suicide Hotline Designation Act of 2020 which:

- **Designates 988** for a national suicide prevention and mental health crisis hotline (Lifeline and the Veterans Crisis Line)
- Requires SAMHSA/VA to report to Congress on **infrastructure needs within six months** of the bill enactment.
- Requires SAMHSA to submit a plan to provide network trainings and access to **specialized services for populations such as LBGTQ youth, minorities, rural individuals and other high-risk populations.**
- Allows States to **levy fees for local 988 related services** on wireless/IP Carrier bills, including crisis outreach, stabilization, MH services responding to 988 contacts

- Requires **FCC to report to Congress** on 1) the collection and distribution of carrier-fee funds, and 2) the feasibility and cost of geolocation services

Rusha provided information on the "Crisis Now" model and adopting this model for 988 implementation. It has three components: 1) centralized call center; 2) mobile crisis; and 3) crisis stabilization. Crisis Now is a system that diverts people in the midst of a mental health crisis away from the caregivers of last resort, emergency departments and law enforcement to those that can best help – behavioral health providers. For more information, https://crisisnow.com/

Rusha shared about the complexities of an effective system and that an effective 988 system requires investments much like the 911 system. For 911, the chain of events is call comes into call center, first responders are law enforcement/EMT, crisis stabilization is the emergency department and follow up is medical. For the 988 system, the flow would be call comes into call center, first responders are a mobile crisis team, crisis stabilization is delivered through services/community resources, and follow up is through behavioral health. This system will operate in conjunction with other systems such as 911 and partner within the community.

Federal legislation prompted state legislation for 988 implementation. The Oregon legislature passed HB 2417, July 2021, to: stand up 988 as an alternative to 911 for all Oregonians; expand current mobile response services across the state; and, create stabilization services and community resources. The bill allocated $10 million for mobile crisis services and $5 million for call center services. The estimated costs to strengthen crisis care system is $31 million. For the mobile crisis, OHA has identified an opportunity to braid together funding to bring up the total investment to #31 million.

- $10 million funding from HB 2417
- $11 million from mental health block grant supplemental funds
- $10 million through current CFAA funding (this funding is separate from the $6.5 million for Mobile Response and Stabilization Services [MRSS] and supplemental block grant funding being utilized for the children's model)

The is the estimated cost to fully fund mobile crisis services by community mental health programs. A transition to Medicaid reimbursable mobile crisis model is planned.

OHA is working with communities to establish the crisis response system. The approach is to engage individuals and families with lived experience to see how they want to crisis services to function in their community. They are bringing providers and families together to inform development and identify what implementation resources/funding are needed from OHA. OHA also wants input on what policy changes (i.e., statutes, administrative

rules, contracts, key performance indicators, funding) are needed to support a responsive system that meets community identified needs. For ongoing information see OHA https://www.oregon.gov/OHA/HSD/AMH/Pages/988.aspx#:~:text=Beginning%20July%2016%2C%202022%2C%20a,call%20for%20all%20other%20emergencies.

David added that in addition to calls, text and chat have been approved by FFA. Currently the national crisis line operates text services but is unable to respond to all texts. As 988 rolls out, Lines for Life will cover all counties in Oregon for text. National partners project calls, texts/chats to be about 100k annually for OR. A new metric for suicide prevention – 95% of all calls have to be answered within 2 minutes. The $10 million put in by legislature is a drop in the bucket for mobile response. To be most effective, it needs to be a rapid response and available in every community as well as have dedicated staff not an add on to another job. Some of the traffic to emergency rooms needs to be diverted to crisis responses/lines to take pressure off of ER. The number of diverted cases will be a measure of success. The federal government is promising a significant level of funding; however, it is dependent on administration which adds to the stress of continued funding. Oregon needs to plan ahead for this and some other states have addressed this through phone fees modeled on the fee currently charged for 911 calls. This is an example of funding behavioral health in a similar way as physical health (i.e., parity). First attempt at having a fee passed in the 2021 session was unsuccessful. Oregon needs to explore this option and others to secure long-term funding.

Q: Will L4L provide training for crisis stabilization centers?
A: Yes. OHA will also be available for training.
Q: The crisis of finding BH staffing levels is dire; how will L4L handle staffing?
A: The appropriated funds will help but it is no doubt a challenge. We need to think of this as a long-term challenge. Alliance can help by advocating statewide for getting folks interested in becoming BH specialist.

Cherryl Ramirez reviewed the service delivery structure for Community Mental Health Programs (CMHP) which includes county departments, not-for-profits, Chapter 190 IGAs and Tribes. County structures vary, however, all counties have CMHP.

A workplan has been developed for Oregon's mobile crisis response. The $10 million has been divided equitably through a formula for distributing funds across the state. Funds will cover staffing costs, however, the pay for this work is not the bet. The big bucket of services is comprised of crisis lines, response, and stabilization. We should have the same level of staffing and funding as we do for fire and police departments – a capacity-based funding for 24/7 staffing. The Mobile Crisis Response Status slide (below) shows we're not starting from scratch.

Mobile Crisis Response Status

Current State for All	Current State for Some	Future State for All
CMHPs operate 24/7/365 mobile crisis response (MCR) services within established access standards, in-person.		MCR services collaborate with 988 crisis call centers and any other crisis response services.
CMHPs have 24/7/365 capacity to triage, screen, assess, provide emotional support, crisis intervention, crisis/safety planning, suicide prevention/intervention, psycho-social support, holds as appropriate, transport, referrals.	Peer support specialist as part of the Mobile Crisis Team Assessments via telehealth	MRSS trained teams for under 18 or at request of 18-21. Face-to-face dispatch criteria for MRSS defined by parent/youth; can be used as preventive action. Within 72 hours of MCR, determine need for continued stabilization services for up to 8 weeks.
MCT collects following information: Name, date of birth, presenting problem, location, history of violence/addiction	Reported presence of weapons Plan to include law enforcement	CMHPs collaborate with 988 crisis call centers on dispatch policies, e.g., no re-evaluation of individuals in crisis
CMHPs ensure that mobile crisis services are accessible throughout county and provided in individual's language either by direct staff or interpretation services.	CMHPs' MCTs have a minimum of two providers, one a QMHP and the second a QMHA or peer support specialist	Families help coordinate services to ensure timely face-to-face response. MCR teams provide crisis intervention dispositions to OHA and 988 call centers within a TBD time period.
CMHPs ensure care coordination for inpatient referrals, outpatient appointments, warm handoffs for ongoing services, and crisis follow up support as needed.	Follow up and outreach to individuals at moderate and high risk within 24 hours of contact	Move all the 'Current State for Some' to statewide status

The information in this slide is from the OHA plan. Last year CHMP received 174,000 calls and we anticipate an increase. We also need to recognize there is a great deal of work to coordination with 911. We all need to advocate for the level of funding needed for a 24/7/365 crisis response to diver individuals from jail/law enforcement and ERs to have better stabilization.

Beth started the presentation on transforming the crisis for children, youth, young adults and their families. She shared that access is for all Oregonians, 988 is a lifespan response. There is a focus on responding to those 20 and under and administrative rules are currently being updated to reflect community feedback and expanding responsibilities for CMHPs. To align Oregon with best practices, OHA reviewed national best practices on crisis response for youth and families and consulted with national expert Liz Manley.

Elements of a crisis continuum for MRSS are:

- Crisis is defined by the caller
- Services are available 24/7
- Able to serve children and families in the natural environments, for example, at home or in school
- Include specialized child and adolescent trained staff and do not rely on predominantly adult-oriented crisis response workers
- Build on natural support structures and reduce reliance (and therefore costs) on hospitals and formal crisis response systems.
- Connect families to follow-up services and supports, including transitions to needed treatment services.

Beth provided a few example of best practices: defining what “crisis” is for youth which is different than for adult; keep children/youth in the community and with family; stabilization services provided in community where they live; and, have services provided for 56 days with 56 days follow up.

Chelsea gave an overview of the timeline for MRSS in Oregon. Youth and family and community engagement unpin the 2022 timeline. Training curriculum development, data, technical assistance, and system of care pathways take place over the 12 months. We are aware of the need for additional resources and by 2023 will be seeking funding for the statewide model. The timeline for 2022 is:

- January – 988/MRSS implementation year begins
- March – June – State plan and OAR
- July – December – MRSS Learning Collaborative
- January 1, 2022

Comments and Discussion

David reminded that the mobile crisis response (MRSS) /988 is one component, and an important one, of a full suicide prevention/intervention model. There is not one intervention and way to prevent suicide.

Q: How do we keep youth and response staff safe during a home response such as an abusive situation where kids aren't safe?
A: Some ways include having two staff go together; triage cases/assess safety before responding; and meeting outside of the home if not safe. There will also be specialized training for safe intervention and safety planning which may be different for youth and adults.

Galli encouraged folks to attend a community meeting related to 988/MRSS. For more information, please check OHA website https://www.oregon.gov/OHA/HSD/AMH/Pages/988.aspx

She thanked the presenters for the very thorough presentation.

12:20 – 12:30 **Looking Forward with Alliance Policy Priorities**
Annette Marcus, Suicide Prevention Policy Manager, AOCMHP

Tabled – Annette will send out information

12 :30 **Adjourn**
Galli Murray, Alliance Chair