Orientation to the Oregon Alliance to Prevent Suicide

HOPE, HELP AND HEALING

Oregon Alliance to Prevent Suicide

AOCMHP

Funded by Oregon Health Authority

Oregon Alliance to Prevent Suicide

Hope • Help • Healing

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.

Let's Take Good Care of Each Other and Ourselves

- Let us know with a private chat if you're having a tough time and need someone to talk with. USE THE CHAT

- Take a break when you need to – get up and stretch, get yourself a cup of tea or a bite to eat. Please mute yourself unless you have a comment.

- Draw, doodles, take notes or pat your cat or dog during the meeting

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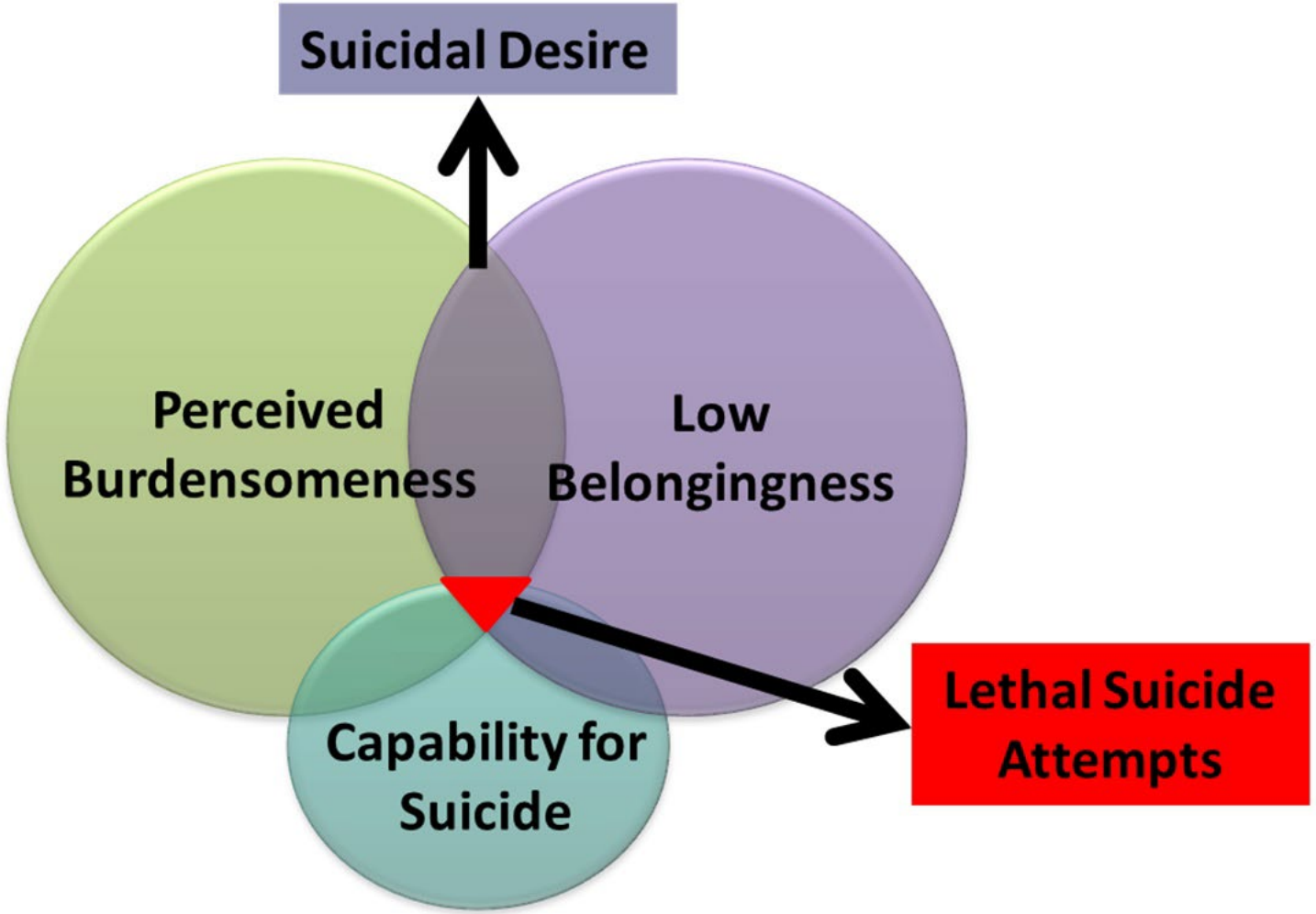
- Established to advise OHA on statewide integration and coordination of youth/young adult suicide prevention, intervention and postvention activities.
- Members are appointed by OHA director. Our Members and Friends: Young People, Loss Survivors, Attempt Survivors, Families, State Agencies, Subject Matter Experts, Regional Coalitions and more
- Passed into statute SB707 in 2019
- Staffed by the Oregon Association of Community Mental Health Programs
- Youth Suicide Intervention and Prevention Plan (YSIPP)

*Youth Suicide Annual Report, 2014-2015

Oregon Health Authority

Interpersonal Psychological Theory of Suicide

- This figure illustrates the circles of Influence that affect suicide risk and must be addressed in suicide prevention activities.



Interpersonal Psychological Theory of Suicide was developed by Thomas Joiner

FRAMING MESSAGES

HOPE

Promote a sense of hope and highlight resilience.

HELP

Make it safe to ask for help and ensuring that the right help is available at the right time.

HEALING

Work with individuals and communities in the healing process after an attempt or suicide

TRANSFORMATION

Alliance Focus

- Monitoring and advising OHA to reduce youth/young adult suicide
- Equity and liberatory practice
- Connecting the field of suicide prevention in Oregon
- Policy development and implementation

Alliance Structure and Committees:

Standing Committees

- Executive
- Workforce Development
- Transitions of Care
- Schools
- Outreach and Awareness

Note: Each Committee Has Specific Policy Priorities

Key Advisory and Work Groups

- LGBTQ+ Advisory
- Youth and Young Adult Engagement
- Lethal Means Access
- University of Oregon Suicide Prevention Lab - Community Academic Partnership with the Alliance

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A Few Key People

Just a Few Members

- Chair, Galli Murray – Suicide Prevention Coordinator, Clackamas County
- Vice- Chair, Ryan Price –American Foundation to Prevent Suicide
- Youth Members – Maya Bryant, Karli Lea Reed and Olivia Nilson
- OHA Youth Suicide Prevention Coordinators – Jill Baker, Shanda Hochstetler

Staff

- Annette Marcus - Policy Manager/Coordinator
- Jennifer Fraga - Youth and Young Adults, Communication,
- Kris Bifulco – Postvention (Connect)

How to get involved with the Alliance

1

Attend quarterly meetings and sign up for the Alliance listserv

2

Volunteer for one of the committees or workgroups

3

Participate in policy advocacy – by testifying, working with legislators, providing feedback on Oregon Administrative Rules

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Oregon Alliance to Prevent Suicide

Hope • Help • Healing

Alliance Quarterly Meeting

March 11, 2022

WELCOME – Please enter your name in chat, pronoun, and your organization and/or role

Oregon Alliance to Prevent Suicide

Hope • Help • Healing

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.

Equity Statement for the Alliance

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.

Today's Agenda

9:30 – 9:45

- Big View, Preview, Review
- December Minutes Approval
- By-laws update vote

9:45 – 10:15

- Oregon Suicide Data, Meghan Crane, OHA Public Health

10:15-10:40

Youth Suicide Intervention and Prevention Plan (ASIPP) Update –Jill Baker, OHA

10:50 – 11:00 Break

10:50– 11:20 (Breakouts)

- Centering Lived Experience, Laura Rose Misaras

11:20 – 12:20

- 988 & MRSS Presentation and Discussion, Beth Holliman/Brian Pitkin – OHA, David Westbrook, Lines for Life, Cherryl Ramirez, AOCMHP

12:20 – 12:30

- Looking forward with Alliance Policy Work, Annette Marcus, Alliance

By-Law Vote

- -Page 1: addition of 2021 legislation
- -Page 2: reordering of language
- -Page 2-3: SB 707 requirements added
- -Page 5: exec committee approvals
- -Page 5: Committee & Advisory group information added
- -Page 6: voting membership information clarified
- -Page 6: information about voting over email removed

Data and YSIPP Presentations and Discussion

Centering Lived Experience

Laura Rose Misaras

1. Healthy & Empowered Individuals, Families and Communities **(7 Comments, 62 Initiatives)**	**Integrated & Coordinated Activities** **Media & Communications** **Social Determinants of Health** **Coping & Connection**
2. Clinical & Community Prevention Services **(8 Comments, 48 Initiatives)**	**Frontline & Gatekeeper Training** **Means Reduction** **Protective Programming**
3. Treatment & Support Services **(12 Comments, 42 Initiatives)**	**Healthcare Coordination** **Healthcare Capacity** **Appropriate Treatment & Management of Suicidality** **Postvention Services**
4. Foundations & Centering Lenses **(2 Comments, 20 items)**	**Data and Research and Evaluation** **Lived Experience Voice & Trauma Informed** **Policy Needs/Gaps and Funding Needs**

Examples of Lived Experience Input on Initiatives

- Lived experience should be active in review and input of messaging as well as distribution of materials and media
- Look at more than just coping and getting by – what do people need to thrive and live
- Hear from people with lived experience on which trainings reflect foundations and drive positive outcomes effectively
- Lived experience input needed for MRSS, before and as 988 rolls out; people on MRSS team should provide feedback on their direct experiences. Ideally, lived experience folks and MRSS staff should work together
- People with relevant lived experience and equity perspectives should included in the creation and review prior to publication, distribution and delivery of toolkits & trainings
- When looking at supporting effective approaches to treatment, it should be individualized, and, informed by people with relevant lived experience and equity perspectives. For example, in treating trauma, for some EMDR can be positively life-changing, for others it can be triggering. For some people, Guided Visualization can be valuable yet for others it can be harmful – "Flooding" can trigger

How we will use small group feedback

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

Small Group Breakout – Self Select

- Loss Survivors
- Lived Experience (past or present) of your own struggles
- Family/Friend/Caregiver supporting person(s) with struggles (past or present)
- Provider/Professional supporting person(s) with struggles

Question:

What does Centering the Voices of People with Lived Experience look like in our shared work to support implementation of the YSIPP?

988/MRSS Overview

Policy Next Steps

Through June

- Recommendations for legislative concepts and priorities discussed in committees
- Submit recommendations to staff
- Executive reviews recommendations and organizes
- June Quarterly we vote on our legislative priorities

Through December

- Build relationships with legislators (there will be new ones)
- Identify questions to ask gubernatorial and other candidates
- Legislative Days
- Convene stakeholders as needed for input a

Advisory Committees

- Children's System Advisory Council
- Addictions and Mental Health Planning Council
- Children's System of Care State Advisory Council
- Oregon Consumer Advisory Council
- Behavioral Health Taskforce (legislative)
- School Safety Task Force
- 988 Lived Experience
- 988 Children and Family
- State Health Improvement Plan
- OHA Community Advisory Council (Equity and Inclusion)

At which tables do we need to be sure the Alliance is represented?

Questions for Consideration

- Does it help prevent suicide or help heal after a suicide?
- How do we know if it helps prevent suicide or help heal after a suicide?
- Does it address the needs of population(s) at high risk of suicide?
- Does it address the needs of historically targeted and/or under resourced communities?
- Is it strategic for us to align with another organization or go it alone? Is there another group pushing something where we can be a visible partner/advocate?
- Is this a lifespan or youth focused issue? Does that make a difference in how much energy we expend here?
- Does the proposed new policy or policy change require legislative action? Or, does it make to use other policy levers to change a policy that is in place but is not legislatively required?

Ease

- Does it require additional funds and/or resources? If so, what will it require to secure needed funds and/or resources?
- Is there organized opposition?
- Are we developing something new or replicating something that has been done/is working?
- Is there an existing effort we can partner with and/or champion?
- Are there sufficient staff and/or volunteer resources to handle the workload of initiating a new policy or a policy change?

Impact

- Will it help us achieve YSIPP goals?
- Is the proposed policy something that will have a statewide impact? How?
- Will the proposed policy require multiple systems to shift and/or change? Is it feasible and reasonable to expect that shift and/or change to occur?
- Is the proposed policy addressing a need of a high-risk group?
- What will be required to implement and sustain the policy change?
- Are we the best people to advocate for a particular issue (such as housing) or would either partnering or being a champion for the cause be more effective?
- Is the proposed policy a recommended priority from Alliance advisory groups and/or workgroups?
- Is it a short-term effort or long-term goal?
- Does it require a legislative fix or can the outcome be achieve through other policy avenues such as a rule change or collaborative agreement reached with a state department and/or advocacy group?

- How is implementation of passed legislation progressing?
- Is additional legislation required to achieve desired outcome of the bill?
- What is standing in the way of full implementation? Will the proposed policy support implementation of passed bills or clear roadblocks? What will be required in terms of staff time, resources, collaboration with partners, etc.?
- Is it an initiative that has gotten stuck that needs a legislative or rules fix?

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Oregon Alliance to Prevent Suicide
Bylaws

Background on the Alliance

Suicide, a major public health issue nationally, is the second most common cause of death for youth and young adults up to age to 24 in Oregon.

In 2014, the Oregon State Legislature mandated development of a 5-year plan to address Oregon's high rate of suicide among individuals aged 10 through 24. The Oregon Youth Suicide Intervention and Prevention Plan (YSIPP) was signed by the Oregon Health Authority (OHA) and submitted to the Legislature in January 2016. The YSIPP calls for the creation of the Oregon Alliance to Prevent Suicide to develop a public policy agenda for suicide intervention and prevention across agencies, systems, and communities.

In 2019 Oregon's legislature passed SB 707 which put the Alliance in statute as the Youth Suicide Intervention and Prevention Advisory Committee, amending ORS 418.731 and 418.733. The Oregon Alliance to Prevent Suicide (Alliance) is serving in this role.

In 2021, Oregon's legislature passed SB 563 making the YSIPP cover ages 5 through 24 for more upstream prevention work.

Purpose and Responsibilities

The Alliance is charged with overseeing implementation of the YSIPP and evaluating outcomes related to suicide prevention in Oregon. The purpose of the Alliance is to serve as an advisory to the OHA with a goal of reducing youth suicides in the state of Oregon. Alliance members are appointed by the OHA to develop a public policy agenda for suicide prevention, intervention, and postvention across agencies, systems, and communities. The Alliance seeks to:

- Promote a sense of **hope** and highlight recovery and resilience,
- Make it safe to ask for **help** and making sure that help is available at the right time.
- Engage individuals and communities in the **healing** process after an attempt or suicide.

Responsibilities of the Alliance Include:

- Advise the OHA on the development and administration of strategies to address suicide intervention and prevention for children, youth and young adults through 24 years of age.
- Recommend potential members to OHA for appointment to the Alliance
- Promote a coordinated approach with the State for youth suicide prevention.
- Develop a plan to foster and sustain statewide policy development and leadership in suicide prevention.

- The Alliance consults with the Youth Suicide Intervention and Prevention Coordinator on updates to the YSIPP under ORS418 733.
- Develop a policy agenda for suicide prevention that identifies state policy priorities and communicate the agenda to state and local policymakers.

Alliance Structure and Membership

Members will be appointed by the Director of OHA. Members serve at the discretion of OHA's director and can only be removed by resignation or by the director. Membership will at a minimum align with the SB707 requirements and include a minimum of four youth and young adults age 24 or younger.

Any current member of the Alliance may recommend an individual for membership to the executive committee. The executive committee will submit recommendations to the director of OHA. Candidates must be confirmed and appointed by OHA's director.

Membership is for a period of three years and is renewable every three years. At the end of each term members may be reappointed. The Executive Committee will vet and recommend members to the director of OHA. Members intending to resign shall submit a letter of resignation to the Chair, with a copy to the Alliance Staff and to the OHA Youth Suicide Prevention Coordinator.

The Alliance places a high value on ensuring that its statewide work connects with efforts in local communities and recognizes the important role of Regional and County Suicide Prevention Coalitions play in that work. When considering membership recruitment, the Executive is encouraged to work towards regional representation of the coalitions.

Alliance staff will track membership attendance and terms and notify OHA and the executive committee of terms coming to an end.
Affiliates are individuals interested in participating in Alliance committees, quarterly meetings or other Alliance activities and who have not been appointed as a member by the director of OHA. Affiliates may provide feedback and help in development of policy but are not voting members.

A current member of the Alliance may nominate an individual for membership to the executive committee for consideration. The recommendation may be submitted either in writing or verbally to the executive committee for consideration. The executive committee will vet and recommend a nomination to the Oregon Health Authority (OHA) Youth Suicide Coordinator who will forward to the director of OHA. Per the Alliance Bylaws, members will be appointed by the Director of OHA, serve at the discretion of OHA's director and can only be removed by resignation or by the director. See Attachment 1, Alliance Bylaws

As indicated by SB 707, the members of the advisory committee should reflect the cultural, linguistic, geographic and economic diversity of Oregon and must include but need not be limited to:

- Individuals who have survived suicide attempts;
- Individuals who have lost friends or family members to suicide;

- Individuals who have not attained 21 years of age;
- 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;
- Representatives of Oregon Indian tribes;
- Representatives of colleges and universities;
- Medical and behavioral treatment providers;
- Representatives of hospitals and health systems;
- Representatives of coordinated care organizations and private insurers;
- Suicide prevention specialists; and
- Representatives of members of the military and their families.

Alliance members must:

- Be familiar with the Oregon Youth Suicide Intervention and Prevention Plan and the responsibilities it designates for the Alliance.
- Learn about and share best practices in suicide, suicide prevention, intervention, treatment, and postvention.
- Communicate the needs and concerns of their constituencies to the Alliance.
- Communicate issues under consideration by the Alliance to their constituencies to obtain feedback.
- Be open to including youth voice and supporting meaningful youth involvement.
- Maintain a statewide perspective for what will work in Oregon.
- Serve on committees or work groups as appropriate.
- Support Alliance public policy agenda and other initiatives, and advocate for them as appropriate.
- Attend quarterly meetings, preferably in person.
- Participate in decision-making with timely responses and by voting in person, by email or by phone.
- Maintain a perspective on what is in the best interest of the Alliance and make this perspective a priority in matters relevant to the Alliance.

Stipends:

The Alliance values participation of youth and young adults, family members and persons with lived experience. Stipends and reimbursement may be provided to individuals not otherwise receiving compensation for time and expenses. Reimbursement under this subsection are subject to the provisions of ORS 292.210 to 292.288

Alliance Chair and Committees

To be eligible for nomination as the Alliance Chair or Vice-Chair a member shall have served on a committee prior to their nomination.

The Alliance Chair will lead meetings, and in their absence, the Vice-Chair may take the lead. The Chair and Vice-Chair terms will be for a period of two years. The Vice-Chair position is intended to support the chair and prepare the individual for serving as Alliance Chair in the future. The Alliance Chair and Vice-Chair will be elected by Alliance members at the quarterly meeting held in June. Chair and Vice-Chair may serve two consecutive terms. At the end of two terms, the Chair must be transitions and can be nominated for appointment after a period of two years.

The work of the Alliance is moved forward through committees. Committees are determined at the June quarterly meeting by the full Alliance. Chairs of these standing committees will serve on the Executive Committee. Ad hoc work groups will be commissioned by the Executive Committee for a specific scope and purpose.

Committees will establish annual goals and action steps each year in the spring. Each committee will meet at least quarterly to assess progress towards the annual goals. Each committee will have a committee chair tasked with facilitating the committee meetings and ensuring goals are met and deliverables are completed.

Executive Committee

The Executive Committee will meet prior to each quarterly meeting of the full Alliance. Additional meetings will be held as needed.

The Executive Committee shall:

- meet to develop and review full Alliance quarterly meeting agendas,
- review and approve recommendations or proposals from each of the committees,
- recommend to the Alliance new or updated policies and procedures,
- review and make recommendations on other items to come before the Alliance,
- make decisions between meetings on behalf of the Alliance membership,
- make recommendations to OHA on new Alliance members, and
- prioritize special projects, especially those focusing on diversity, equity and inclusion and groups that are at disproportionate risk of suicide.

Executive Committee Membership:

- Alliance Chair
- Alliance Vice-chair
- Standing committee chairs
- OHA/Health Systems Division Representative (non-voting)

- OHA Public Health Representative (non-voting)
- Two persons identifying as having direct lived experience of intrusive suicidal thoughts, urges and/or behaviors (including suicidal attempts).
- A person with lived experience identifying as a bereavement loss survivor (i.e. family member of a person who attempted or dies by suicide)
- Two young adult representatives, who may be supported at executive committee meetings by a non-voting adult ally.
- Up to two at-large members
- A healthcare provider
- A person representing schools (K-12) or colleges and universities

Committee Chair Determination

Committee members will recommend a chair or co-chairs. If the committee uses a co-chair structure, only one of the co-chairs shall serve on the Executive Committee. Committee chairs will report to the Executive Committee regarding committee activities and recommendations, and work with the Executive Committee to review, revise and adopt these recommendations. Committees will submit quarterly progress reports to the full Alliance.

Decision Making

Elections

- Committee chairs shall be elected for a period of one year at the committee meeting immediately preceding the June Alliance meeting. Committee chairs, excluding the Executive Committee chair, shall be elected by majority vote of the committee.

- The Alliance Chair and Vice-Chair shall be nominated and voted upon at the June meeting of the Alliance. Nominations may come from any member and may be for any member, including self-nomination. Members of the Alliance must be present in person or by phone to vote and each member may cast one vote per position.

Committee & Advisory Group Meetings

- All Committee meetings will follow Oregon's Public Meeting Law, ORS 192.610 – 192.690.

- Advisory Group meetings do not follow Oregon's Public Meeting Law, ORS 192.610 – 192.690. These groups are population specific and serve as an advisory group to the full Alliance and to Committee work as needed.

- Meetings of the full Alliance will be held quarterly. Special meetings via conference calls will be scheduled as needed. A designee may be delegated by an Alliance member to represent the

member by attending and voting at a quarterly meeting. Members will notify the Staff of the Alliance and the chairperson in advance if they are sending a designee or will miss a meeting.

Voting

- Each appointed member, with the exception of members who are OHA staff, is entitled to one vote on any matter referred to the full membership. Votes will require a quorum.

- A quorum will be 50% plus one of those present who are Alliance appointed members. Decisions will be made by majority vote of the quorum.

- If a motion is made at an Alliance meeting, all members present, as well as those who are in attendance via phone, will participate in the vote. Committee chairs or any member may submit motions for vote to the Executive Committee and at quarterly meetings.

Time Sensitive Matters

- Time sensitive matters are those in which a decision is needed before the next scheduled quarterly meeting. When time allows, feedback will be gathered via email from Alliance members and the Executive Committee will discuss. No less than three business days will be allowed between when an issue is raised and voting. Voting will occur in a teleconference call. Voting records shall be contained in Executive Committee minutes and will be shared with Alliance members via email and at quarterly meetings. Any member of the Alliance may propose a time-sensitive matter for a vote by submitting a request to the Alliance staff who will be responsible for bringing the matter to the Executive Committee.

- The Executive Committee is authorized to vote on policy recommendations and take action between quarterly meetings on behalf of the full Alliance as needed. The Executive Committee will only vote to support proposals that align with the Alliance-approved legislative agenda, are specifically mentioned in the YSIPP, or otherwise have been approved by the Alliance membership. If an issue arises other than those in the approved legislative agenda, specifically mentioned in the YSIPP, or have been approved by the Alliance membership, it will be brought to the Executive Committee and the full Alliance will be informed by email and any decisions will be documented in the minutes.

Suicide Death and Suicide-Related Data

Presented to
Oregon Alliance to Prevent Suicide
March 11, 2022

Meghan Crane, Zero Suicide in Health Systems Coordinator

Oregon Health Authority

Note on Data Systems

- Data systems, like our institutions, have been developed within systems of oppression and racism.

- House Bill 3159, known as the Data Justice Act, passed in 2021.

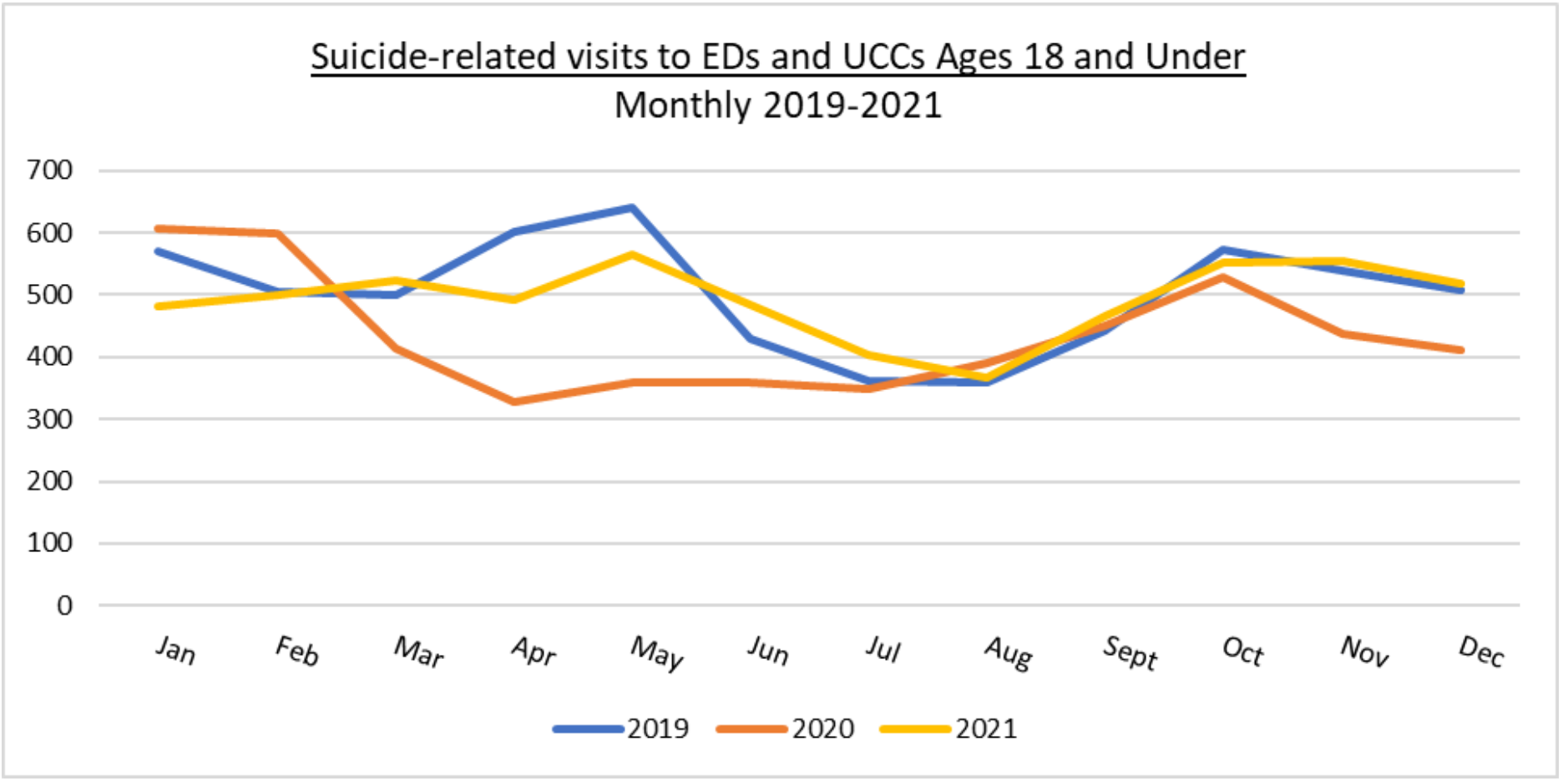
  - Requires healthcare providers to collect and report to the Oregon Health Authority (OHA) data on their patients' sexual orientation and gender identity, race, ethnicity, preferred language, and disabilities.

  - Directs OHA to develop a database for storing and analyzing patient demographic data

- A note on use of the term "small numbers"

Oregon Health Authority

Suicide-related visits to Emergency Depts. and Urgent Care Centers

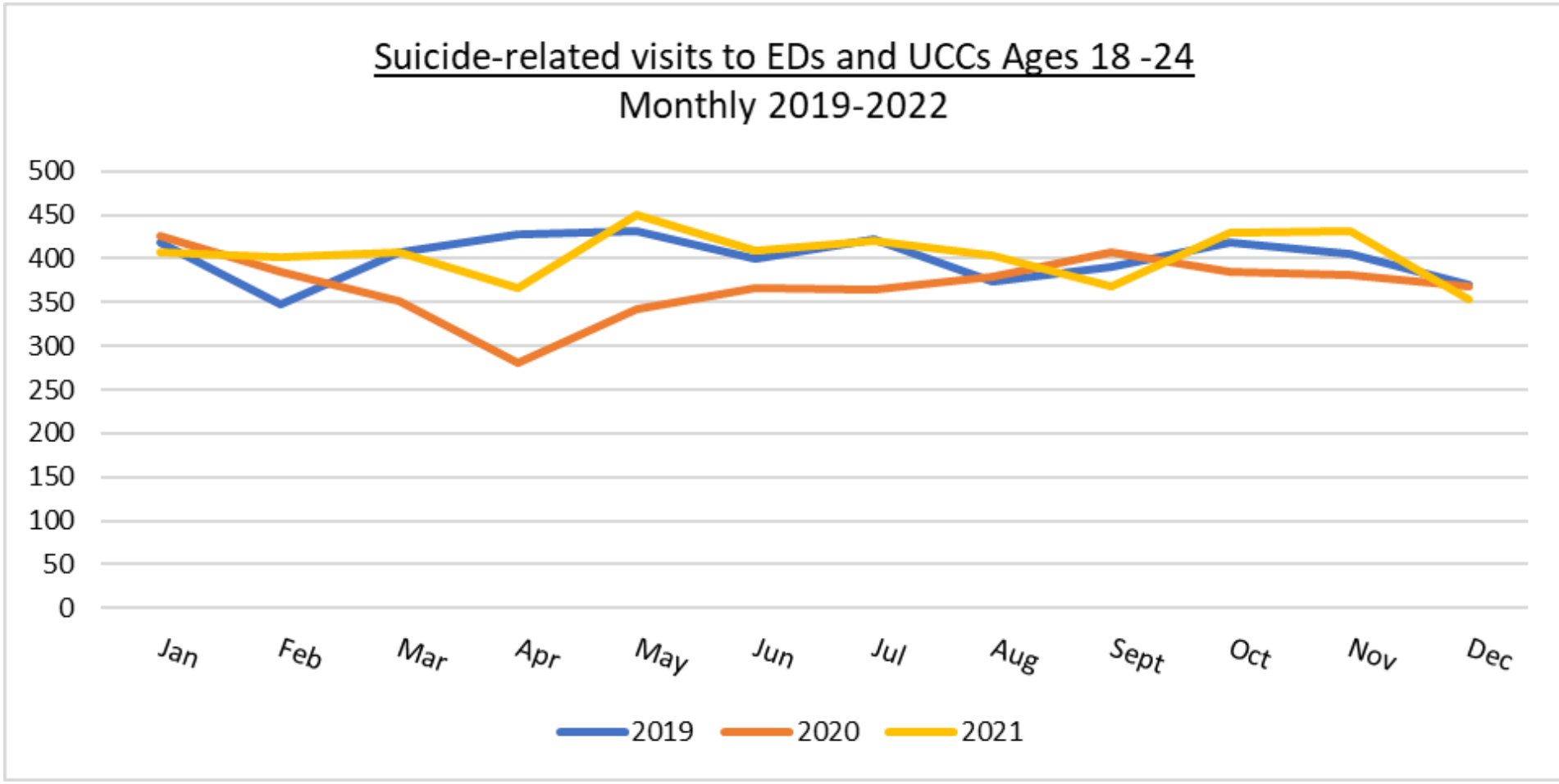


Total visits: 2021 = 5,904; 2020 = 5,227; and 2019 = 6,016

Source: Oregon Electronic Surveillance System for Early Notification of Community-Based Epidemics (ESSENCE). Available through the OHA Monthly Suicide-Related Data Report

Oregon Health Authority

Suicide-related visits to Emergency Depts. and Urgent Care Centers

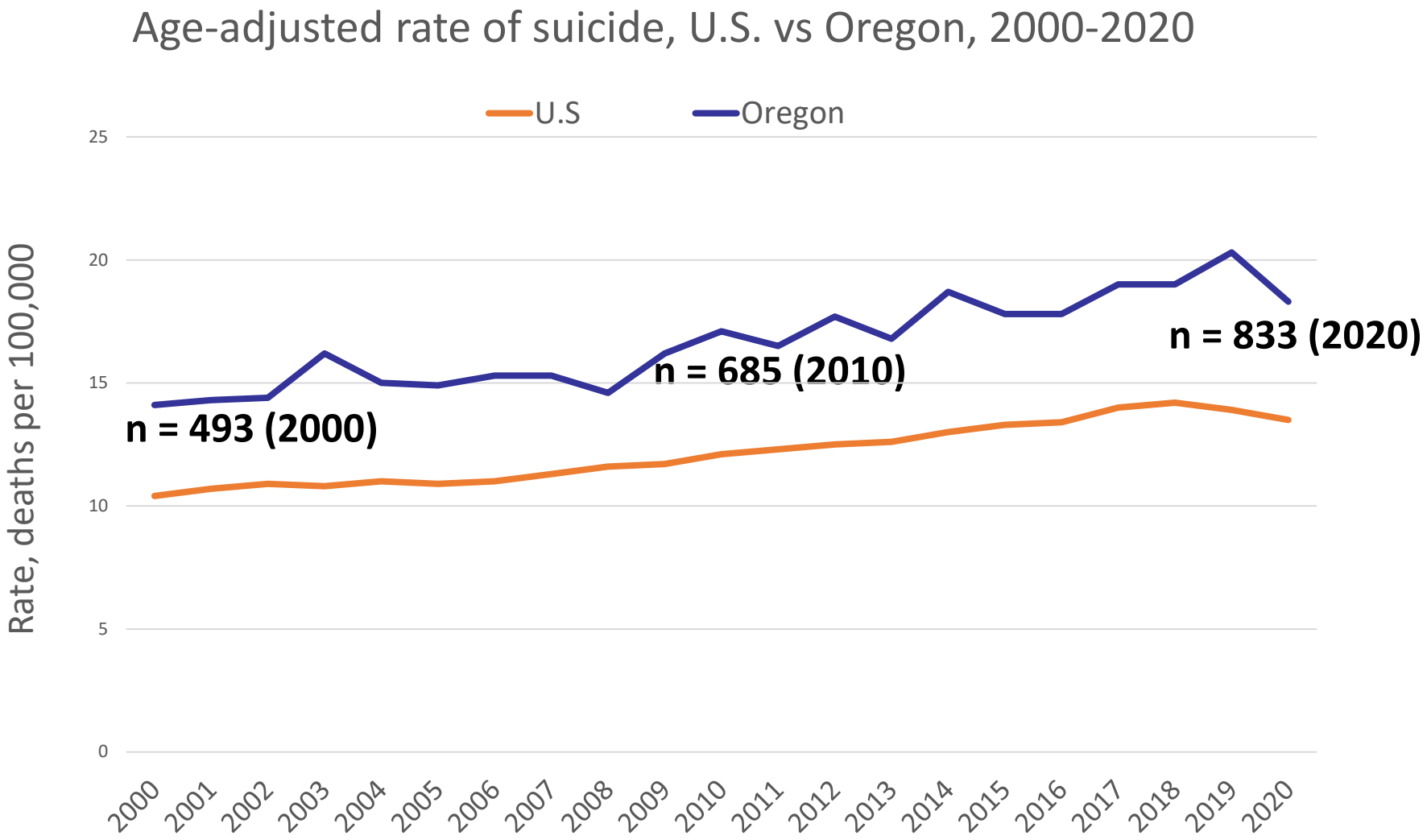


Total visits: 2021 = 4,851; 2020 = 4,436; and 2019 = 4,813

Source: Oregon ESSENCE. Available through the OHA Monthly Suicide-Related Data Report

Oregon Health Authority

Suicide in Oregon



Source: CDC WISQARS

Oregon Health Authority

Youth Suicide in Oregon

Oregon suicide deaths and rates among those aged 10 to 24 compared to national rate

Year	Number of youth suicides	Suicide death rate (per 100,000)	Rank among 50 states (50 is lowest rate)
2014	97	12.9	12
2015	90	12.0	16
2016	98	13.0	15
2017	107	14.1	17
2018	129	17.0	11
2019	116*	15.3	11
2020	101**	13.3	18

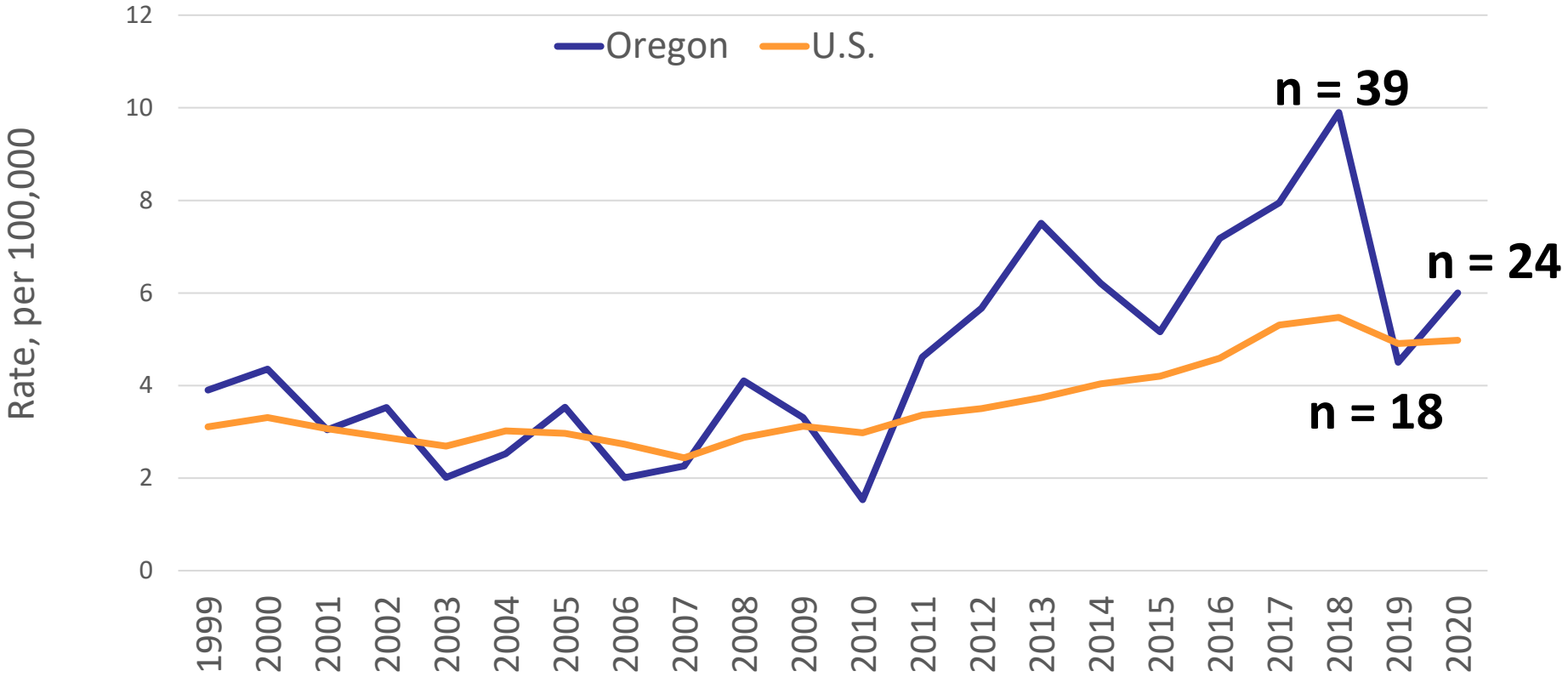
*In addition to these deaths among Oregonians aged 10-24, there were two suicide deaths among children younger than 10 in 2019.

** In addition to these deaths among Oregonians aged 10-24, there was one suicide among Oregon children younger than 10 in 2020.

Oregon Health Authority

Youth Suicide in Oregon

Suicide rates among ages 10 to 17 years by year, U.S. vs. Oregon, 1999-2020

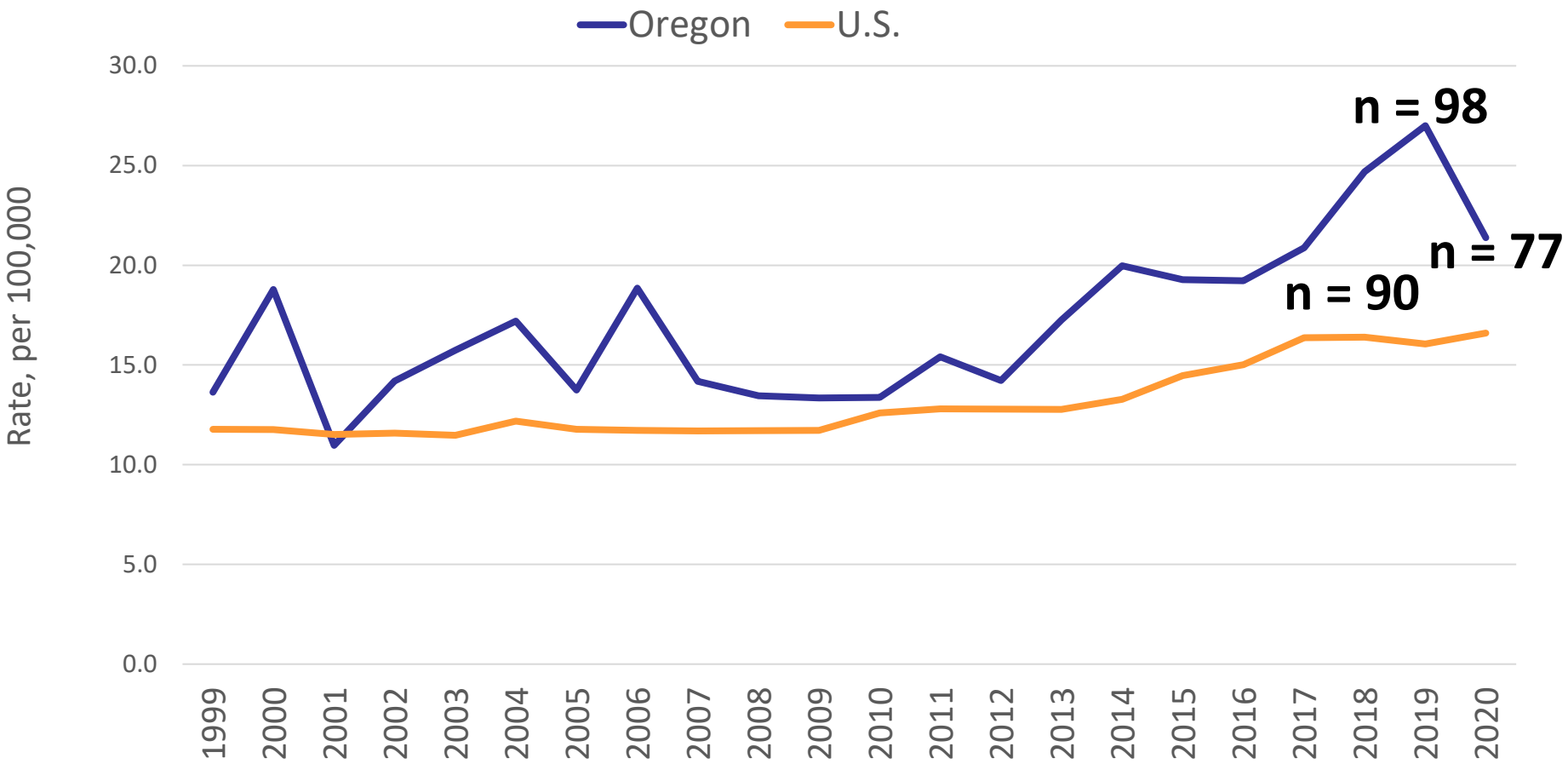


Source: CDC WISQARS

Oregon Health Authority

Youth Suicide in Oregon

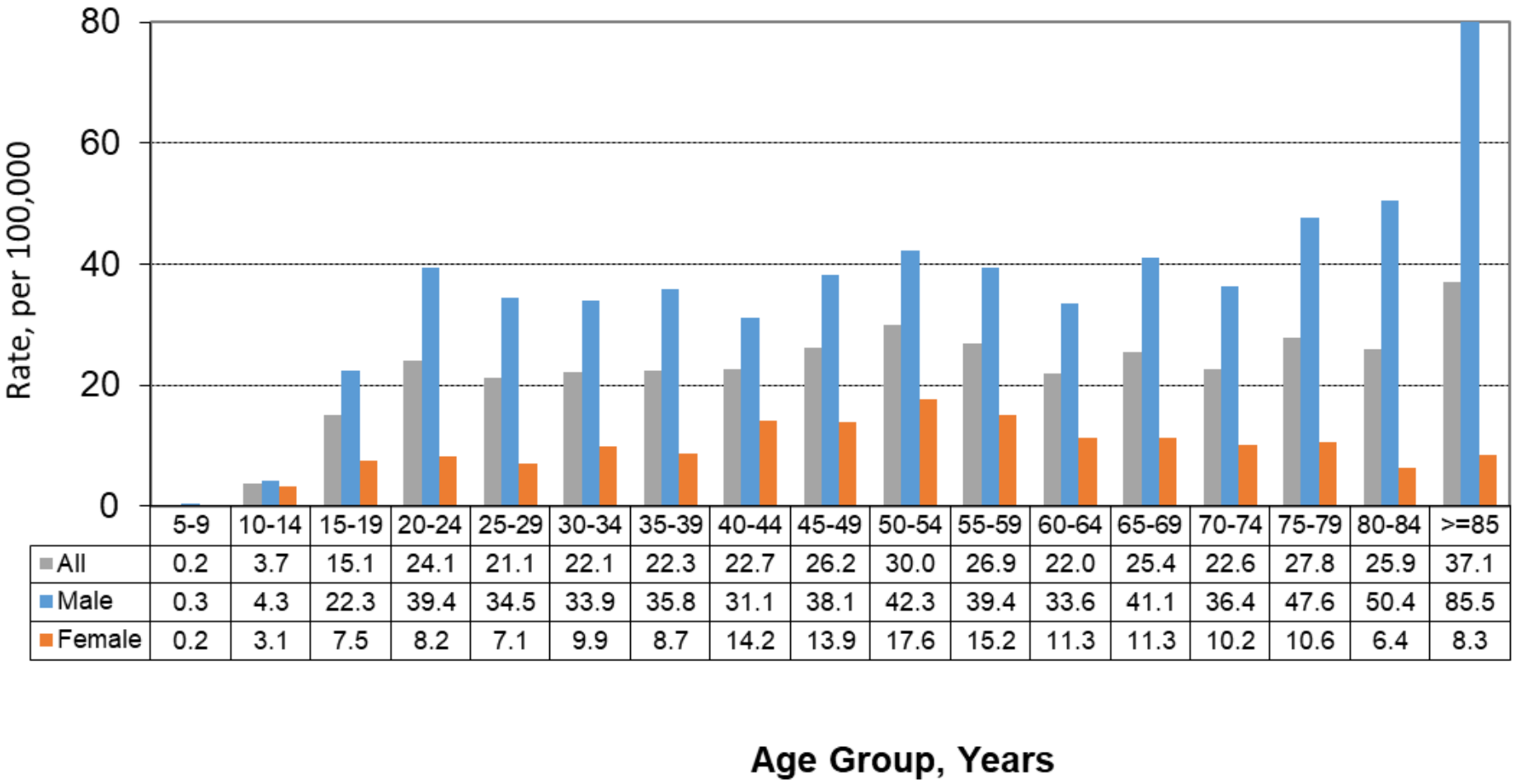
Suicide rates among ages 18 to 24 years by year, U.S. vs. Oregon, 1999-2020



Source: CDC WISQARS

Oregon Health Authority

Age-specific rate of suicide by sex, Oregon 2016-2020



	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	>=85
All	0.2	3.7	15.1	24.1	21.1	22.1	22.3	22.7	26.2	30.0	26.9	22.0	25.4	22.6	27.8	25.9	37.1
Male	0.3	4.3	22.3	39.4	34.5	33.9	35.8	31.1	38.1	42.3	39.4	33.6	41.1	36.4	47.6	50.4	85.5
Female	0.2	3.1	7.5	8.2	7.1	9.9	8.7	14.2	13.9	17.6	15.2	11.3	11.3	10.2	10.6	6.4	8.3

Age Group, Years

Source: CDC WISQARS

Oregon Health Authority

Characteristics of youth suicide aged 24 and younger, Oregon 2020

		Deaths*	% of total
Age	5-14	8	8%
	15-19	36	36%
	20-24	56	56%
Sex	Male	81	81%
	Female	19	19%
Race/Ethnicity**	White	89	89%
	African American	4	4%
	American Indian/Native Alaskan	5	5%
	Asian/Pacific Islander	4	4%
	Multiple race	6	6%
	Other/Unknown	4	4%
	Hispanic	13	13%

*Two 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 CDC WISQARS, there were 102 suicide deaths among Oregon residents 5-24 years old in 2020; one was younger than age 10.

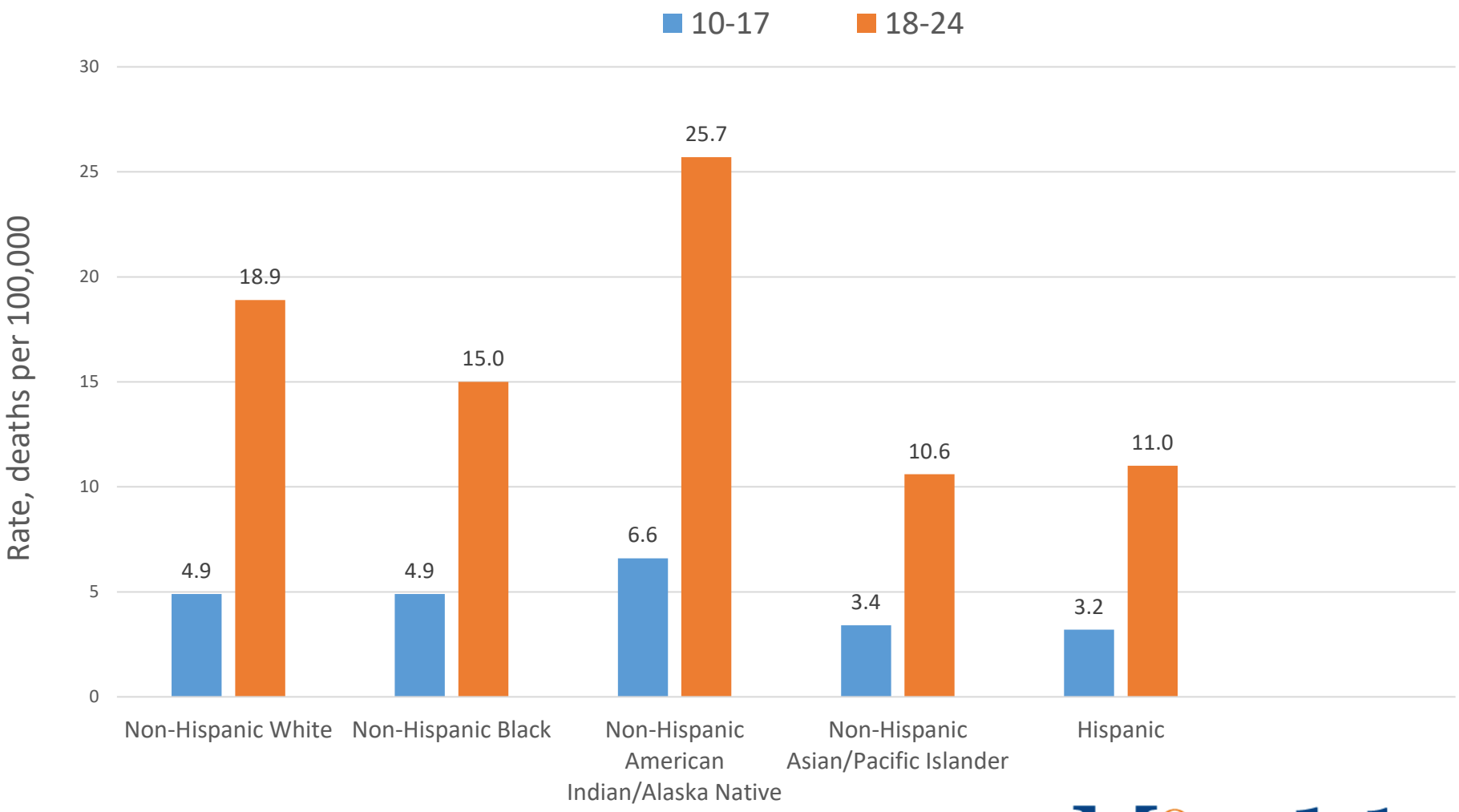
Visualizations of Race and Ethnicity Data

- The following graph on race and ethnicity highlights the unequal impact of suicide by race and ethnicity. Health inequities exist due to historic and systemic policies, rooted in white supremacy, that continue to have harmful effects today.

- The graphs presented use race and ethnicity as imperfect measures to guide our understanding of how the impact of oppression and discrimination based on race and ethnicity is related in higher rates of suicide by different groups.

Oregon Health Authority

Suicide Rates Among Youth ages 10 to 17 and ages 18 to 24 by Race/Ethnicity, Oregon, 1999-2020



Source: CDC WISQARS

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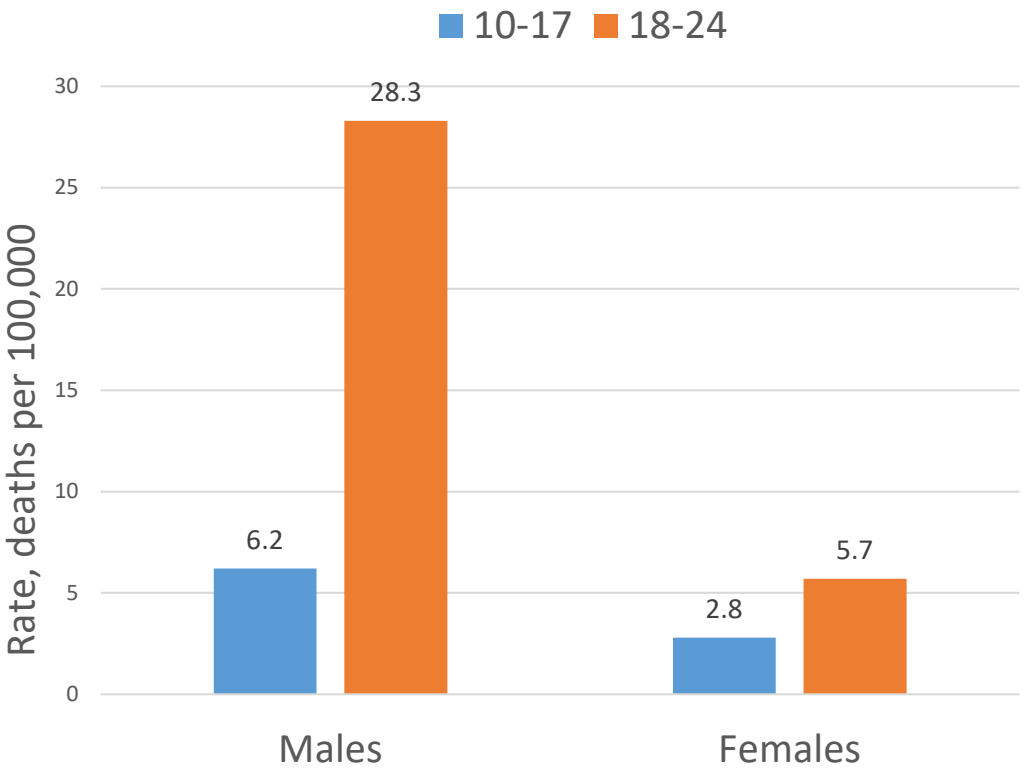
Suicide Rates Among Youth ages 10 to 17 and ages 18 to 24 by Sex, Oregon, 1999-2020

- What is called “sex” in Oregon Violent Death Reporting System refers to the person’s gender identify at the time of their death.
- There is a separate variable for noting if a decedent was transgender, and a person can be identified as “male” or female” and also “transgender”.
- This dataset does not allow for the identification of non-binary, gender nonconforming or other identities.
- OHA is not able to evaluate transgender suicide rates through this data set. Other state and national evidence tells us that transgender, non-binary and gender non-conforming people are more likely than cisgender people to attempt and to die by suicide.



Source: CDC WISQARS

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Note on Sexual Orientation Data

- Sexual orientation data is collected within the Oregon Violent Death Reporting System (ORVDRS). Response options include straight/heterosexual, gay, lesbian, bisexual, unspecified sexual minority, and unknow.

- This dataset does not allow for the identification of other sexual orientation identities.

- OHA is not able to evaluate suicide rates for this population through this data set. Other state and national evidence tells us that people identifying as not straight (including lesbian, gay, bisexual, asexual, queer, fluid, pansexual, questioning) are more likely to attempt and die by suicide than straight people.

- This is not due to how they identify, rather due to issues including homophobia/biphobia/discrimination, acceptance from their family, trauma of experiencing rejection and not having access to healthcare that supports their ability to live their authentic lives.

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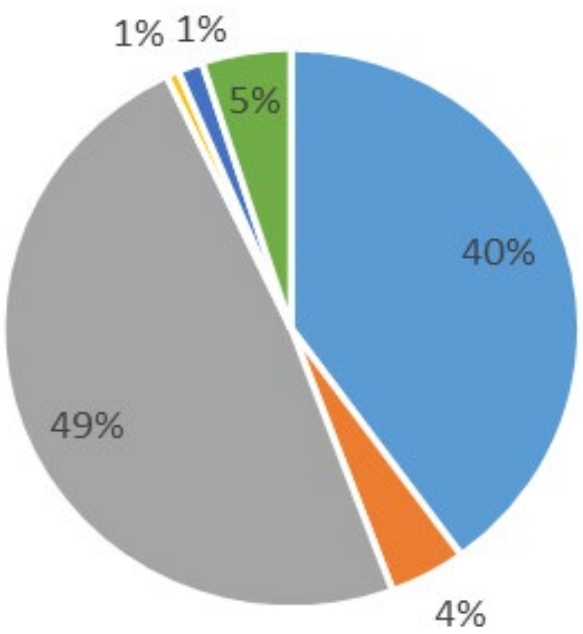
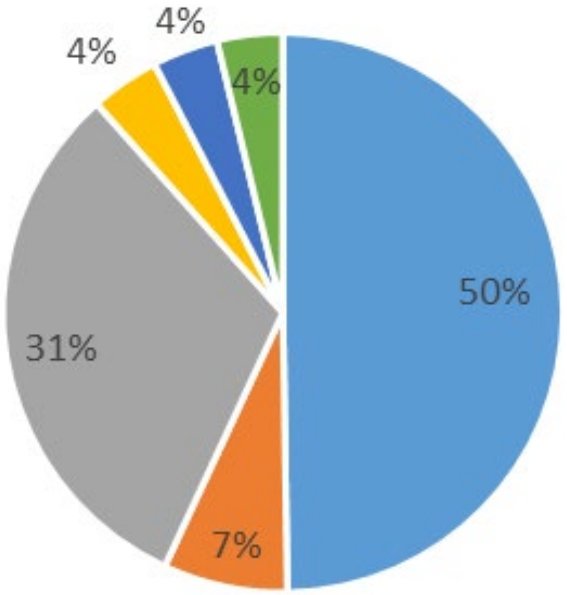
Mechanism of suicide by percentage of age group, 2015-2019

10-17 years of age



18-24 years of age



Firearm | Poisoning | Hanging/Suffocation | Other | Fall | Motor Vehicle/Train

Source: CDC WISQARS, ORVDRS

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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.

Oregon Health Authority

Suicide Death and Suicide-Related Data Sources

Refer to the OHA Injury and Violence Prevention Program (IVPP) Data Glossary for information on data sources and difference: https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/INJURYFATALITYDATA/Documents/Data-Glossary.pdf

What's the difference between ESSENCE and administrative discharge data?

ESSENCE data describe ED and urgent care visits (with or without charges for service) but **do not** include information on hospital stays. Discharge data describe ED visits and hospital stays (only when there is a charge for services) but **do not** include information on urgent care center visits.

Both ESSENCE and discharge data have ED visit information, but the number of visits reported in ESSENCE will not match the number of visits reported in discharge data since each of these sources collect and report data differently. This means that the number of ED visits from discharge data cannot be compared to ESSENCE data.

Instead compare each source to itself over time, *"What was the number of ED visits for traumatic brain injuries from discharge data in 2017 compared to number from discharge data in 2018?"* Both sources can be used to describe general trends, *"Both ESSENCE and discharge data show an increase in the number of ED visits for traumatic brain injuries over the last six months."*

IVPP is doing a revamp of suicide-related death and injury dashboards this year. More to come!

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Suicide Death and Suicide-Related Data Sources

- Where you can currently access state and county suicide data referenced in this presentation:
  - OHA Violent Death Data Dashboard: Provides suicide and firearm death data from mid-2000s through 2018. Some data available by county.
  - OHA Vital Statistics Death Data: Not overseen by IVPP. Several dashboards of interest:
    - Preliminary Death Data: Year-to-date death data. On the Manner Tab, can see suicide deaths by county
    - Fatal injuries, statewide and by county: statewide suicides for 2017-2020 by binary sex, age group, method, and race/ethnicity. County data by manner and method.
    - Historical reports also available outside of dashboards
  - Centers for Diseases Control and Prevention:
    - WISQARS (Web-based injury statistics query and reporting system): National and state level data

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YouthLine
1-877-968-8491
(text teen2teen at 839863)

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

RED NACIONAL de PREVENCIÓN del SUICIDIO
1-888-628-9454
prevenciondelsuicidio.org

Veterans Crisis Line
1-800-273-8255 PRESS 1

CRISIS TEXT LINE

Text **OREGON** to 741741

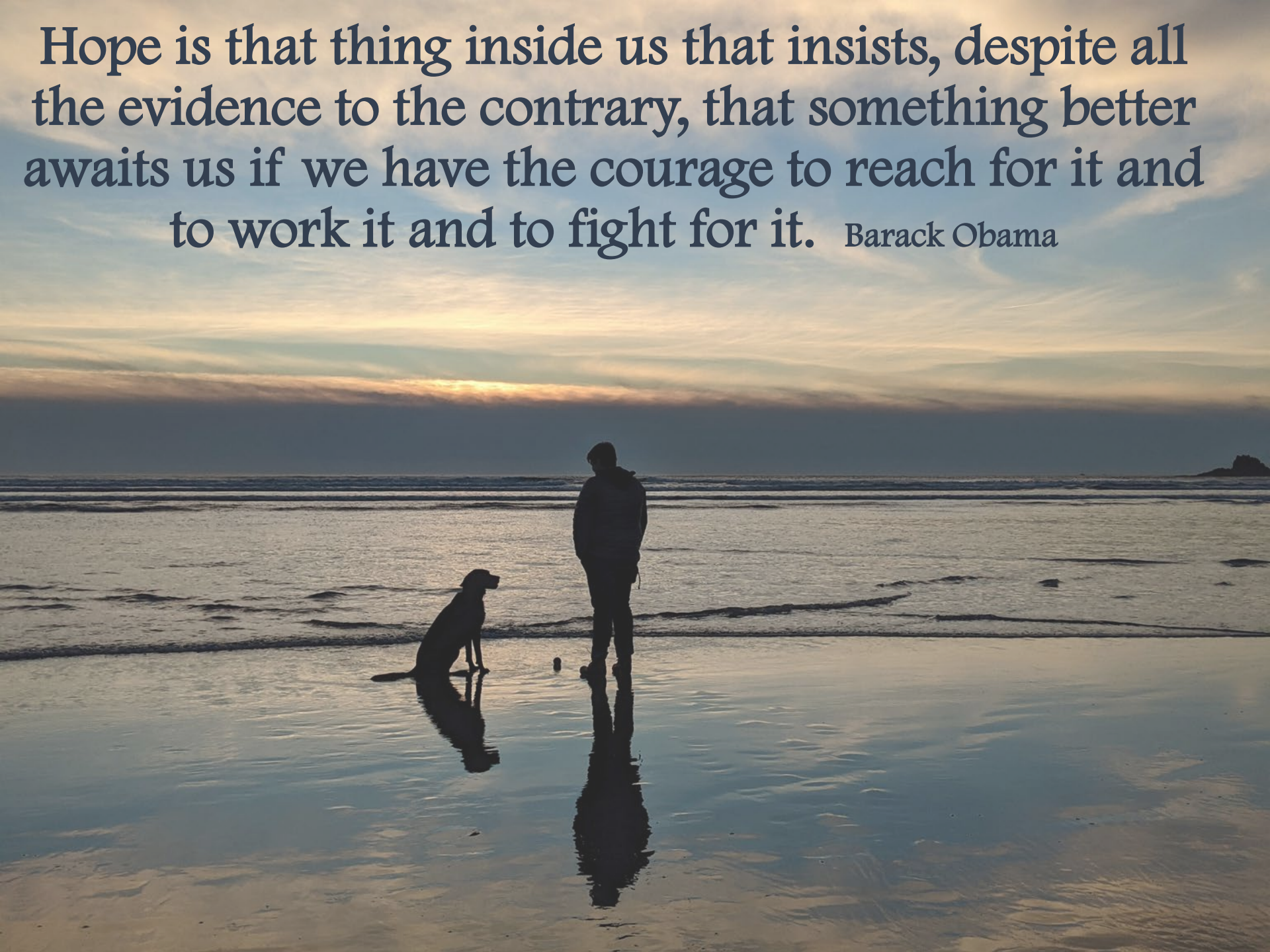
Resources

- **Sign up for the OHA Suicide Prevention Network: http://listsmart.osl.state.or.us/mailman/listinfo/yspnetwork**

- Oregon Violent Death Data Dashboards
- OHA Student Health Survey ***New SHS Dashboard***
- OHA Monthly Suicide-Related Data Report
- Oregon ESSENCE (syndromic surveillance)
- 2021-2025 Youth Suicide Intervention and Prevention Plan and Youth Suicide Intervention and Prevention Plan 2020 Annual Report (includes youth suicide data)
- Oregon Veterans Behavioral Health Services Improvement Study
- CDC: Adverse Childhood Experiences, Overdose and Suicide: intersection and prevention
- CDC: Connecting the dots: Exploring the overlaps between multiple form of violence and collaborative prevention.

Meghan Crane, MPH
Zero Suicide in Health Systems Coordinator
Public Health Division
Injury and Violence Prevention Program
p: 971-271-2025
e: meghan.crane@dhsoha.state.or.us

Oregon Health Authority


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

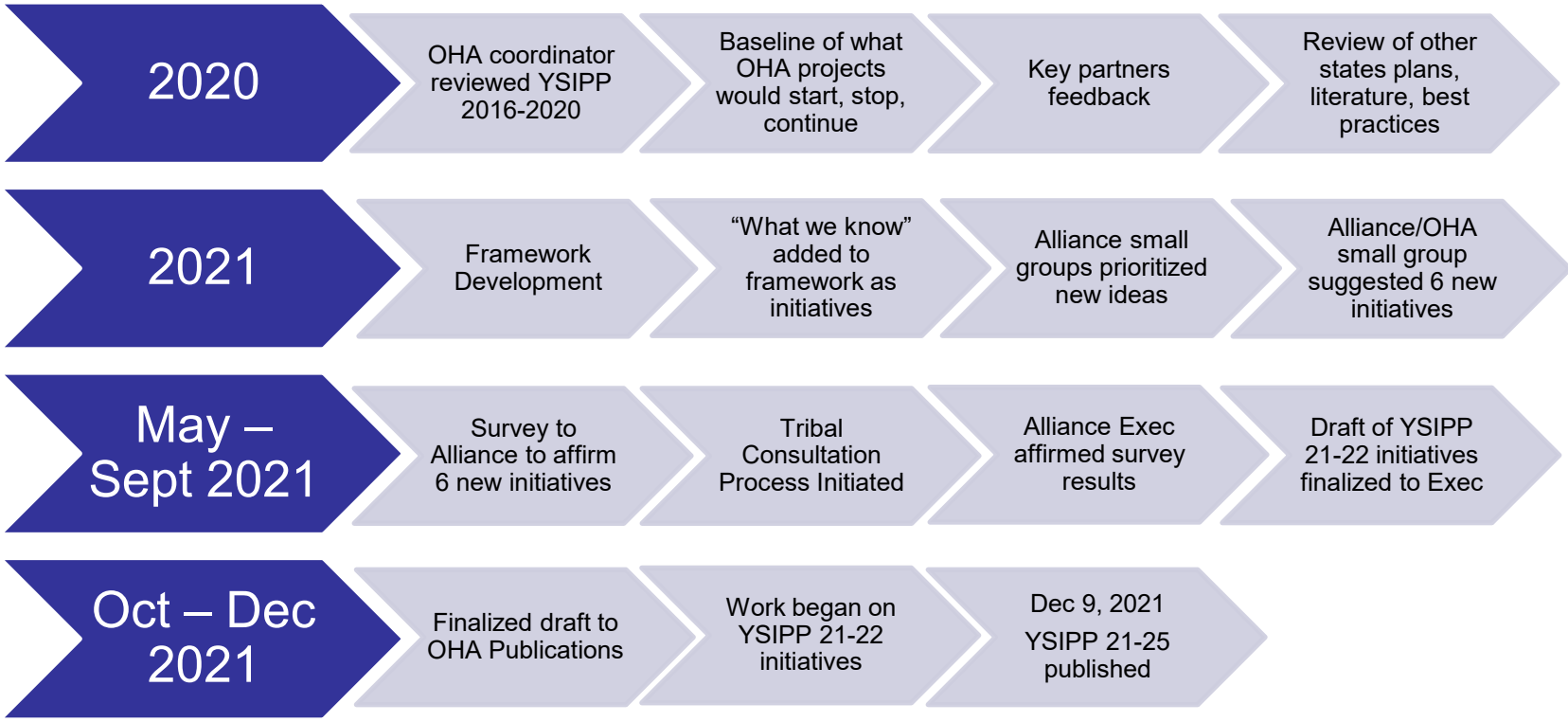
YSIPP Annual Report Summary

Presented to
Oregon Alliance to Prevent Suicide
March 11, 2022

Jill Baker, Youth Suicide Prevention Policy Coordinator

Oregon Health Authority

Where we have been:



YSIPP 21-25 is here.

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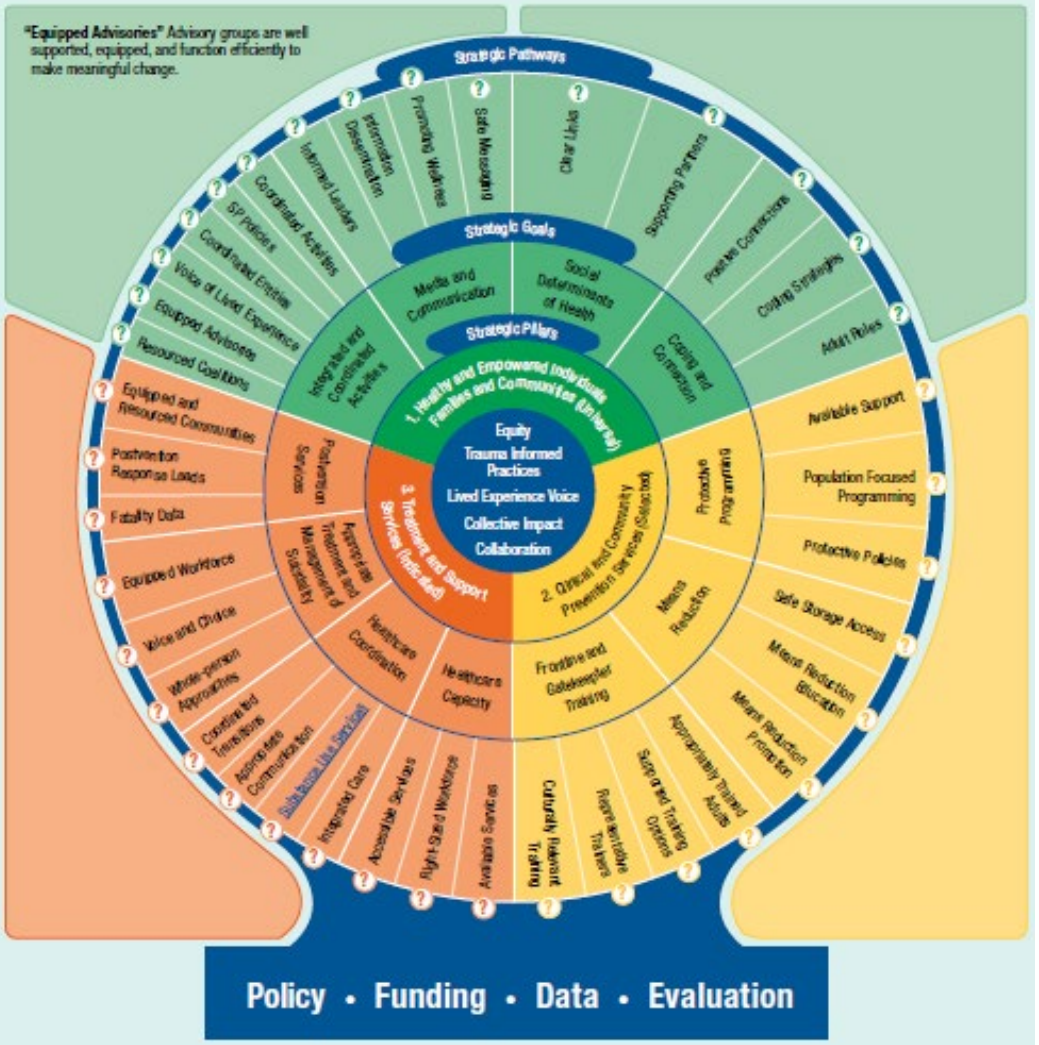
Youth Suicide Prevention Framework



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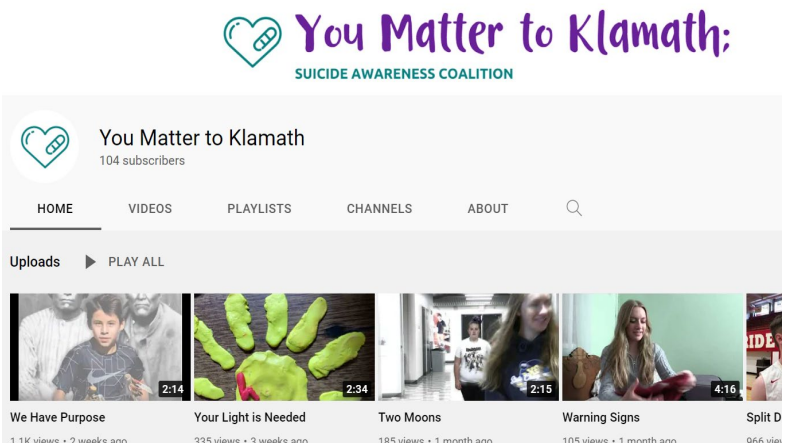
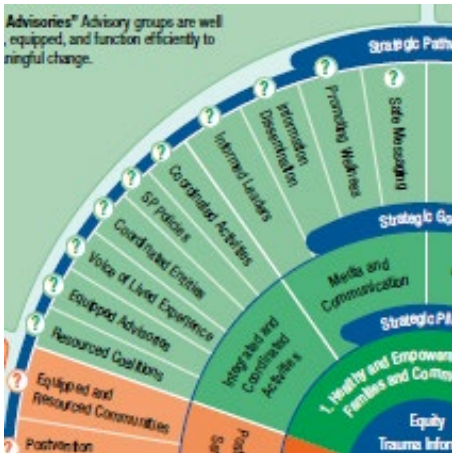
Finding your work in the framework:





Local Initiative: You Matter to Klamath: video contest
YSIPP Goal: Media and Communication
Pathway: All Oregonian receive safe messaging about suicide.

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Finding your work in the framework:

YSIPP 21-22 Initiative: Pilot project to provide no cost safe storage to local mental health authorities

Local Initiative: Clackamas Co strategic distribution to veterans

YSIPP Goal: Means Reduction

Pathway: All Oregonians experiencing a behavioral health crisis have access to safe storage for medicine and firearms.

Bonus: Alliance advocacy letter for Mobile Response Teams

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What you will find in the annual report:

1. Healthy & Empowered Individuals, Families and Communities

1.1 Integrated & Coordinated Activities

1.1.1 “Coordinated Activities” Youth suicide prevention programming is coordinated between Tribes, state, county, and local leaders to maximize reach & ensure equitable access for all Oregonians.

1.1.1.1 New Strategic Initiative for 21/22: Organize the people/staff/infrastructure of suicide prevention across the state.

Early Action

The OHA Suicide Prevention team has assigned lead responsibility for each initiative in the YSIPP 21–22. It has also assigned leads to each committee and advisory group of the Alliance to Prevent Suicide. The Alliance to Prevent Suicide staff has been tasked with updating the contact information for the 18 local suicide prevention coalitions across Oregon. Focus of work in 2022 will include updating suicide prevention staff information for counties, school districts, Tribal health departments, ZeroSuicide programs in health settings and for staff that support suicide prevention in relevant state agencies.

1.1.1.2 Big River statewide coordinators meet monthly to align work, give program updates, connect and learn.

Achieved

Big River Coordinators meet monthly, are connected, regularly have warm handoffs between programs, can speak with clarity about the Big River programs and about the system. They are learning from each other and tackling issues and barriers as a team.

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Key for Status Update Labels and Colors:

Label	Description
NA	Not named as a priority for 21-22
Planning	No significant work has begun, planning phase
Early Action	1-2 steps have been taken
In Progress	Significant progress has been made
Achieved	Fully achieved and sustainable

On track with deadlines

Meeting most, but not all deadlines

Some or all tasks are overdue

Oregon Health Authority

Where can I find who is leading a specific initiative?

Active YSIPP 21-22 initiative tracker here.

YSIPP Initiatives 21-22 - Bolded require workplans	Lead Entity	RASCI	Status Update
1.1.1.1 New Strategic Initiative for 21/22: Organize the people/staff/infrastructure of suicide prevention across the state.	Oregon Health Authori	A/R - Jill Baker	**Early Action**
1.1.1.2 Big River statewide coordinators meet monthly to align work, give program updates, connect and learn.	Oregon Health Authori	R - Shanda Hochstetler	**Achieved**
1.1.1.3 Big River statewide coordinators are equipped to bridge interested organizations and people to related suicide prevention work including other Big River programs and statewide suicide prevention efforts.	Oregon Health Authori	R - Shanda Hochstetler	**In Action**
1.1.1.4 The OHA Suicide Prevention, Intervention and Prevention team (SPIP) is established and each subgroup meets monthly. The four subgroups are: OHA Suicide Prevention Coordinators, OHA Partners - Youth Focused, State Agency Partners - Youth Focused, and OHA Partners - Adult Focused.	Oregon Health Authori	R - Jill Baker	**In Action**
1.1.1.5 Fall coordination meetings between contracted coordinators and specialists supporting Adi's Act implementation. Oregon Department of	Oregon Health Authori	R - Shanda Hochstetler	**Planning**

Oregon Health Authority

2021

Big River Programs

A brief look at the numbers for Suicide Prevention programming in Oregon.

Local Communities Equipped

33 of Oregon's 36 counties have active trainers in one or more of the Big River programs.

1,257

Trainers in Oregon

There are currently 1,257 trainers across the eight Big River programs that have Train-the-Trainer structures. The Big River programs collectively added 391 new trainers in 2021 to this total.

Mental Health Providers

The Big River added "Advanced Skills" training options for mental health providers to get trained in how to treat suicide ideation within their practice. In 2021 alone, 544 providers in Oregon received training across the five training course options supported by OHA.

544

SOME HIGHLIGHTS

Oregon Health Authority

Community Centered & Culturally Responsive Adaptions

7 of the 8 Big River programs have community centered or culturally responsive elements embedded. 2 of the 8 are available in Spanish and 2 more will launch Spanish options in 2022. Work continues to improve this area.

7 of 8

Oregon Tribes

Each of Oregon's nine federally recognized tribes and NARA Northwest receive funding and support for suicide prevention directed by the tribes.

MORE HIGHLIGHTS AND EXAMPLES OF WORK TO GROW

Oregon Health Authority

IN SUMMARY: 2021

- Finalized and published YSIPP 21-25
- Theme of Growing Roots
- Deepened connection to the Oregon Suicide Prevention Framework
- Focused on organization, defining roles and responsibilities
- Laid foundation for ASIPP
- YSIPP 23 initiatives will be collaboratively chosen in Fall 2022

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Crisis System Overview

Oregon Health Authority

Current State: Lifeline, the Nation's Public Mental Health Safety Net

The Lifeline Mission

To effectively reach and serve all persons who could be at risk of suicide in the United States through a national network of crisis call centers.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov

V!brant
Emotional Health

NASMHPD

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

With help comes hope
NATIONAL
SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org
Help is available for you or someone you care about, 24-7

Veterans Crisis Line
1-800-273-8255
PRESS 1

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The future:
A new, national 3-digit number (988)

"The availability of a three-digit number for mental health and suicide prevention could be a transformative step forward in improving national crisis intervention and suicide prevention efforts; if the launch of the new number is accompanied by efforts to develop a more coordinated crisis system with greater capacity and access to sophisticated data and technology." – SAMHSA

- ✓Easier to remember than a 10-digit number
- ✓Sends the message that mental health crises and suicide prevention are of equivalent importance to medical emergencies
- ✓Reduces stigma surrounding suicide and mental health issues

The National Suicide Hotline Designation Act of 2020

- **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, mental health 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

Adopting the "Crisis Now" Model for 988 Implementation

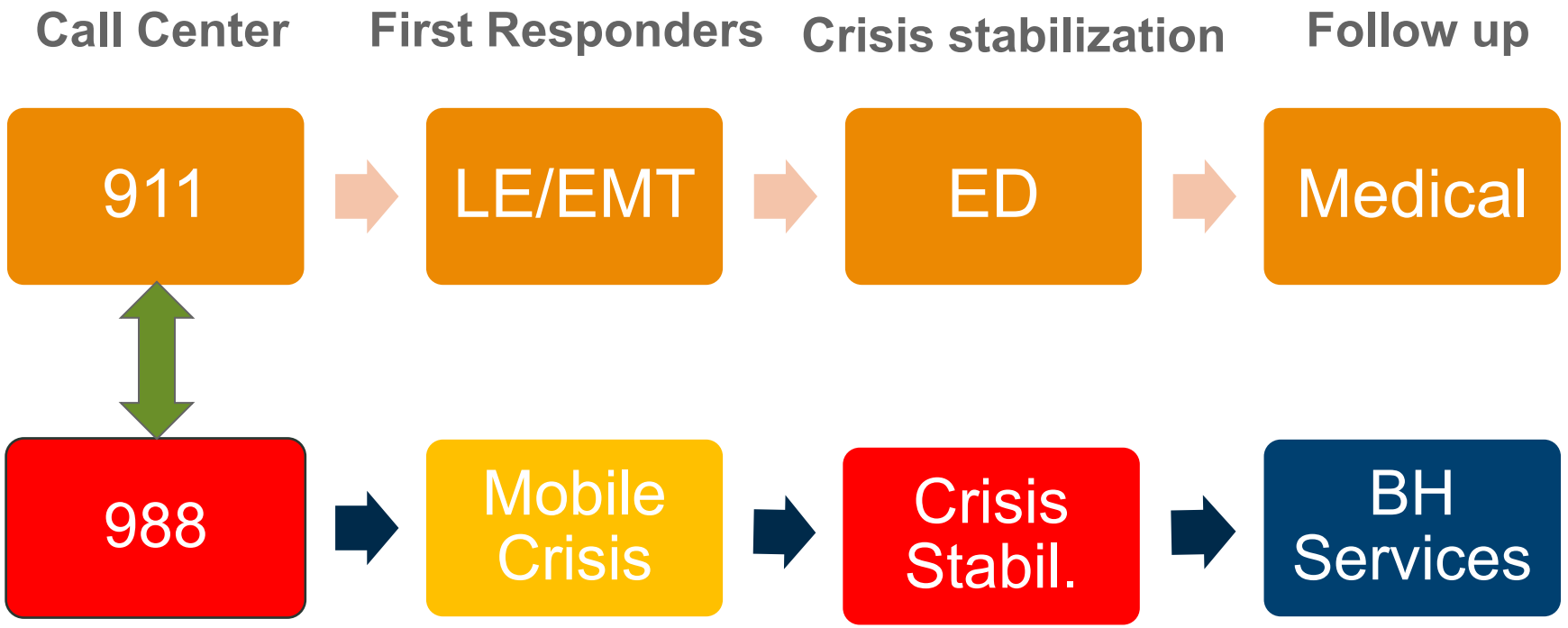
The Crisis Now Model has three components:

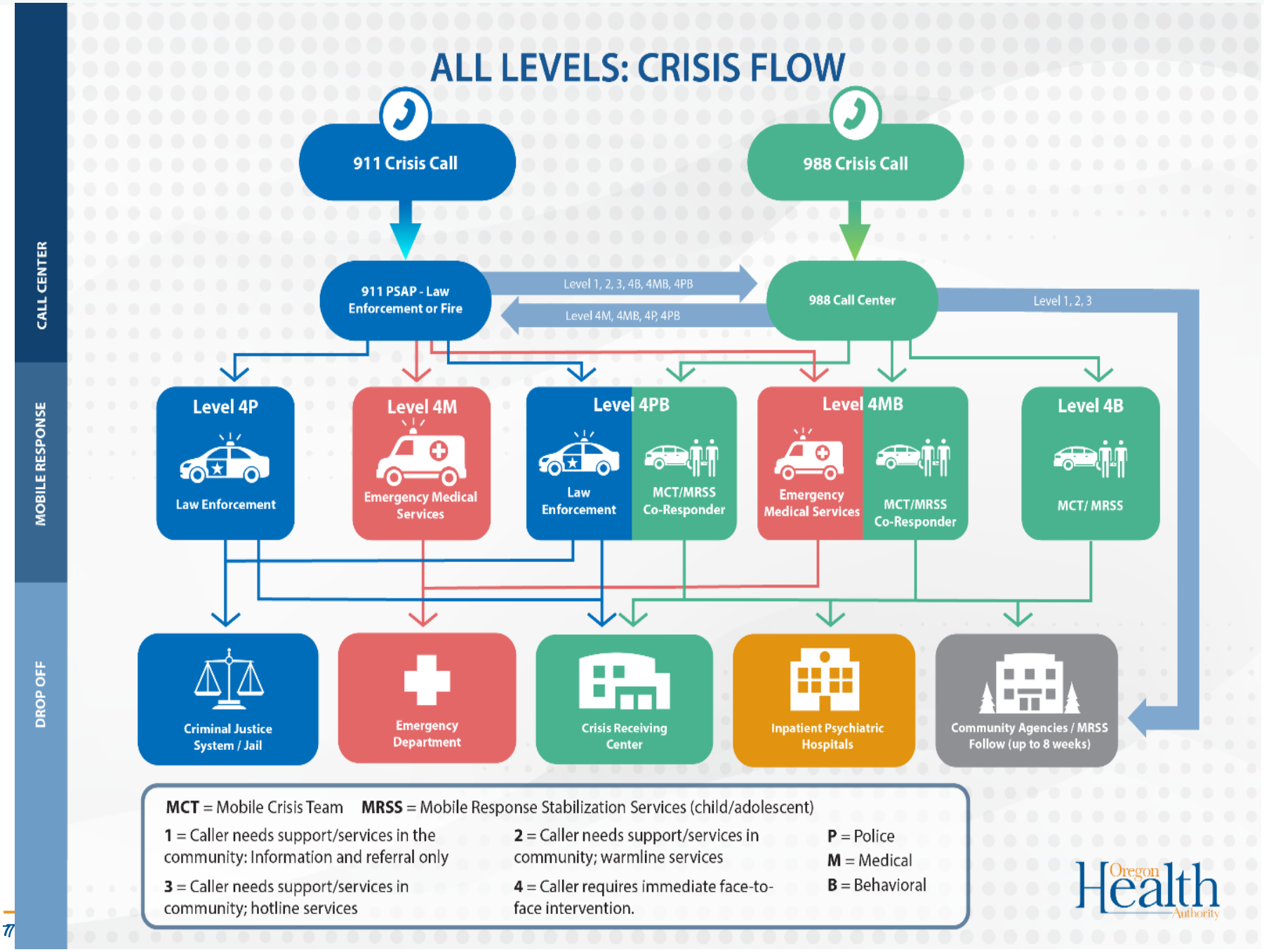
Centralized call center (Air Traffic Control capabilities with Crisis Line Expertise)

Mobile crisis

Crisis stabilization

An effective 988 system will require key investments




CALL CENTER
MOBILE RESPONSE
DROP OFF
ALL LEVELS: CRISIS FLOW
911 Crisis Call
988 Crisis Call
911 PSAP - Law Enforcement or Fire
Level 1, 2, 3, 4B, 4MB, 4PB
Level 4M, 4MB, 4P, 4PB
988 Call Center
Level 1, 2, 3
Level 4P
Law Enforcement
Level 4M
Emergency Medical Services
Level 4PB
Law Enforcement
MCT/MRSS Co-Responder
Level 4MB
Emergency Medical Services
MCT/MRSS Co-Responder
Level 4B
MCT/ MRSS
Criminal Justice System / Jail
Emergency Department
Crisis Receiving Center
Inpatient Psychiatric Hospitals
Community Agencies / MRSS Follow (up to 8 weeks)
MCT = Mobile Crisis Team
MRSS = Mobile Response Stabilization Services (child/adolescent)
1 = Caller needs support/services in the community: Information and referral only
2 = Caller needs support/services in community; warmline services
3 = Caller needs support/services in community; hotline services
4 = Caller requires immediate face-to-face intervention.
P = Police
M = Medical
B = Behavioral
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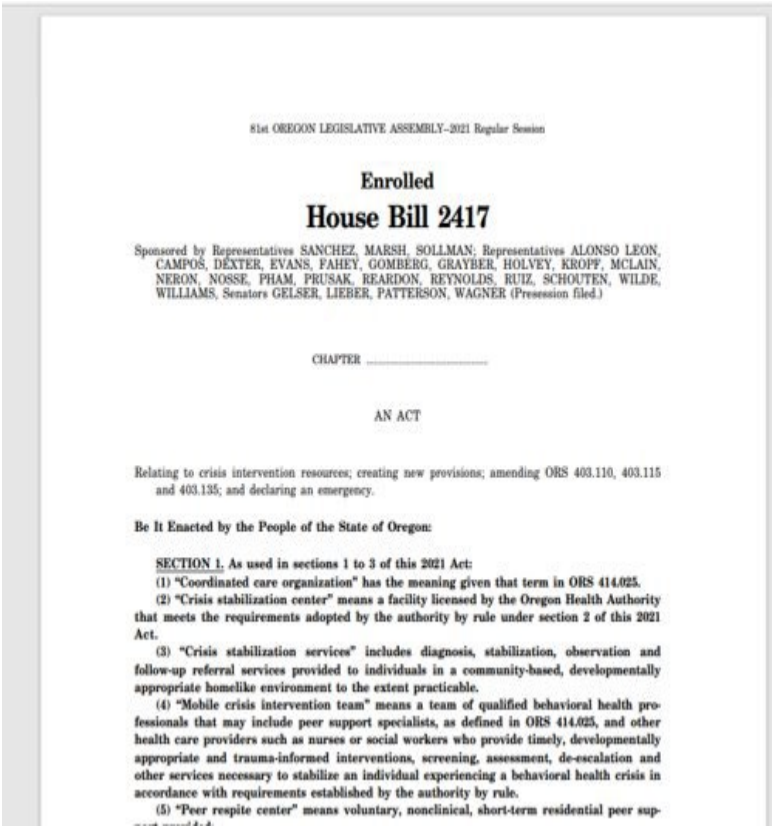
July 2021
HB 2417 passed



81st OREGON LEGISLATIVE ASSEMBLY–2021 Regular Session

Enrolled

House Bill 2417

Sponsored by Representatives SANCHEZ, MARSH, SOLLMAN; Representatives ALONSO LEON, CAMPOS, DEXTER, EVANS, FAHEY, GOMBERG, GRAYBER, HOLVEY, KROPF, MCLAIN, NERON, NOSSE, PHAM, PRUSAK, REARDON, REYNOLDS, RUIZ, SCHOUTEN, WILDE, WILLIAMS, Senators GELSER, LIEBER, PATTERSON, WAGNER (Presession filed.)

CHAPTER .....

AN ACT

Relating to crisis intervention resources; creating new provisions; amending ORS 403.110, 403.115 and 403.135; and declaring an emergency.

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

SECTION 1. As used in sections 1 to 3 of this 2021 Act:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(2) "Crisis stabilization center" means a facility licensed by the Oregon Health Authority that meets the requirements adopted by the authority by rule under section 2 of this 2021 Act.

(3) "Crisis stabilization services" includes diagnosis, stabilization, observation and follow-up referral services provided to individuals in a community-based, developmentally appropriate homelike environment to the extent practicable.

(4) "Mobile crisis intervention team" means a team of qualified behavioral health professionals that may include peer support specialists, as defined in ORS 414.025, and other health care providers such as nurses or social workers who provide timely, developmentally appropriate and trauma-informed interventions, screening, assessment, de-escalation and other services necessary to stabilize an individual experiencing a behavioral health crisis in accordance with requirements established by the authority by rule.

(5) "Peer respite center" means voluntary, nonclinical, short-term residential peer sup-

Highlights:

- Stand up 988 as an alternative to 911 for **all Oregonians**
- Expand current mobile response services across the state
- Create stabilization services and community resources

HB 2417 - Strengthening Crisis Care System: $31 million

- HB 2417 allocated $10 million for mobile crisis services and $5 million for call center resources
- For mobile Crisis, OHA has identified an opportunity to braid together funding to bring up the total mobile crisis investment to **$31 million**
  - $10,000,000 funding from HB 2417
  - $11,000,000 from the mental health block grant supplemental funds
  - $10,000,000 through current CFAA funding
    - This funding is separate from the $6.5 Million for Mobile Response and Stabilization Services and supplemental block grant funding being utilized for the children's model
- This is the estimated cost to **fully fund mobile crisis** services by community mental health programs
- CY22 transition to Medicaid reimbursable mobile crisis model

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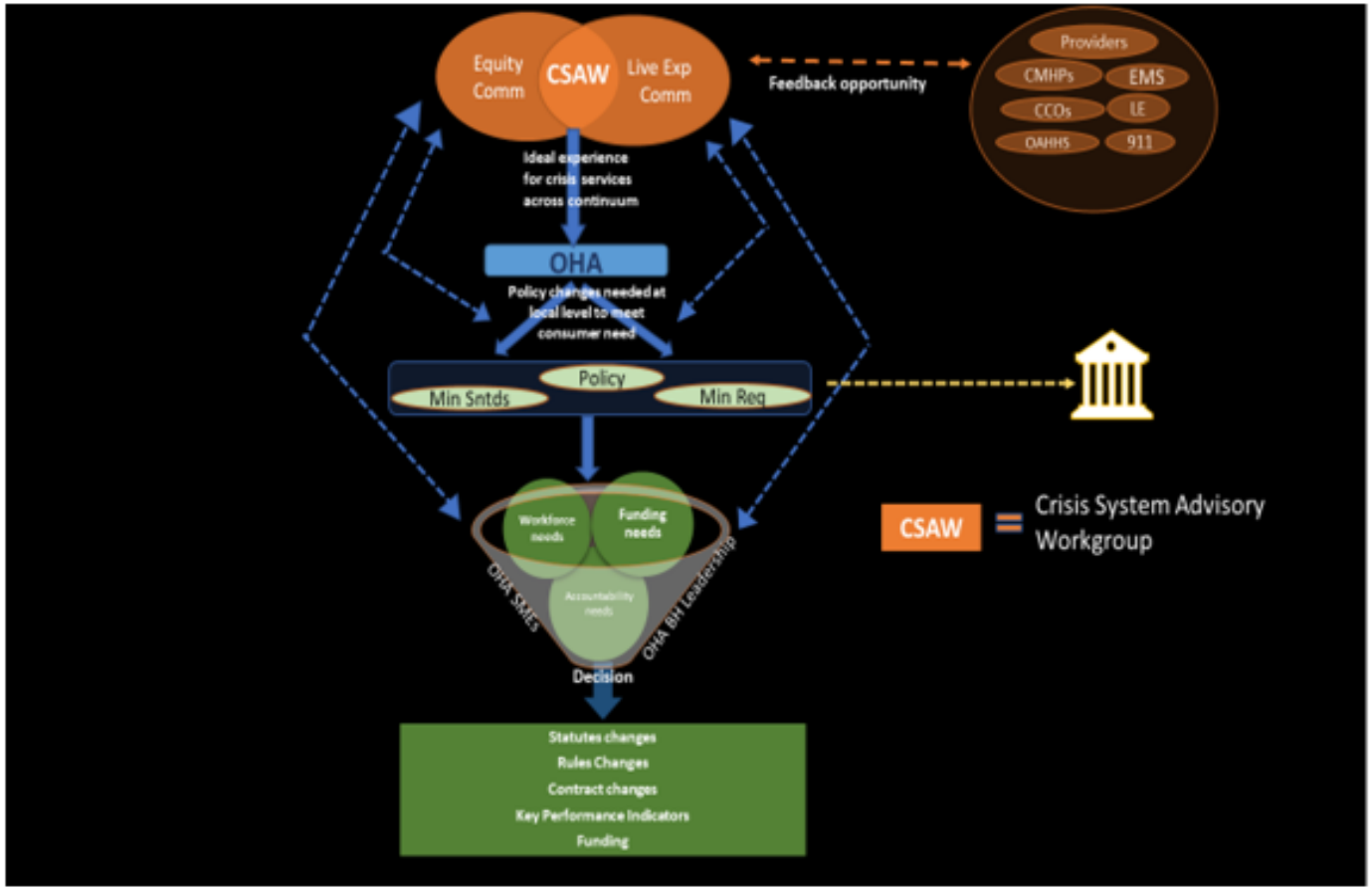
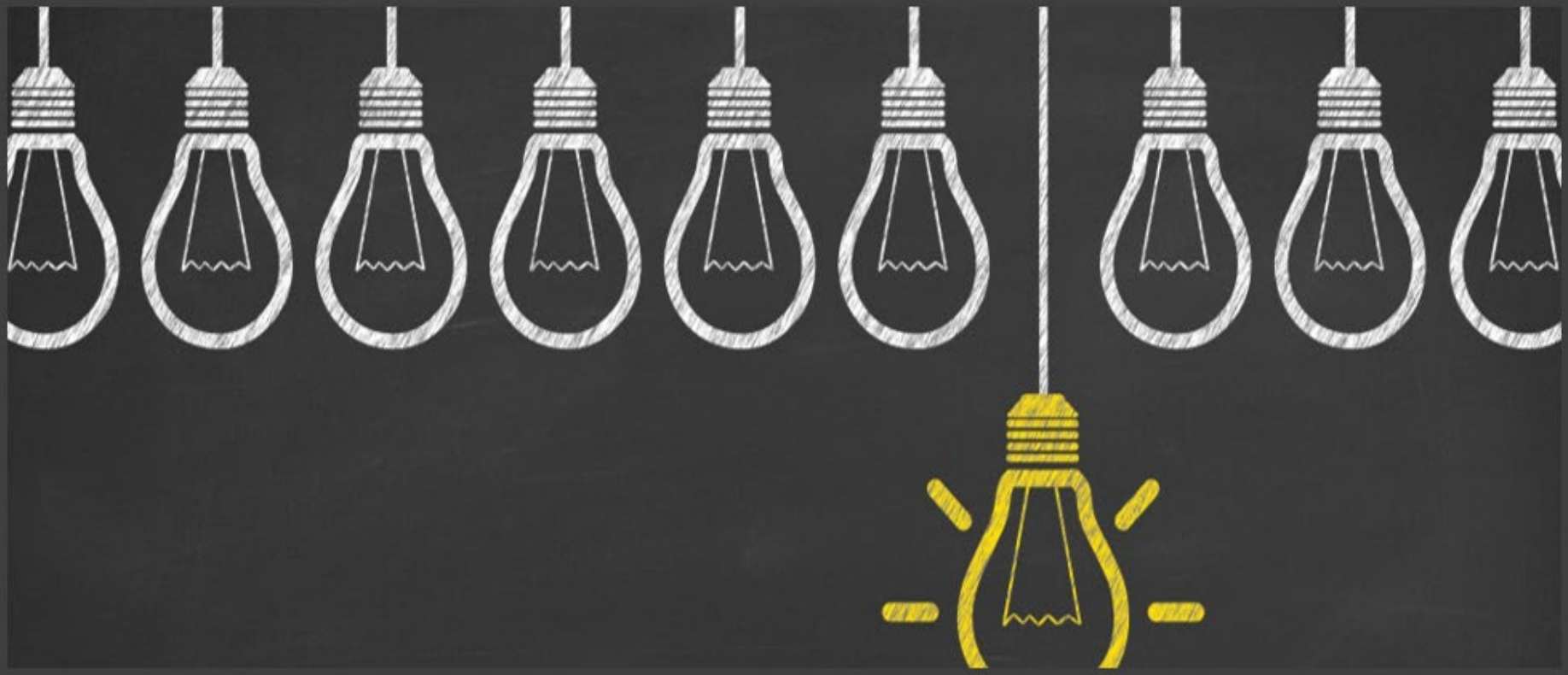
Community Engagement Model





Transforming the crisis system for children, youth, young adults and their families

Oregon Health Authority

Meeting Agenda

- Welcome
- Overview of current Crisis Response System
- National Best Practices
- Customized crisis response services for youth and families
- Questions

Chelsea Holcomb
Child and Family Behavorial Health Director

Rusha Grinstead
Behavioral Health Crisis System & 988 Lead

Beth Holliman
Intensive Community Based Serviced Coordinator

Brian Pitkin
Children's 988/Mobile Response and Stabilization Services Coordinator

Oregon Health Authority

What we hear from the community…

- Fail up system
- Not feeling heard
- Wisdom and experience is not trusted
- Emergency Department is the front door
- Emergency Department is not designed to treat children's behavioral health crises, needs are often left unmet
- Families left to prove how bad things are
- Shame and blame throughout the lifespan of the concern/emergency
- Lack of access to support navigating the system
- Lack of access to peer support
- Concerns and emergencies often started in school and when children were very young

Timeline of Events

Fall/Winter 2019

Policy Option Package (POP) Development

2020 OHA POP refinement, community engagement and presentations

2021 Legislative Investment (partial biennium funding) $6.5 Million

Current Oversight for Mobile Response

309-019 0150 (6-9)

Oregon Health Authority

Health Systems Division: Behavioral Health Services - Chapter 30

Division 19

OUTPATIENT BEHAVIORAL HEALTH SERVICES

309-019-0150

Community Mental Health Programs (CMHP)

(1) Crisis services shall be provided directly or through linkage to a local crisis services provider and shall include th following:

(a) Twenty-four hours, seven days per week telephone or face-to-face screening within one hour of notification of t crisis event to determine an individual's need for immediate community mental health services; and

(b) Twenty-four hours, seven days per week capability to conduct, by or under the supervision of a QMHP, an assessment, resulting in a plan that includes the crisis services necessary to assist the individual and family to stabil and transition to the appropriate level of care.

(2) Case management services shall be provided to assist individuals with the following:

(a) Gaining access to and maintaining resources such as Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing;

HB 2417

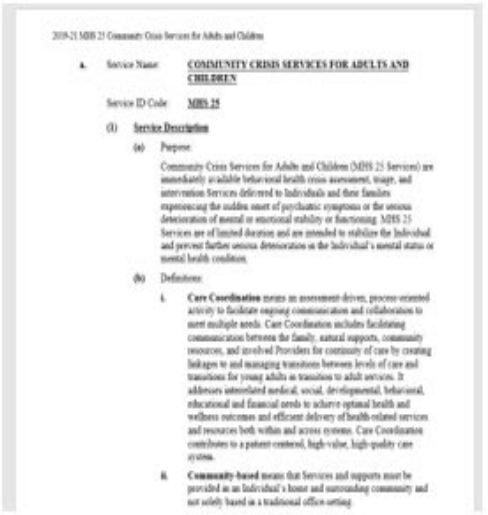
Enrolled

House Bill 2417

AN ACT

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

Service Element MH 25



2019-21 MHS 25 Community Crisis Services for Adults and Children

a. Service Name: COMMUNITY CRISIS SERVICES FOR ADULTS AND CHILDREN

Service ID Code: MHS 25

(1) Service Description

(a) Purpose

Community Crisis Services for Adults and Children (MHS 25 Services) are immediately available behavioral health crisis assessment, triage, and intervention Services delivered to Individuals and their families experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. MHS 25 Services are of limited duration and are intended to stabilize the Individual and prevent further serious deterioration or the Individual's mental status or mental health condition.

(b) Definitions

i. **Care Coordination** means an assessment-driven, process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care Coordination includes facilitating communication between the family, natural supports, community resources, and involved Providers for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults as transition to adult services. It addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes and efficient delivery of health-related services and resources both within and across systems. Care Coordination contributes to a patient-centered, high-value, high-quality care system.

ii. **Community-based** means that Services and supports must be provided in an Individual's home and surrounding community and not solely based in a traditional office setting.

Access to all Oregonians across the Lifespan

Oregon Health Authority

Current Oversight for Mobile Response

309-019 0150 (6-9)

Oregon Health Authority

Health Systems Division: Behavioral Health Services - Chapter 30

Division 19

OUTPATIENT BEHAVIORAL HEALTH SERVICES

309-019-0150

Community Mental Health Programs (CMHP)

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HB 2417

Enrolled

House Bill 2417

AN ACT

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

SECTION 1. As used in sections 1 to 5 of this 2021 Act:

Service Element MH 25

2019-21 MHS 25 Community Crisis Services for Adults and Children

a. Service Name: **COMMUNITY CRISIS SERVICES FOR ADULTS AND CHILDREN**

Service ID Code: **MHS 25**

(1) **Service Description**

(a) Purpose

Community Crisis Services for Adults and Children (MHS 25 Services) are immediately available behavioral health crisis assessment, triage, and intervention Services delivered to Individuals and their families experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. MHS 25 Services are of limited duration and are intended to stabilize the Individual and prevent further serious deterioration or the Individual's mental status or mental health condition.

(b) Definitions:

i. **Care Coordination** means an assessment-driven, process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care Coordination includes facilitating communication between the family, natural supports, community resources, and involved Providers for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults as transition to adult services. It addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes and efficient delivery of health-related services and resources both within and across systems. Care Coordination contributes to a patient-centered, high-value, high-quality care system.

ii. **Community-based** means that Services and supports must be provided in an Individual's home and surrounding community and not solely based in a traditional office setting.

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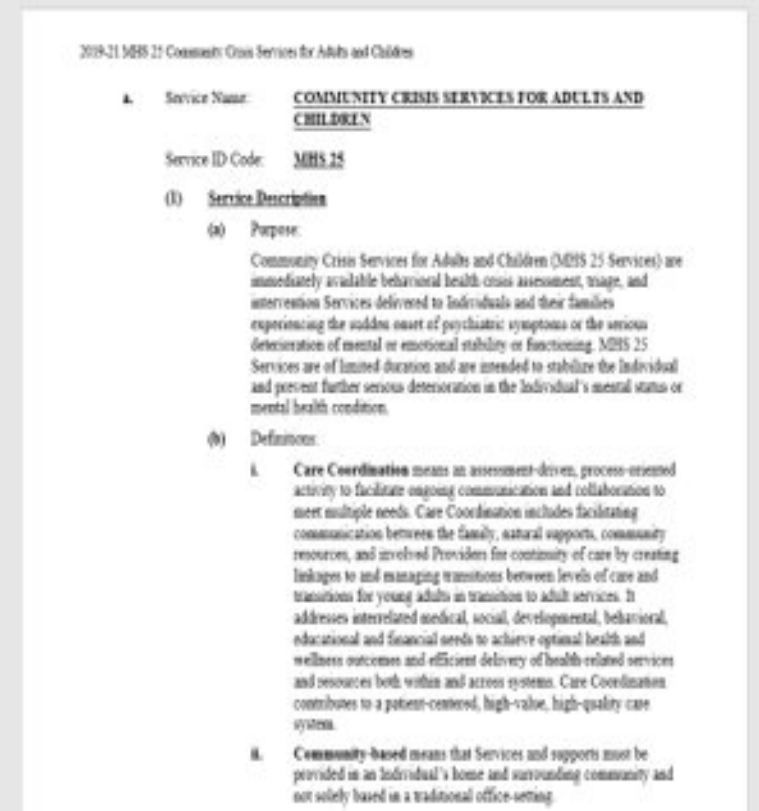
Service Element 25
Community Crisis Services for Adults and Children



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ii. **Community-based** means that Services and supports must be provided in an Individual's home and surrounding community and not solely based in a traditional office-setting.

- Historically overseen by the Adult Unit at OHA
- Mobile response is available across the lifespan
- Looks different in different counties
- Does not include youth and family best practices
- Service Element and OARS need to be updated

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Customize public behavioral health systems to meet the needs of children and their families

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THE INSTITUTE FOR INNOVATION & IMPLEMENTATION

TO: The Honorable Ron Wyden, Chairman and The Honorable Mike Crapo, Ranking Member
United States Senate, Committee on Finance

FROM: Deborah Harburger, MSW, Director, Division of Policy, Finance, & Systems Design
Melissa Schober, MPM, Lead Public Policy Analyst
Michelle Zabel, MSS, Assistant Dean & Director
The Institute for Innovation & Implementation, University of Maryland School of Social Work

RE: Request from the Senate Finance Committee for Input into Improving Access to Timely Behavioral Health Care in the United States

DATE: November 15, 2021

Thank you for the opportunity to provide input into how we can improve access to timely behavioral health care in the United States. The Institute for Innovation & Implementation (The Institute) at the University of Maryland, Baltimore School of Social Work is a national policy, finance, training, technical assistance, evaluation, and workforce development center working in 28 states to support the development, installation, and sustainability of robust, inclusive, culturally responsive, and high quality child-, youth-, and family-serving public systems.

The following recommendations are based on The Institute's more than 15 years of experience in this work across federal, state, local, and private agencies and systems, including serving as the Substance Abuse and Mental Health Services Administration (SAMHSA's) National Training and Technical Assistance Center for Children's Behavioral Health from 2013-2020. The Institute currently provides technical assistance to SAMHSA on its work related to children's crisis response systems and is engaged in multiple grants from SAMHSA, the Children's Bureau, and the Office of Juvenile Justice and Delinquency Prevention, in addition to working at the state and local levels across the United States.

We offer the following evidence-based solutions and recommendations to **improve access to behavioral health care for children and young people and to improve reimbursement mechanisms and financing**. Detail on each of these recommendations is provided below. We are available to provide additional information, resources, and examples for each of these recommendations upon request.

Thank you for the opportunity to provide recommendations and for your commitment to improving access to quality behavioral health care for children and families.

Customize public behavioral health systems to meet the needs of children and families

RECOMMENDATION 1: Require SAMHSA and the Centers for Medicare & Medicaid Services (CMS) to issue an **updated informational bulletin on providing home- and community-based services** to children, youth, young adults, and their families, outlining services and supports that should be available to all and provide consolidated resources, recommendations, and examples of financing mechanisms to support these services.

RECOMMENDATION 2: Expand and promote crisis services customized for children, youth, and youth adults, to include implementation of the 988 National Suicide Prevention Lifeline; use of the set aside in the Mental Health Block Grant for child-specific crisis response models; inclusion of mobile response

Recommendations

- Develop more comprehensive, sustaina ble, and effective home- and community-based services for children, youth, young adults, and their families

- Expand and promote crisis services **customized** for children, youth, young adults and their families

https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/Institute-Recommendations-to-Senate-Finance-Committee-2021.pdf

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National Resources, Research and Models for Children's Crisis Services

CRISIS NOW
Transforming Crisis Services
NASMHPD

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TA NETWORK

SAMHSA
Substance Abuse and Mental Health Services Administration

#CrisisTalk

https://talk.crisisnow.com/wp-content/uploads/2021/12/988-Crisis-Learning-Community-Weekly-Call-20211215-edited.mp4?_=2

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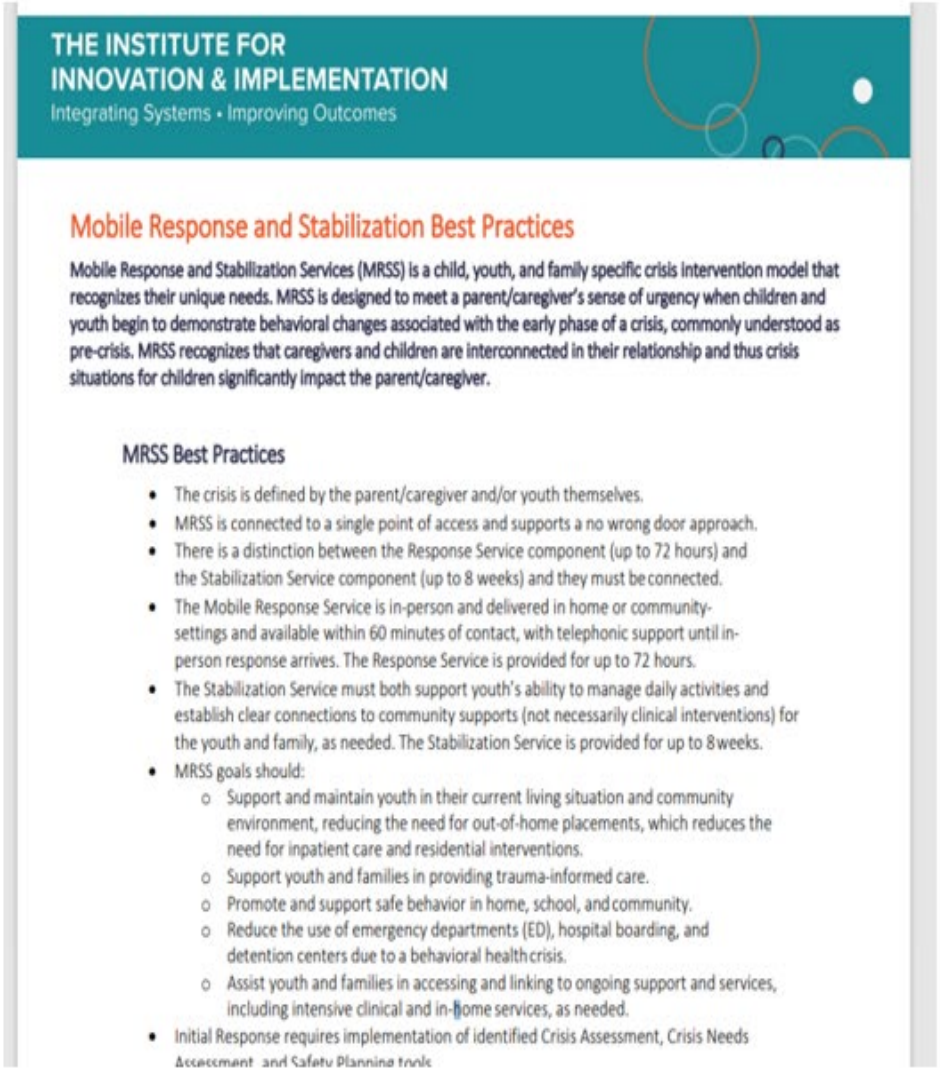
Reviewed national best practices on crisis response for youth and families

OHA consultation with national expert Liz Manley



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Mobile Response and Stabilization Best Practices

Mobile Response and Stabilization Services (MRSS) is a child, youth, and family specific crisis intervention model that recognizes their unique needs. MRSS is designed to meet a parent/caregiver's sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis, commonly understood as pre-crisis. MRSS recognizes that caregivers and children are interconnected in their relationship and thus crisis situations for children significantly impact the parent/caregiver.

MRSS Best Practices

- The crisis is defined by the parent/caregiver and/or youth themselves.
- MRSS is connected to a single point of access and supports a no wrong door approach.
- There is a distinction between the Response Service component (up to 72 hours) and the Stabilization Service component (up to 8 weeks) and they must be connected.
- The Mobile Response Service is in-person and delivered in home or community-settings and available within 60 minutes of contact, with telephonic support until in-person response arrives. The Response Service is provided for up to 72 hours.
- The Stabilization Service must both support youth's ability to manage daily activities and establish clear connections to community supports (not necessarily clinical interventions) for the youth and family, as needed. The Stabilization Service is provided for up to 8 weeks.
- MRSS goals should:
  - Support and maintain youth in their current living situation and community environment, reducing the need for out-of-home placements, which reduces the need for inpatient care and residential interventions.
  - Support youth and families in providing trauma-informed care.
  - Promote and support safe behavior in home, school, and community.
  - Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis.
  - Assist youth and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.
- Initial Response requires implementation of identified Crisis Assessment, Crisis Needs Assessment, and Safety Planning tools

MRSS

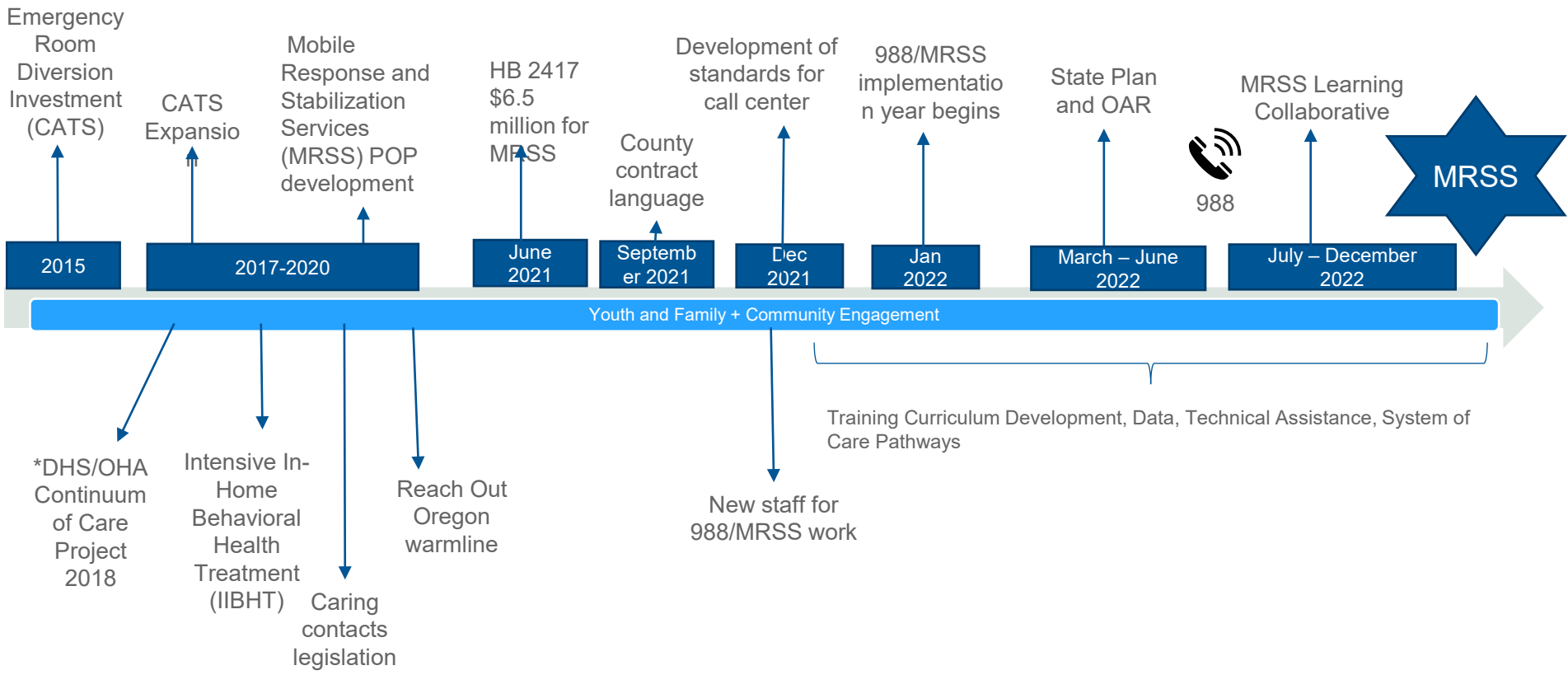
National Best Practices

Crisis Continuum:

MRSS Common Elements:

- Crisis is defined by the caller
- Services are available 24 hours a day, seven days a week
- Able to serve children and families in their 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 transition to needed treatment services

Mobile Response and Stabilization Services



Consumer Feedback

OHA

- Steering Committee: Applications Due Soon!
- Crisis System Advisory Work Group CSAW

Child and Family Behavioral Health Unit Initiatives

- MRSS Community Conversations
- Youth Think Tanks
- CFBH Workgroup includes youth and family peers
- **System of Care Advisory Committee (SOCA)**
- **Children's System Advisory Council (CSAC)**
- **AOCMHP Workgroup**

- more training and education to be youth friendly, anti-racist, LGBTQ2SIA+ friendly
- ask young person if there is someone they can contact to meet them out in the community
- TEXTING OPTIONS!
- “Providers who look like me”
- Integrated care, peer support, culturally responsive
- Resource connection and a provider who can help you with concrete activities, like grocery shopping and getting stressors accomplished- including building natural supports
- Hospitalization should be last resort
- No police involvement
- Important that health insurance is not an issue to accessing care
- Supportive and consistent follow up until a person is stable
- Being very, very clear about if your parents can/will be contacted. Using clear language to express under what context parents may or may not be contacted
- Having 988 responders ready to connect the individual with any kind of service they may need - reproductive health care, social services, emergency, food, shelters, etc.

Comparison Chart

Crisis and Transition Services (CATS)	Mobile Response and Stabilization Services
• Referrals from emergency department across 11 Counties • Face to Face Response within 3 hours •Team includes both clinical staff and Family Support Specialists for 45-90 days •Crisis and Safety Planning • Mental Health Assessment/ Service Planning •Team meeting scheduled with family within 72 hours of discharge from ED •Team assists families in connecting with community support and resources to ensure a warm hand off	•Youth do not have to go to the ED to access services • Face to Face respond within one hour (up to three in rural) • Youth and families define what they need and when they need it, does not have to be an acute, mental health crisis • Access to a variety of services and supports for up to 2 months • Team includes access to QMHP, QMHA and both Youth Peer and Family Support Specialists

The Evolution of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Conditions and Their Families

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The Evolution of the System of Care Approach
for Children, Youth, and Young Adults with Mental Health Conditions and Their Families

By Beth A. Stroul, MEd, Gary M. Blau, PhD, and Justine Larson, MD

The system of care (SOC) approach was first introduced in the mid-1980s to address well-documented problems in mental health systems for children and youth with serious emotional disturbances (SEDs) and their families (Stroul & Friedman, 1986). Among these problems were significant unmet need for mental health care, overuse of excessively restrictive settings, limited home- and community-based service options, lack of cross-agency coordination, and a lack of partnerships with families and youth. The vision was to offer a comprehensive array of community-based services and supports that would be coordinated across systems; individualized; delivered in the appropriate, least restrictive setting; culturally competent; and based on full partnerships with families and young people (Stroul, 2002). The SOC approach has provided a framework for reforming child and youth mental health systems nationwide and has been implemented and adapted across many states, communities, tribes, and territories with positive results (Manteuffel et al., 2008; Pumariega et al., 2003; Substance Abuse and Mental Health Services Administration [SAMHSA], 2017; Stroul et al., 2010; Stroul, et al., 2012).

These efforts have resulted in significant strides across the United States in addressing youth mental health issues. However, notwithstanding this progress, there is a continuing need to improve SOCs based on environmental changes, changes in health and human service delivery, experience, and data from evaluations and research. As such, an update of the approach was published in 2010 (Stroul et al., 2010). This current document builds on the 2010 update and describes the further evolution of the SOC approach, and presents further updates in the philosophy, infrastructure, services, and supports that comprise the SOC framework. The revisions were based on extensive expert consultation and input from the field and reflect a consensus on the future directions of SOCs. (See Appendix A for a list of expert organizations consulted.)

The Need for Systems of Care

In the United States, annual prevalence estimates of mental disorders among children under 18 years of age range from 13 to 20 percent and cost health care systems approximately 247 billion dollars annually (Perou et al., 2013). Within this group are children and youth with SEDs, defined as a diagnosable mental health condition that results in significant functional impairment (SAMHSA, 1993).[1]

[1] Serious emotional disturbance (SED) refers to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role in family, school, or community activities.

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Core Components for a Comprehensive Service Array in SOC

- ❑ **Mobile Crisis and Response Services (MRSS)**
- ❑ **Intensive Care Coordination using Wraparound**
- ❑ **Intensive In-home Mental Health Treatment Services**
- ❑ **Parent and Youth Peer Support**
- ❑ **Respite Care (focus for 2023-2025)**

https://wraparoundohio.org/wp-content/uploads/2021/06/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

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988-more than a call for MRSS

Roughly 80% of calls resolved without the dispatch of a mobile response team.

988-more than a call center

Initial/preliminary assessment of need

Resource for community services

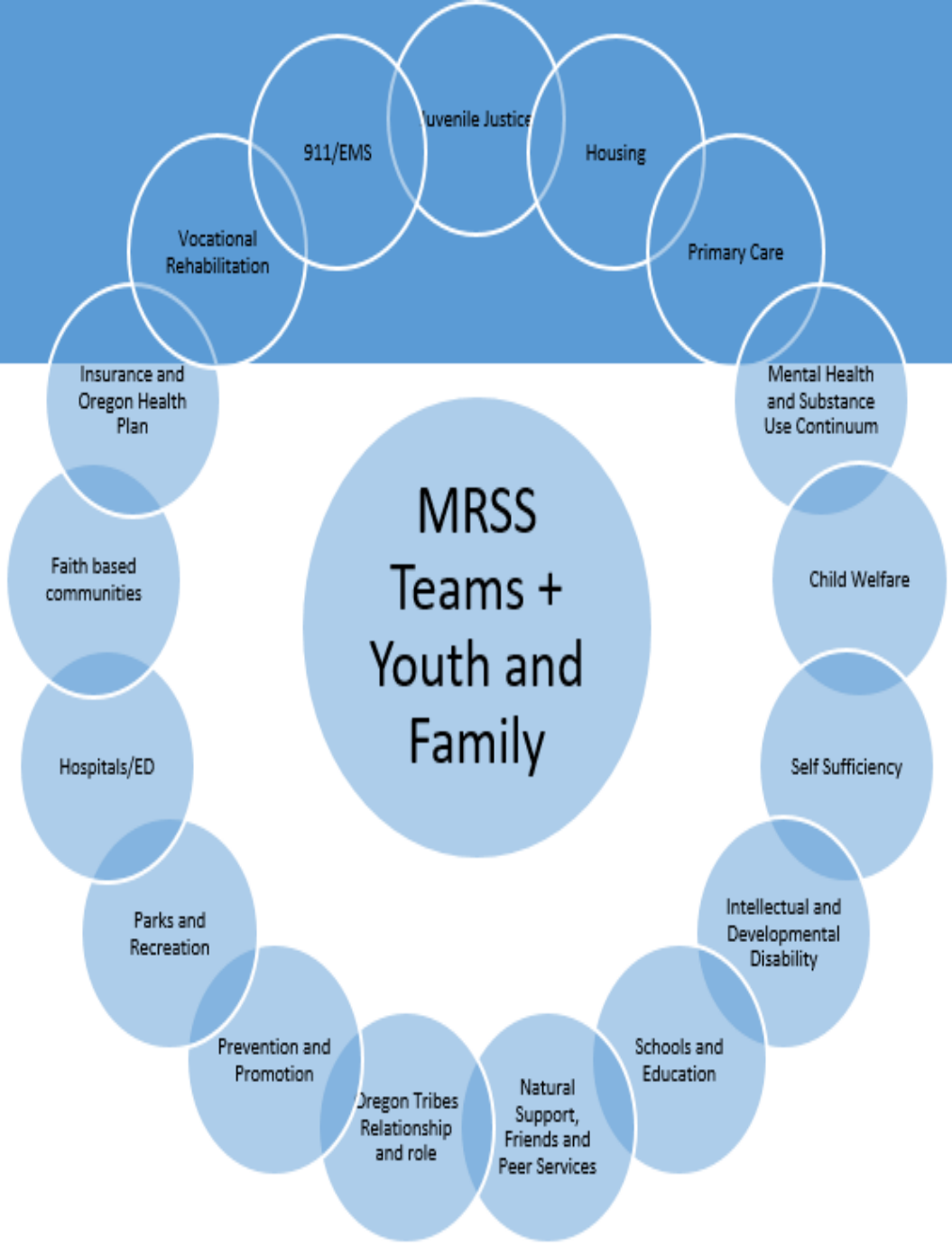
faith-based support, peer support services, food banks, housing assistance, transportation, education resources, etc.

Resource for treatment services

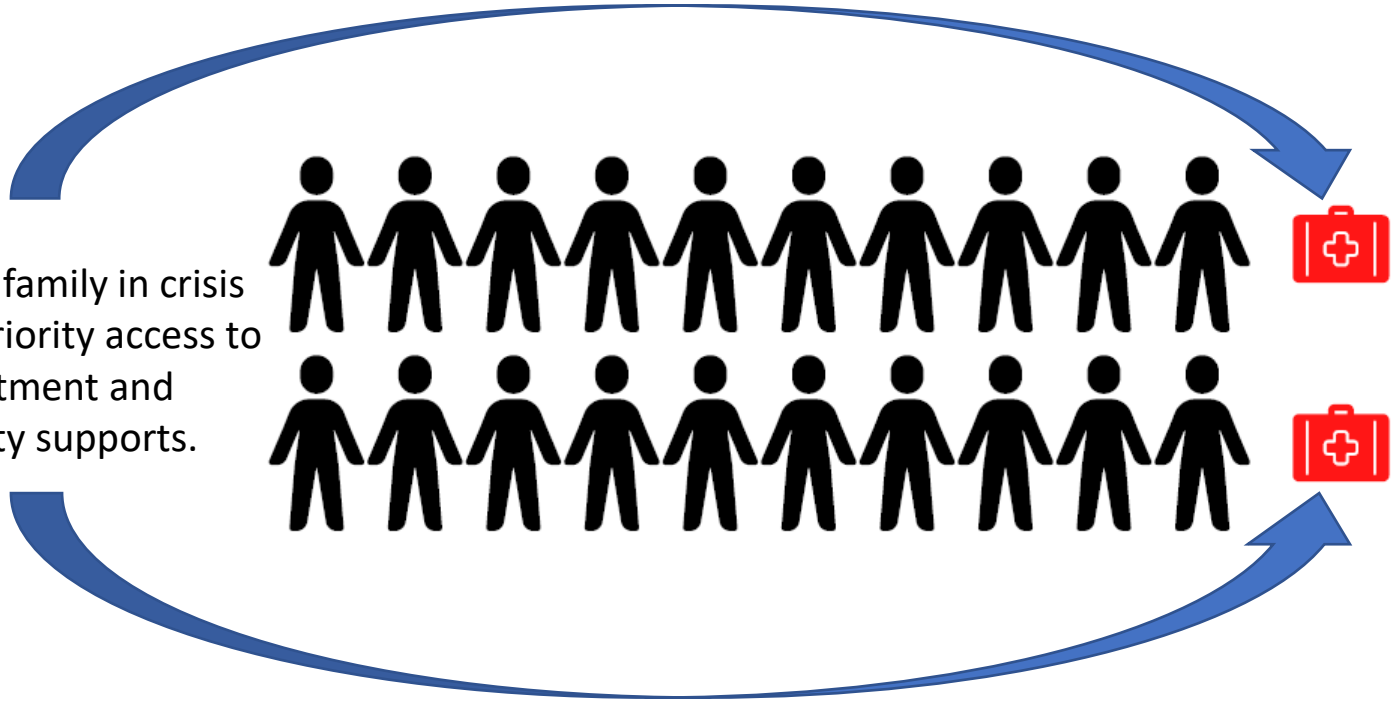
counseling resources, SUD treatment, child psychiatry, developmental pediatricians, IEDD services, etc.

MRSS can be dispatched at any point during the call.

Local Children's System of Care commitment and involvement for MRSS is required for teams to be successful.



A child or family in crisis is given priority access to care, treatment and community supports.



Escalated pathways to care give the most acute cases the fastest access.

HB 2417 - Strengthening Crisis Care System: $31 million

- HB 2417 allocated $10 million for mobile crisis services and $5 million for call center resources
- For mobile Crisis, OHA has identified an opportunity to braid together funding to bring up the total mobile crisis investment to **$31 million**
  - $10,000,000 funding from HB 2417
  - $11,000,000 from the mental health block grant supplemental funds
  - $10,000,000 through current CFAA funding
    - This funding is separate from the $6.5 Million for Mobile Response and Stabilization Services and supplemental block grant funding being utilized for the children's model
- This is the estimated cost to **fully fund mobile crisis** services by community mental health programs
- CY22 transition to Medicaid reimbursable mobile crisis model

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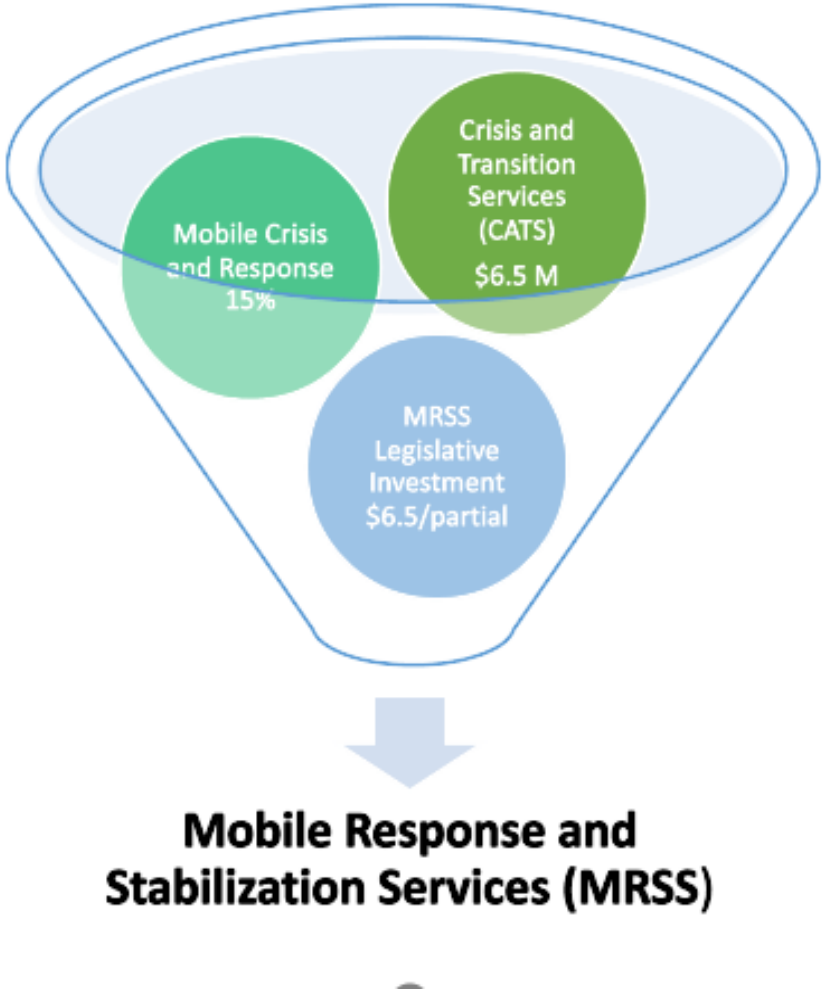
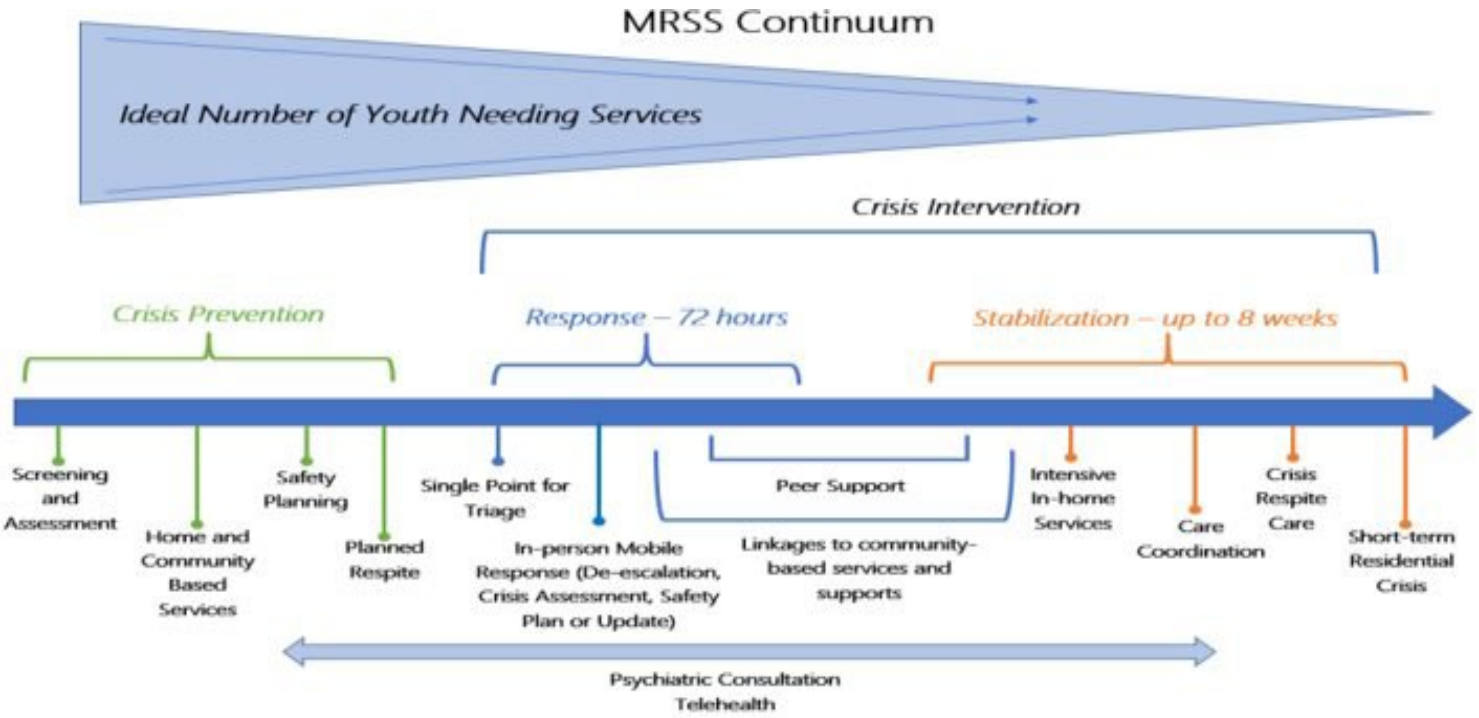
Envisioning and Investing in the Future!



Financial Breakdown

Current Service Element 25	Youth and their families make up about 15% of total Mobile Response in the state. **Recommendation: 15% of total funds should be set aside for youth and family specific crisis response**
Current CATS Contracts	Current General Funds **6.5M/Biennium** for 12 sites. **Recommendation: CATS funding invested into building youth and family specific crisis response system which includes stabilization services**.
Child and Family Behavioral Health- MRSS Budget	**6.5M/partial biennium** approved**.** (13M estimated for 2023-2025) **Recommendation: Funds to be used to build out child and family specific crisis response system.**

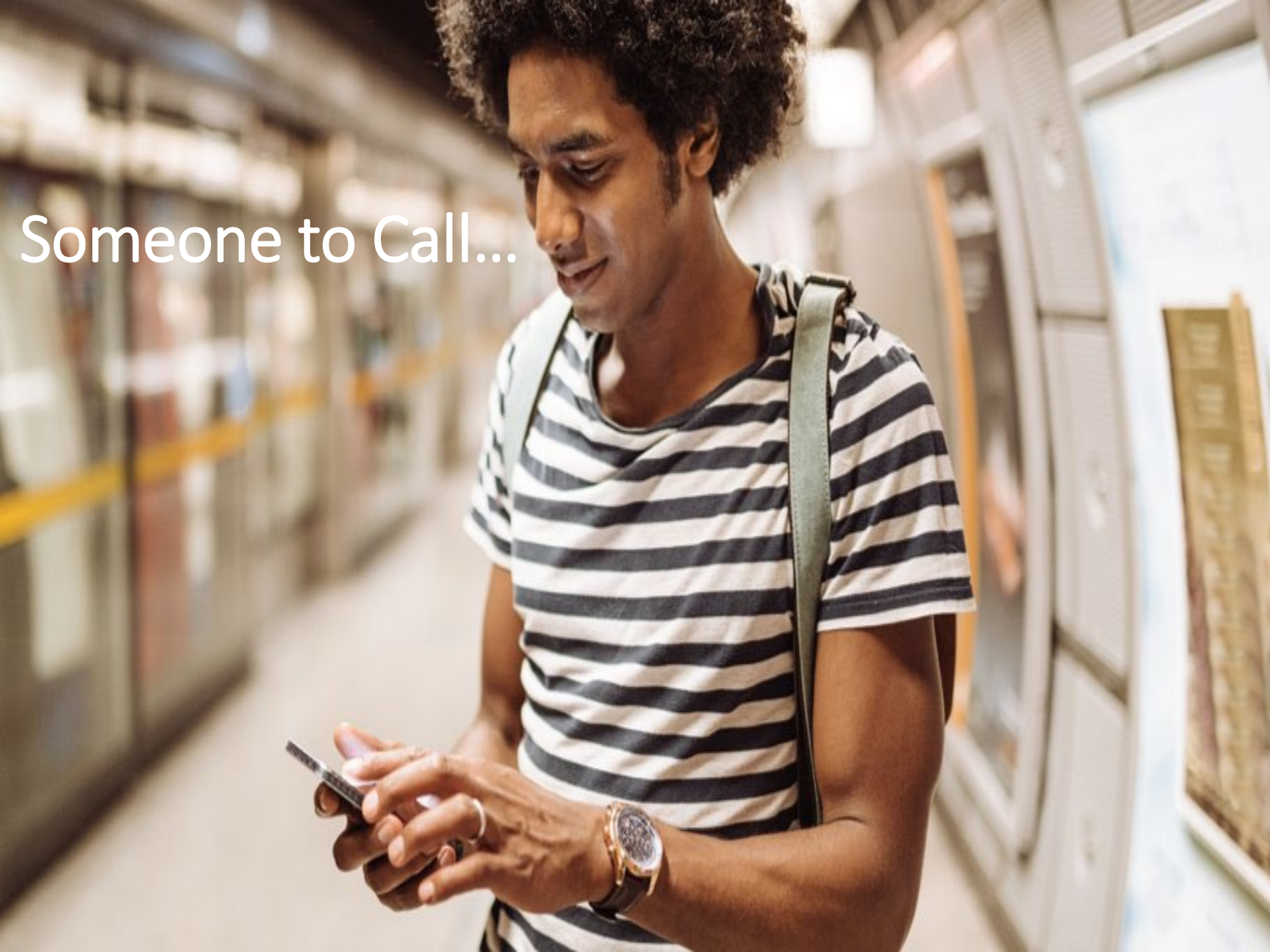


Source: Adapted from the Wisconsin Office of Children's Mental Health. (2015). 2015 Report to the Wisconsin Legislature. Appendix D4. Retrieved from: http://www.wisccap.org/docs/OCMH%202015%20Annual%20Report.pdf

Someone to Call...

Someone to Respond...

A Community of Support...


Someone to Call…

988 Call Center

Coming July 2022
Centralized Call Center for **all Oregonians**

9-8-8
Access to immediate behavioral health support, for Oregonians across the lifespan and their families.

Call Center staffed by Lines for Life


Someone to Respond…

Customized Mobile Response and Stabilization Services for children, youth, young adults and their families

2-person teams, with specialized training working with children and youth, will provide face to face response

- Family Support Specialists
- Youth Peer Support Specialists
- Qualified Mental Health Professionals*
- Qualified Mental Health Associates

position required to receive enhanced rate under Medicaid

Mobile Response teams receive *customized* training

- Trauma Informed Care
- Neurobiology and child development
- Effective engagement strategies for working with children and youth
- Partnering with parents and caregivers
- Youth and Family specific crisis and safety planning
- Cultural considerations when working with youth and their families
- Supporting LGBTQ2S youth
- Screening for Drug and Alcohol use with youth
- **Familiarity and relationship with the continuum of care for children and community resources**

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A community of support…

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MRSS Teams can provide services and supports to children, youth and their families for up to 8 weeks

Initial Response may include:

- ✓ Crisis resolution and problem solving
- ✓ Risk assessments
- ✓ Crisis and Safety Planning
- ✓ Substance Use Screening
- ✓ Mental Health Assessment
- ✓ Connection to community- based services or resources

Stabilization Services for up to 8 weeks may include:

- ✓ Parenting support and advocacy
- ✓ Brief individual and family therapy
- ✓ Skills Training
- ✓ Peer Delivered Services
- ✓ Connection to community services with a warm hand off

NEXT STEPS

What has already happened...

- Community Conversations and Youth Think Tanks
- Community System Advisory Workgroup (CSAW)
- OHA awarded a CMS planning grant
- Counties hired a project manager to oversee
- implementation, working with OHA
- 3 additional positions within OHA
- RI International Consultation
- Training recommendations

What is in process...

- Update OAR to align with HB 2417 and best practices
- Review Medicaid billing codes for crisis services
- Revise Service Element 25 to include Mobile Response and Stabilization Services (MRSS) specific to children, youth and their families for 2023
- Training
- Build out community resources and create expedited pathways to care
- Work with counties to establish what steps are needed to get from where we are now to developing a customized youth and family MRSS state-wide model

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QUESTIONS

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Child and Family Behavioral Health Director
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Beth Holliman, LPC
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Rusha Grinstead, MPH, OCPMP
Behavioral Health Crisis System/ 988 Lead
c: 503-6029214 e:Rusha.grinstead@dhsoha.state.or.us

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Thank You

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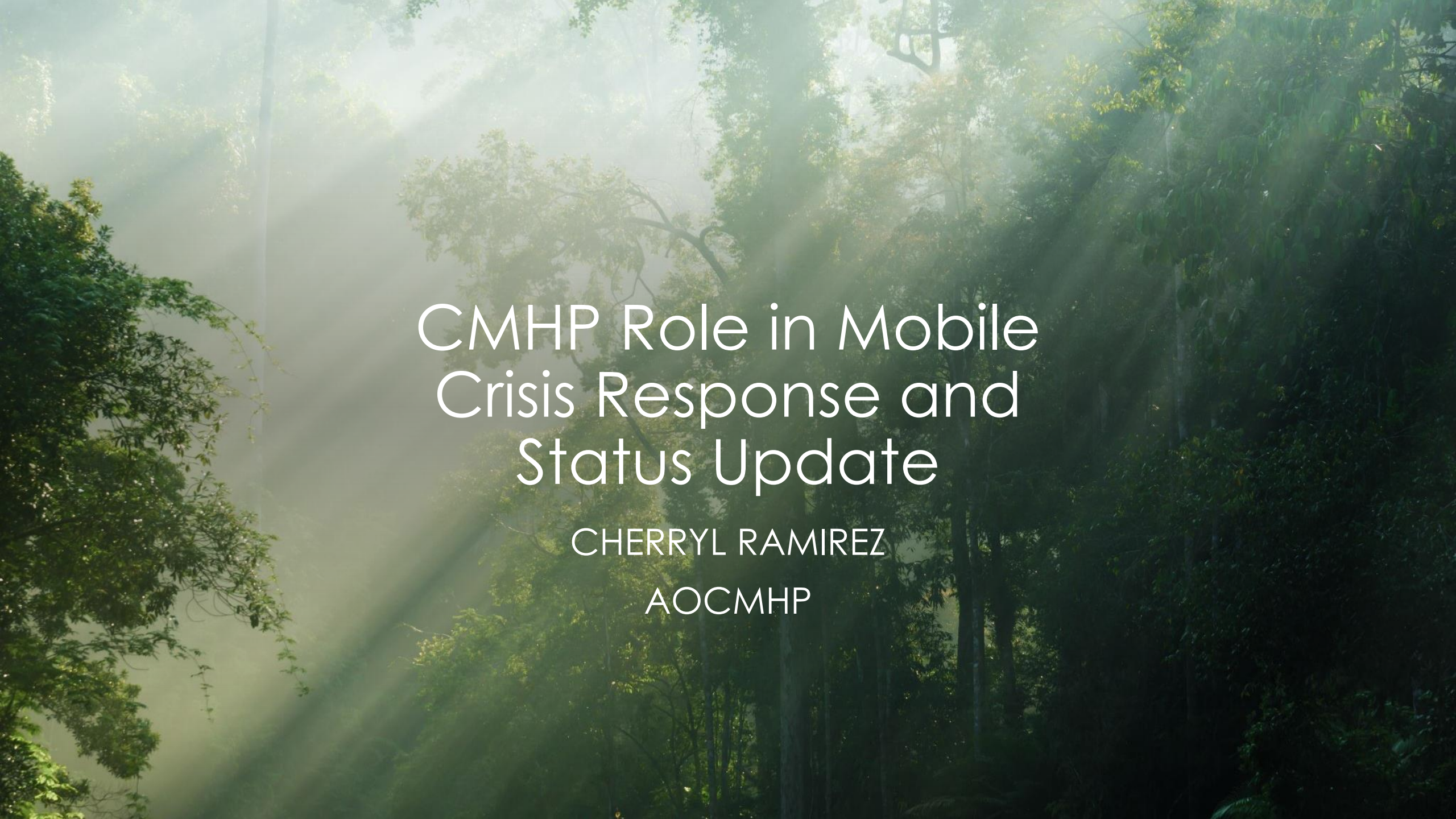


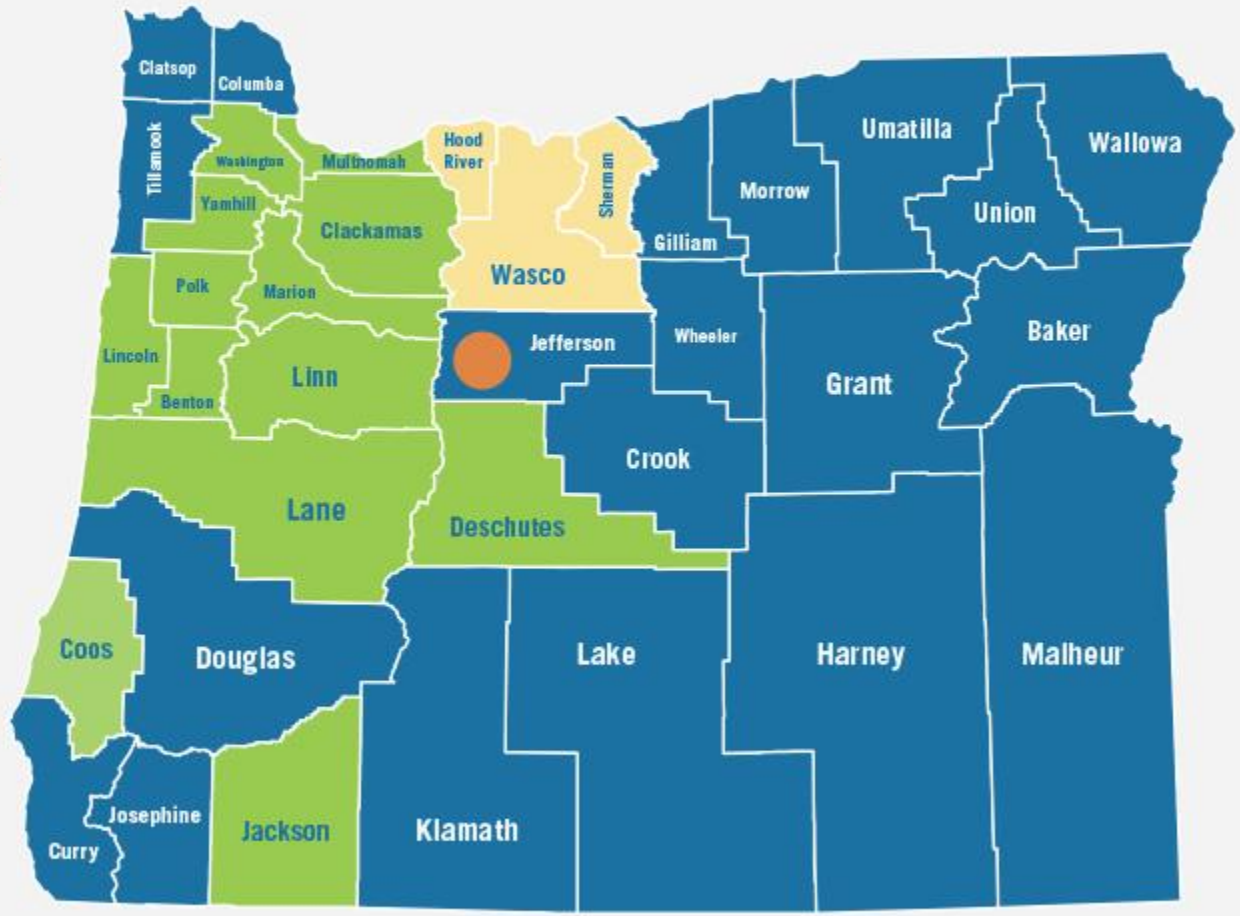
CMHP Role in Mobile Crisis Response and Status Update

CHERRYL RAMIREZ

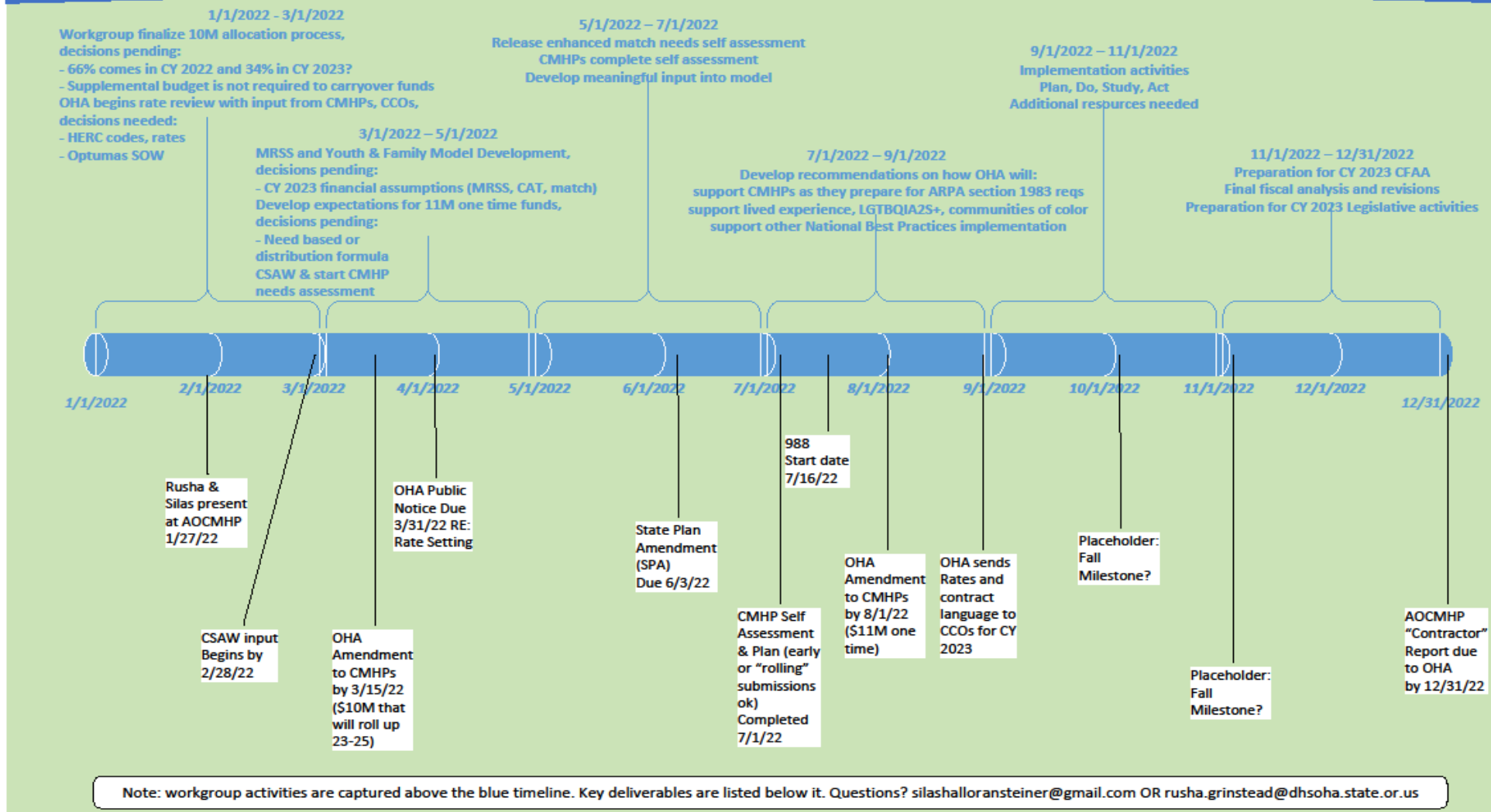
AOCMHP

Service Delivery Structure of Community Mental Health Programs:

- County Department
- Not-for-Profit
- Chapter 190 IGA
- Tribe



DRAFT Mobile Crisis Services Workgroup Activities CY 2022



Note: workgroup activities are captured above the blue timeline. Key deliverables are listed below it. Questions? silashalloransteiner@gmail.com OR rusha.grinstead@dhsoha.state.or.us

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

Mobile Crisis Response Status

Current State for All	Current State for Some	Future State for All
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

Poll Report
Report Generated:
Topic
Alliance Quarterly Meeting

User Name
Leslie Golden (she/her) LFL
Jenn Scott (she/her)
Crystal Larson (she/her)
Jamie Gunter
Kimberly Lindsay
Jacob Dilla
Roxanne Wilson
Liz Schwarz (she/her)# OYA
Boston Colton
Julie Scholz (she/her)# Oregon Pediatric Society
Spencer Lewis (he/him)# OSBA
John Seeley
Pam Pearce
Julie Magers
Debra Darmata
Ryan Price
Kara (they/them/elle) Boulahanis
Rachel Howard (she/her/hers)
Nick Clark (He/Him)
Caroline Suiter (she/her)
SBS Board
Laura Rose (she/hers)
Maria Gdontakis Pos (She/Her)
Wren Fulner
Yasu (he/him) OHA IVPP
Angela Perry (she/her)
Galli Murray (she/her/hers)
Shane NARA NW (he/him/his)

Shanda Hochstetler (she/her) OHA
Emily Watson (she/her) | OHA
Mary Massey (she/her)
Michelle Bangen (she/her)
Jesus she/they
Gordon Clay
Craig Leets's iPhone
Kimberlee Jones
Stephanie Gilbert
Ashley Meilahn# (she#her)
Don Erickson# he# him# his
Jackie Richland
Tia Barnes
Angi Meyer
Stephanie Willard (she/hers)
Jill Baker (she/her) Youth Suicide Prevention
Kirk Wolfe MD
Mandy Kubisch# (she/her/hers)
Taylor Chambers (She/her)
Sierra Henderson
Anders Kass (They/He)- Youth Era
Lucina (she/her)
Shelaswau Crier (she# her# ella) - ODE

1.Which theme should the Alliance use for May's Mental Health Awareness Month messaging campaign?
Are you okay? It's okay to say you're not okay.
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It's okay to not be okay.
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