Appendix VI

EQUITY TOOL FOR OREGON'S

ADULT SUICIDE INTERVENTION AND PREVENTION PLAN (ASIPP)

The Equity Assessment for Oregon's first Adult Suicide Intervention and Prevention Plan (ASIPP) is a tool designed for small groups to assess how power in society impacts populations identified with the highest rates of suicide. The Equity Group sets forth four basic principles about equity as it relates to suicide prevention, providing a tool for assessing each small groups' decision-making, recommendations, and resource allocations. It is a set of principles and reflective questions that will help ASIPP small groups **(1)** move from universal, one-size-fits-all approaches focused on individuals through the lens of the dominant culture to more contextual approaches and **(2)** recommend policies and practices addressing environments and social conditions that lead to suicide.

The ASIPP Equity Group, in alignment with the Oregon State Health Improvement Plan (OSHIP), seeks to make Oregon a place where suicide reduction and suicide prevention is achieved for people of all races, ethnicities, disabilities, genders, sexual orientations, socioeconomic status, nationalities and geographic locations. Acknowledging the impact of white supremacy and multiple forms of oppression, the Equity Assessment was developed with the following core concepts in mind.

The reasons people die by suicide are complex and rooted in a cultural context, and suicide prevention is about changing our beliefs, values, practices, and policies from an individual lens on suicide to a culturally contextualized lens that changes how we look at suicide prevention.

Commented [DD1]: OHA Office of Equity had a concern that the word cultural was too ambiguous and could be mis-understood as criticizing various non-dominant rather than a statement about the dominant culture. Is there a better way that we can explain what we mean here? I was thinking something like "The reasons people die of suicide are complex and rooted in: dominant culture, or socio-political culture? Social Context? Not sure? Any other ideas?

Disparities in suicide and suicide prevention exist in different populations living in environments and social conditions that impact their access to help and support. Specifically, according to OSHIP, how people are treated based on their social identities creates direct forms of adversity, trauma and toxic stress that can lead to higher risk for suicide. Therefore, policies and practices must focus on environments and social conditions that lead to suicide and promote prevention rather than solely individual intervention. **The need for equity exists because disparities strongly and systematically exist for individuals and groups with certain social identities and/or group characteristics.**

Standards and expectations valued by dominant cultures contribute to high rates of suicide in both social identity groups that are harmed and not helped, as wells as those that have easy open access to help and prevention as a result of their social identities. While high-risk populations may be identified as the groups with the largest represented demographic in suicide (i.e. veterans, White-males, LGBTQI+, construction workers), those numbers do not automatically situate suicide in discussions of equity. Naming the largest group populations is not the same as identifying groups that have been impacted by

harm and blocked access to help as a result of their race, sex, class, age, ability, language and sexuality. **Most importantly, in an equity lens we must look at high-risk populations with a lens toward their social identities and systems that have impacted their risk for suicide rather than solely a lens of individualism.**

The following principles of this assessment tool are designed to ensure that recommendations put forth for Oregon's first Adult Suicide Intervention and Prevention Plan have been designed and vetted with equity at the forefront.

CORE CONCEPTS

- The reasons people die by suicide are complex and rooted often in cultural context.
- Suicide prevention is about changing our beliefs, values, practices, and policies from an individual lens on suicide to a culturally contextualized lens.
- Disparities strongly and systematically exist for individuals and groups with certain social identities and/or group characteristics.
- Social identities are gender, race, ethnicity, social class, wealth, educational attainment, religion, sexual orientation, ability, age, language, housing status, immigration status, veteran status, geographical location, and specific professions i.e., military/service members, police officers/first responders, etc.

- While high-risk populations may be identified as the groups with the largest represented demographic in suicide, it is not the same as identifying groups that have been impacted by forms of oppression, including racism, sexism, classism, ageism, ableism, homo-and transphobia, and linguicism.
- Most importantly, in an equity lens, we must consider high-risk populations in the context of their social identities and systems that have impacted their risk for suicide, rather than individual characteristics alone.

EQUITY PRINCIPLES AND REFLECTION QUESTIONS

PRINCIPLE 1

Forms of oppression and exclusion exist, impacting how programming and human and financial resources are distributed, how people are treated, and how suicide is viewed in communities. An equity and liberation focus requires assessing the "common sense assumptions" and institutional barriers in the field and changing the status quo of how decisions are made and resources are allocated.

QUESTIONS TO BE ANSWERED BY SMALL GROUPS

- *What factors of oppression impact the mental health and physical well-being within the community?*
- *What institutional assumptions and expectations are getting in the way of preventing suicide in your community?*
- *What social determinants, environments, and conditions make your group more vulnerable to suicide?*
- *What are the opportunities/what must change in current practices to meet the needs of your group to improve the social conditions that make them vulnerable?*

EXAMPLES

- Help seeking that leads to dead ends because of mental health resource deserts such as shortage of BIPOC/Spanish speaking/trans/military veteran counselors
- Programs designed outside of the context of the group may not take into account...
  - The Black community's value of community care (e.g. other mothering and doing whatever is necessary to take care of each other)
  - Rural values of individualism and managing on their own
  - Gender norms that stigmatize vulnerability for boys and men
  - Religious conceptions of suicide as sin and stigma
- Lack of health insurance, or access only to subsidized health insurance that is catastrophic
- Programs and services that require written documentation or giving personal information deter people who have reason to fear government agencies or community services
- Criminalization of severe and persistent mental illness (SPMI) or mental health episodes, especially for homeless and BIPOC

PRINCIPLE 2

Suicide risk factors are not treated strictly as individual traits and shortcomings, but rather are understood in the context of social determinants, oppression, and community cultural assets based on social identities. Cultural assets like knowledge, skills, abilities, and contacts possessed by oppressed groups are protective factors against suicide. Effective suicide prevention requires understanding the norms, strengths, and local contexts of communities developed over time as a response to oppression.

QUESTION TO BE ANSWERED BY SMALL GROUPS

- *What resources are currently being used to achieve lower suicide rates and improve mental health for your specific population/community?*
- *Who do those resources serve within your specific population/community and who do they leave out?*
- *What are cultural*
- *cognitions and idioms, daily values, ideas, beliefs, and understandings of suicide/death/health of impacted communities?*
- *How do community cultural norms impact help seeking?*
- *What types of community assets/strengths exist within the marginalized group (aspirational, navigational, social, linguistic, familial, resistant, etc.)?*
- *How do community members work with each other to address the pain of oppression and the risk factors for suicide?*
- *What do marginalized communities identify as their strengths?*
- *Who needs to be present in the decision making and how will you ensure they are there?*

EXAMPLES

- Changing requirements by funders that only provide "evidence-based" or known programming to include community-based, localized approaches
- Not assuming that a behavioral health intervention is always the best way to prevent suicide
- Black communities may practice "other-mothering" which is the idea that all kids within the community are raised by all the adults
- Familism of Mexican-American families that the family is more important than the individual
- LGBQTI+ creating families not defined by blood alone
- "Leave No Man Behind" or "No Veteran Stands Alone" mentality from military so they work to support each other
- Community affinity groups (Black Lives Matter, Gay Men's Chorus, Movimiento Estudiantil Chicanx de Aztlán, churches, Alcoholics Anonymous, American Association of University Women, Veterans of Foreign War)
- "Street Smarts" among the homeless about how to navigate agencies and create community with people who will watch out for them

Commented [DD2]:

- Asian-Americans live in multigenerational households in which elders teach and support younger generations
- "The Talk" of older generations speaking frankly with young people about racism and how to protect themselves from police violence

PRINCIPLE 3

Intersections are important. Understanding how social identities overlap with each other, individual lived experiences, and social group characteristics impacts individuals' ability to access appropriate resources and interventions is imperative to equity. The harm and lack of access to help that occurs is not about one social identity, but how an individual has multiple social identities. This is important because prevention and intervention based on one social identity may not address the barriers experienced by an individual at their intersections. This does not mean that small groups must account for all intersections, but rather, think about what social identities are prevalent in their groups that deserve attention.

QUESTION TO BE ANSWERED BY SMALL GROUPS

- *What are the primary intersections that exist within your demographic group that may impact high numbers of suicide?*
- *Within a group, who does the service/recommendation serve and not serve?*
- *How is a recommendation that involves a service, institution, or system actively mindful of multiple social identities?*
- *Are there ways that the service/recommendation negatively impacts parts of an individual's identity while supporting other parts of the same individual's identity?*
- *Does your solution/recommendation attempt to reduce harm for multiple social identities?*

EXAMPLES

- A service intended for a particular social identity also meets the needs of an individual's other salient identities
  - A person of faith finding support in a community that also supports their LGBTQ2SIA+ identity
  - A veteran can find a person who understands military service even if they live in a rural community
  - An older Spanish-speaking adult receives services in Spanish that incorporate the familial context of their multi-generational home
- An undocumented person experiencing housing insecurity is able to access services in a way that protects their anonymity

- Prevention and intervention designed for a broad category of men may not take into account the harm and lack of access for a Mexican-American male who only speaks Spanish (race, gender, and language).

Commented [MB3]: Moved from the description to the examples.

PRINCIPLE 4

Preventing suicide requires working across individual, interpersonal, institutional, and societal levels. A lens towards equity is defined by evaluating the harm and lack of access at each of these levels. Addressing inequities in suicide prevention needs to focus on contexts of systematic power and social identities rather than individual characteristics alone.

- **Individual Level:** Strategies that address attitudes, beliefs, and behaviors about a person's social identities and culture that causes them harm and leaves them vulnerable.
- **Interpersonal Level:** Strategies to strengthen interpersonal relationships, communication, and sense of belonging within the contexts of social identities.
- **Institutional Level:** Strategies that address community conditions and institutional barriers that increase suicide risk.
- **Societal Level:** Strategies that address societal norms that create systems in which certain social identities are liabilities/limitations and address structural determinants of health.

QUESTIONS TO BE ANSWERED BY SMALL GROUPS

- *What are the social identities of your group that impact their individual, interpersonal, community, and societal experiences?*
- *Do recommendations and interventions address inequities across all levels?*
- *Who is impacted?*
- *How are decisions made?*
- *How can power dynamics be shifted to better integrate voices and priorities at each level without being tokenistic?*
- *What are barriers and supports to access and experiences with programs, services, policies, etc.? At what level(s) do these barriers or supports exist?*

EXAMPLES

- Including questions about culture at all levels of assessment and in the interpretation of assessments to avoid mis-labeling, mis-diagnosing, and/or mis-treating (Individual Level)
- A White mental health provider exploring the impact of racism or the social support network of a Black client rather than focusing solely on strategies like gratitude and mindfulness that are

common or well-accepted by White/Western culture, and that situate all the power within the individual (Individual Level)

- ❖ Developing a suicide safety plan that considers the family structure, which may include a person's reliance on aunts, uncles, siblings, or grandparents, rather than only consider the nuclear family as the primary supports (Interpersonal Level)
- ❖ Agencies taking a proactive approach to address unconscious bias to better engage individuals in culturally responsive and culturally specific treatment options (Institutional Level)
- ❖ Strategies that address community conditions like neighborhood poverty, high density of alcohol outlets, lack of transportation (Institutional Level)
- ❖ Strategies that address institutional barriers like excessive bureaucracy, restrictive screening, geographical location, resource gatekeeping (Institutional Level)
- ❖ Adapting evidence-based education and prevention programs, treatment modalities, etc. for communities whose members were likely left out of research that created the evidence base in the first place (Institutional and Societal Levels)
- ❖ Addressing perspectives that reinforce the individualistic nature of mental health and suicide stigma in US culture (Societal Level)
- ❖ Developing a treatment plan for an individual with a disability by including them in the decision-making rather than making decisions solely based on the disability diagnosis and/or by talking to the caregiver rather than the individual seeking treatment (Societal Level)
- ❖ Develop strategies that consider institutional traumas. For example, when helping a person who identifies as LGBTQ2SIA+, it would be most appropriate to provide a list of church's that are open and affirming when providing resources (Institutional Level).

REFERENCE MATERIALS

Balajee et. al. (2012). *Equity and Empowerment Lens (with a racial justice focus).* Portland, OR: Multnomah County. Retrieved from multco.us/diversity-equity/equity-and-empowerment-lens.

Oregon Health Authority, (2020). *Healthier Together Oregon: 2020-2024 State Health Improvement Plan (OSHIP).* Retrieved from oregon.gov/oha/ph/about/pages/healthimprovement.aspx.

Oregon Education Investment Board (OEIB), *Oregon Equity Lens.* Retrieved from oregon.gov/ode/students-and-family/equity/equityinitiatives/Documents/OregonEquityLens.pdf

DRAFT LEGISLATION PROPOSAL FOR MEDICAL PROVIDERS

❶ PROBLEM (describe the problem; attach any additional information)

Suicide is the second leading cause of death in Oregon of young people ages 10 to 24, the third leading cause of death for those 35 to 44 and the eighth leading cause of death overall. Suicide cost Oregon over $740,356,000 in lifetime medical and lost work costs in 2010.

Most medical providers will work with patients that are struggling with this life-threatening mental health issue in their career. For example: the American Association of Pediatricians, 80% of pediatricians have had a patient attempt suicide or die by suicide; yet many pediatricians and other medical providers have no or very little training in how to address and treat suicide. According to SB 48 (2017) report, in Oregon only 6.1% to 34.5% of professionals completed a training in suicide intervention. The completion rates depend on the specific licensing board with 6.1% representing chiropractic physicians and 34.5% representing nurses. This bill would require OHA to ensure that appropriate and accessible suicide assessment and treatment training is available to Oregon's healthcare professionals.

PROPOSED SOLUTION TO THE PROBLEM

Medical providers need continuing medical education in suicide assessment, treatment and management so that patients who have contact with a medical provider will have someone who is competent in screening and assessing for suicide; working with a patient on safety planning and reducing access to lethal means; and connect to community resources and support. This is not intended to change the scope of practice rather it is to equip the workforce to respond to an unmet need and save lives. This bill is intended to ensure that medical providers have access to effective trainings with a goal of increasing the number of practitioners that take this training as measured in SB 48 (2017).

Require the Oregon Health Authority to:

1) Adopt and apply standards for suicide assessment, treatment and management continuing education for doctors, nurses and other medical providers in consultation with suicide prevention bodies and subject matter experts. Included professions are: a) Certified registered nurse anesthetist, as defined in ORS 678.245; b) Chiropractic physician, as defined in ORS 684.010; c) Clinical nurse specialist, as defined in ORS 678.010; d) Naturopathic physician, as defined in ORS 685.010 e)Nurse practitioner, as defined in ORS 678.010; (f) Physician, as defined in ORS 677.010 (g)Physician assistant, as defined in ORS 677.495; (g) Physical therapist as defined in ORS 688.010, and (h) Physical therapy assistant as defined in ORS 688.010 (i) Acupuncturist
2) The training must be approved by the relevant licensing/credentialing authority and must include the following elements: suicide assessment, including screening and referral, suicide treatment, and suicide management. A licensing/credentialing authority may approve a training program that does not include all of the elements if the element is inappropriate for the profession in question based on the profession's scope of practice. A training program that includes only screening and referral must be at least three hours in length. All other training programs must be at least six hours in length. A licensing/credentialing authority may specify minimum training and experience necessary to exempt a practitioner from the training requirement.
3) Scan and develop a model list of training programs in suicide assessment, treatment, and management that meet minimum standards.

4) If existing courses do not meet minimum standards, OHA develops Oregon specific 6-hour training. The training required must be at least six hours in length, unless a disciplining authority has determined that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length. Consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management to contract for training development should OHA not have the capacity to develop training.
5) By January 2024, the department shall adopt rules establishing minimum standards for the training programs included on the model list. The minimum standards must require that six-hour trainings include content specific to higher risk populations and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors.
6) Beginning July 1, 2025, the model list must include advanced training and training in treatment modalities shown to be effective in working with people who are suicidal. The list will be updated at least every two years.
7) Develop centralized website with a training registry of existing and approved suicide assessment, treatment and management continuing education options
8) Provide funding to support licensing board implementation of suicide assessment, treatment and management continuing education for licensing and re-licensure
9) Establish infrastructure to support and monitor licensee engagement in suicide assessment, treatment and management education.