2022

Youth Suicide Intervention and Prevention Plan Annual Report

Oregon Health Authority
PUBLIC HEALTH DIVISION
HEALTH SYSTEMS DIVISION

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Contents

To the people of Oregon:

The work of youth suicide prevention is beautiful and hard. So many people around our state continue to show up at committee meetings, in their schools and in their communities to do this hard, meaningful work because of a personal connection to suicide. As you might expect, these champions for suicide prevention do not always agree about the best way forward to prevent others from the pain and anguish suicide brings. Nevertheless, Oregon suicide prevention champions have done the hard work to decide on the next steps toward making young people in our state safer against suicide.

In this report, you will read about a decreasing trend in youth suicide for 2021. Oregon has experienced a 26% reduction in the youth suicide rate between 2018 and 2021. Oregon's state ranking also moved from the 11th highest in 2018 to the 22nd highest in 2021. While Oregon has moved closer to the national average (11.0 per 100,000 in 2021), its youth suicide rate is still higher (12.4 per 100,000 in 2021). With this positive news, it is important to note that not all communities, counties or races and ethnicities experienced that decrease. Nearly all of these decreases are for youth who identify as white (this includes some young people who are multi-racial with white as one of their racial identities). For Black and African American, American Indian, Alaska Native, Asian, Hispanic, and multi-racial young people, suicide deaths between 2018 and 2021 remained similar or increased.

While a decreasing trend is encouraging, still far too many Oregonian families, schools, and communities experienced the devasting loss of a loved one to suicide. Our work is not done. It is not even close.

It's natural to ask, "Why did Oregon experience a decrease in youth suicide?" National data and the change in our state ranking show that other states did not experience a similar decrease*. Also, we have heard families, educators, young people and community leaders describe the mental distress our young people continue to experience.

Suicide is complex. The reasons that someone dies by suicide are complex. Also, there are a variety of reasons that someone finds enough help, hope and strength to live through a season of suicidal ideation.

* Stone DM, Mack KA, Qualters J. *Notes from the Field:* Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group — United States, 2021. MMWR Morb Mortal Wkly Rep 2023;72:160–162. DOI: http://dx.doi.org/10.15585/mmwr.mm7206a4.

Oregon continues to make efforts to contribute to a decreasing youth suicide rate:

- Key suicide prevention legislation:
  - » Adi's Act (2019) requires every school district to have a suicide prevention, intervention and postvention plan.
  - » House Bill (HB) 2315 (2021) requires behavioral health providers to take training in suicide prevention for relicensing.
- Funding:
  - » Oregon's legislature has included dedicated funding for youth suicide prevention in the state's approved budget since 2019 when the Youth Suicide Intervention and Prevention Plan (YSIPP) was funded at about 50%.
- Coordinated efforts:
  - » YSIPP priority initiatives are chosen annually by the Oregon Alliance to Prevent Suicide, youth-serving state agency partners and the OHA suicide prevention team to align and prioritize the work.
  - » All YSIPP initiatives are nestled within the Oregon Suicide Prevention Framework (pg 8).
  - » There are community partners dedicated to the work. Suicide prevention is only effective if it is implemented at the local level.

Now is not the time to get complacent. We need to anchor in on what we know is having an impact. We need to take a serious look at why youth of color are not seeing a similar decrease as white youth in Oregon. We need to recommit to prevention efforts such as training, policy and procedures that support early identification of suicide risk. That includes creating more opportunities for healing and wellness. Prevention needs constant attention; we know the value of a single training has a shelf life. We know that prevention is powerful and effective.

I am asking each of you to hear this as a call to action. Get involved. Get trained. Ask about what your school district, county and local suicide prevention coalition are doing for suicide prevention. Considering joining or starting a local coalition of folks who work on suicide prevention in your community. If you are worried about someone, don't hesitate to ask the question: Are you thinking about suicide? Encourage folks to text, chat or call the 988 Suicide & Crisis Lifeline to reach out for help.

Together, we can continue building a network of support, hope and healing.

Suicide is everyone's business. How will you make it yours?

Sincerely,

Ebony Sloan Clarke
Behavioral Health Director
OREGON HEALTH AUTHORITY

Executive summary

This is an executive summary of the Youth Suicide Intervention and Prevention Plan (YSIPP) report required by ORS 418.731 as directed in HB 4124 (2014). The report includes information about the progress of implementing the YSIPP as well as updated data on youth suicide in Oregon.

The data in the report shows:

- A three-year decrease in youth suicides (24 and younger) in Oregon, with both fewer total deaths and a lower rate in 2019, 2020 and 2021. This marks a 26 percent decrease in the number of suicide deaths among youth (24 and younger), from a peak in 2018 when 129 youth died by suicide.
- In 2021, 95 Oregon youths died by suicide. Suicide remains the second-leading cause of death among people ages five to 24.
- While Oregon has seen a 27% decrease in suicide rate (26% in suicide deaths) from 2018-2021, there are racial disparities in the data. Specifically, deaths by suicide for youth identified as white have fallen. However, the number of youth suicides for youth of other races and ethnicities have remained similar to 2018 levels or have increased.
- The 2021 data show that Oregon had the 22nd highest youth suicide rate in the United States, down from the 11th highest in 2018.
- Oregon's rate of youth suicide in 2021 was 12.4 per 100,000. In 2018, Oregon's rate was 16.9 per 100,000. This remains above the national average (11.0 per 100,000).
- Preliminary data for 2022 (which will not be official until spring 2024 when the Centers for Disease Control and Prevention (CDC) releases finalized data) indicate that Oregon will not see an additional decrease in youth suicide rates. There is more work to do to ensure our progress continues, as the risk of youth suicide continues to be a concern in Oregon.

The report details the progress that OHA, OHA's contactors, the Oregon Alliance to Prevent Suicide, and youth-serving state agency partners have made in 117 initiatives in 2021-2022. These initiatives include work in suicide prevention, intervention, and postvention (caring response after a suicide death). It also includes work led by OHA, the Oregon Alliance to Prevent Suicide, and youth-serving state agencies. In 2022, Oregon added 408 new trainers to Big River suicide prevention programs. Fifteen counties in Oregon have active trainers in all nine Big River programs.

As of December 2022, 71 (63 percent) of the initiatives were achieved, 25 (22 percent) were in progress, 14 (12 percent) were in the early action stage, and 4 (3 percent) were in the planning stage. Most 2021–2022 initiatives were prioritized to continue into 2023 and were included in the YSIPP 2023 Priority Initiatives. There are 156 youth suicide prevention, intervention and postvention initiatives for 2023.

Oregon Suicide Prevention Framework

The Youth Suicide Intervention and Prevention Plan (YSIPP) (2021-2025) was built by using the Oregon Suicide Prevention Framework blueprint. OHA developed this framework with the University of Oregon Suicide Prevention Lab (UOSPL) under the leadership of Dr. John Seeley. The National Strategy for Suicide Prevention and the Centers for Disease Control and Prevention (CDC) Technical Package for Suicide Prevention provides the grounding for this plan. The San Diego Suicide Prevention Plan and hundreds of pieces of feedback from collaborators and partners across Oregon also informed the framework.

Framework definitions:

Strategic pillars, strategic goals, centering values and foundation

These will not change over the five-year lifespan of the plan. They are the starting point for all suicide prevention work in Oregon.

Strategic pathways

These are not likely to change over five years. These are rooted in the centering values and foundation. They represent measurable areas of focus and are more specific to populations or settings. For example, under the goal of "means reduction," one pathway is "All Oregonians experiencing behavioral health problems will have access to safe storage of lethal means."

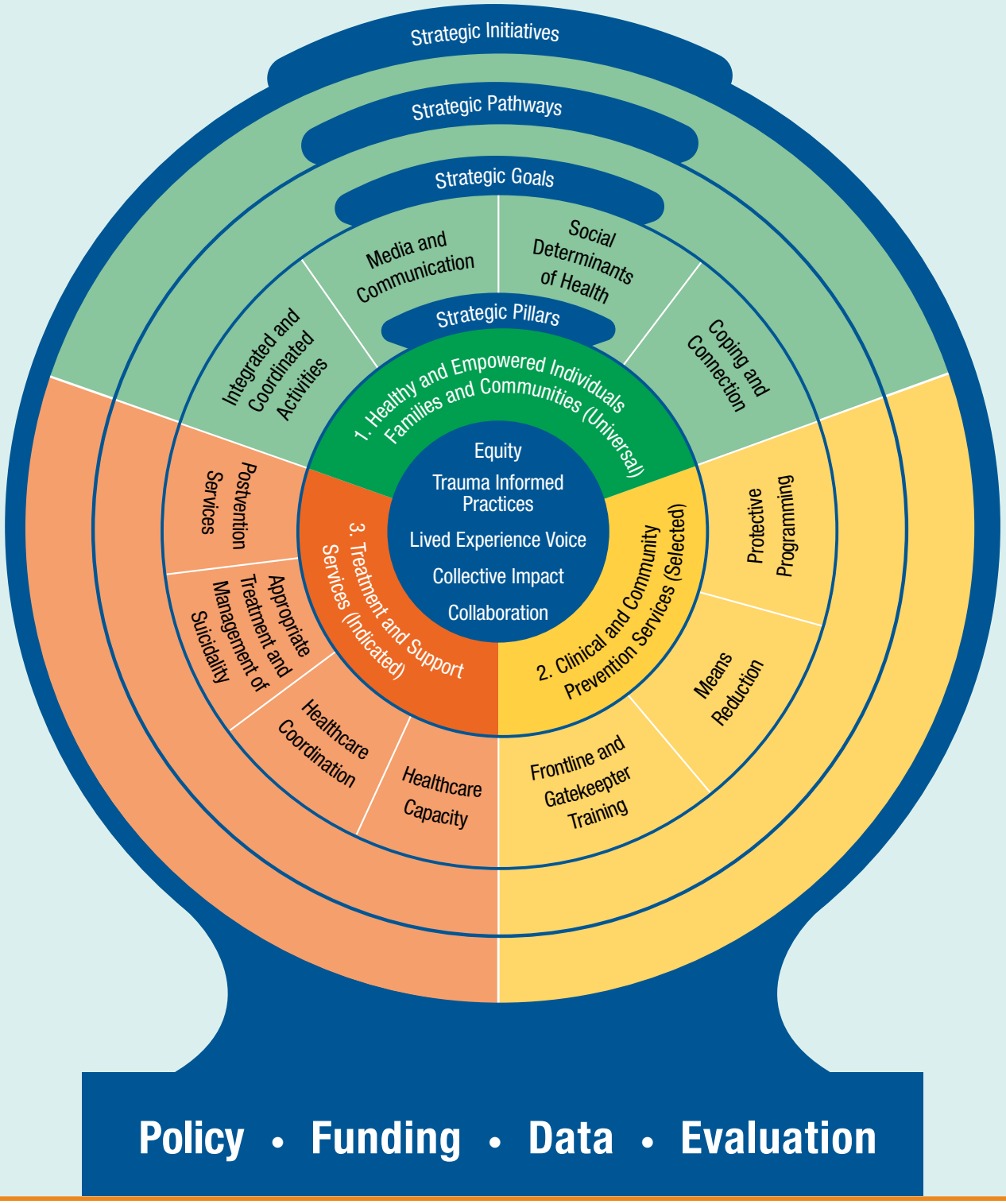
Strategic priority initiatives

These will be adapted, adjusted and added to annually. They are specific actions designed to support the broader pathways and goals. In 2022, Oregon's youth suicide prevention efforts included 117 priority initiatives. In 2023, partners across Oregon named 156 priorities — that list can be found on the OHA website.

The strategic pathways and priority initiatives together comprise the YSIPP 2021-2025. OHA built the five-year YSIPP on the foundation of the strategic goals, strategic pillars, center and base.

This report outlines the progress on the annual priority initiatives that the Oregon Alliance to Prevention Suicide, the OHA suicide prevention team, and youth-serving state agency partners named as the most important projects to work on in 2022. All 117 initiatives included in this report align with the Oregon Suicide Prevention Framework.

Oregon Suicide Prevention Framework



The Big River programming summary

A large part of the youth suicide prevention work involves statewide programming for suicide prevention, intervention, treatment, and postvention (after a suicide loss). This programming is called the Big River. The suicide prevention team developed an interactive map of Big River Programming options. OHA's suicide prevention team supports the programs listed below with contracted statewide coordination, hosted learning collaboratives and train-the-trainer support when applicable. Before 2019, OHA had limited support for these program options.

This programming collectively added 408 trainers or coaches in suicide prevention, intervention and postvention training programs in 2022.

One of the centering lenses of the Oregon Suicide Prevention Framework is equity. Identified areas of needed improvement include culturally specific, responsive, and appropriate training options for suicide prevention. While there is more work to do, the Big River programs made progress in 2022.

Some examples of how the Big River is moving equity to the center:

- Mental Health First Aid (MHFA) increased training to diverse populations, provided cultural consideration guides to trainers, supported Spanish-speaking instructors with a monthly learning collaborative, and provided information about Youth MHFA for Tribal Communities and Indigenous Peoples.
- The advanced skills coordinator requested all training include information on serving people with intellectual and developmental disabilities.
- Question, Persuade, Refer (QPR) continued outreach to culturally-specific organizations to increase diversity in the trainer pool.
- Youth SAVE (Suicide Assessment in Various Environments) applied for funding together with a culturally-specific organization to develop safety planning recommendations and protective factors for African American youth.
- Sources of Strength collaborated with another state partner and the Northwest Portland Area Indian Health Board (NPAIHB) to plan a train-the-trainer event for 2023 for tribes.
- Big River programs have embedded multiple layers of youth engagement, positive youth development, and youth feedback opportunities throughout programming.

Looking ahead:

In 2023, the OHA suicide prevention team intends to add training options for Spanish-speaking providers and a course for all providers focused on Latinx considerations for suicide prevention.

Table 1 – Advanced skills training for providers 2022

Training name	Number of providers trained	Number of counties with providers trained
Cognitive Behavioral Therapy (CBT)	209	26
Dialectical Behavioral Therapy (DBT) Skills and Suicide Prevention	117	19
Collaborative Assessment & Management of Suicidality (CAMS)	40 online course 67 role-play training 74 consultation calls	22
Attachment-Based Family Therapy (ABFT)	53	10
Assessing and Managing Suicide Risk (AMSR)	112	3
Totals:	672	33 unique counties

Table 2: Big River implementation 2022

Program name	Number of active trainers statewide	New trainers added in 2022	Number of counties with trainers	Available in Spanish	Tribal specific adaptations	Youth engagement efforts included
Sources of Strength: Elementary grades K-6	K-6: 142 3-6: 170	81	19	Yes	No	Yes
Sources of Strength: Middle, high, and college	73	44	19	Yes	Yes	Yes
Mental Health First Aid (MHFA)	106	32	31	Yes	Yes	Yes
QPR (Question, Persuade, Refer)	781	185	36	Yes	Yes	Yes
ASIST (Applied Suicide Intervention Skills Training)	139	26	26	No	No	No
Youth SAVE (Suicide Assessment in Various Environments)	31	0	19	No	No	Yes
Youth SAVE (Suicide Assessment in Virtual Environments): Primary Care	4	4	4	No	No	No
Oregon CALM (Counseling on Access to Lethal Means)	13	0	8	No	No	No
Connect: Postvention (Oregon adaptation)	70	36	14	No	No (in development)	No
Total:	1,387	408	15	4	3	5

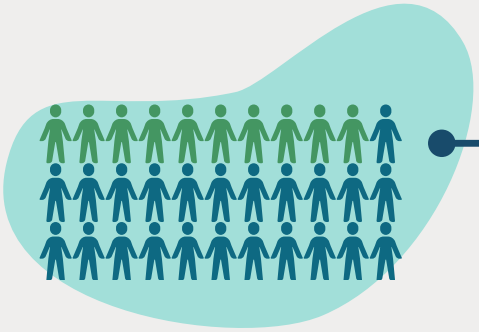
Figure 1: Big River Programs

2022
Big River Programs

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

Local Communities Equipped

Each of Oregon's **36** counties has active trainers in one or more of the Big River programs.

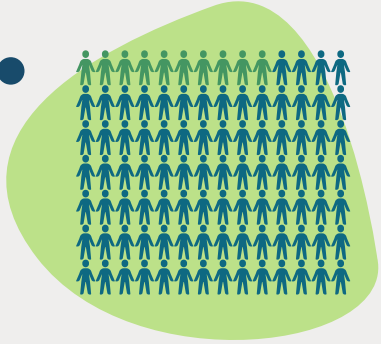


Trainers in Oregon

There are currently **1,387** active trainers across the 9 Big River programs that have Train-the-Trainer structures. Collectively, the Big River added **408** new trainers in 2022.

Equipped Workforce

In 2022, hundreds of providers had access to Advanced Skills courses designed to equip them to treat suicide ideation within their practice. **379** providers took advanced coursework through Big River programming.



Youth suicide prevention funding

The Health Systems Division (**HSD**), Child and Family Behavioral Health (**CFBH**) unit's budget for suicide prevention in 2022 was about $5 million in general fund dollars.

The Public Health Division (**PHD**) Injury and Violence Prevention Program (**IVPP**) manages several federal grants that contribute to **YSIPP** efforts. These are delivered through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC). IVPP staff carrying out the YSIPP initiatives outlined in these grants sit on the OHA suicide prevention team. They coordinate across state and federal funding streams to meet both grant and YSIPP goals. These grants include the following:

SAMHSA (Substance Abuse and Mental Health Services Administration) Garrett Lee Smith Memorial Act (GLSMA) (Oregon GLS): OHA received a new round of GLSMA funding for June 2019 through June 2024. Oregon receives $736,000 a year through this grant mechanism. This funding supports suicide prevention capacity grants in select Oregon counties and through the Oregon Department of Human Services. It also supports community and clinical training to reduce suicides of youth 10-24 years old. The 2021 YSIPP report includes grant accomplishment highlights.

SAMHSA Zero Suicide in Health Systems Grant: OHA received this new funding stream for September 2020 through August 2025. Oregon receives $700,000 a year through this grant mechanism. This grant supports OHA working with Oregon health systems to provide safer specific suicide care for adults ages 25 and older using a nationally recognized model, Zero Suicide. This grant allowed **IVPP** to hire a dedicated Zero Suicide in Health Systems coordinator to develop a Zero Suicide program. While the new grant focuses on reducing suicide risk for adults 25 and older, the position also supports existing Oregon Zero Suicide work in health systems that focuses on youth populations. It also expands learning and training opportunities for all health systems using Zero Suicide, including youth-focused initiatives. The Zero Suicide in Health Systems coordinator sits on the Alliance's Transitions of Care Committee to ensure coordination across programs.

Grant accomplishments include:

- Hosting a two-day Zero Suicide Academy with national and local leaders for Oregon health systems to learn about the Zero Suicide model and action plan to move their Zero Suicide efforts forward
- Supporting Community Counseling Solutions serving Gilliam, Grant, Morrow, Umatilla and Wheeler counties to advance their Zero Suicide Initiative

- Providing a Zero Suicide plenary session and breakout session at the 2022 Oregon Suicide Prevention Conference, and
- Providing a Zero Suicide breakout session at the 2022 Oregon Opioids and Other Drugs, Pain and Addiction Treatment Conference to highlight the intersection of substance use, chronic pain and suicide.

CDC Firearm Injury Surveillance Through Emergency Rooms (FASTER): OHA received this new funding stream for September 2020 through August 2023. It provides $225,000 in year one and $180,000 in year two. This grant provides funding for OHA PHD to partner with the Oregon Health & Science University-Portland State University School of Public Health (OHSU-PSU SPH) to demonstrate the feasibility of monitoring and gathering data on nonfatal firearm injuries, including suicide attempts and self-harm. Data on firearm injury in Oregon would allow the state to design ways to reduce injury and inform prevention efforts. Grant activities in 2022 included:

- Engaging community partners to understand how they currently use firearm injury data and how best to share firearm injury data for use to support prevention work,
- Developing the Oregon FASTER Project Data Dashboard and releasing the Oregon FASTER Project Data Report, based on community partner feedback, including firearm injury emergency department data and information on prevention strategies, and
- Continuing to validate and improve the quality of firearm injury data for state and community partner use.

CDC Comprehensive Suicide Prevention: OHA was one of six awardees in the second round of funding. The grant funds are for September 2022 through August 2027. It provides $855,000 a year. Led by the OHA Public Health Division in partnership with the Health Systems Division, the grant provides funding to implement and evaluate a comprehensive public health approach to suicide prevention in Oregon to reduce suicide attempts and deaths in rural areas and adults aged 55 and older by 10%. There is a focus on culturally-responsive interventions to reduce the higher burden of suicide in firearm owners, veterans and those who served in the military. Additional grant activities include creating awareness of the connection between suicide and alcohol use. The Adult Suicide Prevention coordinator actively coordinates grant work in the OHA Adult Suicide Intervention and Prevention Plan. While the grant focuses on adults, grant activities contribute to creating protection for youth through well-informed adults and communities. Initial work on the grant involves:

- Establishing a grant project advisory committee
- Creating a partnership plan that includes reviewing and analyzing data sources
- Creating and disseminating a survey to assess current adult suicide prevention work happening across the state
- Developing a communication plan, and
- Gaining community feedback on the grant activities for finalization

Progress report on YSIPP 21-22 initiatives

This section describes the progress and status of each of the YSIPP 2021–2022 priority initiatives at the time of this report. OHA maintains current progress and status updates here. The OHA suicide prevention team and the Oregon Alliance to Prevent Suicide have updated and posted YSIPP priority initiatives for 2023.

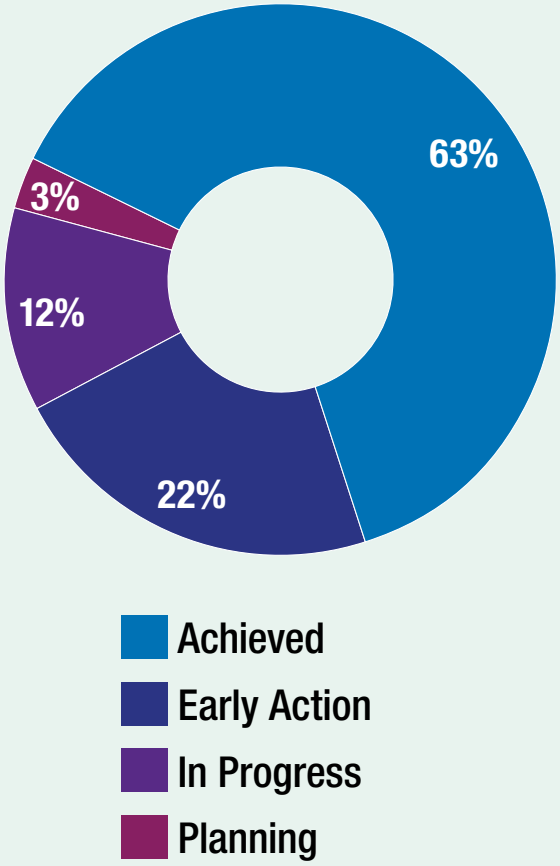
Status update categories and color codes for initiatives defined:

- **Planning:** This initiative is in the planning or preparatory stages. No action steps have been taken.
- **Early action:** One or two steps have been taken.
- **In progress:** Significant progress has been made. However, the initiative is not fully completed.
- **Achieved:** This initiative has been fully completed or there is sustained ongoing work.

Progress summary

OHA, the Oregon Alliance to Prevent Suicide, and youth-serving state agency partners worked on 117 initiatives in 2022. As of Dec 2022, 63 percent (71 count) of the initiatives were achieved, 22 percent (25 count) were in progress, 12 percent (14 count) were in the early action stage, and 3 percent (4 count) were in the planning stage. Most of the 2021–2022 initiatives were prioritized to continue into 2023 and were included in the YSIPP 2023 Priority Initiatives. There are 156 initiatives for 2023.

Figure 2: YSIPP 21-22 status of all initiatives (117 count)



Progress key

 On track and no current barriers to implementation

 Most, but not all deadlines are being met, or there are some barriers to implementation

 Some or all of the tasks are overdue, or there are significant barriers to implementation

1. Healthy and empowered individuals, families and communities

1.1 Integrated and coordinated activities

1.1.1 "Coordinated activities" — Youth suicide prevention programming is coordinated between Tribes, state, county, and local leaders to maximize reach and ensure equitable access for all Oregonians.

1.1.1.1 New Strategic Initiative for 2021–2022: Organize the people, staff, and infrastructure of suicide prevention across the state.

In Progress

Work completed: The OHA Suicide Prevention team has assigned lead responsibility for each initiative in the YSIPP 2021–2022. The team assigned leads to each committee and advisory group of the Alliance to Prevent Suicide. The Alliance staff has been tasked with updating the contact information for the 18 local suicide prevention coalitions across Oregon. Planning meetings were scheduled in Sept 2022 to map known school district suicide prevention contacts. A list of tribal contacts for notification after a suicide death was gathered by OHA's tribal affairs. Work to be done: Continue to update suicide prevention staff in counties, school districts, tribal health and prevention departments, place ZeroSuicide programs in health settings, and staff who support suicide prevention in relevant state agencies.

This work will be ongoing. Significant progress was made in 2022 to organize the internal OHA suicide prevention team, the Oregon Alliance to Prevent Suicide, county contacts, and tribal contacts. This will continue to be a priority in 2023.

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

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.

In Progress

Big River collaboration meetings include updates from programs. Big River coordinators are provided with tools to connect to other programs. Big River coordinators frequently create warm hand-offs to other Big River programs and frequently connect local and statewide partners to the work of their program and other Big River programs.

1.1.1.4 The OHA Suicide Prevention, Intervention and Prevention (SPIP) team is established. 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.

Achieved

Partners meet monthly in each of the listed categories to align work and provide support. These meetings occur regularly and will continue into 2023.

1.1.1.5 Fall coordination meetings between contracted coordinators and specialists supporting Adi's Act implementation, Oregon Department of Education (ODE), and OHA coordinators are scheduled with each Educational Service District.

Planning

There was a delay in the Inter-Agency Agreement (IAA) between ODE and OHA. There was a large group meeting scheduled for February 2022. Individual coordination meetings were originally planned for spring 2022. These coordination meetings were then planned for Sept 2022.

The Inter-agency Agreement was signed in March 2022.

Coordination meetings were completed with OHA, Lines for Life, and the School Safety and Prevention Specialists in Sept and Oct 2022 with each regional SSPS. Areas for collaborative work and connection were discussed at each meeting. Notes shared with ODE and with each SSPS.

1.1.1.6 Garrett Lee Smith grant recipients have staff for suicide prevention (Multnomah, Lane and Deschutes counties).

Planning

OHA received a new round of GLSMA funding for July 2019 through June 2024.

Gatekeeper training has been implemented to increase the number of persons in youth-serving organizations trained to identify and refer youth at risk. From the start of grant activities in June 2019–Dec. In 2022, over 8,450 people have been trained. Deschutes, Lane, and Multnomah counties all have GLS-funded coordinators leading the work.

1.1.1.7 The Oregon Alliance to Prevent Suicide (The Alliance) will organize committees, advisory groups, and workgroups to align with YSIPP 2021–2025.

In Progress

Alliance committees and workgroups provided recommendations to OHA about updating and revising YSIPP. In fall 2022, a new co-chair for the full Alliance was elected and new leadership stepped into chair or co-chair the Schools, Equity and Evaluation Committees. To align with YSIPP priorities more closely, the lethal means advisory group transitioned to become a standing committee and the chair joined our Executive Committee.

1.1.1.8 Big River statewide coordinators will make local training data available to local leaders including a "heatmap" of Big River trainers.

Early Action

The Big River program map is widely distributed. Users can click on the electronic map to reach programs. All programs made program information, including a heatmap, available on each Big River program website during 2021–2022. The focus of work in 2022-2023:

- Provide data to local leaders, and
- Continue efforts to compile the data in one centralized place.

1.1.2 "SP (suicide prevention) policies" — Organizations and agencies have suicide prevention policies for clients and staff that are known and used.

1.1.2.1 Rules for Senate Bill (SB) 563 (2021) were written through OHA's rulemaking process. The Alliance to Prevent Suicide assigned representation to take part in this process.

Achieved

Oregon Administrative Rules 309-027 went through rules revision starting in March 2022. Tribal leaders were notified of the rules revision process in Jan 2022. The rules advisory committee meeting was held in March and May 2022. The rules were completed on Jan. 1, 2023.

1.1.3 "Coordinated organizations" — Organizations and agencies are coordinated and understand their role in suicide prevention.

1.1.3.1 OHA hosts a monthly meeting with state agencies to discuss Suicide Prevention initiatives and needs (called SPIP — State Agency Partners — Youth Focused). State agency representatives are from Oregon Youth Authority, ODE, Oregon Department of Human Services — Self Sufficiency, and Oregon Department of Human Services — Child Welfare.

Achieved

This group currently meets on the second Tuesday of each month. ODHS secured funding for a half-time suicide prevention coordinator position within the Child Welfare team in mid-2021. This position works to meet GLS grant requirements as well as coordinates with broader OHA youth suicide prevention efforts. This will continue into 2023.

1.1.3.2 OHA and The Alliance continue to build connections with youth-serving community based organizations to invite participation in the Alliance and youth suicide prevention trainings and work.

In Progress

Maintain a shared contact list of staff or leaders in youth-serving community-based organizations and conduct town halls and focus groups with youth and young adults to gather input. Met with Youthline staff and will partner on bringing youth to the Capitol for a suicide prevention advocacy day with The Alliance. Provided scholarships and supported three young adults to attend the Oregon Suicide Prevention Conference.

1.1.4 "Voice of lived experience" — People with lived experience have a meaningful voice in Oregon's suicide prevention, including programming decisions and links to key leaders.

1.1.4.1 Stipends are provided for youth representatives and people with lived experience that are not paid to attend state advisory committees

Achieved

Stipends are regularly paid for youth representatives and people with lived experience. The stipend amount increased in 2021 which required new forms and processes. Alliance staff and OHA staff have updated their processes and continue to explore ways to make the stipend payment process accessible.

1.1.4.2 Youth representatives (including at least one person that has not yet reached age 18) serve on The Alliance

In Progress

There are currently several vacancies for youth representatives. A youth engagement team is meeting to discuss how to better and more meaningfully engage this age group moving forward. Staff received two applications for youth and young adults during the application period. Staff met with both new members to review The Alliance, the stipend process, and engagement opportunities. One new youth actively engaged in the last quarter and has been regularly attending meetings. Two young adult members are on the verge of "aging out." More support is needed to recruit and engage youth — especially those 18 and under.

1.1.4.3 The Alliance will maintain youth reps on each committee and ensure the following populations are represented whenever larger feedback is gathered: members 18 or younger, rural youth, racial and ethnically diverse youth, LGBTQIA2S+ youth.

In Progress

There are currently several vacancies for youth representatives. The youth engagement team was created and submitted a proposal to the executive committee about a new youth engagement strategy. This was approved by the Alliance Executive Committee and OHA and included funding for this strategy in the 2021–2022 contract. Staff received two applications

for youth and young adults during the application period. Staff met with both new members to review The Alliance, the stipend process, and engagement opportunities. Staff will continue to regularly check in with them and make sure they can connect with The Alliance how they want. We have two youth and young adults that regularly attend a variety of Alliance committees. The Alliance recommends revising this initiative to allow for more flexible youth engagement strategies.

1.1.4.4 OHA will require diverse youth engagement and a meaningful feedback loop in all relevant OHA suicide prevention contracts

Achieved

This requirement of diverse youth engagement was included in all suicide prevention contracts in July 1, 2022, and will continue into 2023.

1.1.4.5 OHA will contract specifically for youth engagement and meaningful feedback including Youth and Young Adult Engagement Advisory (YYEA), focus group stipends and facilitation, including in program planning and evaluation efforts.

Achieved

This requirement was included in all relevant suicide prevention contracts in July 1, 2022, and will continue into 2023.

1.1.5 "Equipped Advisories" — Advisory groups are well supported, equipped, and function efficiently to make meaningful change.

1.1.5.1 The Alliance will continue to be staffed at 2.0 full-time equivalent (FTE).

Achieved

This staff support is currently in a contract with the Association of Oregon Community Mental Health Programs and will continue into 2023.

1.1.5.2 Youth and Young adult Engagement Advisory (YYEA) receives OHA support for .5 FTE staff.

Achieved

YYEA receives OHA support for .5 FTE staff — although the position is not currently filled due to workforce shortage.

1.1.5.3 OHA will continue to provide coordination for the Children's System Advisory Council (CSAC) and collaborate with the System of Care Advisory Council (SOCAC).

Achieved

Achieved: OHA staff provide logistical support and facilitation of CSAC and collaborate with SOCAC.

1.1.6 "Resourced coalitions" — Regional suicide prevention coalitions are informed and resourced to address their local needs and priorities.

1.1.6.1 The Alliance staff hosts a quarterly webinar to provide networking support for regional suicide prevention coalitions and other local suicide prevention champions.

In Progress

These meetings occurred in February, June, August and November 2022 Meetings continue to be held quarterly. Each webinar highlights the works of one of the regional coalitions to promote mutual learning, and suicide prevention-related topics (for example, messaging and talking about suicide and LGBTQIA2S+ youth). For 2023, there will be an equity-related topic each quarter, so we continue to center this work. Typically, at least 35 to 45 people from across the state attend.

1.1.6.2 The Alliance staff hosts a quarterly learning collaborative for regional suicide prevention coalition leaders.

In Progress

The coalition leaders developed suicide prevention campaign materials for Mental Health Month in May and Suicide Prevention Month in September. About 20 leaders of coalitions joined a meeting focused on the upcoming mini-grant opportunity. They provided feedback about requirements and how to create a meaningful, low-barrier application process.

1.1.6.3 Statewide resources, educational opportunities, and programming options are shared with the regional suicide prevention coalition leaders.

Achieved

This resulted in a coordinated effort during Suicide Prevention Awareness Month to create the "Don't Give Up" public awareness and positive messaging campaign. More information is on the Alliance website. This work is ongoing into 2023.

1.2 Media and communications

1.2.1 "Safe messaging" — All Oregonians receive safe messaging about suicide and self-injury.

1.2.1.1 American Foundation for Suicide Prevention (AFSP) and Suicide Prevention Resource Center (SPRC) national safe messaging projects are promoted on OHA's suicide prevention listserv and The Alliance listserv.

Achieved

Resources and projects are regularly promoted on both listservs.

1.2.2 "Promoting wellness" — Organizations and agencies routinely and strategically promote wellness, emotional strength, mutual aid examples, and protective factors.

1.2.2.1 OHA will maintain a statewide calendar of press releases and media events for various populations of focus

Achieved

Press releases are scheduled for March, June, September and December 2023.

1.2.2.2 Oregon AFSP will continue social media campaigns to promote wellness and bolster protective factors.

Achieved

This occurs regularly.

1.2.2.3 Oregon Sources of Strength will continue to promote positive culture change in Oregon schools K-12 and post-secondary and will continue to grow program reach to other youth-serving spaces.

In Progress

Sources of Strength for grades K–2 began in the Fall of 2022. Sources of Strength is widely available and growing in grades K–12 and post-secondary. It is connecting to other youth-serving spaces including ODHS Child Welfare, independent living programs, after-school programs, pediatric practices, and several Tribal youth services.

1.2.3 "Information Dissemination" — Suicide prevention programming, information and resources are widely advertised and centrally located on one website. Information is kept up-to-date.

1.2.3.1 Youth Suicide Prevention listserv messages are sent by OHA regularly with training, resources, conferences, and announcements pertinent to youth suicide prevention statewide.

Achieved

A message is sent out every 2–4 weeks on this listserv. The listserv currently has over 400 members.

1.2.3.2 Safe + Strong website will continue to be a reliable place to find Oregon resources and support.

Achieved

The Safe + Strong website will continue to be a reliable place to find Oregon resources and support.

1.2.3.3 Oregon Suicide Prevention website will continue to develop as a place to find current information about Oregon suicide prevention work for behavioral health providers, schools, and community members.

Early action

The Oregon Suicide Prevention website will continue to develop as a place to find current information about Oregon suicide prevention work for behavioral health providers, schools and community members. Update: Training information is regularly updated with new web pages as necessary. Additional content is on hold due to funding to support development.

1.2.3.4 Alliance to Prevent Suicide Website will continue to make information available regarding Alliance activities, legislative work, opportunities for community members to be involved, and resources.

Achieved

The Alliance to Prevent Suicide Website will continue to make information available about Alliance activities, legislative work, opportunities for community members to be involved, and resources.

1.2.3.5 OHA Public Health Division and Health Systems Division websites will be accurate and offer updated information.

In Progress

The HSD youth suicide prevention website was updated in January 2022 and December 2022. Update: the Public Health Division youth suicide prevention website is currently being reviewed and updated. The website includes links to the YSIPP, the latest YSIPP annual report, and national and local crisis lines.

1.2.3.6 Oregon Suicide Prevention Conference will be held annually in diverse areas of Oregon and be led by a collaborative and representative advisory group.

Achieved

The October 2022 conference took place from October 11-13. There was a pre-conference training day held on October 10, 2022. OHA provided $10,000 in scholarships to fund primarily those with lived experience to attend the conference. This was the first in-person conference held since 2019. There were over 200 registered attendees. The 2023 conference is scheduled for October 2023 in Hood River.

1.2.3.7 OHA will issue a press release related to suicide prevention quarterly.

Achieved

Press releases are scheduled for March, June, September and December 2023.

1.2.4 "Informed leaders" — Key decision-makers are kept well-informed and up-to-date about suicide activity and prevention efforts (including legislators, Oregon Health Authority leaders, Oregon Department of Education leaders, and county commissioners).

1.2.4.1 Within the OHA Recovery Report suicide prevention work is highlighted at least quarterly.

Achieved

The Recovery Report is not being issued at this time. Suicide Prevention has a regular monthly report in the Children and Family Behavioral Health Unit's newsletter, called Holding Hope. Suicide prevention is featured at least quarterly and will continue into 2023.

1.2.4.2 Annual YSIPP report is published and disseminated widely by March 2023.

Achieved

1.2.4.3 The Alliance will schedule presentations with key lawmakers before each legislative session.

Early action

Alliance to Prevention Suicide legislative priorities were not named for the 2022 short session. However, a policy agenda for the 2023 long session was developed as was a flyer describing the agenda supported by Lines for Life, Basic Rights Oregon and AOCMHP.

The Alliance partnered with the American Foundation for Suicide Prevention's Oregon Chapter for the 2022 virtual Capitol Days. Alliance staff and members presented during the actual event and staff met with legislators to discuss their 2023 policy options package (POP) recommendations and what they hoped to advocate for in the 2023 legislative session. The virtual event was attended by 160 people.

1.3 Social determinants of health

1.3.1 "Clear links" — The link between economic factors and the risk of suicide is highlighted outside of typical suicide prevention work.

There were no named priority initiatives in this section for 2022.

1.3.2 "Supporting partners" — Suicide prevention advocates and experts support the work of those decreasing disparities and inequities.

There were no named priority initiatives in this section for 2022.

1.4 Coping and connection

1.4.1 "Positive connections" — All Oregonians have access to meaningful places and spaces to experience positive connections and promote mutual aid.

1.4.1.1 Sources of Strength programming available statewide for all students grade 3 to postsecondary.

Achieved

Sources of Strength is available to any school in Oregon. The use of this program is growing in grades K–12 and post-secondary.

1.4.1.2 YouthERA, Youthline, and Oregon Family Support Network (OFSN) are available and advertised widely.

Achieved

These resources are widely advertised and continue to be available.

1.4.1.3 Statewide partners in building positive youth connections are identified and receive communication from OHA suicide prevention coordinators and The Alliance including Oregon Afterschool & Summer for Kids Network (OregonASK), ODHS, Oregon Foster Youth Connection (OFYC), and Oregon Alliance.

In Progress

There has been significant work to identify partners in ODHS. The Alliance and OHA have refined the initiative for 2023 to reflect priority organizations with whom to build connections.

1.4.2 "Coping strategies" — All Oregonians understand and have access to what helps them to cope with hardship themselves and within their community including culturally specific strategies.

1.4.2.1 Sources of Strength Elementary (grades 3-5) suicide prevention programming is available statewide.

Achieved

This is available to any school in Oregon. In the 2021–2022 school year, 55 schools implemented Sources Elementary.

1.4.2.2 Explore possibilities for K-2 suicide prevention programming

In Progress

An elementary suicide prevention coordinator was hired in 2021 through Matchstick Consulting. More than 100 schools indicated an interest in K-2 programming. Sources of Strength K-2 will be available for the 2022-2023 school year in English and Spanish. An elementary suicide prevention workgroup led by Matchstick Consulting is creating Tier 2 tools for elementary schools.

1.4.3 "Support roles" — People, family and caregivers understand and feel equipped to fulfill their role and understand their important impact on suicidality.

1.4.3.1 Sources of Strength makes Adult Advisor training widely available for youth-connected adults in areas with Sources programming.

Achieved

There are 3.0 FTE trainers available for statewide training, in person or virtual. One trainer is bilingual. In August 2021, new trainers were hired. Local trainers are being trained through training for trainers (T4T) and certified through a statewide program.

1.4.3.2 Mental Health First Aid has a version created for youth-serving adults and training for trainers in the youth curriculum is widely available.

Achieved

Youth Mental Health First Aid (YMHFA) is available. YMHFA T4T took place in 2022 and is planned for 2023. Organizations are supported to connect staff with this training where appropriate.

2. Clinical and community prevention services

2.1 Frontline and gatekeeper training

2.1.1 "Appropriately trained community" — Oregonians receive the appropriate level of training for suicide prevention (basic awareness, enhanced, or advanced) and are retrained appropriately.

2.1.1.1 The K-12 school sector-based resource called "Suicide Prevention, Intervention, Postvention: Step By Step" will be available at no cost. This resource outlines recommendations for the appropriate level of training and retraining recommendations.

Achieved

This guide is available free online at https://oregonyouthline.org/step-by-step/. The step by step (SBS) guide was updated in 2021 to ensure the centering of equity and inclusion.

2.1.1.2 All OHA-funded school-based mental health providers will receive recommendations and tracking tools for retraining for the appropriate level of suicide prevention, intervention and postvention training.

In Progress

These tools were shared with all school-based mental health providers. The tools are also explicitly named in the contract documents if programs request them.

2.1.1.3 House Bill (HB) 2315 rulemaking process will include recommendations from OHA defining continuing education opportunities applicable and relevant to meet the suicide prevention training requirement for re-licensure.

Achieved

A rules advisory committee met twice, and draft rules are complete. The rules were finalized on Jan. 1, 2023. The coordinator drafted recommendations for training by provider role and disseminated them to the licensing boards.

2.1.2 "Supported training options" — Suicide prevention frontline and gatekeeper training is widely available at low- or no-cost for Oregon communities.

2.1.2.1 OHA will support Big River Programming by providing low- or no-cost access to train-the-trainer events, statewide coordination, evaluation support, and limited course support for the following programs:

Achieved

Big River programs are widely available. T4Ts are scheduled and available widely.

Appropriate screening is in place for all programs. Ongoing support, evaluation and course support are available on some level for all programs.

2.1.2.1.1 Basic suicide prevention training options are available statewide and include Question, Persuade, Refer (QPR), Youth Mental Health First Aid, and Adult Mental Health First Aid.

Achieved

See the Table 2 training infographic to learn about the implementation of these programs in 2022. In addition to statewide efforts, ODHS made computer-based QPR training mandatory for all employees. There is an exemption process for employees who did not feel they could participate due to their lived experience with suicide. As of Dec. 31, 2021, over 6,000 ODHS employees and partner agency staff had completed the training.

QPR for Parents is developed. QPR for Teens is currently under development. MHFA is available in several sector-specific modules.

2.1.2.2 OHA will support Big River programming by providing low- or no-cost access to the following training programs: Applied Suicide Intervention Skills Training (ASIST), Oregon Counseling on Access to Lethal Means (OCALM)

Achieved

Big River programs are widely available. T4Ts are scheduled and available widely to equip local leadership. Appropriate screening is in place for all programs. Ongoing support, evaluation and course support are available on some level for all programs. There is work to ensure programs are reaching diverse populations, including Black, American Indian and other communities of color, as well as rural and remote areas and people who use languages other than English.

OCALM was added in 2021.

2.1.2.2.1 Enhanced suicide prevention training options are available statewide for mental health providers including Youth Suicide Assessment in Virtual Environments (YouthSAVE), Collaborative Assessment & Management of Suicidality (CAMS), Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), and Assessing and Managing Suicide Risk (AMSR).

Achieved

These are available widely for appropriate service providers. There is work to ensure training is available to providers working with Black, American Indian and other communities of color.

2.1.2.3 University Oregon (UO) and OHA will explore internet-based options for local community members and youth-serving adults to locate and register for suicide prevention training.

Early action

OHA suicide prevention staff requested information about the internal capacity for this technology from OHA's Business Information Systems. After mapping system needs, it was determined there is no funding for this project in 2022-2023. OHA is exploring new options at this time.

2.1.3 "Representative trainers" — The trainer pool in Oregon for suicide prevention programming represents the cultural and linguistic diversity of the communities in which they train.

2.1.3.1 All Big River statewide coordinators will continue to assess the gaps in the availability of culturally and linguistically diverse trainers and training and will recruit accordingly and in collaboration with other Big River statewide coordinators.

Early action

Big River coordinators (collectively and individually) are working on recruiting and supporting a diverse pool of trainers. Work includes building relationships with community partners and leaders in diverse communities, ensuring programs are adaptable and culturally responsive, and connecting with local leaders. AOCMHP hired a Spanish training coordinator. Many of Oregon's federally recognized Tribes are using their suicide prevention funds to connect to the Big River programs. Tribal-specific training is being coordinated for QPR, Connect: Postvention, Sources, and MHFA

2.1.4 "Culturally relevant training" — Suicide prevention programming is regularly evaluated and updated to ensure equity, cultural relevance and responsiveness, and linguistic needs are addressed. Culturally relevant training" — Suicide prevention programming is regularly evaluated and updated to ensure equity, cultural relevance and responsiveness, and linguistic needs are addressed.

2.1.4.1 All OHA Youth Suicide Prevention contracts will require training in cultural agility or anti-racism for all contractor staff.

Achieved

All current contracts contain this requirement.

2.1.4.2 Big River statewide coordinators are equipped to assess and evaluate gaps in the cultural relevance and availability of their programs. Big River statewide coordinator meetings engage in regular and ongoing assessment of opportunities to increase cultural relevance and availability.

Early action

Big River coordinators all meet with UOSPL regularly to grow evaluations. They are all working on multifaceted approaches to assess the gaps and needs in an equity-centered way. There is work to ensure programs are reaching diverse populations including Black, American Indian and other communities of color, as well as rural and remote areas and people who use languages other than English. All Big River contracts require anti-racism or cultural agility training for staff and also require translation services to be available when needed.

2.1.4.3 New: The K-12 school-based resource called "Suicide Prevention, Intervention, Postvention: Step By Step" will go through equity and anti-racist revision.

Achieved

Completed by Lines for Life in 2021. The resource is available at https://oregonyouthline.org/step-by-step/.

2.2 Means reduction

2.2.1 "Safe storage access" — All Oregonians experiencing a behavioral health crisis have access to safe storage for medicine and firearms.

2.2.1.1 Strategic Initiative for 2021–2022: The Alliance will create a work plan for lethal means work that includes safe storage, collaboration between stakeholders, and policy recommendations.

Achieved

Lethal means advisory group leadership is creating a draft work plan that the full advisory group will review. They will decide how to move forward with recommendations. The draft was submitted to OHA on August 6, 2022.

2.2.1.2 Limited pilot project through the Association of Oregon Community Mental Health Programs to provide no-cost lock boxes for medication to local mental health authorities

Achieved

Approximately 5,000 medicine lock boxes were distributed to local mental health authorities in 2021. An additional 2,000 were distributed in 2022. The total distributed was 7,000.

2.2.1.3 Limited pilot project through the Association of Oregon Community Mental Health Programs to provide no-cost secure storage of firearms to local mental health authorities.

Achieved

Approximately 1,600 firearm vaults and cases were distributed to local mental health authorities in 2021. An additional 1,489 items were ordered and designated in 2022. The total distributed and designated is 3,089.

2.2.2 "Means reduction education" — Oregon communities are equipped with means reduction strategies and resources.

2.2.2.1 Counseling on Access to Lethal Means (CALM) course is available online at no cost.

Achieved

CALM training is available through the Suicide Prevention Resource Center's website. Additionally, OHA developed an online training focused on how primary care and direct service providers can work with firearm owners in rural areas who may be at risk of suicide to voluntarily limit access to firearms. The training is based on focus group research with firearm owners in rural Oregon. Over 400 people completed the course since it launched in late 2019. Course evaluation shows that participants found the course useful. Over 80 percent of those who completed an evaluation indicated they plan to change an aspect of their practice based on the training. Over 90 percent stated they would recommend this course to colleagues. This training is funded through the GLS grant. Update: Oregon is contracting with the Education Development Center that oversees CALM to get information on the number of participants in Oregon that have completed the CALM training for tracking and follow-up purposes. Since January 2019, over 5,421 course completions with Oregon ZIP codes have completed CALM training (these may not all be different people). The primary care and direct providers training is also still available and meets OHA Cultural Competence Continuing Education (CE) requirements. Over 1,650 people have completed the course to date. The course does not currently have continuing education credits available. However, there will be an update in 2023 including updating data, to obtain CE.

2.2.2.2 Train-the-trainer event for in-person Counseling on Access to Lethal Means (CALM) course held in Fall 2021 and statewide coordination added.

Achieved

GLS grant activities are supporting the development of in-state trainer capacity to provide Oregon CALM in-person and virtual training. Oregon CALM is based on a national CALM course and incorporates aspects of the rural firearm research described above. A cohort was certified as Oregon CALM trainers in August 2021. GLS funds are supporting a trainer learning collaborative. Oregon CALM training began in February 2022 with additional train-the-trainer opportunities planned. Through June 2022, five training courses were held with a total of 60 participants. Trainers meet monthly to discuss training implementation and successes. Oregon CALM training should increase over the next year. An additional train the trainer will be held in Spring 2023.

Update Feb. 2023: OCALM training is continuing with 139 people completing training. OCALM training will continue through the GLS grant and are an objective of OHA's CDC Comprehensive Suicide Prevention grant to hold 12 OCALM training courses by the end of Sept. 2023. OHA anticipates hosting an OCALM Train the Trainer opportunity in Fall 2023 with updates to the curriculum including data and changes based on participant and trainer feedback.

2.2.3 "Means reduction promotion" — Means reduction practices are promoted regularly in Oregon and are linked to suicide prevention.

2.2.3.1 Representatives from OHA's Suicide Prevention team and the Alliance will take part in the rulemaking process for SB 554 (2021).

Early action

The rulemaking was not required for the sections of SB 554 that were of interest to the Alliance (related to storage and transfer). The Oregon Firearm Safety Coalition is to gain clarity on legislative intent and legal interpretation. OHA regularly attends Oregon Firearm Safety Coalition meetings to align efforts.

2.3 Protective programming

2.3.1 "Available support" — Oregonians who need immediate support or crisis intervention have access to it.

2.3.1.1 Crisis Text Line is available 24/7, and data is tracked using code "Oregon".

Achieved

This is active and data tracking with code "Oregon" is available through May 2022. Update: OHA has not renewed the contract with Crisis Text Line given the launch of 988 Suicide & Crisis Lifeline. Data shared through the contract through May 2022 were shared with the Alliance's Data and Evaluation Committee.

2.3.1.2 Lifeline through Lines for Life is available 24/7.

Achieved

Completed by Lines for Life. Includes a nationwide rollout of 988 in July 2022.

2.3.1.3 Teen-to-teen text and phone support is available through YouthLine from 4 p.m.–10 p.m. PST.

Achieved

Teen-to-teen text and phone support is available through YouthLine from 4 p.m.–10 p.m. PST

2.3.1.4 Emotional support lines are widely available (David Romprey Oregon Warmline, Reach Out Oregon, Safe + Strong, Behavioral Health Support Line).

Achieved

These lines are active and available.

2.3.1.5 A comprehensive website to identify behavioral health needs, supports, and providers called Here For You Oregon.

Early action

This work has been delayed. More consumer input needs to be gathered to determine the needs for this service.

2.3.1.6 A federally mandated project to transition the National Suicide Prevention Lifeline number to "9-8-8" will be ready to implement by July 2022.

Achieved

This project launched in July 2022.

2.3.1.7 Mobile response and support services (MRSS) system is being developed in Oregon, including a children's specific system.

In Progress

Mobile Response and Stabilization Services (MRSS) will be an expanded version of our current crisis response system focused on providing 24/7 connection for youth and their families. It includes immediate, face-to-face response and up to 8 weeks of stabilization services. MRSS teams will work in the community, as requested by the youth and their family. The teams provide screening and assessment; stabilization and de-escalation; and coordination with and referrals to health, social and other services, as needed. MRSS teams include both a qualified behavioral health care professional and a qualified mental health associate or peer support specialist trained in crisis response, and sometimes both of the latter two. The anticipated launch for these services is January 2023.

2.3.2 "Population-focused programming" — People within populations at greater risk for suicide have access to positive and protective programming in their community.

2.3.2.1 OHA and the Association of Community Mental Health Programs will support 16 LGBTQIA2S+ suicide prevention projects with mini-grants, evaluation support, and learning collaborative meetings.

Achieved

This pilot project was completed in 2021. Some grantees received additional funding and are continuing. Some grantees were able to secure other funding to continue. This pilot project grew the capacity of many grantees and connected people doing this challenging work. AOCMHP has led this project.

2.3.2.2 OHA will support the development of YouthSAVE for transitional-aged youth (ages 18–24).

In Progress

The original target date to launch was June 2021. This project has experienced several delays. The current target launch date is the fall of 2023.

2.3.2.3 Oregon Sources of Strength will continue to focus on diversity and equity within its program of positive culture change.

In Progress

Sources of Strength continues to focus on diversity and equity in the peer-led culture change program. Local trainers and leaders are being equipped to lead in an equity-centered way. The contractor committed to training all employees in equity. For the 2022-2023 school year, Sources of Strength adult advisors will have access to equity-intensive training.

2.3.2.4 Each of Oregon's nine federally recognized tribes and the Native American Rehabilitation Association (NARA) receive suicide prevention programming funding from OHA. Each Tribe and NARA submitted a plan for funding unique to their population.

Achieved

2.3.3 "Protective policies" — Organizations and agencies have policies and procedures that increase protection against suicide risk (including passive risk, active risk, and crisis intervention) and those policies are implemented.

2.3.3.1 Adi's Act plans are legislatively mandated for each school district in Oregon. District plans were due in Oct 2021 to ODE.

Achieved

190 of Oregon's 197 school districts self-reported compliance with Adi's Act. A scan of districts' websites in Fall 2022 showed that many school districts did not have their Adi's Act plans posted (a requirement of Adi's Act).

2.3.3.2 School suicide prevention and wellness specialists (SSPW), also called the Adi's Act support team, provide support to school districts for writing, implementing, and updating Adi's Act plans (5.0 full-time equivalent (FTE)

Achieved

The SSPW team is active at the time of this report. Over 125 unique school districts or school buildings have been provided hands-on support, warm hand-off referrals to resources, training or programs, or both. In the summer of 2022, there was a statewide scan of Adi's Act plans. Those results are in the process of being made available.

2.3.3.3 School safety and prevention specialists (11.0 FTE) are housed in Educational Service Districts (ESD) and funded by ODE to support Sect 36 of the Student Success Act, which includes suicide prevention.

Achieved

The original 11.0 FTE has been hired and the team is active. ODE received an additional $3M from Governor Brown's Emergency Education Relief funds in July 2022 to add a 1.0 FTE to all 19 ESDs.

2.3.3.4 Annual coordination meetings (starting September 2021) to align communication and coordination for Adi's Act implementation between ESDs, Lines for Life (LFL), OHA and ODE.

Early action

This initiative was delayed. A large group meeting occurred in February 2022. Individual coordination meetings were planned for later in spring 2022. Meetings were completed with OHA and LFL in September and October 2022 with each SSPS.

2.3.3.5 LGBTQ2SIA+ Student Success Program, codified by SB 52 (2021), funds 1.0 FTE and $2M per biennium in grant funding to support Oregon communities to implement the LGBTQ2SIA+ Student Success Plan, which includes protective policies and increasing mental health supports for LGBTQ2SIA+ population Pre-K, K-12, and Post-Secondary.

In Progress

Grant Program permanent rules were adopted in June 2022 by the State Board. An advisory group was appointed in August 2022. Forty-four applications were received for the first LGBTQIA2S+ Student Success Grant Program Request for Applications (RFA), which was open Oct. 27, 2022–Dec. 7, 2023. Grant applications were under review by ODE. The first grantees are scheduled for award in late January or early February 2023. ODE may offer grantees the opportunity to extend grant agreements into the 2023-2025 biennium, based on available funding and satisfactory progress.

2.3.3.6 University of Oregon Suicide Prevention Lab will lead a pilot project for evaluating and monitoring the implementation of Adi's Act plan. Advised by ODE, OHA, and representation from Big River coordinators.

In Progress

The Oregon School Suicide Prevention Project (OSSPP) completed the initial project phase with an intensive three-month planning process. In this process, participating schools helped co-design a strategic action plan for their school and provided in-depth context around the systems that suicide prevention operates within. Five schools completed this stage fully. Ten schools are participating in this project. They represent geographic diversity including rural, remote, and urban school buildings.

2.3.3.7 Strategic Initiative for 2021–2022: Build capacity to monitor implementation of plans for Adi's Act, increase meaningful participation in Adi's Act from school districts, and increase the use of best practices in school districts. Begin by organizing infrastructure and clarifying roles and responsibilities.

Early action

The schools committee has initiated a project plan to draft, prioritize and assign action items. As a result of that planning, the committee prioritized clarifying all roles and responsibilities. Since January 2022 a breakout team has been working to map the school-support infrastructure and complete a responsibility chart for all Adi's Act requirements. The Alliance prioritized promoting Adi's Act to key audiences and gave workshops to statewide associations of school boards, school counselors and school psychologists. Additionally, the schools committee developed and distributed guidance about advocacy at school board meetings for LGBTQIA2S+ youth and strategies for responding to dangerous anti-LGBTQIA2S+ rhetoric and policies at school board and other meetings.

3. Treatment and Support Services (Indicated)

3.1 Health care coordination

3.1.1 "Coordinated transitions" — All Oregonians who access health care for behavioral health crises or suicidal ideation receive coordinated care in transitions between levels of care.

3.1.1.1 In the Fall of 2021, OHA published the results from the HB 3090 (2017) resurvey project of Oregon hospitals about emergency department policies and behavioral health crises. This report includes recommendations to the legislature.

Achieved

OHA worked with multiple partners, including the Oregon Association of Hospitals and Health Systems (OAHHS) and Oregon Alliance to Prevent Suicide (Alliance) to develop the resurvey tool. OHA worked with OAHHS to notify hospitals in advance to ensure that staff familiar with the development and implementation of HB 3090 requirements responded to the survey. The resurvey resulted in a 100 percent response rate among the eligible hospitals. OHA provided several opportunities for partners to inform the report development through partner meetings and written comments. OAHHS and the Alliance provided written feedback. OHA submitted this

document to Publications and Creative Services in the spring of 2022. In July 2022, the report, Emergency Department Discharge Practices for Behavioral Health Crisis Care: A Statewide Survey of Hospitals, was published and distributed and is available on the OHA website.

3.1.1.2 The Alliance will respond to OHA's HB 3090 resurvey project report (which was due Fall 2021) and develop a work plan to monitor the next steps.

In Progress

The Transitions of Care Committee responded to the draft HB 3090 resurvey report. This committee has not yet developed a work plan to monitor the next steps. The deadline was extended to October 2022 due to the committee waiting on the final HB 3090 report to be published by OHA.

3.1.1.3 The Crisis and Transition Services (CATS) program provides short-term, intensive support to children and adolescents who have had a mental health crisis and are presented to an emergency department or crisis center. The program serves as a bridge from emergency department discharge to connection to long-term outpatient support. Current programming level: 12 sites in 11 counties.

Achieved

Current programming continues in 12 sites within 11 counties. This programming will be incorporated into the Mobile Response and Support Services (MRSS) model. OHA continues planning for implementing the MRSS model across Oregon. Therefore, 2022 was a transitional year.

3.1.1.4 Identify infrastructure needs for mobile crisis response and stabilization services for statewide access.

In Progress

MRSS will be an expanded version of Oregon's current crisis response system focused on providing 24/7 connection for youth and their families. It includes immediate, face-to-face response and up to eight weeks of stabilization services. MRSS teams will work in the community, as requested by the youth and their family. Teams provide screening and assessment; stabilization and de-escalation; and coordination with and referrals to health, social and other services, as needed. MRSS teams include both a qualified behavioral health care professional and a qualified mental health associate or peer support specialist or both, trained in crisis response.

3.1.1.5 Caring Contacts billing code activated in Medicaid.

Early action

There has not been significant progress on this objective. However, OHA suicide prevention staff have started conversations with the Medicaid program. There will be recommendations related to Caring Contacts in the pending HB 3090 report based on survey results and partner

feedback that may provide momentum in this effort. OHA is working internally to identify potential coding to use for caring contact billing purposes.

3.1.2 "Appropriate communication" — There is a formal communication between health care providers, behavioral healthcare providers and social and family supports (including schools for youth).

3.1.3 "Substance use services" — Substance use disorder and mental health services are integrated when possible and coordinated when not fully integrated.

3.1.3.1 Recommendations for suicide risk assessment and treatment included in the Measure 110 requirements for addiction recovery centers established by this law.

Achieved

These recommendations were submitted in 2021.

3.1.4 "Integrated care" — Oregonians will receive integrated care between primary care and behavioral healthcare (including school-based care for youth).

3.1.4.1 ODE and OHA will publish a toolkit for universal suicide risk assessment, screenings, and safety planning.

Early action

This work has been delayed. ODE and OHA have created a list of resources to include in this toolkit. OHA is currently working to subcontract the development of this toolkit. The expected completion is June 2023.

3.2 Health care capacity

3.2.1 "Accessible services" — Oregonians can access the appropriate services on the continuum of behavioral healthcare at the right time for the right amount of time, regardless of health insurance.

There were no named priority initiatives in this section for 2022.

3.2.2 "Right-sized workforce" — There is an adequate behavioral health care workforce to meet the need.

There were no named priority initiatives in this section for 2022.

3.3 Appropriate treatment and management of suicidality

3.3.1 "Equipped and well workforce " — The behavioral health care workforce is well-equipped to help Oregonians with suicidality (including understanding variations of risk and protective factors and current risk and protective conditions).

3.3.1.1 Behavioral health providers (including peer support workforce) in Oregon have access to low or no-cost courses in evidence-based treatment of suicidality that address various levels of risk of suicide and teach interventions accordingly.

Achieved

This is available widely for youth-serving providers. Work is being done to ensure training is also made available to providers working with Black, American Indian and other communities of color, as well as in rural and remote areas and people who use languages other than English.

There is work to make better training available for the peer support workforce including the development of two new training courses.

3.3.1.2 Oregon Pediatric Society with OHA funding develops and delivers custom behavioral health and suicide prevention training for pediatricians and clinics

Achieved

This is available widely for youth-serving providers. There is work is to ensure training is also made available to providers working with Black, American Indian and other communities of color, as well as in rural and remote areas.

3.3.1.3 Enhanced training options in Big River programming menu available statewide — Youth SAVE, Collaborative Assessment and Management of Suicidality (CAMS), Assessing and Managing Suicide Risk (AMSR)

Achieved

This is available widely for youth-serving providers. There is work is to ensure training is also made available to providers working with Black, American Indian populations and other communities of color, as well as in rural and remote areas.

3.3.1.4 Advanced training options in Big River programming menu available statewide — Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), Dialectical Behavioral Therapy — Skills and Suicide Prevention modules (DBT)

Achieved

This is available widely for youth-serving providers. There is work is being done to ensure training is also made available to providers working with Black, American Indian populations and other communities of color, as well as in rural and remote areas.

3.3.1.5 Oregon Pediatric Society will add the development of YouthSAVE training modules for those serving young adults (ages 18–24) and for primary care providers.

In Progress

The young adult module was planned to launch in June 2022. However, the launch was delayed. It's expected to be completed in May 2023. The primary care provider module launched in March 2022. The young adult module will be available for all trainers. Only developers will conduct the primary care module due to the specificity of the training and limited capacity among qualified people, particularly medical experts.

3.3.1.6 Presentation of universal suicide risk assessment, screening, and safety planning toolkit and case examples will be given at the Oregon Suicide Prevention Conference to equip school-based youth-serving adults.

Achieved

This presentation occurred in October 2021 at the Oregon Suicide Prevention Conference.

3.3.2 "Voice and choice" — Oregonians have a voice and choice in treatment.

3.3.2.1 Emergency department guide for children and families is available and distributed regularly to hospitals in Oregon.

Achieved

In spring 2022, this document began being rewritten to include new 988 and Mobile Response and Stabilization Services information.

3.3.3 "Whole-person approaches" — Whole-person approaches are used to enhance treatment for suicide and to increase the effectiveness of management of long-term symptoms.

3.3.3.1 Strategic Initiative for 2021-2022: Increase availability of culturally and linguistically appropriate and relevant approaches to treatment.

In Progress

OHA suicide prevention staff requested and received a literature review from the UO Suicide Prevention Lab to scan for current research in this area and continue to scan for available treatment approaches. Pay differential for culturally or linguistically appropriate services were added to Medicaid provider reimbursement.

3.3.3.2 Strategic Initiative for 2021-2022: Support effective approaches to treatment including suicide prevention training, bodywork, movement work, sleep therapy, Tribal-based practices, and other evidence-informed treatments for reducing suicidality.

Planning

OHA suicide prevention staff requested and received a literature review from the UO Suicide Prevention Lab to scan for current research about culturally-specific suicide prevention training and treatment approaches. OHA suicide prevention staff are working with the Native American Rehabilitation Association of the Northwest, Inc. (NARA NW) to incorporate Tribal-based practices into the Suicide Rapid Response program. OHA suicide prevention staff compiled examples of Tribal-based suicide prevention activities planned by the nine federally recognized tribes in Oregon and was shared that with Tribal behavioral health directors and with Tribal prevention staff.

3.4 Postvention services

3.41 "Equipped and resourced communities" — Oregon communities are equipped to provide trauma-informed postvention care for those impacted by a suicide death.

3.4.1.1 OHA will support Connect: Postvention training by providing low- or no-cost access to train-the-trainer events, statewide coordination for local training needs, evaluation support and limited course support.

Achieved

Connect: Postvention is available widely, is adapted for Oregon, has spaciousness built in for local communities to adjust in ways that make sense and is engaged in ongoing evaluation. Trainers are supported. Work is led by AOCMHP. There is work being done on a trainer portal for resource support.

3.4.1.2 OHA will support youth-serving entities through the Suicide Rapid Response program through Lines for Life.

Achieved

This program continues to support local postvention response efforts.

3.4.2 "Postvention response leads" — Postvention response leads (PRLs) and teams are supported and equipped to fulfill their legislative mandates.

3.4.2.1 Suicide Rapid Response program is accessible and responsive to community needs.

Achieved

This program continues to support local postvention response efforts.

3.4.2.2 OHA hosts quarterly statewide collaborative meetings with PRLs.

Achieved

These meetings occur on the first Thursday of the month in January, April, July and October.

3.4.2.3 Rulemaking for the enrolled HB 3037 (2021) led by the OHA Suicide Prevention team and included the development of a statewide postvention response plan.

Achieved

The rules advisory committee was held on March 29, 2022. Oregon Tribal Nations received notification of these rule edits in January 2022. Tribal behavioral health directors received a presentation about this legislation in February 2022. Postvention Response Leads received the draft rules in January 2022 via their OHA listserv. OHA Tribal Affairs gathered a list of tribal contacts. That list is available by request to Jill Baker. Oregon Administrative Rules have been drafted, but have experienced significant delays in being noticed, having a public hearing, and finalization. The rules were noticed in Sept 2022. Rules were finalized on Jan. 1, 2023.

3.4.2.4 Vicarious Trauma Pilot Project for PRLs with Trauma Informed Oregon completed in Fall 2021 and replicated according to recommended next steps.

Early action

No postvention response lead expressed readiness to continue with this project. Therefore, it will be taken off the prioritized list for 2023.

3.4.3 "Fatality data" — Suicide fatality data is gathered, analyzed, and used for future system improvements and prevention efforts.

3.4.3.1 Psychological Autopsy (PA) Project led by OHA will consider ways to increase the availability of PA for youth suicide deaths in Oregon.

Early action

A cohort was trained in the Psychological Autopsy Certification Training in 2021. OHA sent an interest survey to those trained in that cohort to assess readiness and interest in being a pilot site. Two counties were identified. The pilot project will begin in 2023.

3.4.3.2 ESSENCE Syndromic Surveillance Report released monthly by OHA. The report includes emergency department data, urgent care centers data, calls to poison control and calls to LifeLine.

Achieved

The Suicide-related Public Health Surveillance Update report, which includes the types of data listed above, was issued monthly in 2022 and distributed each month via a listserv with more than 3,500 members. The report will be issued quarterly starting in 2023.

3.4.3.3 Death review teams meet (county and state level) to analyze child fatalities, including suicide deaths, and produce system recommendations for prevention opportunities.

Achieved

The State Child Fatality Review and Prevention team met quarterly in 2022. The UO Suicide Prevention Lab developed and prioritized an action plan to guide the achievement of the action items identified as needs from an assessment completed in 2021. The state website (https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/CHILDDEATHREVIEWPREVENTION/Pages/County-Child-Death-Review-Teams.aspx) has been extensively updated, including a new toolkit for county death review teams, including resources for enhancing equity in local review processes, trauma-informed practice, and nuts-and-bolts operational resources for local teams on operations, meeting prep, facilitation and data reporting. The state team continues to identify ways to support local child death review processes to ensure quality and consistency with best practices.

4. Foundations and centering lenses

4.1 Data and research

4.1.1 The University of Oregon Suicide Prevention Lab is funded to support data and research efforts of OHA's Suicide Prevention team and the priorities named by The Alliance's Executive Committee.

Achieved

This was funded in 2021 and 2022.

4.2 Evaluation

4.2.1 The University of Oregon Suicide Prevention Lab is funded to support the evaluation efforts of OHA's Suicide Prevention team and the priorities named by The Alliance's Executive Committee.

Achieved

This was funded in 2021 and 2022.

4.2.2 The University of Oregon Suicide Prevention Lab will create a central database in RedCap software for tracking Big River program evaluations.

Planning

The UO team determined that they did not have the capacity for this project given the scope of the need. OHA suicide prevention staff have requested information about the internal capacity for this technology from OHA's Business Information Systems. OHA will adjust this initiative for 2023 due to the change in capacity through UO.

4.2.3 Limited evaluation is contracted to Portland State University to support Garret Lee Smith's grant activities and other pilot projects.

Achieved

PSU collects required data by SAMHSA as part of grant activities including the number of training. The current iteration of the GLS grant goes through June 29, 2024.

4.3 Policy needs and gaps

4.3.1 The Alliance will name policy recommendations for the 2023 legislative session.

Achieved

Alliance staff drafted a policy handbook to equip Alliance members in preparation for naming legislative concepts and policy needs. The Alliance submitted recommendations to OHA for funding needs related to suicide prevention for the 2023 long session in January 2022. In June 2022, the full Alliance voted to approve the 2023 policy agenda.

4.4 Funding needs

4.4.1 OHA's Suicide Prevention team will maintain a list of funding needs related to YSIPP strategic initiatives.

In Progress

OHA maintains this list and updates it periodically based on emerging system needs and feedback from key partners (including the Oregon Alliance to Prevent Suicide).

4.4.2 OHA's Suicide Prevention team proposed a Policy Options Package to management in February 2022 for consideration to include in OHA's 2023-2025 budget to address suicide prevention funding needs.

Achieved

The OHA Suicide Prevention team submitted a Policy Option Package in 2022 with identified funding needs for the 2023-2025 biennium. This included many of the priorities named by the Alliance to Prevent Suicide.

4.4.3 Each of Oregon's nine federally recognized Tribes will receive suicide prevention specific funding from the Oregon Health Authority.

Achieved

OHA funded all nine federally recognized Tribes for youth suicide prevention in the 2021-2023 biennium.

4.5 Equity

4.5.1 The Alliance will continue to focus on equity work and make recommendations to OHA.

In Progress

The Alliance contracted with Uprise Collective to provide equity training and assess needs and gaps and strengths in the Alliance. Recommendations were to address three areas: 1) Transparency in internal processes, 2) Focus on collaboration and collective impact, and 3) Demystifying systems and breaking barriers. An equity steering committee for the Alliance has gained traction in the past few months. The equity committee has worked in partnership with the ASIPP equity workgroup to develop a suicide prevention equity screening tool which the Alliance plans to use moving forward when they make recommendations to OHA. Additionally, the Alliance developed an equity statement and key working agreements.

4.5.2 Strategic Initiative for 2021-2022: Promote programming, partnerships, and funding for historically underserved communities and higher-risk populations (for example, people who are transgender, rural, Latinx, Tribal, LGBTQIA2S+, young adults, people with schizophrenia, people with substance use disorders, people with depression, people who identify as male).

Planning

The need for funding in these areas will be included in the list of funding needs referenced in 4.4.1.

Partnerships are being grown and nurtured with organizations and leaders in populations over-represented in risk factor categories by all Big River partners. Two Big River partners have staff focused on training in Spanish and connecting with Latine community groups. New training is being developed in Spanish.

YouthSAVE submitted for a grant to develop a Black youth-focused module in partnership with REAP.

Sources launched an equity intensive for adult advisors in partnership with the Center for Equity and Inclusion.

Tribal prevention leaders are being connected to Big River programs.

4.6 Trauma-informed practices

4.6.1 Trauma Informed Oregon will continue to be available for consultation and special projects related to suicide prevention.

Achieved

This was funded in 2021-2023.

Data section

Suicide numbers, rates and rankings by county or state vary by year. Tracking trends across time is the most effective way to study the data. Oregon youth suicide deaths and rates increased significantly between 2011 and 2018. Suicides among people younger than 25 years old decreased from 129 deaths in 2018 to 95 deaths in 2021. This represents a 26% (26% decrease for deaths; 27% decrease for rate) from 2018 to 2021.

Compared to 2020, the 2021 rate decreased by 6 percent to 12.4 per 100,000. Oregon's suicide rate was 22nd in the nation in 2021 (Table 3).

Table 3. Oregon suicide deaths and rates among those age 10 to 24 compared to the national rate

Year	Number of youth suicides	Suicide death rate (per 100,000)	Rank among 50 states (50 is the lowest rate)
2014	97	12.9	14
2015	90	12	15
2016	98	13	12
2017	107	14.1	17
2018	129	17	11
2019	116*	15.3	11
2020	101†	13.3	17
2021	95	12.4	22

* In addition to these deaths among youths in Oregon age 10–24, there were two suicide deaths among children younger than 10 in 2019.

† In addition to these deaths among youth in Oregon age 10–24, there was one suicide death among children younger than 10 in 2020.

Source: CDC WONDER. Note: Due to significant delays in the Centers for Disease Control and Prevention updating their Web-based Injury Statistics Query and Reporting Systems (WISQARS) with 2021 data, this report is using CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) 2021 data. Data from previous years has been updated using WONDER data to allow for year to year comparison. While WISQARS and WONDER data systems use the same data source, data definitions and data processing protocols vary between the two systems that can lead to slight variations in suicide rates. These variations can influence state rankings. Therefore, previous YSIPP Annual Reports using WISQARS data should not be compared to this report.

The following data analysis addresses Oregon Revised Statute 418.731

Section 3. Data presented are for Oregon residents ages 5–24 who:

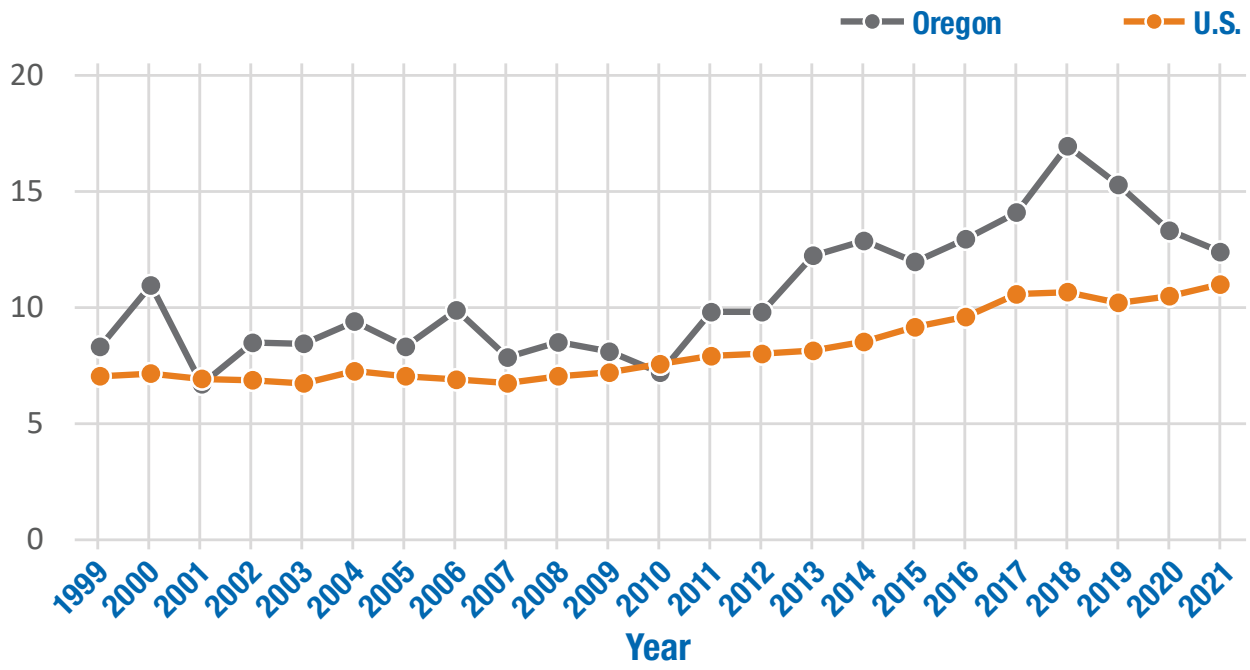
- Died by suicide
- Were hospitalized due to self-inflicted injury, or
- Had suicidal ideation and behaviors or both.

Suicide was the second leading cause of death among youth younger than 25 in Oregon in 2021. (1)

Oregon suicide deaths and rates among youth younger than 25 increased significantly between 2011 and 2018. Oregon saw a decrease in youth suicide rates in 2019–2021. Oregon youth suicide rates continue to be higher than the United States average and have stayed that way over the past decade.

- Male youth were more than three times more likely to die by suicide than female youth (Figure 2).
- Among youth, suicide rates increased with age (Figure 2).
- From 2016 to 2020, the Oregon Violent Death Reporting System (ORVDRS) identified 14 suicides among transgender youth. An additional eight suicides were identified among youth who identified as lesbian, gay, bisexual or had a sexual orientation other than straight or heterosexual. These deaths accounted for 3.8 percent of Oregon youth suicides between 2016 and 2020. This is likely an undercount of LGBTQIA2S+ youth who died by suicide due to existing data collection methods.

Figure 1. Suicide rates among youth aged 10 to 24 years, U.S. and Oregon, 1999-2021



Source: WONDER and OPHAT

Table 4. Comparison of suicide death rates per 100,000 among youth age 25 and younger in Oregon and the United States, 2003–2021 (1)*

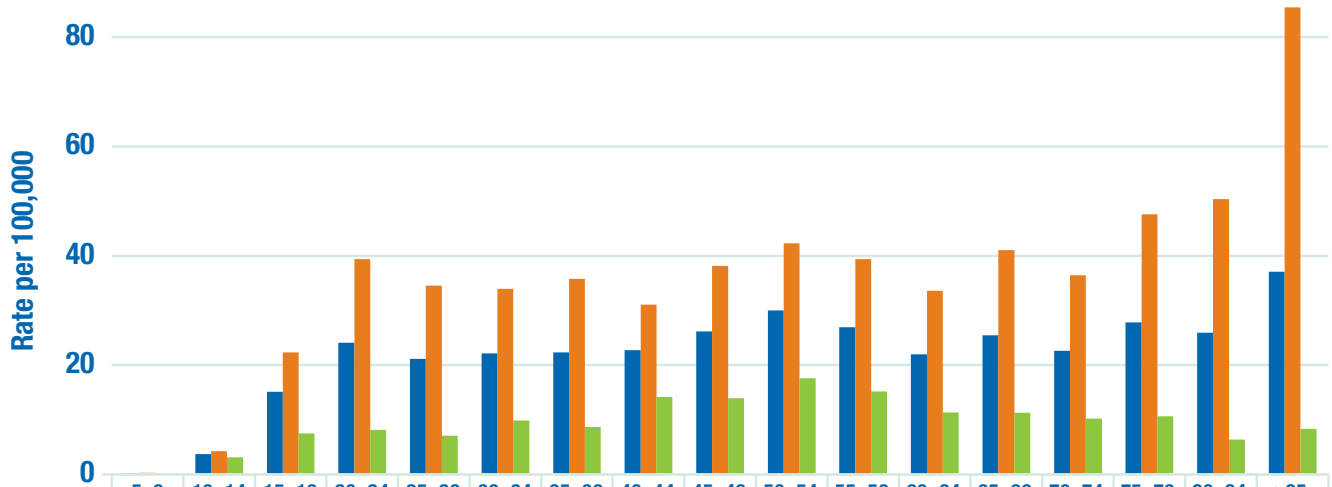
Year	Oregon	United States
2003	8.4	6.7
2004	9.4	7.3
2005	8.3	7
2006	9.9	6.9
2007	7.9	6.8
2008	8.5	7
2009	8.1	7.2
2010	7.2	7.6
2011	9.8	7.9
2012	9.8	8
2013	12.3	8.1
2014	12.9	8.5
2015	12	9.2
2016	13	9.6
2017	14.1	10.6
2018	17	10.7
2019	15.3	10.2
2020	13.3	10.5
2021	12.4	11

* Rates are deaths per 100,000

Source: CDC WONDER

Note: This does not include deaths younger than age 10. There was one death in 2007, two deaths in 2019 and one death in 2020 of children younger than age 10.

Figure 2. Age-specific rate of suicide by sex, Oregon, 2018–2021



	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

Source: OPHAT

Common circumstances for suicide

Table 5 highlights common circumstances surrounding suicide deaths for youth age 5–24. This information can inform prevention and intervention activities. Some of these circumstances vary by age subcategories. Between 2016 and 2020, the most common circumstances in Oregon for youth younger than 25 include:

- Mental health concerns or current depressed mood
- History of suicidal ideation and attempts
- Romantic relationship break-ups
- Non-alcohol substance use problems, and
- A crisis in the past two weeks.

Table 5. Common circumstances surrounding suicide incidents by age group, 2016–2020

	Aged 5–17			Aged 18–24		
Circumstance	**All sexes (n=148)**	**Males (n=100)**	**Females (n=48)**	**All sexes (n=428)**	**Males (n=355)**	**Females (n=73)**
Diagnosed mental disorder, % of total suicides	45.9	39.0	60.4	33.2	29.0	53.4
Alcohol problem, % of total suicides	3.4	2.0	6.3	10.7	11.3	8.2
Non-alcohol substance use problem, % of total suicides	8.1	6.0	12.5	17.8	17.2	20.5
Current depressed mood, % of total suicides	28.4	31.0	22.9	26.2	25.4	30.1
Current treatment for mental health or substance use problem, % of total suicides	34.5	28.0	47.9	17.5	14.9	30.1
Recently disclosed intent to die by suicide, % of total suicides	19.6	19.0	20.8	18.9	18.3	21.9
History of suicide attempt, % of total suicides	20.9	16.0	31.3	20.1	16.3	38.4
Left a suicide note, % of total suicides	36.5	36.0	37.5	30.6	28.7	39.7
History of expressed suicidal thought or plan, % of total suicides	37.2	34.0	43.8	31.5	29.3	42.5
Intimate partner problem, % of total suicides	16.2	19.0	10.4	22.9	21.1	31.5
Family stressor(s), % of total suicides	27.0	23.0	35.4	7.2	6.5	11.0
Recent criminal or non-criminal legal problem, % of total suicides	4.1	5.0	2.1	5.6	6.8	0.0
Financial or job problem, % of total suicides	0.7	1.0	0.0	5.8	6.2	4.1
Physical health problem, % of total suicides	2.0	1.0	4.2	1.4	1.4	1.4
Death of family member or friend within past five years, % of total suicides	2.7	2.0	4.2	3.7	4.5	0.0
Suicide of family member or friend within past five years, % of total suicides	1.4	1.0	2.1	1.2	1.1	1.4
School problem, % of total suicides	16.9	19.0	12.5	2.1	2.3	1.4

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Circumstance	Aged 5–17			Aged 18–24		
	All sexes (n=148)	Males (n=100)	Females (n=48)	All sexes (n=428)	Males (n=355)	Females (n=73)
Experienced a crisis within two weeks, % of total suicides	18.9	21.0	14.6	14.5	13.8	17.8
Crisis related to problem with intimate partner, % of total suicides	7.4	8.0	6.3	8.2	7.3	12.3
Crisis related to physical health problems, % of total suicides	0.0	0.0	0.0	0.0	0.0	0.0
Crisis related to recent criminal or civil legal problem, % of total suicides	1.4	2.0	0.0	1.4	1.7	0.0
Crisis related to family stressor(s), % of total suicides	4.7	5.0	4.2	1.6	1.7	1.4
Crisis related to financial or job problem, % of total suicides	0.0	0.0	0.0	0.2	0.3	0.0
Crisis related to eviction, % of total suicides	0.0	0.0	0.0	0.7	0.6	1.4
Suspected alcohol use prior to incident	7.4	10.0	2.1	20.6	21.1	17.8

Source: ORVDRS

2021

Final data reported 95 suicides among Oregon youth younger than age 25 with no death among youth younger than age 10 (characteristics and location are not available for three out-of-state deaths). Most suicides occurred among males (78 percent), White persons (84 percent) and persons age 20 to 24 (63 percent). While Oregon has seen a 26% decrease in youth suicide deaths between 2018-2021, there are racial disparities in the data. Specifically, deaths by suicide for youth identified as White (this includes some young people who are multi-racial with White as one of their racial identities) have fallen. However, deaths for youth of other races and ethnicity have remained similar to 2018 level or have increased. Sixteen deaths were among middle school and high school students (Table 6). In 2021, the most often observed mechanisms of injury in suicide deaths among youth included:

- Firearms (61 percent)
- Suffocation or hanging (26 percent), and
- Poisoning (9 percent).

Table 6. The characteristics of youth suicides, Oregon 2021

		Deaths*	% of total
Age (years)	5-14	7	8%
	15-19	27	29%
	20-24	58	63%
Sex	Male	72	78%
	Female	20	22%
Race or ethnicity†	White	77	84%
	African American	8	9%
	Am. Indian/Native Alaskan	4	4%
	Asian/Pacific Islander	4	4%
	Multiple races	5	5%
	Other or unknown	4	4%
	Hispanic	16	17%
Student status	Middle school	6	7%
	High school	10	11%
Mechanism of death	Firearm	56	61%
	Hanging or suffocation	24	26%
	Poisoning	8	9%
	Other	4	4%

* Three out-of-state deaths are not included because their death certificate information is not accessible.
† Includes any race (one or more, any mention) and ethnicity mention. Race categories will not sum to the total since multiple race selections could be made for each decedent.
Source: Oregon Violent Death Reporting System
Note: According to the CDC WONDER, there were 95 suicides aged 5 to 24 in 2021.

The mechanism used in suicide deaths among youth varies by gender. Table 7 shows mechanism of injury among suicide deaths by age group and sex in Oregon between 2016 and 2020. Among 10 to 17-year-olds, males died overwhelmingly by firearm or suffocation at 45% for each mechanism. Among females age 10 to 17 years old, 62.5 percent died by hanging or suffocation followed by firearm suicide (18.8 percent). Among males 18–24, firearm suicide is the leading cause of death (57.5%) followed by hanging or suffocation (26.5%). Nearly half of females age 18–24 died by hanging or suffocation (43.8 percent) followed by poisoning (20.5%) and firearm (19.2%).

Table 7. Mechanism of injury among suicide deaths, by age group and sex, Oregon, 2016–2020

Age group	Mechanism of injury	Males	% Males	Females	% Females	All sexes*	% All
10–17 years	Firearm	45	45.0	9	18.8	54	36.5
	Other or unknown	0	0.0	0	0.0	0	0.0
	Sharp instrument	0	0.0	0	0.0	0	0.0
	Poisoning	2	2.0	6	12.5	8	5.4
	Hanging or suffocation	45	45.0	30	62.5	75	50.7
	Fall	2	2.0	0	0.0	2	1.4
	Drowning	0	0.0	0	0.0	0	0.0
	Fire or Burn	0	0.0	0	0.0	0	0.0
	Motor vehicle or train	6	6.0	3	6.3	9	6.1
	Total	100		48		148	
18–24 years	Firearm	205	57.7	14	19.2	219	51.2
	Other or unknown	0	0.0	0	0.0	0	0.0
	Sharp instrument	5	1.4	2	2.7	7	1.6
	Poisoning	19	5.4	15	20.5	34	7.9
	Hanging or suffocation	94	26.5	32	43.8	126	29.4
	Fall	16	4.5	3	4.1	19	4.4
	Drowning	6	1.7	2	2.7	8	1.9
	Fire or Burn	0	0.0	0	0.0	0	0.0
	Motor vehicle or train	10	2.8	5	6.8	15	3.5
	Total	355		73		428	

* Includes unknown sex

Source: ORVDRS

Suicide attempts

In 2021, there were a total of 4,536 youth younger than 25, compared to 4,204 in 2020, admitted to the emergency department or hospital related to a suicide attempt, suicide ideation or self-harm (Table 8). Females were far more likely to be hospitalized for suicide attempt, suicide ideation or self-harm than males. COVID-19 had a significant impact on emergency department and hospital admissions. There was a significant overall drop in both non-COVID-19 emergency department and hospitalization visits in 2020 and 2021. Consider any trending data with caution as these are still lower numbers compared to 2018 and 2019.

Table 8. Emergency department and hospitalization admission numbers for suicide attempt, suicide ideation or self-harm and suicide deaths among youth younger than age 25 by county, Oregon, 2021

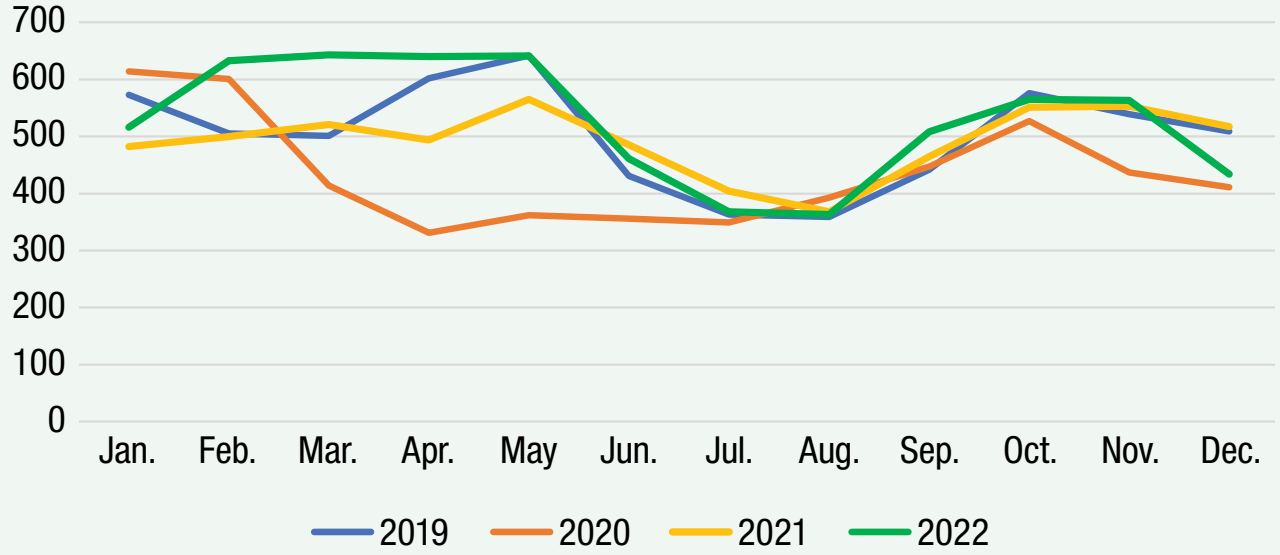
County	Emergency Department and Hospitalization Admissions*		Deaths†	
	Count	% of total	Count	% of total
Baker	16	0.4	4	4.3%
Benton	99	2.2	2	2.2%
Clackamas	403	8.9	7	7.6%
Clatsop	33	0.7	0	0.0%
Columbia	44	1.0	3	3.3%
Coos	60	1.3	0	0.0%
Crook	28	0.6	0	0.0%
Curry	25	0.6	0	0.0%
Deschutes	215	4.7	4	4.3%
Douglas	89	2.0	0	0.0%
Gilliam	—	0.1	0	0.0%
Grant	—	0.1	0	0.0%
Harney	12	0.3	1	1.1%
Hood River	24	0.5	1	1.1%
Jackson	225	5.0	3	3.3%
Jefferson	65	1.4	1	1.1%
Josephine	88	1.9	2	2.2%
Klamath	125	2.8	1	1.1%
Lake	13	0.3	0	0.0%
Lane	458	10.1	13	14.1%
Lincoln	51	1.1	2	2.2%
Linn	185	4.1	5	5.4%
Malheur	19	0.4	0	0.0%
Marion	449	9.9	10	10.9%
Morrow	—	0.1	1	1.1%
Multnomah	821	18.1	16	17.4%
Polk	89	2.0	2	2.2%
Sherman	0	0.0	0	0.0%
Tillamook	27	0.6	1	1.1%
Umatilla	78	1.7	0	0.0%
Union	45	1.0	1	1.1%
Wallowa	—	0.2	0	0.0%
Wasco	31	0.7	0	0.0%
Washington	551	12.1	10	10.9%
Wheeler	0	0	0	0.0%
Yamhill	144	3.2	2	2.2%
State	4536	N/A	92	NA

* Oregon Hospital Discharge Index. Please note that a new methodology to calculate 2018 youth self-harm hospitalizations was implemented based on CSTE (Council of State and Territorial Epidemiologists) guidelines. Therefore, 2018–2021 data is not comparable to previous years. Counts less than 10 and not 0 are not reported due to low counts and are represented by a line in the table.

† Oregon Violent Death Reporting System. Three out-of-state deaths in 2021 are not included because their death certificate information is not accessible.

Suicide-related visits to emergency departments (EDs) and urgent care centers (UCCs) for youth age 18 and younger in 2022 were slightly higher than in previous years.

Figure 3. Suicide-related visits to emergency departments and urgent care centers, ages 18 and younger, Oregon

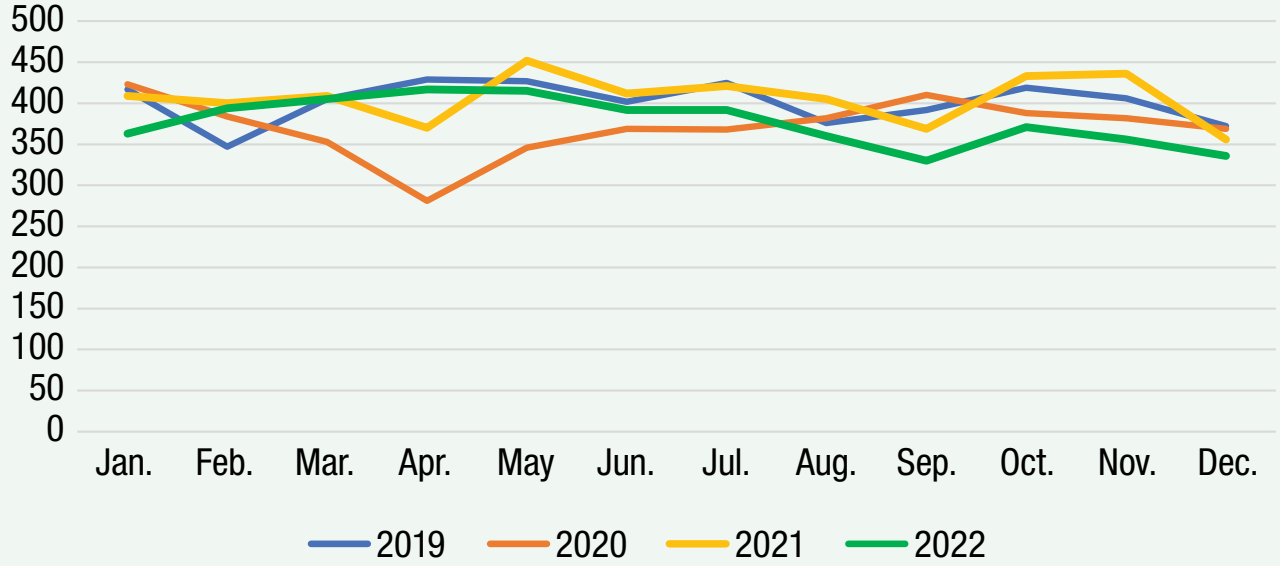


Total visits: 2021 = 6,336; 2021 = 5,905; 2020 = 5,242; 2019 = 6,042

Source: ESSENCE syndromic surveillance suicide-related data, including visits for self-harm, suicide ideation and suicide attempt, from all nonfederal hospital emergency departments and select urgent care centers across Oregon.

The number of suicide-related visits to emergency departments (EDs) and urgent care centers (UCCs) for youths ages 18 to 24 in 2022 is similar to previous (Figure 4).

Figure 4. Suicide-related visits to emergency departments and urgent care centers, ages 18 to 24, Oregon



Total visits: 2022 = 4,531; 2021 = 4,872; 2020 = 4,455; 2019 = 4,817

Source: ESSENCE syndromic surveillance suicide-related data, including visits for self-harm, suicide ideation and suicide attempt, from all nonfederal hospital EDs and select UCCs across Oregon.

Suicide-related measures from the 2020 Student Health Survey

Oregon's Student Health Survey (SHS) is a collaborative effort between the Oregon Health Authority (OHA) and the Oregon Department of Education (ODE). The survey is a comprehensive, school-based, anonymous and voluntary health survey for sixth, eighth and 11th graders.

The 2020 SHS replaces OHA's two previous youth surveys, the Oregon Healthy Teens Survey (OHT) and the Oregon Student Wellness Survey (SWS). Combining the two youth surveys is part of OHA's ongoing efforts to make Oregon's public health system more efficient. This reduced the time and resources asked of schools and students. SHS data is not directly comparable to prior OHT and SWS results due to differences such as methodology, grades surveyed, learning environment, data collection period and recruitment. For more information, view the full 2020 SHS State Profile and County Profile Reports on the OHA SHS webpage. Data from the 2022 SHS was not yet available and therefore are not included in this report. OHA anticipates that 2022 SHS results will be available mid-May 2023.

The Student Health Survey asked several questions related to youth suicide and mental health described below. Note, each grade was not asked all SHS questions. If a grade level is not included below (sixth, eighth or 11th), that grade level was not asked the question.

- Percentage of youth that felt sad or hopeless almost every day for at least two weeks in a row due to COVID-19 or COVID-19 symptoms:
  - 14 percent of eighth graders
  - 27 percent of 11th graders
- Percentage of youth that seriously considered attempting suicide due to coronavirus or coronavirus symptoms:
  - 6 percent of eighth graders
  - percent of 11th graders
- Percentage of youth that seriously considered attempting suicide:
  - 10 percent of sixth graders
  - 14 percent of eighth graders
  - 17 percent of 11th graders
- Percentage of youth that attempted suicide one or more times:
  - 3 percent of sixth graders
  - 6 percent of eighth graders
  - 5 percent of 11th graders

Suicide attempts involving a firearm are more likely to result in injury or death than other mechanisms such as suffocation (hanging) or poisoning. Since firearms account for a high percentage of youth suicide deaths, easy access to guns may increase the risk of suicide attempts and deaths. Although more than half of eighth and 11th graders say they do not have access to a loaded gun, about a third, 37 percent of eighth graders and 41 percent of 11th graders, say they could get one in less than a day. About a quarter, 22 percent of eighth graders and 23 percent of 11th graders say they could get a loaded gun in less than 10 minutes.

Limitations of data used for suicide surveillance

Refer to the OHA Injury and Violence Prevention Program Data Glossary for more information on datasets used in this report. Suicide is one of the leading causes of death for the general population in Oregon. It is the second leading cause of death among people in Oregon age 10 to 24. Suicide prevention is one of OHA's top priority issues. Suicide is a complex behavior and is associated with many factors, including:

- Mental health
- Substance use
- Physical health
- Relationships
- Life events
- Isolation
- Social connectivity
- Other environmental and societal conditions
- Adverse childhood experiences, and
- Lack of access to mental and behavioral health services.

Oregon uses various existing administrative data sets, surveys and active surveillance efforts to monitor and track suicide and some risk and protective factors that lead to or prevent suicide. These sources include data elements of interest to policymakers. However, these data sources may fall short in other areas of interest. Standard administrative data used to track outcomes (such as death certificates, hospitalizations or ED visits) do not usually collect:

- Data on risk and protective factors for suicide (for example, depression)
- Past medical and behavioral histories (for example, treatment episodes)
- Other data elements that can tie personal risk and protective factors to suicidal behaviors, or
- Outcomes among persons (for example, the number of previous suicide attempts among persons who died by suicide).

The following data are not available for each youth who died by suicide:

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

Gathering missing data would require more resources, position authority and planning. It would involve many steps, including:

- Linking several large administrative data sets
- In-person case interviews
- Requirements for law enforcement agencies and health care providers to release each person's information
- Personnel for data entry and database management, and
- Requirements for hospitals to report more types of data and specific reporting criteria.

Specific considerations for administrative public health data sets to track suicide, self-harm and suicide ideations

Emergency department and hospitalization administrative data sets typically capture population data for all their admissions. However, tracking public health trends is not their primary function. For example, administrative data sets do not capture all deaths within Oregon or suicide attempts since many may never be admitted to the emergency department or hospital before death. They do capture all diagnosed self-harm, suicide ideation and suicide attempt admissions. The data are limited on factors that may have led the person to suicide, such as untreated depression or life stressors. It depends on the datasets used. However, support varies to track suicide trends and potential factors that contribute.

Oregon uses many datasets (not limited to those described below) to track outcomes such as deaths, hospital admissions, emergency department admissions, and some participating urgent care center visits. These data sources include:

- Death certificates collected by the Center for Health Statistics (CHS) at the Oregon Public Health Division (PHD)
- Hospitalization discharge data (HDD) and emergency departments (ED for 2018 forward) from the Oregon Association of Hospitals and Health Systems (OAHHS), and

- Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) data for emergency departments and urgent care centers across Oregon.

Specific considerations for survey data

Survey data can capture information on factors associated with suicide, such as depression. However, survey data are based on population samples. Data does not link risk and protective factors for suicide to specific persons. Survey data come, in part, from the following:

- The Behavioral Risk Factor Surveillance System (BRFSS)
- The Student Health Survey (SHS)
- The National Survey on Drug Use and Health (NSDUH), and
- The American Community Survey (ACS).

These surveys are both state and nationally administered. Some surveys sometimes include questions about suicidality or mental health issues. However, surveys often depend on funding from individual programs (for example, BRFSS and SHS) to continue data collection for specific questions year to year. Recent response rates to telephone surveys have been low (sometimes less than 50 percent). Low response rates affect how well the data reflect the general population. Therefore, it limits the findings from such data sources.

Some active surveillance data sources and systems link outcomes to a person's risk. The Oregon Violent Death Reporting System collects active surveillance data from multiple sources to provide a more complete picture, such as:

- Detailed demographics
- Mechanism of death, and
- Circumstances surrounding suicide incidents.

Specific considerations for active public health tracking efforts

The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) provides real-time data from all non-federal hospital emergency departments (ED) and select urgent care centers (UCC) across Oregon. These data allow public health agencies and hospitals to monitor what is happening in emergency departments across Oregon before, during and after a public health emergency. The International Society for Disease Surveillance's Syndrome Definition Committee with input from the CDC Division of Violence Prevention created the suicide-related query used to provide data for this report. It includes ED and UCC visits for self-harm, suicide ideation and suicide attempt. Important limitations of these data include the following:

- They do not distinguish suicide attempts from other forms of self-harm.
- Data from emergency department and urgent care center visits fluctuate as they receive and update information.
- Not all people in Oregon have access to an emergency department or urgent care center.
- People with suicidal ideations may forgo medical assistance.

Specific considerations for death certificate data

The Center for Health Statistics (CHS) at the Oregon Public Health Division (PHD) collects death certificate data. The data have been traditionally used for public health surveillance. The data provide detailed demographics, general mechanism of injury, health outcome and geographical information. However, the data:

- Do not tell the story behind deaths, such as why the people die by suicide, and
- Do not include factors that may have led persons to suicide, such as untreated depression or life stressors

Specific considerations for Oregon Violent Death Reporting System (ORVDRS) data

ORVDRS data link deaths to medical examiner reports and law enforcement reports to look at individual risk. ORVDRS data provide a more complete picture, including:

- Detailed demographics
- Mechanism of death
- Circumstances surrounding suicide incidents, and
- Associated suicide risk factors.

However, the lack of standard questionnaires and investigations on deaths in Oregon means data collection and reporting are not always consistent. ORVDRS data does not always include certain data elements (for example, LGBTQIA2S+ status among people who died by suicide). The data rely on witnesses and contacts of a person who died by suicide. So, the incident information is not always complete. Therefore, ORVDRS data may underestimate some given circumstances or risk factors.

Appendix I

Suicide rates among youth aged 10 to 24 years by state, U.S. 2021

State	Deaths	Crude rate
Alaska	61	41.5
Montana	71	33.7
Wyoming	36	31.1
South Dakota	54	29.4
New Mexico	91	21.4
North Dakota	31	18.9
Colorado	204	18.2
Oklahoma	147	17.7
Nevada	101	17.4
Kansas	106	17.0
Idaho	60	15.0
Utah	124	15.0
Missouri	178	14.8
West Virginia	48	14.8
Arizona	211	14.5
Delaware	26	14.3
Washington	200	14.1
Indiana	190	13.6
Kentucky	120	13.6
Georgia	294	13.2
South Carolina	130	13.1
Oregon	95	12.4
Virginia	208	12.4
Arkansas	74	12.2
North Carolina	249	12.0
Tennessee	160	12.0
Texas	763	12.0
Wisconsin	138	11.9
Maine	27	11.8
Iowa	77	11.7
Nebraska	48	11.6

State	Deaths	Crude rate
Mississippi	70	11.5
Ohio	260	11.5
Louisiana	103	11.3
Alabama	109	11.1
Michigan	214	11.0
Minnesota	118	10.6
New Hampshire	26	10.5
Hawaii	24	9.6
Pennsylvania	228	9.5
Florida	350	9.4
Illinois	213	8.6
Maryland	98	8.4
Connecticut	58	8.3
California	550	7.2
Massachusetts	71	5.3
New Jersey	92	5.3
New York	184	5.1
Rhode Island	15	Unreliable
Vermont	12	Unreliable
District of Columbia	<10	Suppressed

Rates are deaths per 100,000.

Source: CDC WONDER

Appendix II University of Oregon Report

Endnotes

1. Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2023. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on Mar 21, 2023

Oregon Health Authority

PUBLIC HEALTH DIVISION
Health Systems Division

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