

>> Youth Suicide Intervention and Prevention Plan Annual Report



Oregon
Health
Authority

PUBLIC HEALTH DIVISION
Health Systems Division

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Executive summary

A death by suicide creates a traumatic journey that no family, friends or community should have to experience. The ripples of a suicide death are far reaching and take years to heal. Oregon continues to experience too many youth deaths by suicide, despite brave and relentless work by many in the suicide-prevention field. In 2018, the most recent yearly data reported to the Oregon Health Authority (OHA), there were 129 suicide deaths by young people age 24 and younger. This makes suicide the leading cause of death for ages 10-24 in Oregon.

Historically, funding for youth suicide prevention work has been sporadic, inadequate and inconsistent. That changed in 2019 when the Legislature allocated over \$6 million for the 2019-21 biennium to fund goals, objectives and strategic directions of the 2016-2020 Youth Suicide Intervention and Prevention Plan (YSIPP). Those funds were a huge step up for Oregon's young people. However, OHA estimates that full implementation of the YSIPP requires a \$12 million budget. Despite underfunding, implementation of the YSIPP by OHA and the Alliance to Prevent Suicide has continued to progress. This is largely due to dedicated Oregonians for whom suicide prevention is a high priority.

New funding and an additional youth suicide prevention staff position at OHA make for a strong finish to 2016-2020 YSIPP goals and objectives. This includes an emphasis on initiatives that:

- Include youth and young adult voices at every level and are led by peers
- Focus on upstream prevention, rather than reaction in crises
- Are available and accessible to all young persons in Oregon, and
- Build connections among those who do suicide prevention work.

Work often billed as suicide prevention is, in fact, intervention. Intervention focuses on:

- What warning signs to watch for, and
- How to refer persons to help.

This is vital to the big picture of creating a suicide safer community. However, true prevention focuses on creating young people who are:

- Resilient
- Strong, and
- Well.

In spending time, energy and money on true prevention, before signs of suicide become evident, more of Oregon's youth will find:

- Help
- Hope and
- Strength.

In 2019, OHA (Health Systems and Public Health), and community partners and stakeholders saw incredible gains in suicide prevention work in Oregon. It was a year of building infrastructure to make best practices available to all Oregon youth.

Sample of initiatives implemented in 2019:

- **Live to Tell** – a youth led non-profit created by students in the Salem-Keizer school district. The non-profit strives to make suicide a never event in the Salem-Keizer School District. Live to Tell looks to destigmatize mental health through advocacy, awareness and education. All board members are high school students dedicated to making their schools and communities suicide safer.
- **Lines for Life Suicide Lifeline** – OHA immediately increased funding for the 24/7 statewide crisis hotline to full funding levels.
- **Lines for Life – Youthline Program** – through a request for proposal (RFP) process, a peer-to-peer text, chat and telephone line and youth leadership development program received funding. This also included funding for a school suicide prevention support person to provide technical assistance and limited mini-grants to school districts.
- **Sources of Strength** – OHA put forth an RFP seeking proposals to implement Sources of Strength statewide (or some description of the RFP) and awarded a contract to Matchstick Consulting, LLC. Matchstick will oversee a scale-up of this evidence-rich best practice for upstream prevention. Oregon is the first and only state to secure an agreement with the national office of Sources of Strength for a statewide trainer. This is groundbreaking work and something to celebrate!
- **The Connect: Postvention program (Connect)** – OHA contracted with the Association of Oregon Community Mental Health Programs (AOCMHP) to scale-up best practice postvention work statewide. AOCMHP and the Suicide Prevention Research Lab at the University of Oregon worked with the National Alliance on Mental Illness (NAMI) New Hampshire to evaluate Connect and rewrite pieces of curriculum to better meet Oregon's needs.

- **Alliance to Prevent Suicide** – Increased staffing with the directive to meaningfully include and engage youth and young adults.
- At the time of this report, several RFPs are posted to support statewide access to these programs or services:
 - » [Question, Persuade, Refer \(QPR\)](#) suicide prevention training
 - » [Suicide Alertness for Everyone \(safeTALK\)](#) training program
 - » [Applied Suicide Intervention Skills Training \(ASIST\)](#) two-day workshop
 - » Support schools and school districts to write plans for:
 - » Suicide prevention
 - » Suicide intervention, and
 - » Postvention response.

This includes mini-grants to purchase curriculum if needed.

2019 Legislation related to suicide:

- **Senate Bill (SB) 52 – Adi’s Act** – mandates every school district in Oregon have a suicide prevention, intervention, postvention plan and school board policy in place for the 2020-2021 school year.
- **SB 707** – this bill codifies the Alliance to Prevent Suicide into statute as the Youth Suicide Intervention and Prevention Advisory Committee. It is a group of professionals and community members dedicated to implement the YSIPP. The Alliance serves as an advisory body to OHA. The bill also outlined membership requirements for groups that must be represented in their membership.
- **SB 485** – directs youth serving entities (such as K-12 schools, college/universities, residential treatment programs) to report a suspected suicide death of someone 24 or younger to OHA within seven days of the death.
- **SB 918** – directs local mental health authorities to notify youth serving entities and individuals of a suicide death of someone 24 or younger as a part of post-vention efforts to address loss and contagion risk.

The numbers were higher than ever before for youth suicide in 2018. There will always be more work to do in intervention, prevention and postvention response. Even so, 2019 was a year of re-energizing, careful planning and hope for the youth of our great state. OHA Suicide Prevention staff remain dedicated and focused on creating infrastructure that will make Oregon a suicide safer state.

Evaluation report

The Oregon Youth Suicide Intervention and Prevention Plan (YSIPP) continued to progress in implementation efforts for 2018-19. Support and evaluation included:

- Assessment and analysis from the University of Oregon (UO) evaluation team
- Guidance from Oregon Health Authority (OHA), and
- Collaboration with the Oregon Alliance to Prevent Suicide (Alliance).

Below is an outline of key accomplishments and recommendations by YSIPP strategic direction.

Strategic Direction 1: Healthy and empowered individuals, families and communities

Key accomplishments:

- Launching the Oregon Alliance to Prevent Suicide website
- Evaluation of the Oregon Suicide Prevention Conference
- Development of a tribal networking framework

Summary and recommendations:

Use the Alliance website as a network hub that can serve as a centralized digital space. This is a place where practitioners may obtain evidence-based tools and information. Work began on a tribal framework to initiate participatory dialogue between tribal governments and local communities about mental health and suicide prevention.

Strategic Direction 2: Clinical and community preventative services

Key accomplishments:

- Support for the Connect suicide postvention training scale-up.
- LGBTQ Initiative
- School suicide prevention scan and response

Summary and recommendations:

Connect suicide postvention training is transitioning to a locally supported and sustainable initiative. At the same time, a continued effort should be made to

connect local trainers across the state through a learning collaborative. Also, the evaluation team recommends increasing support efforts for suicide prevention in schools by providing:

- Best practice recommendations
- Example plans and toolkits, and
- Overall implementation guidance for suicide:
 - » Prevention
 - » Intervention, and
 - » Postvention.

Strategic Direction 3: Treatment and support services

Key accomplishments:

- Pre-service scan
- Drug and alcohol treatment scan

Summary and recommendations:

Scans of treatment and support services have continued and include:

- a. Pre-service graduate school curriculums to prepare students on the subject of suicide prevention, and
- b. Suicide prevention activities in drug and alcohol treatment centers.

Strategic Direction 4: Surveillance, research and evaluation

Key accomplishments:

- Clackamas County needs assessment
- Regional suicide coalition network
- Suicide prevention coordinator network
- Survey of Alliance members

Summary and recommendations:

Through identification, connection and communication with local suicide prevention coalitions, the Alliance can better facilitate best practices in community-level suicide prevention. Additionally, the use of a coordinated network, for coalitions and coordinators, will allow UO and the Alliance to obtain contextual local data. This data can help better explain the various and diverse challenges that communities face across the state.

Policy highlights and legislative follow-up

Senate Bill (SB) 52 – Adi’s Act (2019)

The Alliance to Prevent Suicide and many other community partners and agencies supported this bill. SB 52 requires school districts to develop plans for:

- Suicide prevention
- Intervention, and
- Postvention.

SB 52 also requires a school board policy to address suicide before the 2020-2021 school year. The bill assigned the Oregon Department of Education (ODE) to implement the bill. OHA and the Alliance to Prevent Suicide provided feedback and technical help to ODE in 2019, and will continue this support in the future. The Youth Suicide Prevention coordinator facilitated work to implement SB 52 that result in direct and accessible support for school districts in the planning and implementation of district plans to address suicide. Students at Sabin-Schellenberg High School in Clackamas designed a “menu” of OHA supported services. The Alliance to Prevent Suicide also supported SB 52 in 2019 by gathering best practices and guidance documents for school districts.

OHA plans to widely share the menu of services with school districts and other youth-serving organizations around the state in 2020. Additionally, OHA will provide technical help through contracts and mini-grants to schools to support implementation of district level suicide plans.

SB 485 (2019)

This bill directs youth serving organizations (such as K-12 schools) to inform OHA within seven days of becoming aware of a youth suicide death. The bill also directs OHA to write the administrative rules to implement the bill. Work began in 2019 to gather input from stakeholder groups such as:

- SB 561 (2015) reporters
- Higher education
- K-12 schools, and
- Local mental health authority directors.

OHA plans to convene the Rules Advisory Committee in spring 2020. The committee will write rules for SB 485 and SB 918, due to overlap in stakeholders.

SB 918 (2019)

This bill directs local mental health authorities (LMHA) to inform youth-serving persons and entities about a youth suicide death if the LMHA believes the notice is necessary to prevent suicide contagion. Contagion occurs when a suicide influences the suicidal behaviors of others. OHA is tasked to write the administrative rules in this bill. Work began in 2019 to gather input from stakeholder groups such as:

- SB 561 (2015) reporters
- Higher education
- K-12 schools, and
- Local mental health authority directors.

OHA plans to convene the Rules Advisory Committee in spring 2020. The committee will write rules for SB 918 and SB 485 (2019) due to overlap in stakeholders.

SB 707 (2019)

This bill put the Oregon Alliance to Prevent Suicide into statute as an advisory group to OHA. Alliance leadership worked with OHA in late 2019 to:

- Comply with public meeting laws for all Alliance committees
- Conduct the quarterly meeting of the full Alliance, and
- Ensure that Alliance membership included all categories listed in SB 707.
 - » Now includes a member under the age of 21.

SB 561 (2015)

This bill aims to reduce risk of suicide contagion after a youth suicide death. This bill mandates that each LMHA in Oregon develop a postvention plan for response after a youth suicide death. This includes reporting the death to OHA within seven days of being aware of the death. Since this legislation passed in 2015 compliance remains an issue. OHA is working on developing the relationship between Youth Suicide Prevention staff and SB 561 reporters for each county. Strategies have included:

- Regular communication emails to the SB 561 Listserv
- Hosting and coordinating quarterly meetings of SB 561 reporters, and
- Reminders of deadlines to submit the county-level postvention plan.

This outreach resulted in 100 percent compliance for postvention plans (Tables 1 and 2). However, there is more work to do to ensure death-reporting compliance.

Table 1 – SB 561 death reporting compliance

Year	Number of youth suicide deaths reports to OHA via SB 561 reporting	Number of youth suicide deaths reported via violent death data dashboard	Percentage by SB 561 reports
2016	Data not available	98	n/a
2017	56	107	52%
2018	65	129	50%
2019	63	TBD in 2020 report	TBD

Table 2 – SB 561 postvention plan submission compliance

Year	Number of LMHAs	Number of LMHAs that submitted postvention plans to OHA	Percentage of LMHAs in compliance
2017	33	17	52%
2018	33	22	67%
2019	36	36	100%

SB 48 (2017)

SB 48 directs OHA to submit a report to the legislature in even numbered years that details the courses behavioral health professionals and educators have taken in assessment, treatment or management of suicide ideation.

An updated report will be submitted to the Oregon legislature in Fall 2020.

OHA activities in 2019

Legislatively mandated sections for this report (ORS 418.704) are below. Each section has a bulleted list of action items completed or underway. This is the fourth year of the YSIIPP's implementation. For the activities and initiatives completed in prior years, please reference the annual reports from [2016](#), [2017](#) and [2018](#).

Section 1

Section 1 (2)(a): OHA hired a suicide intervention and prevention coordinator as of Dec. 1, 2014. This person retired on Dec. 31, 2018. OHA hired another person into the role in June 2019.

Status: Completed

Progress: Completed. An additional suicide intervention and prevention specialist position was hired in December 2019.

Section 1 (2)(b): Outreach to special populations.

Status: Ongoing

Progress in 2019:

OHA, its contractors, and the Alliance to Prevent Suicide completed the following activities. The intent is to have a positive effect on these Oregon youth populations:

LGBTQ: The Alliance to Prevent Suicide's LGBTQ work group continued to meet this year. In 2019, the Family Acceptance Project held a training. The group hosted and debriefed that training. The group made recommendations to the Alliance Executive Committee about how to move that work forward. More than 200 people attended the Family Acceptance Project workshop and conference. About 175 people attended LGBTQ specific training at the annual Suicide Prevention Conference (sponsored by OHA). In addition, the Alliance provided an LGBTQ ally training to the Oregon Family Support Network. This training helps family peer providers effectively support families with LGBTQ children. Also, the University of Oregon's Suicide Prevention Lab completed a scan of current resources and activities (such as support groups) for LGBTQ and allies in Oregon. That list of resources is available through the Alliance website. In 2020, the work group plans to recommend to OHA and the Alliance solutions for gaps in services, programs or both for this vulnerable population.

Native American youth: Through Policy Options Package 402, the Legislature allocated \$450,000 for tribes to increase suicide prevention efforts. OHA provided a menu of possible options for use of these funds to tribal leadership in late fall of 2019. OHA will disburse these funds when tribal leadership states how they want to have them disbursed.

Oregonians with lived experience (loss survivors, attempt survivors, people with chronic suicidal ideation): The Alliance to Prevent Suicide convened a work group to recommend best practices to the executive committee for a trauma-informed environment for persons with lived experience to take part in Alliance work. The greater goal is to increase involvement of persons with lived experience in the Alliance. OHA contracted with Trauma Informed Oregon to support the goal of this work group. Trauma Informed Oregon will produce a best practices document and guidelines for working with persons who were or are experiencing suicide-specific trauma. This document will be available in 2020.

Veterans: In November 2019, Lines for Life, an OHA contractor and community partner, hosted a suicide prevention conference specifically for:

- Veterans, and
- Family members of military service professionals.

OHA provided support for pre-conference training. The training courses included:

- Applied Suicide Intervention Skills Training
- Question, Persuade, Refer and Counseling on Access to Lethal Means, and
- The veteran module of Mental Health First Aid.

OHA also included funding for an expansion of the veteran module of Mental Health First Aid. This includes increasing the number of trainers available for that course.

Youth engagement: In 2019, the Alliance to Prevent Suicide identified a need to expand the number of youths engaged in suicide prevention work. OHA increased the FTE that Youth Era's young adult engagement coordinator allocated to recruitment and support of youth and young adults. (Youth Era is a national nonprofit dedicated to supporting teens and young adults at risk of or experiencing depression, thoughts of suicide and trauma). The Alliance Executive Committee also began work to:

- Actively recruit more youth
- Make space for meaningful youth engagement, and
- Allocate FTE in Alliance staffing for youth engagement.

Youth engagement is critical in this area. Youth respond best to other youth trained as leaders.

Section 1 (2)(c): Identify barriers to accessing intervention services.

Status: Ongoing

Progress:

Action items in the plan address barriers to accessing intervention services.

This includes:

- Improving discharge and safety planning for youth in emergency or inpatient care. OHA worked with providers and stakeholders on rules for services to individuals in behavioral health crisis at release from emergency departments (HB 3090 and 3091) (2018). ORS 441.053 (HB 3090) (2018) rules were finalized in 2018. Rules include:
 - » Best practices in suicide risk assessment
 - » Lethal means counseling
 - » Safety planning
 - » Caring contacts, and
 - » Peer and family support services.
- HB 3091 (2018) set up a payment infrastructure for HB 3090's new aspect of case management services. A [report](#) released in 2019 indicates that 62 percent of hospital staff responding to the survey implemented procedures to comply with HB 3090's requirement. The requirement is for hospitals to schedule a behavioral health appointment within seven days of release from an emergency department. Less than half of hospitals (43 percent) reported that all patients with suicide ideation were released with a suicide safety plan. Please note that only 36 percent of hospitals completed the survey. OHA's behavioral health team convened a task group to look at recommendations for further work on this topic.
- Training for behavioral and physical health providers in conducting timely best practice suicide:
 - » Risk assessments
 - » Intervention, and
 - » Treatments.
- The Oregon Pediatric Society and Trauma Informed Oregon designed suicide practice interventions:
 - » Prevention
 - » Intervention, and
 - » Postvention.

- They now include them in training curricula for physical and behavioral health providers. Their trainings involve:
 - » Primary care and clinic staff
 - » Behavioral health clinicians
 - » School-based health clinics
 - » Tribal providers, and
 - » Social service workers.

- Crisis and acute transition services (CATS)

Funding for the Emergency Room Diversion Project, currently called CATS (crisis and acute transition services), initially rolled out to four sites in late 2014 and early 2015 and expanded to 11 sites in 2018. CATS addresses the needs of youth discharged from emergency departments, and their families, to reduce re-hospitalizations later. CATS provides care until the youth is connected with the appropriate level of outpatient support. Early data suggests that CATS is effective in diverting youth from emergency department stays. Hospitals give families receive quick responses and connect them to needed supports. From January to June 2019, CATS served 389 youth. Approximately 62 percent of youth seen in the program presented at the emergency department with suicidal ideation or after a suicide attempt. Only 9 percent of youth served by CATS returned to the emergency department. In 2019, services were available in these counties:

- » Benton
- » Clackamas
- » Deschutes
- » Jackson
- » Klamath
- » Linn
- » Malheur
- » Marion
- » Multnomah
- » Umatilla
- » Washington

Oregon Health & Science University (OHSU) is conducting an evaluation and will recommend outcomes and promising practices. Future reports will include a statement of results. The study needs to also monitor youth returns to emergency departments within 12 months post program.

- The Children’s Systems Advisory Council created a parent guide to emergency department services and guidelines. This guide is for use of peer and family support for at-risk youth. More than 3,500 guides were distributed around Oregon, which does not include e-distribution.
- Increasing funding (\$3.17 million) through Policy Options Package 402 to increase access to school-based mental health services. This funding expanded school-based mental health services in seven more counties in Oregon without school-based health centers. It uses clinicians from local community mental health programs to work with students directly in the school environment.
- Providing full funding for a suicide crisis line through Lines for Life. This ensures that Oregonians have access to caring intervention 24 hours a day, seven days a week.
 - » Funding for a peer-to-peer text, chat and telephone line through Lines for Life’s YouthLine Program.

Section 1 (2)(d): Technical assistance

Status: Ongoing

Progress:

As required by ORS 418.704, the Health Systems Division (HSD) youth suicide intervention and prevention coordinators provide technical assistance in suicide:

- Prevention
- Intervention, and
- Postvention.

The Zero Suicide coordinator (located in the Public Health Division) provides technical help to hospitals and health systems implementing the Zero Suicide initiative. Groups or programs receiving technical help include:

- State boards and commissions
- Schools and Education Service Districts
- K-12 athletic directors, coaches and trainers
- Community mental health programs
- Hospitals and health systems
- Outpatient behavioral health providers

- Parents and groups representing interests of youth
- Suicide prevention staff and advocates
- Coordinated care organizations and private insurance companies
- Organizations representing groups at disproportionate risk of suicide, and
- Any youth serving entity, including employers.

The coordinators also provide technical help to OHA staff. This includes:

- School-based health programs,
- Health Policy and Analytics, and
- Adult behavioral health.

Section 2

Section 2 (1): Recommendations for access to mental health intervention, treatment and supports for depressed and suicidal youth.

Status: Ongoing

Progress:

In 2019, the youth suicide intervention and prevention coordinator continued to strengthen the infrastructure for long-term sustainability of suicide prevention in Oregon. This included contracted work through a variety of contractors. This will ensure statewide access to youth suicide prevention, intervention and postvention programs and supports. These include:

- Prevention (to create healthy and well Oregon youth):
 - » Sources of Strength statewide coordinator, trainer and supports – Contractor: Matchstick Consulting, LLC
 - » PAX Good Behavior Game – this game consists of instructional and behavioral health strategies used by teachers. OHA has researched PAX and other best practices for social and emotional learning for elementary age children. The plan is to release an RFP in early 2020.
 - » Mental Health First Aid – a skills-based training course to teach participants about mental health (youth version and teen version). – Contractor: Association of Oregon Community Mental Health Programs
- Intervention (to act when signs of suicide arise):
 - » LifeLine fully funded (24-hour crisis line) – Contractor: Lines for Life
 - » YouthLine funded (Peer-to-peer text, telephone and chat line and youth leadership development program) – Contractor: Lines for Life

- » Question, Persuade, Refer training and School curriculum support – Contractor: Lines for Life
- » safeTALK and ASIST training – Contractor: Association of Oregon Community Mental Health Programs
- Postvention (to respond well after a suicide death):
 - » Connect: Postvention statewide training expansion: Contractor – Association of Oregon Community Mental Health Programs
 - » Quarterly meetings of SB 561 (2017) for coordination, learning and accountability: OHA led
 - » Suicide rapid response: OHA contractor Lines for Life coordinates with local mental health authorities to deploy services quickly to address contagion risk among youth. Services available include:
 - » Classroom activities
 - » Community listening sessions
 - » Youth peer support
 - » Family peer support
 - » Grief processing
 - » Interventions for staff, and
 - » Parent programs.

Section 2 (2): Recommendations to improve access to care and supports. This includes affordability, timeliness, cultural appropriateness and availability of qualified providers.

Status: Ongoing

Progress:

Policy Option Package 402 (2019) funded through the Governor’s budget, allowed for significant progress in this area:

- \$450,000 allocation to tribes to increase suicide prevention efforts. OHA provided a menu of possible options for use of these funds to tribal leadership in late fall of 2019. OHA will disperse these funds when tribal leadership states how they want to have them dispersed.

- \$3.17 million allocation to increase access to school-based mental health services. This funding helps provide services to students in the moment and:
 - » Makes it possible for them to remain in school and in the learning environment when possible, or
 - » Get the help that they need through referral.

Section 2 (3): Recommendations including best practices to identify and intervene with youth who are depressed, suicidal or at risk of self-injury.

Status: Ongoing

Progress:

- OHA contracted with the Oregon Pediatric Society to train primary care doctors on depression and substance use screening to include:
 - » Adverse childhood experiences
 - » Best practices in suicide risk assessment and depression screening
 - » Safety planning, and
 - » Lethal means counseling.

In 2019, approximately 368 doctors were trained in this complex and critical topic.

- OHA put forth RFPs in 2019 to fund statewide access for several best practice programs and trainings. Proposals were to be proven effective to identify and intervene with youth who are depressed, suicidal or at risk of self-injury. The six current OHA sponsored programs include:
 1. Sources of Strength training
 2. safeTALK training
 3. Youth Mental Health First Aid (for adults working with youth)
 4. Question, Persuade, Refer training
 5. Applied Suicide Intervention Skills Training (ASIST)
 6. CONNECT postvention training
- In 2020, OHA anticipates contracting for other evidence-based programs. OHA is especially looking for programming for elementary-age children.

Section 2 (4): Recommendations for collaborations among schools, school-based health clinics and CCOs for school-based programs.

Status: Ongoing

Progress:

- OHA continues to support the suicide rapid response team, which is available to local mental health authorities (LMHAs) when the following conditions exist:
 - » A youth suicide death occurred
 - » Risk of suicide contagion is identified
 - » Lack of resources or fatigued resources for response is identified, and
 - » The local community (through an LMHA) requests support.
- OHA's youth suicide intervention and prevention coordinator included school support in three requests for proposals in 2019. This was to provide resources to schools in best practices for suicide prevention, intervention and postvention programs. Support for schools include:
 - » Consultation, and
 - » Limited funding for suicide prevention curriculum.
- The Alliance to Prevent Suicide and the University of Oregon completed a scan of school suicide prevention curricula, training and supports in Oregon schools. This collaboration also produced a toolkit which outlines:
 - » Research-based practices for suicide prevention, intervention and postvention, and
 - » A crosswalk of several available toolkits available to schools.
- In 2019, OHA's youth suicide intervention and prevention coordinator presented suicide prevention efforts to all school-based health clinic directors. The coordinator also recommended opportunities for collaboration.

Section 2 (5): Recommendations for use of social media in intervention and prevention of youth suicide and self-inflicted injury.

Status: Ongoing

Progress:

Lines for Life, Youth MOVE (now called Youth Era), and a number of youth received one-time funding in 2017-2019 to pilot social media strategies to create safe online spaces for youth. The project required those receiving funds to do extensive research and planning because of its innovative nature. In 2019, Lines for Life and Youth ERA launched separate live monitoring projects. Plans are to continue the work into the next biennium — with funding outside of OHA.

The model for intervention of social spaces is:

- A social media monitor trained in crisis intervention with:
 - » Has access to supervision support if needed, and
 - » Scrolls through posts on targeted social media applications.
- The monitor directly messages persons who have shared content related to self-harm, suicide or both, to offer resources and support. All persons are sent resources regardless of whether they respond to the monitor’s message.
 - » For those who respond, the monitor follows YouthLine texting protocol to help the contact form a safety plan. The monitor discloses that they are a young adult and work at a crisis center.
- As necessary, the monitor suggests apps, works with emergency medical services (EMS), or both when facing high-risk contacts who cannot form a safety plan.

Because of staffing changes at Lines for Life, this project has been fully operating for three months (and partially operating for three additional months) as of the writing of this report. In that time, Lines for Life:

- Gave over 200 youth support and resources
- Received reports from nine youth that they “definitively” did not self-harm because of the intervention, and
- Learned that three suicide deaths were avoided.

Given the short duration of this project, these are promising statistics.

Lines for Life is also working with app developers and staff to develop memorandums of understanding to communicate when a user is at risk and unable to contract for safety. They are also working with apps to promote and implement safety standards for users to address suicidal ideation and self-harm.

Section 2 (6): Recommendations to respond to schools and communities following completed youth suicides.

Status: Ongoing

Progress:

Refer to Section 2 (4) above for more information about the progress of the:

- Suicide rapid response team
- Alliance school toolkit, and
- Funding for postvention activities in schools in multiple requests for proposal.

Section 2 (7-8): An analysis of intervention and prevention strategies used by states with the five lowest suicide rates.

Status: Completed

Progress:

A comparison of Oregon's youth suicide rates and prevention strategies with other states is in the plan. Rankings for 2018 are with the statistics provided in Table 11 of this report.

Section 2: Action items requiring additional resources to complete.

Status: Underway

Progress:

OHA prepared a budget proposal for \$13 million in 2019-2021 to address gaps in services. Of that proposal, OHA allocated \$10 million to youth suicide prevention, intervention and postvention. Based on this proposal, the Legislature allocated \$6.83 million for suicide prevention, intervention and postvention services in Oregon. The Legislature allocated an additional \$3.17 million for school based mental health services. These services have been shown to have an effect on suicide prevention. OHA estimates there is a need for an additional \$5.17 million to fully fund the current YSIPP. Additionally, the Adult Suicide Prevention and Intervention Plan, which OHA will begin to draft in 2020, will need its own funding.

Section 3

Section 3: Review data and prepare an annual report to the Legislature.

Status: Ongoing

Progress:

Suicide numbers, rates and rankings by county or state vary by year. Monitoring trends across time is the most effective way to study the data. For example, both the number of youth suicides and the state suicide rate in Oregon have changed over the past several years. While suicide is the leading cause of death for youth ages 10-24, the ranking change is due to both an increase in suicide deaths and a downward trend in unintentional injury deaths (i.e. overdoses, motor vehicle accidents) (2). Oregon ranks 11th in the nation for suicide rate, which is the highest rate in the past five years.

Table 3. Oregon suicide death rate compared to national suicide death rate

Year	Number of youth suicides	Suicide death rate (per 100,000)	Rank among 50 states (50 is lowest rate)
2014	97	12.9	12
2015	90	12.0	16
2016	98	13.0	15
2017	107	14.1	17
2018	129	16.7	11

The following data analysis addresses Section 1 (3) (a-g) of HB 4124.

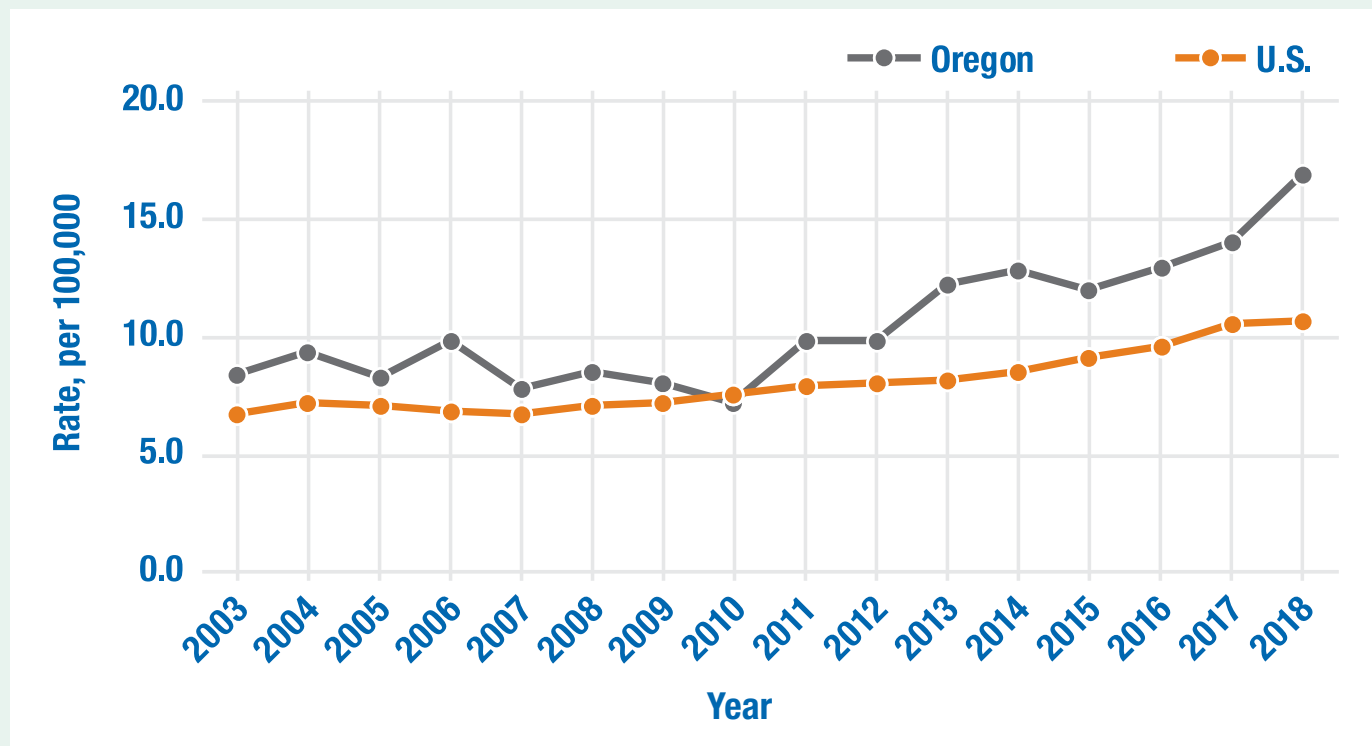
Suicide was the leading cause of death among youth aged 10 to 24 years in Oregon in 2018. (1)

Overall, Oregon suicide deaths and rates among youth aged 10 to 24 years have increased significantly since 2011. Oregon suicide rates were higher than the United States rates in the past decade. From 2015 to 2018, adolescent (10 to 17 years old) suicides have increased from 20 deaths a year to 39 deaths in 2018. (1)

Male youth were significantly more likely to die by suicide than female youth. (3)

During 2013 to 2017, Centers for Disease Control and Prevention (CDC) Web-based Inquiry Statistics Query and Reporting System (WISQARS) and the Oregon Public Health Assessment Tool (OPHAT) data identified 12 youth suicides as among LGBTQ Oregonians. This accounts for 2.4 percent of Oregon youth suicide deaths.

Figure 1. Suicide death rates among youth aged 10 to 24 years, 2003-2018



Rates are deaths per 100,000
Source: CDC WISQARS and OPHAT

Table 4. Comparison of suicide death rates per 100,000, among youth aged 10 to 24 years in Oregon and the United States, 2003-2018 (2)*

Year	Oregon	United States
2003	8.4	6.7
2004	9.4	7.3
2005	8.3	7.0
2006	9.9	6.9
2007	7.9	6.8
2008	8.5	7.0
2009	8.1	7.2
2010	7.2	7.6
2011	9.8	7.9
2012	9.8	8.0
2013	12.2	8.2
2014	12.9	8.5
2015	12.0	9.2
2016	13.0	9.6
2017	14.1	10.6
2018	16.9	10.7

* Rates are deaths per 100,000

Source: CDC WISQARS and OPHAT

Figure 2. Suicide death rate by age group, Oregon, 2003-2018



Source: CDC WISQARS and OPHAT

Common circumstances for suicide (Table 5):

- Mental illness and substance abuse
- Previous suicide attempts
- Interpersonal relationship problems or poor family relationships
- Recent criminal legal problems
- School problems
- Exposure to a friend or family member's suicidal behavior

Table 5. Common circumstances surrounding suicide deaths by age group, 2013-2018

Circumstance	Aged 10-17 (n=132)		Aged 18-24 (n=362)		Aged 10-24 (n=494)	
	Count	%	Count	%	Count	%
Mental health status						
Mentioned mental health problems*	85	64	252	70	337	68
Diagnosed mental disorder	50	38	137	38	187	38
Problem with alcohol	3	2	54	15	57	12
Problem with other substance	12	9	76	21	88	18
Current depressed mood	58	44	147	41	205	41
Current treatment for mental health problem†	34	26	80	22	114	23
Interpersonal relationship problems						
Broken up with boyfriend or girlfriend, or intimate partner problem	23	17	100	28	123	25
Suicide of family member or friend within past five years	1	1	10	3	11	2
Death of family member or friend within past five years	4	3	13	4	17	3
Family stressors	39	30	44	12	83	17
History of abuse as a child	8	6	12	3	20	4
Life stressors						
A crisis in the past two weeks	22	17	68	19	90	18
Physical health problems	2	2	14	4	16	3
Job or financial problems	1	1	34	9	35	7
Recent criminal legal problems	4	3	36	10	40	8
School problem	25	19	9	2	34	7
Suicidal behaviors						
History of expressed suicidal thought or plan	36	27	116	32	152	31
Recently disclosed intent to die by suicide	31	23	100	28	131	27
Left a suicide note	43	33	111	31	154	31
History of suicide attempt	22	17	87	24	109	22

*Include diagnosed mental disorder, problem with any or all: alcohol, other substance, or depressed mood.

†Include treatment for problems with alcohol, other substance or both.

Source: Oregon Violent Death Reporting System (ORVDRS)

2018

- Final data reported 129 suicides occurred among Oregon youth aged 10 to 24 years (characteristics and location are not available for 2 out of state deaths). Most suicides occurred among males (78 percent), white persons (87 percent) and persons aged 20 to 24 years (52 percent).
- Thirty-nine deaths were among middle school and high school students. (Table 6)
- In 2018, these were the most often observed mechanisms of injury in suicide deaths among youth (Table 6):
 - » Firearms (51 percent)
 - » Suffocation or hanging (32 percent), and
 - » Poisoning (6 percent).

Table 6. Characteristics of youth suicides, Oregon 2018

		Deaths*	% of total
Age	10-14	13	10%
	15-19	48	38%
	20-24	66	52%
Sex	Male	99	78%
	Female	28	22%
Race[†] or ethnicity	White	111	87%
	African American	5	4%
	American Indian or Alaska Native	4	3%
	Asian and Pacific Islander	3	2%
	Multiple race	1	1%
	Other or unknown	5	4%
	Hispanic	19	15%
Student status	Middle school	9	7%
	High school	30	24%
Mechanism of death	Firearm	65	51%
	Hanging or suffocation	41	32%
	Poisoning	8	6%
	Other	13	10%
Other	Veteran	3	2%

* Two out-of-state deaths are not included because 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 Center for Health Statistics, OHA, there were 129 suicides aged 10 to 24 in 2018.

Suicide attempts

More than 900 Oregon youth ages 10 to 24 years were hospitalized for self-inflicted injury or attempted suicide in 2018 (Table 7).

- Females were far more likely to be hospitalized for suicide attempts than males.

Table 7. Numbers of self-harm hospitalizations and suicides among youth aged 10 to 24 years by county, Oregon, 2018

County	Hospitalizations*		Deaths†	
	Count	% of total	Count	%
Baker	1	0.1%	2	1.6%
Benton	15	1.6%	6	4.7%
Clackamas	89	9.5%	13	10.2%
Clatsop	11	1.2%	0	0.0%
Columbia	11	1.2%	2	1.6%
Coos	20	2.1%	1	0.8%
Crook	0	0.0%	0	0.0%
Curry	1	0.1%	1	0.8%
Deschutes	34	3.6%	6	4.7%
Douglas	17	1.8%	4	3.1%
Gilliam	0	0.0%	0	0.0%
Grant	0	0.0%	0	0.0%
Harney	0	0.0%	1	0.8%
Hood River	3	0.3%	0	0.0%
Jackson	66	7.1%	7	5.5%
Jefferson	12	1.3%	1	0.8%
Josephine	22	2.4%	3	2.4%
Klamath	10	1.1%	2	1.6%
Lake	1	0.1%	0	0.0%
Lane	106	11.3%	8	6.3%
Lincoln	6	0.6%	4	3.1%
Linn	17	1.8%	2	1.6%
Malheur	2	0.2%	1	0.8%
Marion	117	12.5%	20	15.7%
Morrow	1	0.1%	1	0.8%
Multnomah	170	18.2%	26	20.5%
Polk	21	2.2%	1	0.8%
Sherman	0	0.0%	0	0.0%
Tillamook	4	0.4%	0	0.0%
Umatilla	5	0.5%	2	1.6%
Union	5	0.5%	0	0.0%
Wallowa	0	0.0%	0	0.0%

Wasco	8	0.9%	2	1.6%
Washington	144	15.4%	11	8.7%
Wheeler	0	0.0%	0	0.0%
Yamhill	17	1.8%	0	0.0%
State	936	N/A	127	NA

* Oregon Hospital Discharge Index, 2018. New methodology to calculate 2018 youth self-harm hospitalizations was implemented based on CSTE (Council of State and Territorial Epidemiologists) guidelines. Therefore, 2018 estimates are not comparable to previous years.

† Oregon Public Health Division, Injury and Violence Prevention Program, 2018 OPHAT. Two out-of-state deaths are not included because their death certificate information is not accessible.

Source: Injury and Violence Prevention Program, Oregon Public Health Division.

Suicidal ideation: Oregon Healthy Teens Survey

- Percentage of youths who seriously considered suicide in the past 12 months, in 2019:
 - » 20 percent of eighth graders
 - » 19 percent of 11th graders
- Percentage of youths who attempted suicide one or more times in the previous 12 months, in 2019:
 - » 10 percent of eighth graders
 - » 7 percent of 11th graders
- Percentage of lesbian and gay youth who contemplated suicide in the past 12 months, in 2019:
 - » 50 percent of eighth graders
 - » 37 percent of 11th graders
- Percentage of transgender or gender diverse youth who contemplated suicide in the past 12 months, in 2019. This includes those who identify as:
 - » Transgender male or transgender female
 - » Gender fluid or genderqueer
 - » Gender nonconforming
 - » Agender
 - » Multiple responses,
 - » “Not sure of gender,” and
 - » Those whose gender identity response differs from their birth sex response:
 - » 47 percent of eighth graders
 - » 41 percent of 11th graders

Source: Oregon Public Health Division, Oregon Healthy Teens Survey, 2019. Available from: <https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Documents/2019/2019%20State%20of%20Oregon%20Profile%20Report.pdf>

Limitations of data used for suicide surveillance

Suicide is one of the leading causes of death for the population at large in Oregon and the leading cause of death among Oregonians aged 10 to 24. OHA has set suicide prevention as one of its top priority areas. Suicide is a complex behavior and associated with many factors:

- Mental health
- Substance use
- Physical health
- Relationships
- Life events
- Isolation
- Social connectivity
- Stress, and
- Other environmental and societal conditions.

To monitor and track suicide as well as some risk and protective factors that lead to or prevent suicide Oregon uses:

- Various existing administrative data sets
- Surveys, and
- Active surveillance efforts.

Oregon uses administrative data sets to track outcomes such as deaths from suicide. In addition, medical outcomes such as inpatient hospitalizations and emergency department (ED) visits for suicide attempts or self-harm. These data sources include:

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

A standardized ED discharge data set has been an objective of the State Health Improvement Plan and a high priority for OHA. PHD currently has access to 2017 ED discharge data from OAHHS. However, the data use agreement between OHA and OAHHS does not currently allow use of the data beyond evaluation of the data (i.e. does not permit public release). ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics) provides real-time syndromic surveillance data for public health and hospitals to monitor health events (ED visits) in emergency departments across the state. ESSENCE was designed primarily to quickly identify emerging infectious disease

events such as bioterrorism attacks. ESSENCE data are “passively” collected by PHD through direct reporting by hospitals. ESSENCE data are available for tracking ED visits for suicide or self-harm. However, ESSENCE data are not part of a standardized administrative data set. Also, the data the hospitals report can vary. Reporting data to ESSENCE by hospitals is not a requirement or mandated by statute. Although most hospital EDs report data, missing and incomplete data is a known system issue. Some standardized, coded data are available. However, the system is based on data that are in written narrative text about the chief complaint. Data sets are not standardized. Therefore, the system cannot consistently distinguish suicide attempts from other forms of self-harm.

Administrative data sets typically capture data at the population level. For example, all instances of deaths within Oregon, or all hospital inpatient visits for suicide attempt. However, the data include limited to no information on factors that may have led persons to suicide. For example, untreated depression, life stressors, etc. In addition, administrative data sets were not created to conduct public health surveillance but were created for billing and clinical purposes.

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

- Behavioral Risk Factor Surveillance System (BRFSS)
- Oregon Healthy Teens (OHT) survey
- Student Wellness Survey (SWS)
- National Survey on Drug Use and Health (NSDUH)
- American Community Survey (ACS)

These surveys are both state and nationally administered. Some of these surveys periodically include questions about suicidality or mental health issues. However, questions often depend on funding from individual program (e.g. BRFSS, OHT) to continue data collection for specific questions year-to-year. As of late, the response rate to these telephone surveys (e.g. BRFSS) has been low (e.g. < 50 percent, which has implications on the generalizability of the data).

Some active surveillance data sources and systems link outcomes to individual risk. The Oregon Violent Death Reporting System (ORVDRS) and the Oregon Child Fatality Review (CFR) collect active surveillance data from multiple sources to provide a more complete picture, such as:

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

Due to lack of standardized questionnaires and investigations on each death, ORVDRS does not mandate that all agencies to collect some data elements (e.g. LGBTQ status among people who died by suicide). In addition, limited witnesses and contacts with a person who died by suicide can result in incomplete information about the incident. Therefore, the data from the system may underestimate some given circumstances or risk factors. CFR data only covers youth aged 18 and younger. Some deaths did not have a review by county teams.

These data sets, surveys and surveillance activities include data elements of interest to policy makers. However, these data sources may fall short in other areas of interest. Standard administrative data used to track outcomes (i.e. death certificates, hospitalizations, ED visits) do not typically also collect:

- Data on risk and protective factors for suicide (e.g. depression)
- Past medical and behavioral histories (e.g. treatment episodes)
- Other data elements that are can tie individual risk and protective factors directly to suicidal behaviors, or
- Outcomes among persons (for example, the number of previous suicide attempts among individual decedents).

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

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

Generation of missing data would involve many parts:

- More resources, position authority and planning
- Linkage of several large administrative data sets
- In-person case interviews
- Requirements for law enforcement agencies and health care providers to release individual information
- Personnel for data entry and database management, and
- Statute to require hospitals to report some types of data, such as ED data, and specify the way to report data.

Senate Bill 23 passed during the 2019 legislative session. As of Jan. 1, 2020, hospitals are required to submit their ED discharge data. Rulemaking on the ED requirements took place in November 2019. The Health Policy and Analytics Division (HPA) at OHA is working on a contract with the hospital association, OAHHS, to obtain the data. The contract is currently with Oregon Department of Justice undergoing legal sufficiency review. HPA is on track to begin receiving ED discharge data in July 2020. Data will cover discharges from the first quarter of 2020. HPA will then receive quarterly updates thereafter.

OHA PHD has received a three-year grant from CDC to look at ED surveillance of nonfatal suicide-related outcomes. The aim of the grant is to pilot and evaluate processes to obtain and report timely suicide attempt and self-harm data to inform prevention efforts. This will entail tracking of:

- Nonfatal self-directed violence (including suicide attempts)
- Suicidal ideation, and
- Intentional opioid overdose.

PHD will track the data with the Oregon ESSENCE syndromic surveillance system. In addition, the grant will allow PHD to create, validate and monitor quality of indicator syndrome definitions in ESSENCE. Grant activities also include convening stakeholders to identify data elements of interest and provide input on how data should be reported.

Appendix I

Public Health Division: 2019 Garrett Lee Smith grant activities

The Oregon Health Authority, Public Health Division (PHD), manages the Garrett Lee Smith Memorial Act (GLSMA) funding through the Substance Abuse and Mental Health Services Administration (SAMHSA). OHA completed grant activities for funding for the Oregon Caring Connections Initiative (OCCI) between September 2014 and September 2019. OHA received a new round of GLSMA funding for June 2019 through June 2024. This is referred to as the Oregon GLS. Oregon receives \$736,000 a year through this grant mechanism to implement activities required in the SAMHSA funding opportunity announcement. The below description includes:

- Accomplishments from the Oregon Caring Connections Initiative, and
- Goals and objectives for the new Oregon GLS grant.

Initiative objectives align with Strategic Direction 2 and Strategic Direction 4 of the Youth Suicide Intervention and Prevention Plan.

Oregon Caring Connections Initiative (September 2014 – September 2019)

Five counties received funding to implement grant activities:

1. Deschutes
2. Jackson
3. Josephine
4. Umatilla
5. Washington

Grant activities for counties include:

Gatekeeper training to increase the number of persons in youth-serving organizations trained to identify and refer youth at risk.

Clinical training to increase health, mental health and substance abuse clinicians trained to assess, manage and treat youth at risk for suicide.

Improved continuity of care for:

- » Youth discharged from emergency departments and inpatient psychiatric units
- » Veterans and military families receiving care in the community, and
- » Establishing full wraparound services within updated county crisis response plans.
- Promotion of the National Suicide Prevention Lifeline (NSPL) in multiple venues and events in these counties and across the state.

Additional grant activities completed through PHD include:

- Supporting Oregon health care organizations implementing the Zero Suicide Initiative. PHD provided technical help, funding and learning opportunities.
- Providing project evaluation through data collection from county grantees and health care organizations to:
 - » Inform work, and
 - » Report on outcomes.

Grant accomplishments

The following section describes grant activities and accomplishments completed over the five-year SAMHSA Oregon Caring Connections Initiative grant. Sections match the strategic directions and objectives in the Youth Suicide Intervention and Prevention Plan (YSIPP).

1. Gatekeeper training

Information about gatekeeper training completed through the OCCCI funded projects, consistent with Goal 6 of YSIPP, is below. Trainings include:

- Applied Suicide Intervention Skills Training (ASIST)
- safeTALK
- Question, Persuade and Refer (QPR)

Gatekeeper trainings are best-practice or evidence-based. These trainings are means to prepare lay people and professionals to identify and refer persons at risk for suicide to appropriate care. This activity is an objective in the national suicide prevention plan and Objective 6.1 under Strategic Direction 2 in Oregon's YSIPP.

Funded counties exceeded the target of implementing one gatekeeper training per quarter (Table 8 below) during the grant period.

Table 8. Completed QPR, ASIST and safeTALK trainings and participants trained during the OCCI grant, by grant year

Year	QPR	ASIST	safe-TALK	Total
Year 5 Total	36 trainings (1,072 people)	18 trainings (444 people)	-	54 trainings (1,516 people)
Year 4 Total	71 trainings (1,745 people)	13 training (301 people)	-	84 trainings (2,046 people)
Year 3 Total	66 trainings (1,758 people)	13 trainings (313 people)	-	79 trainings (2,071 people)
Year 2 Total	42 trainings (1,300 people)	21 trainings (492 people)	1 training (17 people)	64 trainings (1,809 people)
Year 1 Total	10 trainings (274 people)	21 trainings (567 people)	-	31 trainings (841 people)
Cumulative	225 trainings 6,149 people	86 trainings 2,117 people	1 training 17 people	312 trainings 8,283 people

Note: Washington County trainings for years 1-4 were in-kind (not funded through OCCI)

Counties trained various community members and professionals. These groups include:

- City staff
- Foster grandparents
- Sobering center staff
- Juvenile justice staff
- Local newspaper staff
- Hospital chaplains
- Boys & Girls Club staff
- Veteran Affairs staff
- Community and shelter assistance staff, and
- Police.

Through the grant, PHD provided an opportunity for school professionals to use a web-based gatekeeper training through Kognito. In Oregon, 472 school professionals representing 50 schools took this training.

The curriculum revision for Response: a high school-based suicide prevention is completed. It now reflects current:

- Pedagogy
- Health standards, and
- Highlight activities to engage students.

The curriculum is available for purchase.

2. Clinical training

Through the grant, PHD provides an opportunity for professionals to take a web-based gatekeeper training through Kognito. Persons had access to complete these training who work in:

- Emergency departments
- Primary care, and
- School-based health centers.

Table 9 provides data on the settings, number of locations and users who completed Kognito training.

Table 9. Implementation and completion of Kognito clinical training by setting, year 1-5

Type of setting	Locations	Users completing training
Emergency departments*	8 [†]	73
Primary care providers and school-based health centers [†]	34 [†]	103
Total	42[†]	176

*Promotion of these Kognito programs started in year two.

[†]PHD could not identify by location participants grouped in the “Other” category. Therefore, the exact number of locations is unknown.

The Oregon Health Authority, PHD Injury and Violence Prevention Program continued to work with the School-Based Health Center (SBHC) Program to promote Kognito for primary care. PHD arranged several learning opportunities for SBHC staff with the creator of the Columbia-Suicide Severity Rating Scale (C-SSRS) on various aspects of suicide intervention and safety planning. The recorded webinars are available on the OHA School-Based Health Centers Training and Presentations webpage.

Some health care organizations found Kognito to be an appropriate tool to encourage staff to use. Still, other organizations used other trainings to train staff on suicide prevention and intervention. This information informed working with health care organizations to support training and online training that meets their needs in the Oregon GLS grant (2019–2024). See more information below.

The OCCI required funded counties to implement a clinical training designed for mental health service providers known as Assessing and Managing for Suicide Risk (AMSR). Table 10 includes information about the county level implementation of AMSR training.

Table 10: Total AMSR trainings completed year 1–4 (Target: Complete 11 trainings and train 550 participants by Dec. 29, 2019)

Training Date	Training Location	Clinicians Trained
2/27/2015	Washington	49
Year 1 Total	1	49
10/30/2015	Jackson	42
03/30/2016	Josephine	41
07/12/2016	Deschutes	49
08/05/2016	Malheur	47
09/16/2016	Lane and Douglas	51
09/22/2016	Multnomah	46
Year 2 Total	6	276
09/01/2017	Umatilla	17
09/22/2017	Jackson	20
Year 3 Total	2	37
04/27/2018	Jackson	19
05/03/2018	Josephine	34
Year 4 Total	2	53
10/31/2018	Deschutes	28
07/12/2019	Washington	28
8/23/2019	Umatilla	19
Year 5 Total	3	75
Total to date	14	490
Total remaining to train	0	60

Over the grant period there were 14 AMSR trainings. This exceeded the grant target of 11 trainings. The original goal of training 550 clinicians assumed a 100 percent enrollment rate of 50 participants per training. Unfortunately, given the rural nature of some of the OCCI funded counties, this was not realistic. SAMHSA has approved extended funding to offer two more AMSR trainings by April 2020 to meet clinician targets.

In year 5, thanks to OCCI funding, the following was shared via hard copy and the web:

- A brochure for firearm owners, and
- A tip sheet for primary care providers (PCPs).

OCCI funded counties and a contractor have promoted this work. It has also been promoted through outreach events, training events, webinars and conference presentations. These include:

- Oregon Suicide Prevention Conference, Sunriver
- Oregon Health & Science University Early Psychosis and the Early Assessment and Support Alliance (EASA)
- EASA Regional Teams throughout Oregon
- Oregon Pediatric Society (webinar)
- Regional suicide prevention coalitions around the state
- PHD and contractor distributed in Oregon throughout the entire grant period:
 - Over 7,500 physical firearm safety brochures for firearm owners, and
 - Over 1,075 firearm tip sheets for providers.

PHD and contractor also distributed the electronic links to these materials at many events and through multiple listservs.

Building on this work, four brief videos for providers and clinicians on how to address firearm safety with a rural patient at risk of suicide are complete and available online. These videos were created based on the research that emphasizes appropriate language to use with a patient at risk of suicide. The videos show how to:

- Discuss firearms with a patient at risk of suicide (Video 1)
- Develop a safety plan focused on firearm safety (Video 2)
- Engage the patient who becomes defensive when the subject of firearms is addressed (Video 3), and
- Respond when a high-risk patient becomes angry when a provider brings up the topic of firearm safety and leaves the office (Video 4).

The videos and lessons from the research conducted with rural firearm owners are being incorporated into a free, online training that will provide continuing medical education credits to health care professionals by a PHD contractor. The anticipated release date is March 2020.

3. Zero Suicide initiative promotion and implementation

The Oregon Health Authority, PHD, Injury and Violence Prevention Program continues to work with Oregon health care organizations on Zero Suicide Initiative implementation. The Zero Suicide initiative is a commitment to suicide prevention in health and behavioral health care systems. It is also a specific set of tools and strategies. Its core propositions are that suicide deaths for people under care are preventable. The bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept and work toward. The approach aims to improve care and outcomes for persons at risk of suicide in health care systems.

PHD hosted a two-day Zero Suicide Academy in Oregon in September 2018. Sixteen Oregon health care organizations attended. These health care organizations represent a geographically diverse group as well as a various system types. This includes:

- Hospitals
- Youth serving organizations
- Tribal entities
- County services
- Behavioral health-focused organizations, and
- Primary care.

All 16 health care organizations produced a 90-day work plan to move their Zero Suicide efforts forward after attending the Academy.

As a follow-up to the Oregon Zero Suicide Academy, a community of practice (CoP) for better suicide care with nine organizations that attended the academy took place between November 2018 and September 2019. It was facilitated by the OHA, PHD Injury and Violence Prevention Program. The CoP allowed Oregon health care organizations implementing better suicide care practices to connect and hear from experts on their experiences doing the same. Organizations taking part:

- Gained knowledge and ideas to address on the ground challenges, and
- Had opportunities to share expertise from their implementation efforts.

PHD sent surveys after each CoP meeting. Surveys reflected strong agreement or agreement that CoP sessions were of value to participants. During a debrief of the CoP during the last session in September 2019, organizations asked for continued support from OHA in:

- Learning opportunities, and
- Communicating Zero Suicide efforts to OHA leadership.

PHD provided Zero Suicide mini-grants to selected health care organizations. These organizations attended Zero Suicide Academy. The grants were to move Zero Suicide efforts forward. PHD awarded six organizations funding after a formal application and review.

Funds were for activities between July and September 2019. Grant activities included:

- Training opportunities for staff on suicide prevention
- Strategic planning efforts with committed leadership time, and
- Electronic health record improvements.

All funded organizations met their work plans and showed progress in their Zero Suicide efforts.

With grant evaluators, PHD also created a tool to assess implementation of Zero Suicide for planning and evaluation purposes. Ten organizations that completed the Zero Suicide Academy used the tool to show progress over the year since the Zero Suicide Academy. Health care organizations received individual reports to share with their leadership. This was to help prioritize Zero Suicide efforts. A statewide progress report was also created. This report shows great overall progress in Zero Suicide implementation, particularly in:

- Gaining leadership support and buy-in
- Training staff, and
- Supporting patients as they transition from different levels of support, to other organizations for care, or both.

Oregon Garrett Lee Smith (GLS) Grant (June 2019 – June 2024)

PHD received new SAMHSA GLS funding to build on previous work and support additional work. The same five counties supported in the Oregon Caring Connections Initiative received funding for the first year of the grant:

1. Deschutes
2. Jackson
3. Josephine
4. Umatilla
5. Washington

A competitive request for grant proposal (RFGP) for LPHAs and Community Mental Health Programs is being developed with advisement from the Oregon Coalition of Local Health Officials and the Association of Oregon Community Mental Health Programs. The RFP will be released later in 2020. After review and awards are extended, funding will start June 29, 2020, and run through the end of the grant period. Grant activities include:

- Gatekeeper training
- Clinical training
- Continuity of care efforts
- Zero Suicide Initiative implementation
- Supporting school suicide prevention training and student curriculum, and
- Creating a community coalition to support work.

Additional grant activities include:

- Continuing work with the School Based Health Center program to bring technical help and learning opportunities to SBHCs around the state
- Working with Oregon Department of Human Services on training staff in:
 - » Suicide prevention
 - » Developing a suicide prevention plan, and
 - » Collaborating with partner organizations
- Holding a Zero Suicide Academy for new Oregon health care organizations interested in implementation, and
- Continuing to support previous Zero Suicide Academy attendees through technical help and learning opportunities.

Future YSIPP reports will provide information on these grant activities and outcomes.

Appendix II: Suicide Rates by State

Table 11: Suicide death rate among youth aged 10 to 24 years by state, United States 2018

State	Deaths	Crude Rate
Alaska	45	30.2
South Dakota	44	24.7
Idaho	87	23.5
Montana	46	22.8
Wyoming	25	22.1
New Mexico	90	21.4
Colorado	205	18.5
Kansas	111	18.1
North Dakota	28	17.7
Utah	133	17.1
Oregon	129	16.9
Missouri	185	15.5
New Hampshire	37	14.8
Arizona	212	14.7
West Virginia	46	14.2
Washington	195	14.0
Nevada	78	13.9
Oklahoma	108	13.4
Maine	30	13.3
Kentucky	114	13.0
Indiana	179	13.0
Michigan	251	12.8
South Carolina	122	12.5
Delaware	22	12.5
Arkansas	74	12.3
Virginia	203	12.3
Alabama	116	12.2
Ohio	271	12.0
Louisiana	103	11.3
Iowa	72	11.1
Minnesota	120	11.0

Pennsylvania	256	10.8
Tennessee	139	10.7
Mississippi	66	10.7
Vermont	13	10.6
Georgia	229	10.5
Texas	635	10.4
Wisconsin	114	10.0
Nebraska	40	9.9
North Carolina	202	9.9
Florida	320	8.7
Hawaii	21	8.4
Maryland	93	8.2
Illinois	201	8.1
California	546	7.0
Massachusetts	82	6.1
New Jersey	102	6.1
New York	213	5.9
Connecticut	41	5.8
District of Columbia	<10	Not calculated
Rhode Island	<10	Not calculated

Rates are deaths per 100,000

Source: CDC WISQARS

Endnotes

1. Deaths and Perinatal Deaths Data [Internet]. Oregon Health Authority: Deaths and Perinatal Deaths Data: Annual Report Volume 2: State of Oregon. [cited 2019 Dec 14]. Available from: <http://www.oregon.gov/oha/PH/BirthDeathCertificates/VitalStatistics/annualreports/Volume2>
2. WISQARS Fatal Injury Reports [Internet]. Centers for Disease Control and Prevention. Centers for Disease Control and Prevention; 2018 [cited 2020 Feb 21]. Available from: <https://webappa.cdc.gov/sasweb/ncipc/mortrate.html>
3. Oregon Public Health Division, Oregon Violent Death Reporting System, 2003-2012. Available from: <http://www.oregon.gov/oha/ph/diseasesconditions/injuryfatalitydata/pages/index.aspx>



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