2016-2020

Youth Suicide Intervention and Prevention Plan

Oregon
Health
Authority

Health Systems Division

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Contents

Dear Oregonians,

Suicide is one of Oregon's most persistent, yet largely preventable public health problems. Nearly two people in Oregon die every day from suicide. The State Health Improvement Plan, published in September of 2015, identified suicide prevention among Oregon's entire population as a health priority. While the highest rates of suicide occur among older males, Native Americans and veterans, this plan focuses on preventing suicide at the earliest ages where it begins to occur among youth aged 10–24 years. The framework of this plan draws on the four strategic directions, goals and objectives in the National Strategy for Suicide Prevention. One-hundred families and youth, private and public behavioral health providers, primary care clinicians, CCOs and private insurance companies, advocates and other subject matter experts worked together to plan how we can operationalize the National Strategy for Suicide Prevention in Oregon.

The planning group adopted the aspirational goal of eliminating suicides among youth aged 10–24 years in Oregon. An initiative known as "Zero Suicide" has been modeled successfully in health systems and it is a theme that runs through this plan. Zero Suicide requires every one of us to take a role in suicide prevention. For too long, Oregon's youth suicide rate has been nearly twice the national rate. OHA joins with our stakeholders in believing that Zero Suicide is possible.

This plan also calls for elimination of the stigma that results in discrimination against people with mental health and substance use disorders, as well as for suicide attempt survivors and those who have lost a loved one or community member to suicide. A 2015 Harris Poll commissioned by the Anxiety and Depression Association of America, American Foundation for Suicide Prevention and National Action Alliance for Suicide Prevention, demonstrates that public opinion about mental health and suicide is changing for the better. Ninety-three percent of respondents said they would take action if someone close to them were thinking about suicide. This plan is designed to address the need to guide individuals, health care providers, health systems, institutions and government in taking that action to intervene to help our loved ones.

Action items in this plan are ambitious. OHA is committed to work alongside our partners toward their successful completion within the five year life of the plan. For too long we've seen too many Oregonians die by suicide. It's time for all Oregonians to take action.

Respectfully,

Lynne Saxton

Lynne Saxton
Oregon Health Authority Director

About this plan

In 2014, the Oregon Legislature mandated development of a five-year Youth Suicide Intervention and Prevention Plan. The Oregon Health Authority's Health Systems Division (HSD) and Public Health Division (PHD) worked with interested parties from across Oregon to adopt strategic directions, goals and objectives from the 2012 National Strategy for Suicide Prevention (NSSP), develop actions to operationalize and start discussions to implement the plan in 2016. From December 2014 through November 2015, approximately 100 subject matter experts from across the state worked together as members of a steering committee and/or as members of one or more work groups to develop realistic and actionable activities for preventing suicides among Oregon children, youth and young adults 10–24 years of age (referred to collectively as "youth").

A participatory process was designed to get input from stakeholders to develop the plan. A steering committee of 32 stakeholders reviewed the NSSP and selected strategic directions, goals and objectives for inclusion in the plan. The steering committee emphasized activities that could leverage the state's priority in behavioral health and primary care integration, and link the actions in this plan as much as possible to health systems transformation. That work was then turned over to six work groups to write action steps for the strategic directions, goals and objectives identified by the steering committee. Over multiple meetings, each work group discussed critical issues relating to suicide risk and protective factors and identified social, system, community and individual issues affecting suicide, attempt rates and self-injurious behaviors.

Additional work groups for populations that experience a disproportionate rate of suicide were formed for: lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth and young adults; military members, veterans and their families; and suicide loss and attempt survivors (people who have lost a loved one to suicide and persons who have experienced serious ideation or attempted suicide). In addition, all work groups were charged with addressing the needs of subpopulations, including children, youth and young adults with behavioral health conditions or youth in foster care or juvenile justice systems. OHA's tribal liaisons reached out to Oregon tribes and agencies that serve them to include the needs of this high-risk group. Youth M.O.V.E. Oregon held regional focus groups to ensure youth input was incorporated. In addition, OHA Children's System Advisory Committee (CSAC) was actively engaged and members volunteered to serve on each work group to represent the views of youth and young adults, families, and the providers who serve them.

The action items are the work of these stakeholders, representing health and behavioral health systems, CCOs and private insurance companies, providers and clinicians, suicide prevention advocates, families, youth, a tribal liaison, LGBTQ youth, military members and their families, people with behavioral health conditions, suicide prevention professionals, and other subject matter experts.

We encourage the reader to access the NSSP on the web to better understand the strategic directions, goals and objectives in this plan: www.actionallianceforsuicideprevention.org/NSSP.

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Guiding principles

The steering committee adopted the following foundational principles for suicide prevention in Oregon and to guide work groups in preparing the plan. The steering committee emphasized the principles should be taken in their entirety, not individually, as collectively they provide a framework for reducing Oregon's high suicide rate among children, youth and young adults.

1. Suicide is a serious preventable public health problem that negatively affects communities and individual community members.

2. Suicide is complex and arises from the interaction of individual mental and emotional risk factors and family, social and community factors. Suicide touches people of all ages and from all walks of life.

3. Societal attitudes and conditions have a profound effect on suicide and suicide prevention. Everyone with mental health concerns, including those with suicidal thoughts, is to be accepted and supported, without stigma or discrimination.

4. Suicide prevention is the responsibility of the entire community and requires vision, will and a commitment from the state, communities and individuals of Oregon. All Oregonians should adopt Zero Suicide as their aspirational goal.

5. Knowing when and how to ask about suicide saves lives. It is important for everyone to have the competence and confidence to intervene with persons at risk for suicide.

6. Promoting hope and resiliency is central to suicide prevention. Effective suicide intervention and prevention activities promote resiliency, enhance protective factors and reduce risk factors.

7. Quality, accessible services, supports and resources that promote mental wellness and treat mental illnesses are essential to children/youth and to their families and personal support networks.

8. Suicide prevention should be part of adequately funded and supported public and private health systems that address education, awareness, treatment and community engagement. They should include programs by and for youth, families, schools, integrated public and private health systems, and communities, with special attention paid to protect those known to be at high risk.

9. Suicide prevention programs and program materials need to be culturally informed, respectful and developed with the groups for which they are designed based on the best available evidence for safe messaging. They should be trauma-informed, reflect the needs of people who have attempted suicide or lost a loved one to suicide, and ensure the needs of vulnerable populations are addressed, such as LGBTQ youth, young military members, veterans and their families, foster youth, youth with behavioral health disorders and cultural, ethnic and racial groups.

10. Suicide prevention efforts should incorporate knowledge-informed strategies based in research, data, culture and lived experience. Efforts should be responsive to the social, emotional, cultural, educational, physical and developmental needs of each child/youth and family/social supports.

11. Suicide prevention leaders and supporters should challenge and question routine ways of thinking about suicide and have a curiosity and appreciation of diverse points of view.

A framework for suicide intervention and prevention

This section of the plan is designed to explain current theories and research on suicide prevention and best practices in intervening with those experiencing suicidal ideation, who have attempted suicide, and their families, friends and communities. How these issues were incorporated into the plan also is discussed.

Zero Suicide

A basic tenet of the plan is suicide is a preventable public health problem. In adopting the Zero Suicide framework, work group and steering committee members agreed there is no acceptable number of suicides for Oregon children, youth and young adults. Zero Suicide is a program with an evidence base in reducing suicides in health care systems. Health systems have shown the number of suicides among their patients can be drastically reduced or eliminated through a continuous quality improvement framework. Work group and steering committee members went beyond the health system model. They also adopted Zero Suicide as an <u>aspirational</u> goal for individuals and communities and their leaders. They felt health systems need a wider community committed to eliminating suicide for overall success of the Zero Suicide initiative in health care settings. While some may believe Zero Suicide is an admirable goal, they may doubt it can be achieved. The steering committee and work groups were nevertheless committed to the need for every Oregonian to aspire to eliminate suicide with its great human suffering and financial toll. *Note: Deaths relating to Oregon's Death with Dignity Act are not classified as suicides by Oregon law and therefore are excluded from this plan.*

Models for suicide intervention and prevention

This section provides a context for how the plan addresses suicide prevention, intervention and activities for responding to suicide (postvention). These theoretical models frame how to focus prevention efforts, determine individual risk for suicide and approach postvention activities in an effective way.

There is no single reason for or cause of suicide. Suicide is multidimensional, involving many factors at many levels of influence. The social-ecological model illustrated below, provides a lens for understanding the dynamic interrelations among various personal and environmental factors on the societal, community, relationship and individual

levels. Influences and the interrelation among individuals and their environment have an impact on risk and protective factors for suicide among youth ("youth" includes children, youth and young adults 10–24 years of age).

Figure 1. Social-ecological model of suicide

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

Societal   Community   Relationship   Individual
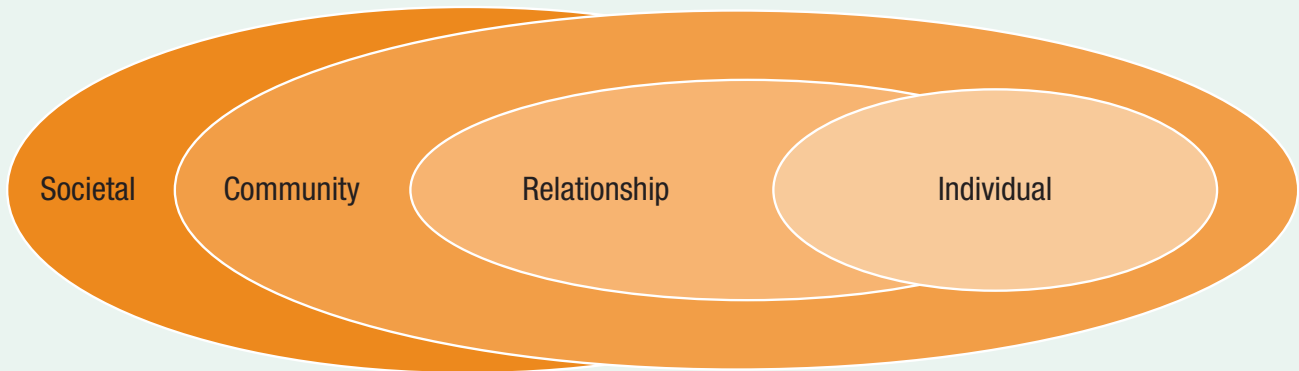
Source: National Strategy for Suicide Prevention (2012)

Table 1 below illustrates how this plan addresses risk factors by each of the circles in the social-ecological model. It also provides samples of interventions proposed in this plan to address them.(1,2)

Table 1. Social and ecological levels of influence on suicide, suicide risk factors and examples of recommended interventions in this plan for preventing suicide among youth aged 10–24 years

Social-ecological level of influence	Suicide risk factors associated with the level of influence	Sample of recommended interventions from the plan
Individual	• Mental illness • Substance use disorder • Previous suicide attempt • Impulsivity/aggressiveness	• Enhancing coping and problem-solving skills • Assisting individuals at risk to identify reasons for living • Providing timely, appropriate and quality mental and behavioral health care • Best practice suicide risk assessments, policies and protocols and a workforce trained to administer them
Relationship	• High conflict or violent relationships (including bullying) • Family history of suicide • Lack of positive peer, family or other relationships with adults	• Connectedness to individuals, family, community and social institutions (e.g., schools) • Supportive relationships with family and peers • Supportive relationships with trained physical/behavioral health providers
Community	• Few available sources of supportive relationships • Barriers to health or behavioral health care (e.g., lack of access to providers or medications, prejudice and stigma, etc.)	• Safe and supportive school and community environments • Access to continued best practice care after inpatient or psychiatric hospitalizations and emergent/urgent care
Societal	• Lack of resources for physical and behavioral health providers • Unaddressed barriers to care after emergency intervention • Legal barriers to family involvement in their children's mental health care • Insufficient availability of peer supports for at-risk youth	• Access to timely behavioral health services • Integrated physical and behavioral health care • Continuity of care across systems • Education of providers on the benefits of family involvement • Development of widespread family/peer support specialists

Interpersonal psychological theory of suicide

This section provides context on individual suicide risk assessment explored in the goals, objectives and action items. Understanding interpersonal and psychological aspects of suicide provides a framework for assessing the level of risk to the individual and which interventions can be effective in preventing a person's suicide. Thomas Joiner has proposed the interpersonal psychological theory of suicide that points to the human need for belongingness and connectedness to supportive others and the individuals' perception they are a burden to others.(3–5) Thwarted belongingness is the sense that a person is alienated from social connections, their families and their peers, which often is an aspect of bullying or social isolation. Burdensomeness involves individuals believing their family, peers, community and others would be better off without them. Joiner's theory also includes the person's capability to attempt suicide, such as a prior suicide attempt, habituation to pain through self-injurious behaviors such as cutting, or otherwise overcoming the instinct to live. As illustrated in Figure 2 below, Joiner's theory states when the three aspects (thwarted belongingness, burdensomeness and acquired ability) exist at the same time, a person is at highest risk for suicide.(3–5) Through interventions to enhance a person's sense of belongingness (such as reconnecting to family and friends), reduce a person's feelings of burdensomeness (reinforce their value to the community), or by interrupting acquired ability, the level of a person's suicide risk can be reduced.

Figure 2. Interpersonal psychological theory of suicide

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

Perceived burdensomeness

Acquired ability

Thwarted belongingness

Individuals at highest risk
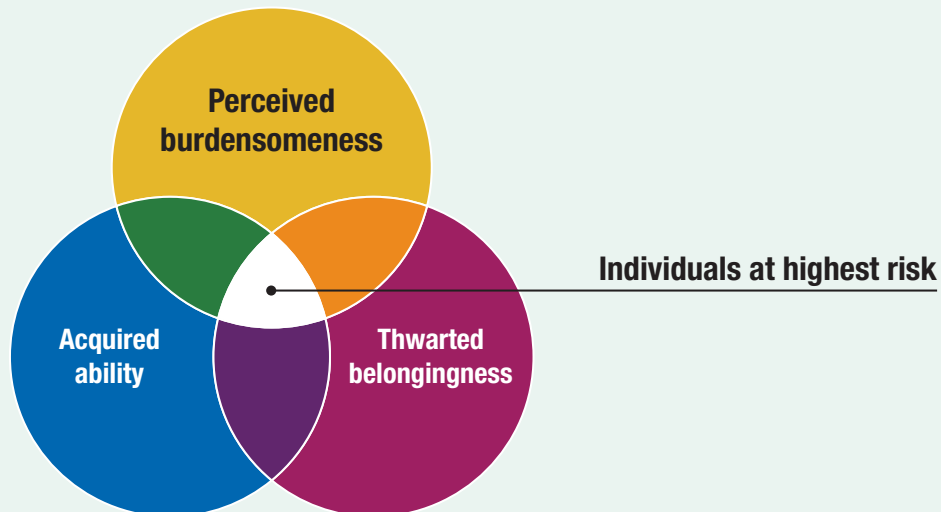
Source: Thomas Joiner, 2005

Impulsivity also can be related to suicide in youth, likely due to a combination of factors, including brain development and life experience.(6) Additional research implicates genetics as a risk factor for suicide.(7) For example, recent research on gene expression reflects evidence of the negative impact of historical trauma on genetics (and suicide risk) in the offspring of Holocaust survivors.(8) The bulk of research into biological and genetic risks for suicide nevertheless includes a role for personal experience. "Experiences occurring during adolescence may serve to customize the maturing brain in a way commensurate with those experiences. Depending on the nature of those experiences, their timing, and hence their consequences, this customizing of the brain can be viewed as an opportunity as well as a vulnerability."(9)

Contagion

Suicide intervention and prevention involve activities that range along a continuum from:

1. Universal upstream actions (such as teaching emotional self-regulation, good decision-making and problem-solving skills to elementary school children to buffer thoughts of suicide);

2. Risk assessment, intervention and treatment of youth experiencing suicidal ideation or who have attempted suicide; and

3. Interventions to prevent additional intentional deaths ("clusters" or "contagion") following a completed suicide. While contagion is rare, youth and young adults are more vulnerable to contagion than other population groups.(10)

This indicates an acute need for post-suicide activities (postvention), both in K–12 schools, on college campuses and workplaces. After an immediate crisis response, activities are needed for months or years while individuals bereaved by suicide grieve over varying lengths of time. Long-term postvention is needed in the community, within families, schools and among key gatekeepers, such as clergy, funeral directors, youth recreational programs or law enforcement.

In examining a suicide and developing short- and long-term postvention activities, it is important to determine those at most risk of a suicide themselves, screen them for level of risk (often over an extended period), and make services available to them. The Australian Living is for Everyone program (LIFE) recommends identifying potentially at-risk individuals through the Circles of Vulnerability model (see Figure 3). As illustrated below, the degree of risk for suicide for any individual depends on three factors:

1. Geographical proximity (or proximity through social media) to the deceased, including eyewitnesses or extensive media coverage;

2. The level of psychosocial proximity to or identification with the deceased; and

3. Personal suicide risk factors, such as mental and substance use disorders, a history of trauma or adverse childhood events, prior suicidal behavior, or family conflict.

This model uses the circles to screen those who were in geographical and psychosocial proximity to the deceased and people in high-risk groups. Communities and schools can "layer" or prioritize their postvention activities to address individuals within each of the three categories and those at highest risk who fall into all three categories.

The LIFE program also outlines a process available online at no cost for developing and implementing a community-wide plan for preventing and responding to suicide clusters (www.livingisforeveryone.com.au/Expert-Insight-4.html).

Figure 3. Circles of Vulnerability Mapping Process

This figure illustrates the circles of influence that affect suicide risk and must be addressed in suicide postvention activities.

Those at most risk:
Witnessed the suicide or aftermath, perceived psychological or social connection, have pre-existing vulnerabilities, perceive they helped the suicide to occur or failed to stop it.

Geographic proximity:
Eyewitness, physical distance from location of the incident, those discovering the body, those exposed to the immediate aftermath, extensive media coverage

Psychosocial proximity:
Victims of bullying, team members, classmates, same school, same gang, perceive they are like the deceased. Also family members, friends, romantic or ex-romantic interests, same social circle.

Population at risk:
Current mental disorder, history of trauma, prior suicidal behavior, substance abuse, family conflict

Source: University of Melbourne

School interventions to prevent contagion

Because families and communities often look to schools for suicide prevention and postvention activities, the plan offers many recommendations for the academic setting, including staff training, policy development, postvention to reduce the risk of contagion and school-community links. This section provides a framework for school interventions and context for the plan's goals, objectives and action items on this topic.

The Suicide Prevention Resource Center and the American Foundation for Suicide Prevention provide a best-practice toolkit for schools, covering:

- Crisis response;

- Information sharing;

- Helping students cope;

- Working with families and protecting their privacy;

- Guidelines for memorializing students;

- Social media issues; and

- Preventing suicide contagion

(The toolkit can be found at www.sprc.org/library_resources/items/after-suicide-toolkit-schools.)

Recommendations in the toolkit include:

1. Treat all student deaths in the same way;

2. Do not inadvertently simplify, glamorize or romanticize the student or death;

3. Emphasize the student was likely struggling with a mental disorder that can cause substantial psychological pain; and

4. Make counseling services available to students and let them know mental disorders can be successfully treated.

5. The toolkit provides templates for letters home, checklists, sample media messages and fact sheets about mental disorders in children, youth and young adults.

An Oregon-specific toolkit also was developed.(11) The Oregon Youth Suicide Prevention Intervention and Postvention Guidelines: A Resource for School Personnel is designed to help schools understand the nature of youth suicide, establish school-based protocols for prevention and response, build connections with the community, and educate school

Recommendations for schools and communities

Because schools exist within the context of a larger community, it is important that in the aftermath of a suicide (or other death) the school administrative team establish and maintain open lines of communication with community partners, such as the coroner/medical examiner, police department, mayor's office, funeral director, clergy, and mental health professionals. Even in those realms where the school may have limited authority (such as the funeral), a collaborative approach allows for the sharing of important information and coordination of strategies. A coordinated approach can be especially critical when the suicide receives a great deal of media coverage and when the community is looking to the school for guidance, support, answers, and leadership.

SPRC Toolkit for Schools: www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf?sid=49463

staff and students about suicide intervention and prevention (http://www.lcmhb.org/downloads/youthpostvention.pdf). RESPONSE also is used across Oregon. It is a comprehensive high school-based program that increases awareness about suicide among high school staff, students and parents. The program heightens sensitivity to depression and suicidal ideation, offers response procedures to refer a student at risk for suicide and provides sample guidelines for postvention (http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Pages/response.aspx). Other opportunities for school suicide intervention and prevention include behavioral health services at school-based health centers, school nurse programs, student-led initiatives and best-practice prevention programs, such as Sources of Strength and Signs of Suicide. Garrett Lee Smith Memorial Act grant funds to Oregon have been used for professional gatekeeper trainings (including school staff) on identifying those at risk of suicide, talking to individuals who are suicidal and referring them to care. This plan anticipates expanded gatekeeper training programs, including promoting additional educational opportunities to school staff.

Risk factors and warning signs

This section explores common risk factors for suicide in youth and the warning signs peers, families, caregivers, gatekeepers and others will observe among at-risk youth. It is provided here to provide a context for suicide intervention and prevention approaches outlined in the plan's goals, objectives and action items.

Risk factors: bullying

According to the Centers for Disease Control and Prevention, bullying involves making threats, spreading rumors, attacking someone physically or verbally, or excluding them from a group intentionally. Bullying occurs both in-person and electronically. Bullying has serious and lasting effects on mental health and well-being of youth, whether they are bullied, bully others or witness the bulling of others.(12) Outcomes can include depression, anxiety, participating in interpersonal or sexual violence, substance use, poor social functioning, and low school performance and attendance.(12) Bullies themselves, those who are bullied and those who witness bullying are all at higher risk of suicide. While bullying is generally not seen as a cause of suicide, it nevertheless contributes to vulnerability when present with other risk factors.(12) Risk is especially acute among lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. SAMHSA has created a mobile application to help parents talk to their children about bullying and offer guidance to educators on assisting youth who are being bullied: http://store.samhsa.gov/apps/knowbullying/index.html?WT.mc_id=EB_20151014_knowbullying.

> " Bullying is an unwanted aggressive behavior among school-aged children that involves real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. "
>
> –Centers for Disease Control and Prevention

Risk factors: community and society

The public health model focuses on the social determinants of health beyond individual psychological factors. Influences such as economic insecurity, child abuse and other trauma, lack of food, transportation, access to medical care, substance use, and the absence of positive social supports have an impact on the health of a population.(13)

As in physical health, these determinants affect the mental health and life expectancy of the population. Children, youth and young adults growing up in a home or community with challenging social determinants of health are more likely to develop risk factors for suicide, such as social isolation (thwarted belongingness), perceived burdensomeness to family and society, and, if exposed to physical or emotional pain or the suffering of others, an acquired ability to attempt suicide. Adverse childhood events (ACEs) have been implicated in suicide risk among adolescents, young adults and into later adulthood. Poverty, childhood abuse and neglect, sexual trauma, parenting practices and family environment have been associated with mental health problems and suicide risk.(14–18) Long-term unemployment of a parent creates family stressors and affects parenting practices (19) with associated exposure to potential ACEs likely increasing the chances of mental health problems in offspring. Unemployed teens and young adults who are not able to locate jobs in tough economic times also may be at increased risk for mental health problems, such as depression, anxiety and substance use — all risk factors for suicide.(20) Additionally, individuals who have experienced the suicide of a loved one also may experience ACEs as a trauma, with accompanying grief responses. This plan acknowledges social determinants of health and ACEs are critical factors in overall well-being and in reducing suicide deaths for Oregon youth. The plan discusses the need for state and local policy development to affect social determinants of health and reduce ACEs.

> " As social beings, we need not only good material conditions but, from childhood onwards, we need to feel valued and appreciated. We need friends, we need more sociable societies, we need to feel useful and we need to exercise a significant degree of control over meaningful work. Without these, we become more prone to depression, drug use, anxiety, hostility, and feelings of hopelessness, which all rebound on physical health. "
>
> –Social Determinants of Health: The Solid Facts
> Wilkinson RG, Marmot MG. World Health Organization. 2003

Warning signs

At the time of this plan's preparation in 2015, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and other partners issued new guidelines to outline the unique suicide warning signs of individuals up to 24 years of age.

Warning signs include assessing whether the person is:

1. Talking about or making plans for suicide;

2. Expressing hopelessness about the future;

3. Displaying severe/overwhelming emotional pain or distress; and

4. Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the other warning signs, including:

  • Significant withdrawal from or changes in social connections/situations;

  • Changes in sleep (increased or decreased); anger or hostility that seem out of character or out of context; and

  • Recent increased agitation or irritability.

For youth who may be assessing warning signs in a peer, the list is worded differently, specifically:

1. Are they talking about wanting to die, be dead, or about suicide, or are they cutting or burning themselves?

2. Are they feeling like things may never get better, seem to be in terrible emotional pain (like something is wrong deep inside but they can't make it go away) or struggling to deal with a big loss in their life?

3. Is your gut telling you to be worried because they have withdrawn from everyone and everything, have become more worried or on edge, seem unusually angry or just don't seem normal to you?

Garrett Lee Smith Grant to Oregon

The Oregon Health Authority, Public Health Division, manages the Caring Connections Youth Suicide Prevention Initiative with funding (2014 to 2019) through SAMHSA.

Funding is appropriated by Congress through the Garrett Lee Smith Memorial Act (GLSMA) originally sponsored by former U.S. Senator Gordon H. Smith from Oregon, who lost his son, Garrett, to suicide. Action items from the Caring Connections work plan are included to reflect the work of communities across Oregon during the life of the plan. Caring Connections capitalizes on a long history of successful public/private collaboration and Oregon's dynamic health care delivery system to reduce the burden of suicide among youth aged 10–24 years through comprehensive suicide prevention and early identification best practices. The initiative targets 468,809 youth aged 10–24 years with a focus on at-risk youth. The at-risk groups include those who live in seven Oregon counties with a higher-than-national rate of youth suicide, military families, youth involved in the foster care and juvenile justice systems, Native American youth, Latino youth and sexual minority youth. PHD's multifaceted approach for comprehensive suicide prevention and early identification includes use of evidence-based and best practice strategies at the both the state and community level.

Caring Connections mobilizes 28 key partners, including:

• Community mental health programs;

• Public health;

• Hospitals and health centers;

• Schools;

• Addictions and mental health clinicians;

• Universities;

• Juvenile justice;

• Veteran's organizations;

• Tribes; and

• Coordinated care organizations in seven counties in the Willamette Valley, Southern Oregon, Central Oregon, Northeastern Oregon, and the Portland area.

These partners will implement the following strategies:

- Gatekeeper training to increase by 30% the number of individuals in youth serving organizations trained to identify and refer youth at risk by:

  - Hosting quarterly Applied Suicide Intervention Skills Trainings (ASIST) to behavioral health clinicians, and/or Question, Persuade and Refer (QPR) or Safe Talk trainings to community members annually;

  - Establishing RESPONSE in half of the high schools in three CMHP catchments areas; and

  - Providing Kognito At Risk for High School Educators and Step In! Speak Up! LGBTQ module training to 20,000 educators and school staff.

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

  - Hosting 11 trainings in Assessing and Managing Suicide Risk (AMSR) for 550 behavioral health clinicians;

  - Training staff at all school-based health centers and pediatricians in three counties on Kognito At-Risk for Primary Care; and

  - Training emergency department staff in all four Portland metro health systems on Kognito At-Risk for ED. (These four hospitals treat more than 300,000 patients annually.)

- Improving continuity of care for youth discharged from emergency departments and inpatient psychiatric units, and for veterans and military families receiving care in the community; and

- Improving county crisis response plans for full wrap-around services.

- Comprehensive implementation of goals 8 and 9 of the NSSP in Washington County, a Portland metro county that has adopted the Zero Suicide approach to reduce rates of suicidal ideation, suicide attempts and suicide deaths.

- Promotion of the National Suicide Prevention Lifeline and project evaluation with all partners.

OHA is funding and working with four cohort 1 (high suicide rate) counties through 2019: Deschutes County Health Services, Jackson County Health and Human Services, Josephine County through Options for Southern Oregon, Inc., and Washington County Mental and Public Health. Three cohort 2 counties will be funded in years three through five: Klamath Child & Family Treatment Center, Linn County Health Services and Umatilla County Public Health. Other contract partners include Portland State

University's Regional Research Institute for program evaluation, the Association of Oregon Community Mental Health Programs (AOCMHP) to organize trainings, and a consultant from Oregon State University-Cascades to work with cohort 2 counties.

Core Injury and Violence Prevention Program

The Oregon Health Authority, Public Health Division, manages the Core Injury and Violence Prevention Program with funding (2011 to 2016) administered by the Centers for Disease Control and Prevention. This funding supports prevention in the top four leading injury problems in the state (suicide, drug overdose, motor vehicle crash injury and traumatic brain injury). This work uses a public health method of establishing and maintaining injury and violence surveillance and epidemiologic capacity, informs policy development, works with partners to develop and implement prevention strategies, provides technical assistance and evaluates progress. The Injury and Violence Prevention Program produces an annual injury data report and has a five-year plan to direct the program's work.

Cultural implications

The plan incorporates cultural relevance in prevention, intervention and postvention programs. Even when a group's suicide rates appear low, such as for Latinos and African Americans, social and cultural issues can create high-risk subgroups of those populations. For example, while the overall suicide rate for African Americans in the U.S. is far below rates for the total population, suicide was nevertheless the third-leading cause of death for young Black males aged 15–34 years from 2001–2010.(21) Among Latinos, the suicide rate is about half the rate of the total population.(22) However, from 2000–2010, suicide was the third-leading cause of death for Latino males aged 15–34 years. Latinos born in the U.S. have higher rates of suicidal ideation and attempts than Latino immigrants; immigrants who came to the U.S. as children have higher rates than those who came as adolescents and adults.(22) An alarmingly high suicide rate among Native American youth has prompted the Indian Health Service (IHS) to collaborate with tribes on activities in the American Indian/Alaska Native National Suicide Prevention Strategic Plan 2011–2015.(23)

Groups with increased risk for suicide

While suicide knows no social, economic or demographic boundaries, the NSSP references specific groups with increased suicide risk, including heightened ideation, attempts or completed suicides.

These include:

- Individuals who have attempted suicide (attempt survivors);

- Those who have lost a loved one to suicide (loss survivors);

- LGBTQ persons;

- Individuals with disabilities and behavioral health conditions;

- Native Americans;

- Older adult males;

- Individuals in the justice and child welfare systems;

- Those who engage in non-suicidal self-injury; and

- Military members, veterans and their families.

While youth as a group are not at highest risk for suicide, this plan focuses on the youngest age groups where suicide risk is most often first observed, youth ages 10–24 years. Youth, families and representatives from systems that serve these groups were involved in preparing the plan. For example, a work group of attempt and loss survivors prepared section 10.1 of the plan. Section 5.1.c. was written in consultation with tribal members and the tribal liaisons for the Oregon Health Authority. This plan also includes recommendations for individuals with disabilities and behavioral health conditions; child welfare and justice-involved youth; those who engage in non-suicidal self-injury; LGBTQ youth; and veterans, members of the military and their families.

People with disabilities, medical conditions

Individuals with disabilities and medical conditions are vulnerable to depression and suicide risk. While suicide risk screening tools for individuals with intellectual disabilities are limited, research demonstrates screening can be effective in reducing suicide risk in these youth.(24) Children and youth with developmental disabilities, such as autism and intellectual disability, are more likely to engage in other forms of

self-injury than children without these disabilities. Youth with depression and anxiety or conduct disorder have a higher chance of self-violence, including suicide, than children without these disorders.(25) It is important to coordinate care given by family, school and health care providers for these youth. Additionally, studies of youth with chronic medical conditions, such as cancer and multiple sclerosis, demonstrate suicide risk can become acute and these populations should be screened regularly for risk. (26) This plan addresses use of best-practice suicide risk screening tools, including risk assessment in emergency departments and primary care offices where immediate suicide risk and environmental risk factors are assessed.

People with mental and substance use disorders

Not everyone who attempts or completes suicide has a mental illness, and not all people with mental illnesses become suicidal. However, mental illnesses — especially depression — are widely recognized as risk factors for suicide. According to the Center for Substance Abuse Treatment, while 95% of individuals with a mental illness and/or substance use disorder will never complete suicide, several decades of evidence consistently suggests as many as 90% of individuals who do complete suicide experience a mental or substance use disorder, or both.(27) Stigma and shame about mental illnesses and substance use frequently keep individuals who need help from asking for it. Luckily, public attitudes about mental health and suicide are changing. A 2015 Harris Poll showed that 9 in 10 adults believe mental and physical health are equally important and 93% would take action if someone close to them were thinking about suicide.(28) About 78% would encourage them to seek help from a mental or physical health provider or the clergy, and 61% would call a crisis hotline or give the number to the other person. In fact, the survey found that young adults aged 18–34 years are more likely to consider seeing a mental health professional as a sign of strength, when compared with older age groups, and are also more likely to believe suicide can always or often be prevented (www.adaa.org/survey-finds-americans-value-mental-health-and-physical-health-equally).

> **Objective 3.2:** Promote the understanding that recovery from mental and substance use disorders is possible for all.

People with self-inflicted injury

Non-suicidal self-injury, also called "self-directed violence," is defined as "deliberate destruction of one's own body tissue in the absence of intent to die."(29,30) People may cut, scratch, burn or hit themselves. While the intent is not suicide, self-injurious behavior can cause serious injury and require medical care. According to Joiner's theory, a person who engages in this activity can become habituated to pain, increasing risk for a future suicide. A review of international research found suicide risk was significantly higher among self-harm patients than in the general population.(1 pg109) Regardless of whether individuals intend suicide, there is evidence they are at increased risk for repeating the behaviors and dying of suicide within 10 years.(1)

Attempt and loss survivors

Twelve attempt and loss survivors and professionals who serve them participated in the work group responsible for action items included in Section 9.1. Individuals who have lost a loved one, friend or close community member to suicide experience dramatic and often traumatic responses to those deaths. According to the NSSP, 13 million Americans report they knew a person who died by suicide in the past year.(1)

Objective 9.1: Engage suicide attempt and loss survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for support groups.

Multiple studies indicate loss survivors have an increased risk of attempting suicide themselves. Addressing the complicated grief, mental health challenges and social isolation loss survivors experience is needed to reduce their risk of suicide. An attempt survivor movement has surfaced nationally during the past few years. In 2014, the American Association of Suicidology for the first time created a division specifically to address attempt survivor issues. According to Joiner's theory, those who have become accustomed to pain or who have attempted previously have increased capability for another attempt or death by suicide. In its 2014 report, The Way Forward, the Suicide Attempt Task Force of the National Action Alliance for Suicide Prevention called for engaging those with lived experience to share their insights on staying alive and finding hope for the future.(31) Initial work also is being done for use of peer support specialists in suicide intervention and postvention activities. This plan calls for expanding services to attempt survivors and adopting best practices for resources and support groups as they emerge over time.

Native Americans

In 2000–2010, Native American males aged 15–24 years experienced a 51.93 per 100,000 suicide death rate vs. 16.9 among all U.S. males in that age group.(32) Among females aged 15–24 years, the rate for Native Americans was 16.74 per 100,000 compared with 3.89 for the total female population. This plan addresses the need for the Oregon Health Authority to collaborate with tribes on suicide prevention and offer technical assistance on

Objective 4.1.c: In implementing the Youth Suicide Intervention and Prevention Plan, OHA will collaborate with tribes and agencies serving Native Americans in Oregon to review programs and services identified in the plan for cultural relevancy, responsiveness and appropriateness, and provide technical assistance on request.

request. However, it does not supplant the IHS strategic plan for suicide prevention among Native Americans or activities underway in Oregon by tribes and other agencies that serve Native Americans.

LGBTQ youth

While data on suicide death rates are not readily available because sexual orientation and gender identity are not customarily reported on death certificates, data clearly show the rate of suicide attempts among LGBTQ individuals is far higher than the

population overall. According to the Suicide Prevention Resource Center, lesbian, gay and bisexual youth, as a group, experience more suicidal behavior than other youth.(33) Several studies indicate that LGB youth are 1.5 to 7 times more likely than other youth to report attempting suicide.(33) While LGB youth are at high risk for suicide, some subgroups are at especially high risk, including those who are homeless, runaways, living in foster care or involved with the juvenile justice system.(33) While the SPRC cited insufficient data about transgender youth as a limitation to its findings, the 2011 National Transgender Discrimination Survey did include questions concerning suicide among this group. The study found that 41% of transgender survey respondents reported attempting suicide compared to 1.6% of the general population, with rates rising for those who lost a job due to bias (55%), were harassed/bullied in school (51%), had low household income, or were the victim of physical assault (61%) or sexual assault (64%). (34) Both reports conclude a safe school climate devoid of bullying and family and peer acceptance/support are significant protective factors for LGBTQ youth.

The following are recommendations from the LGBTQ work group for the Oregon Youth Suicide Intervention and Prevention Plan:

1. A statewide central coordinating body should be created, specifically to identify and disseminate appropriate education, training, resources, programs and equity initiatives to prevent suicide among LGBTQ youth and young adults.

2. Trainings should be offered to university and K–12 educators and students, foster parents, child welfare and juvenile justice staff, behavioral and physical health providers, youth advocacy organizations, and personnel at other agencies serving children, youth and young adults, to understand issues of concern to LGBTQ youth, including bias and discrimination, where to access appropriate services across systems, and how to work effectively with the LGBTQ population.

3. Technical assistance should be offered to organizations participating in trainings to provide tools and supports to implement policies, procedures and programs to prevent suicide among LGBTQ youth and young adults.

4. Caseworkers, behavioral and physical health providers, peer and family support specialists, prevention specialists and others serving LGBTQ youth across agencies statewide should be trained to ensure they are aware of resources for cross-system referrals to programs, services and support for LGBTQ youth and young adults.

5. Online education and support resources, prepared in collaboration with LGBTQ youth, should be identified and promoted statewide for LGBTQ youth and young adults, including establishing and maintaining an online support group for transgender individuals.

6. The Alliance to Prevent Suicide should include representatives of LGBTQ youth and young adults and agencies that serve them.

Military members, veterans and their families

Twelve individuals served on the military work group to develop recommendations for Oregon's military members, veterans and their families. Members included veterans from multiple branches of the service, Oregon National Guard and U.S. Veterans Health Administration service providers, military/veteran advocates and families. The military work group's operational definition of this population was, "Anyone who has ever served in the U.S. military, Coast Guard, National Guard or Reserves and their family members, whether they were honorably discharged or not. This also includes those currently in ROTC and their family members."

In Oregon, suicide was the second-leading cause of death for young veterans (aged 18–24 years) from 2008–2012.(35) The rate has increased since 2001, when it was 40.6 per 100,000 population, compared with 48.3 in 2012. While veterans made up 8.7% of Oregon's residents from 2008–2012, 23% of suicide deaths occurred among veterans. According to SAMHSA, three fifths of Afghanistan and Iraq war veterans receive medical services outside the U.S. Department of Veterans Affairs (VA) system, requiring community behavioral and physical health providers to understand military culture and provide appropriate care to these warriors.(36) It also is important to note that National Guard members, who generally remain in the service after returning home from deployment, are not considered veterans and are not served by the VA. Most returning veterans do not have behavioral health conditions and have not experienced traumatic brain injury. But "all veterans experience a period of readjustment as they reintegrate into life with family, friends and community. The veterans' juggling of military and family responsibilities, reintegration into civilian life in the United States after living in unfamiliar settings, and processing exposure to combat may contribute to problems for veterans themselves, as well as their spouses and family members."(36) Among veterans using the VA health care system, the suicide rate has increased among those younger than 30 years of age, especially for those aged 18–25 years.(37) Among veterans using the VA health system aged 18–24 years, the suicide rate went from 46.1 in 2009 to 79.1 in 2011.(37) A study by the University of Southern California indicates teenagers with family members in the military appear more at risk for suicide if those relatives are deployed abroad multiple times.(38) A study out of the University of Iowa found elevated rates of drug and alcohol use among children whose parents currently or recently deployed.(38)

The following are recommendations from the military members, veterans and their families work group, designed to implement culturally informed suicide prevention communication and training programs for military service members, veterans and their families, and for clinicians, school staff, first responders and other gatekeepers.

1. OHA will collaborate with military service members, veterans, their families and support services to identify and distribute awareness and education materials for behavioral and physical health providers, first responders, clergy and other gatekeepers to increase understanding of military culture and links to available services.

2. OHA will collaborate with military service members, veterans, their families and support services to identify communication tools to distribute to parents and staff in Oregon colleges/universities and K–12 schools to address warning signs and risk factors for mental health problems and suicide risk, and information on services available to children of military service members, veterans and their families.

3. OHA will collaborate with military service members, veterans, their families and support services to identify training programs for the physical and behavioral health workforce to provide culturally competent and developmentally appropriate care addressing unique psychological and social needs and challenges of military service members, veterans and their families.

4. OHA will collaborate with military service members, veterans, their families and support services to identify developmentally appropriate suicide prevention communication and training programs for military service members, veterans and their families, emphasizing the benefits of help-seeking for mental health and substance use issues.

5. The Alliance to Prevent Suicide should include representatives of young adult miltary members, veterans and their families and agencies that serve them.

Suicide and suicidal behavior in Oregon youth aged 10–24 years

Suicide

Basic facts*,†

- Suicide is the second leading cause of death among youth aged 10 to 24 years in Oregon.

- Overall, Oregon suicide rates were higher than the U.S. rates in the past decade; and Oregon suicide rates rose after 2011 (Figure 4).

- From 2012 to 2013, Oregon youth suicide rate of 11.0 per 100,000 ranked 14th among all U.S. states.

- Male youth were four times more likely to die by suicide than female youth.

- Suicide rates increased with age. The rate increased from approximately 1.0 per 100,000 among youth aged 10 to 14 years to 16.0 per 100,000 among youth aged 20 to 24 years.

- Suicide rate among male veterans was more than four times higher than non-veteran males.

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* Oregon Public Health Division, Oregon Violent Dealth Reporting System. Suicides in Oregon: Trends and Associated Factors, 2003–2012.
† The CDC WISQARS.

Figure 4. Suicide rates among youth aged 10–24 years, U.S. and Oregon, 2000–2013
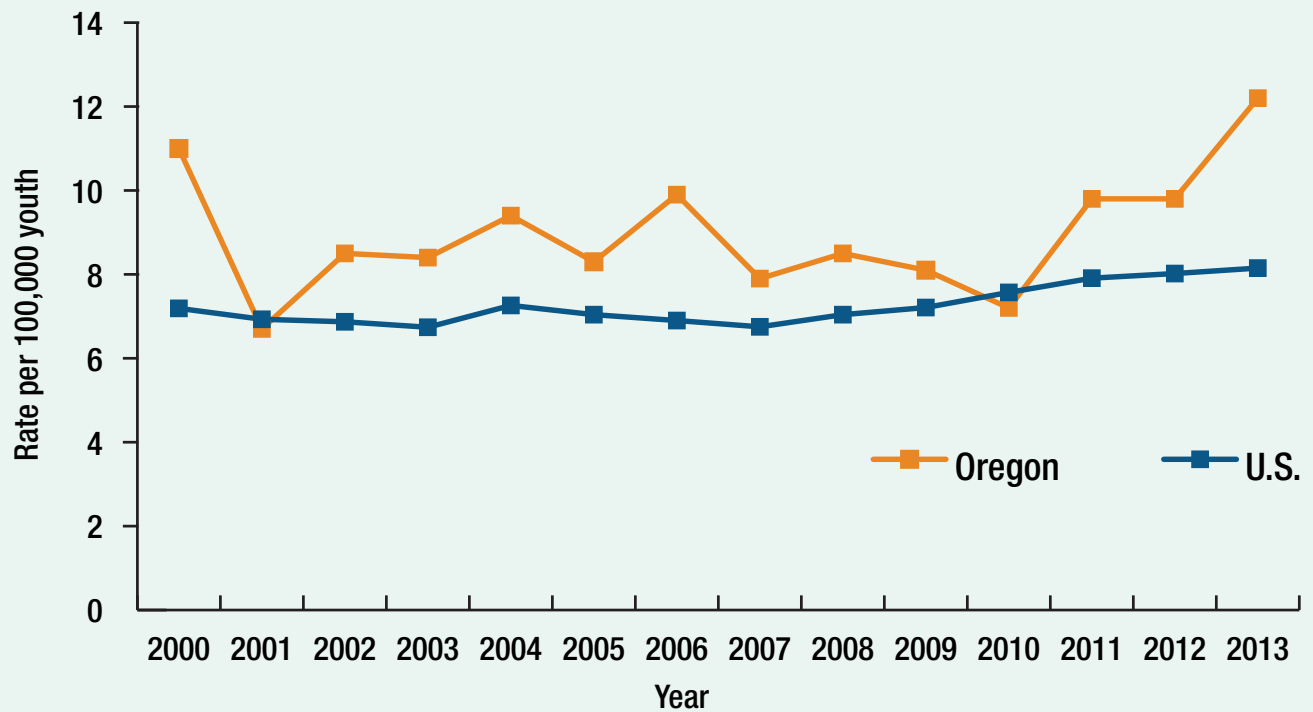
Source: CDC WISQARS

Common risk factors (Table 2):

- Mental illness and substance abuse

- Previous suicide attempts

- Interpersonal relationship problems/poor family relationships

- Recent criminal legal problem

- School problem

- Exposure to a friend or family member's suicidal behavior.

Table 2. Common circumstances surrounding suicide incidents by sex, among youth ages 10–24 years, Oregon, 2003–2012

Circumstance	Males (N=532)		Females (N=119)		All (N=651)	
Mental health status	Count	%	Count	%	Count	%
Mentioned mental health problems*	348	65	88	74	436	67
Diagnosed mental disorder	171	32	66	55	237	36
Problem with alcohol	83	16	14	12	97	15
Problem with other substance	83	16	24	20	107	16
Current depressed mood	210	39	54	45	264	41
Current treatment for mental health problem†	127	24	55	46	182	28
Interpersonal relationship problems	Count	%	Count	%	Count	%
Broken up with boy/girlfriend, Intimate partner problem	185	35	47	39	232	36
Suicide of family member or friend within past five years	14	3	3	3	17	3
Family stressor(s)‡	66	32	27	49	93	36
History of abuse as a child‡	2	1	8	15	10	4
Life stressors	Count	%	Count	%	Count	%
A crisis in the past two weeks	207	39	45	38	252	39
Recent criminal legal problem	79	15	3	3	82	13
School problem	44	8	11	9	55	8
Suicidal behaviors	Count	%	Count	%	Count	%
Disclosed intent to die by suicide	199	37	44	37	243	37
Left a suicide note	157	30	46	39	203	31
History of suicide attempt	95	18	48	40	143	22

Source: Oregon Violent Death Reporting System.

* Include diagnosed mental disorder, problem with alcohol and/or other substance, and/or depressed mood.
† Include treatment for problems with alcohol and/or other substance.
‡ Data were not collected before 2009.

In 2014: (Table 3 and Table 4)

- Ninety suicides occurred among Oregon youth aged 10 to 24 years (the rate was 12.0 per 100,000).

- The majority of suicides occurred among males (77%), White (86%) and those aged 20–24 years (57%). Twenty-six of them were middle school students and high school students.

- Firearms, suffocation (hanging) and poisoning are the most frequently observed mechanisms of injury in suicide deaths. Firearms alone were accounted for more than half of deaths.

- Among 23 suicides of adolescents aged 10 to 17 years, 19 deaths were reviewed by county child fatality review teams.* Of 19 adolescent suicides reviewed, eight cases (42%) had received a mental health service before suicide, seven were receiving mental health service and three were taking psychiatric medication at the time of death.

- Of 19 adolescent suicides, one child had a prior suicide attempt and two had a history of self-mutilation. Five children had talked about suicide and three had made a suicide threat before suicide.

- Four of 19 adolescent suicides had a history of substance abuse and three had been victims of child maltreatment (two experience with physical abuse, two with emotional abuse and one with sexual abuse). One child had a foster care history.

- Of 19 adolescent suicides, the most reported personal crises before suicide were breakup with boyfriend/girlfriend (n=5), parents' divorce/separation (n=2), family discord (n=2), bullying as victim (n=2), and drug/alcohol use (n=2). No case was reported due to a problem of sexual orientation.

Table 3: The characteristics of youth suicides among youth aged 10–24 years, Oregon, 2014

	Deaths	% of total
Age		
10–14	7	8%
15–19	32	36%
20–24	51	57%
Sex		
Male	69	77%
Female	21	23%
Race/ethnicity		
White	77	86%
African American	0	0%
Am. Indian/Native Alaskan	1	1%
Asian/Pacific Islander	3	3%
Multirace	1	1%
Other/unknown	6	7%
Hispanic	9	10%
Student status		
Middle school	5	6%
High school	21	23%
Mechanism of death		
Firearm	48	53%
Hanging/suffocation	30	33%
Poisoning	6	7%
Other	6	7%
Other		
Veteran	4	4%

Source: Oregon Violent Death Reporting System.

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* Oregon State Child Fatality Review Team. Child Death in Oregon: 2014.

Table 4: Numbers of self-harm hospitalizations and suicides among youth 10–24 years of age by county, Oregon, 2014

County	Hospitalizations		Deaths	
	Count	% of total	Count	% of total
Baker	2	0.4	1	1.1
Benton	8	1.4	3	3.3
Clackamas	54	9.5	3	3.3
Clatsop	2	0.4	1	1.1
Columbia	19	3.4	3	3.3
Coos	10	1.8	4	4.4
Crook	3	0.5	0	0.0
Curry	3	0.5	0	0.0
Deschutes	27	4.8	6	6.7
Douglas	13	2.3	1	1.1
Gilliam	0	0.0	0	0.0
Grant	0	0.0	0	0.0
Harney	3	0.5	0	0.0
Hood River	3	0.5	0	0.0
Jackson	28	4.9	6	6.7
Jefferson	3	0.5	1	1.1
Josephine	11	1.9	0	0.0
Klamath	7	1.2	5	5.6
Lake	3	0.5	0	0.0
Lane	57	10.1	8	8.9
Lincoln	2	0.4	2	2.2
Linn	18	3.2	2	2.2
Malheur	0	0.0	2	2.2
Marion	39	6.9	6	6.7
Morrow	0	0.0	0	0.0
Multnomah	135	23.9	19	21.1
Polk	11	1.9	2	2.2
Sherman	0	0.0	0	0.0
Tillamook	4	0.7	0	0.0
Umatilla	3	0.5	1	1.1
Union	1	0.2	1	1.1
Wallowa	1	0.2	0	0.0
Wasco	3	0.5	0	0.0
Washington	76	13.4	10	11.1
Wheeler	1	0.2	0	0.0
Yamhill	16	2.8	3	3.3
State totals	**566**	**N/A**	**90**	**N/A**

Source: Oregon Hospital Discharge Index

Suicide attempts*

- Each year, more than 500 Oregon youth aged 10 to 24 years were hospitalized for the self-inflicted injury/attempted suicide. There were 566 hospitalizations (75.2 per 100,000) in 2014 (Table 4).

- More than 90% of the self-inflicted injury hospitalizations were attributable to poisoning, followed by cutting/piercing, fall and firearms.

- In contrast to suicide, females were far more likely to be hospitalized for suicide attempt than males.

Suicidal ideation†,‡

- Approximately 17% of eighth graders and 11th graders reported seriously considering suicide in the past 12 months in 2013.

- Nearly 10% of eighth graders and eight percent of 11th graders self-reported having attempted suicide one or more times in the previous 12 months in 2013.

- Female students were more likely to report seriously considering suicide and having attempted suicide than male students.

Limitations of data used for suicide surveillance

Suicide in Oregon is monitored and tracked using a variety of existing administrative data sets, surveys and active surveillance efforts.

Administrative data sets:

- Death certificates (collected by local health departments and sent to the Center for Health Statistics at the Public Health Division)

- Hospitalization discharge data (from the Oregon Association of Hospitals and Health Systems)

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* Oregon Public Health Division, Injury and Violence Prevention Program. Injury in Oregon, 2013 injury data report
† Oregon Health Authority, Addictions and Mental Health Division. 2014 Student Wellness Survey.
‡ Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance – United States, 2013

Survey data:

- Oregon Healthy Teen Survey
- National Household Survey on Drug Use and Health
- American Community Survey

Active surveillance data:

- Oregon Violent Death Reporting System
- Oregon Child Fatality Review Data System

These data sets, surveys and surveillance activities include variables of interest to policy makers, but may fall short in other areas of interest. Data not available include information on sexual orientation, transgender status, the school a student attended, primary spoken language and foster care status. Data availability is also limited due to funding and staff resources to conduct systematic ongoing suicide surveillance in public health. Routine suicide surveillance does not include information about requests for intervention services related to depression in the past 12 months among the youth involved, previous attempts, emergency department visits or hospitalizations. Producing these types of complex analyses of large administrative data sets would involve linking, deduplication and analysis tasks, requiring additional funding and position authority. Other data components would require active in-person case investigation, data entry and database management. Both these components would require significant resources and planning.

The Oregon Health Authority, Public Health Division has made a request through Health Analytics and Policy to obtain a complete standardized set of emergency department discharge data from the Association of Hospitals and Health Systems. These data are one of the major missing pieces needed to provide population-based estimates that examine how past attempts treated at emergency departments might be associated with hospitalizations and deaths. Obtaining a standardized emergency department discharge data set is an objective of the State Health Improvement Plan and a high priority for the Oregon Health Authority.

Expediting surveillance capacity to create rapid response and information for policy makers is a growing interest and priority as outlined in Senate Bill 561 (2015). OHA's Health Systems Division is collaborating with local mental health authorities and other stakeholders to implement SB 561. It should be noted that current legal restrictions and confidentiality protections in the Health Insurance Portability and Accountability Act (HIPAA) limit Oregon Health Authority's ability to obtain information and disseminate it. To deliver actionable data in relatively quick time frames it will be necessary for the state to examine legal considerations, privacy needs of families and youth, as well as the "need to know" identifiable information about youth and families struggling with suicidal behavior and suicide completion.

Strategic directions, goals, objectives and action steps

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

Goal 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Objective 1.1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

1.1.a. Oregon Health Authority (OHA), in collaboration with other partners, will develop a charter that defines the membership and purposes of an Oregon Alliance to Prevent Suicide (Alliance) by March 2016.

- The Alliance will oversee integration and coordination of suicide prevention activities statewide.

- Members will include, but not be limited to, executives in private business and government, clergy, behavioral health and primary care providers, advocates, youth/ young adults and families, attempt and loss survivors, and diverse cultural groups.

1.1.b. OHA, in collaboration with other partners, will recruit identified executives and stakeholders for the Alliance by March 2016.

1.1.c. The first meeting of the Alliance will take place by June 30, 2016.

1.1.d. By June 2017, the Alliance will develop a plan to foster and sustain statewide policy development and leadership in suicide prevention.

Objective 1.2: Integrate suicide prevention into all relevant health care reform efforts.

1.2.a. By December 2016, the Alliance will promote adoption of Zero Suicide as an organizational goal for health systems and payers, and will review and provide recommendations on model policies, practices and outcome measures that support behavioral health and primary care integration among providers and health systems.

Goal 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes and behaviors.

Objective 2.1: Develop, implement and evaluate communication efforts designed to reach defined segments of the population.

2.1.a. By June 2017, OHA will identify communication needs, review available local, state and national resources, and collaborate with stakeholders to prepare a communication plan to promote statewide safe suicide prevention messages.

2.1.b. By December 2017, OHA will collaborate with members of target audiences to adopt and design communication tools for community audiences, including gatekeepers, health and behavioral health care providers, parents, youth, siblings, young adults and youth-serving agencies.

Objective 2.2: Reach policymakers with dedicated communication efforts.

2.2.a. By July 2016, the Alliance will develop a policy agenda for suicide prevention that identifies state and local policy priorities, needed fiscal investments, and information on the value and return on investments, and develop a plan to communicate the agenda to state and local policymakers.

Objective 2.3: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

2.3.a. By September 2017, OHA will collaborate with stakeholders (including Lines For Life, Youth M.O.V.E. and ReachOut, among others) to produce a youth-informed strategic plan for online and text-based communication that leverages state-specific and national resources for the creation of best practice, online community spaces, safe messaging and crisis intervention. The plan will incorporate methods for training youth and young adults from across Oregon in delivery of such services, with particular attention to those groups most at risk for suicide.

Goal 3. Increase knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.

Objective 3.1: Reduce the prejudice and discrimination associated with suicidal behaviors, mental and substance use disorders and help-seeking.

- Communication should focus on mental wellness as essential to overall health, normalize help-seeking and address the impact of adverse childhood experiences, bullying, current or historical trauma, military service, sexual orientation/gender identity and racial/ethnic status.
- Key messages should emphasize the unique needs of diverse groups and promote social connectedness for children, youth and young adults.
- Communication must follow best practice guidelines for safe messaging.

3.1.a. Beginning January 2016, marketing tools for adult audiences will emphasize behavioral health is critical to overall health, that treatment works, and will encourage adults to build positive social connections with children, youth and young adults. Tools will be consistent with recommended best practices and principles.

Objective 3.2: Promote the understanding that recovery from mental and substance use disorders is possible for all.

3.2.a. Beginning January 2016, OHA will incorporate positive personal stories from suicide attempt and loss survivors and people living with behavioral health disorders into communication messages to illustrate a full, productive life is possible for all.

Strategic direction 2: Clinical and community preventive services

Goal 4. Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective 4.1: Strengthen the coordination, implementation and evaluation of comprehensive state, tribal and local suicide prevention programming.

4.1.a. By January 30, 2016 and each succeeding year, the youth suicide prevention coordinator in the Public Health Division will disseminate data and evaluation findings from the SAMHSA-funded Garrett Lee Smith Memorial Act Caring Connections Initiative to stakeholders using the Youth Suicide Prevention (YSP) Network listserv moderated by the Public Health Division and to the Alliance.

4.1.b. By January 30, 2016 and each succeeding year, the youth suicide intervention coordinator in the Health Systems Division will, consistent with legislation, disseminate the data and evaluation findings from the youth suicide prevention plan to legislators, YSPNetwork listserv, Alliance, the Health Systems Division Children's System Advisory Committee, behavioral and physical health providers, payers, peer and advocacy organizations, and other stakeholders.

4.1.c. In implementing the Youth Suicide Intervention and Prevention Plan, OHA will collaborate with tribes and agencies serving Native Americans in Oregon to review programs and services for cultural relevancy, responsiveness and appropriateness, and provide technical assistance on request.

4.1.d. Community mental health directors will collaborate with local partners to identify a process for implementing SB 561 by March 2016.

Objective 4.2: Encourage community-based settings to implement effective programs and provide education to promote wellness and prevent suicide and related behaviors.

4.2.a. Beginning March 2017, OHA will work with communities to assess availability of culturally and developmentally appropriate universal, evidence-based practices across systems that will increase protective factors and decrease risk factors to prevent suicidal behaviors among children, youth and young adults.

4.2.b. By September 30, 2016, OHA will work with communities to ensure community health improvement plans assess the availability of programs and practices to increase protection from suicide and self-inflicted injury for children, youth and young adults.

4.2.c. By June 30, 2017, OHA will work with communities to disseminate results of culturally and developmentally appropriate universal, evidence-based practices used across systems in Oregon to increase protective factors and decrease risk factors to prevent suicidal behaviors and self-inflicted injury among individuals aged 24 years or younger.

4.2.d. By March 2018, OHA will work with communities to develop a plan to expand universal, evidence-based practices to prevent suicidal behaviors. Specifically, practices need to:

Increase:

- Social connectedness to home, school and community for all youth;

- Knowledge and practices for nonviolent problem-solving skills for families and youth in grades K–12;

- Positive relationships and environments for children, families and communities;

- Use of the Good Behavior Game in first grade classrooms, including training for teachers and peer mentors to ensure continued program fidelity and success;

- Programs that promote mindful, psychological flexibility;

- Home visiting programs that promote attachment and resiliency within families; and

- Parent education programs that also promote attachment and resiliency within families.

Decrease:

- Exposure to violence and adverse experiences.

Goal 5. Promote efforts to address means safety among individuals with identified suicide risk.

Objective 5.1: Gather information needed to implement means safety programs as research becomes available.

5.1.a. By March 2018, the Alliance will oversee a strategic plan for developing, implementing and evaluating means safety counseling and other programs that are research-informed, culturally relevant and respectful of community values.

Goal 6. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Objective 6.1: Provide training on suicide prevention to community groups with a role in the prevention of suicide and related behaviors.

6.1.a. The Oregon Department of Education will collaborate with schools to identify gaps and opportunities for staff training and protocol development on suicide prevention and postvention.

6.1.b. Beginning January 2016, OHA will collaborate with partners to expand and fund additional in-person and online training opportunities for school staff in best practice programs, such as Applied Suicide Intervention Skills Training (ASIST), Kognito, RESPONSE, QPR (Question, Persuade, Refer) and Mental Health First Aid, and others as the evidence base is established.

6.1.c. By December 2019, OHA Health Systems Division will collaborate with school districts to pilot the best-practice Sources of Strength program for building positive social connections and norms among middle/high school students in at least three regionally diverse school districts to encourage peer-to-peer support and relationships with supportive adults.

6.1.d. Beginning January 2016, funding options will be explored for ongoing sustainability of best practice gatekeeper training programs to increase early recognition and build awareness of warning signs, risk and protective factors and to improve response to at-risk children, youth and young adults. Trainings should be held for a wide array of community groups and gatekeepers, including peers, families, families of choice, siblings, law enforcement, clergy, primary care providers, foster parents, juvenile justice professionals, staff of agencies that serve youth and others as needed.

6.1.e. At least eight additional Oregon counties will provide ASIST trainings for clinicians and communities and/or QPR trainings for communities through September 2019. OHA will explore funding options for systematic statewide implementation by March 2020.

6.1.f. The Association of Oregon Community Mental Health Programs (AOCMHP) member programs will provide and support ongoing Mental Health First Aid training in counties throughout Oregon at least through 2017.

6.1.g. By September 30, 2019, there will be RESPONSE training in high schools in four additional counties. OHA will explore funding options for statewide implementation by March 2020.

6.1.h. By September 30, 2017 Kognito At-Risk for High School Educators and Step In, Speak Up! training will be in up to 100 Oregon high schools that previously implemented RESPONSE.

6.1.i. By June 2019, the Oregon Pediatric Society will provide its START training to clinics in five geographically diverse settings around the state and ensure the local community referral agencies are part of each of these trainings.

6.1.j. Beginning in 2016, Trauma Informed Oregon will incorporate information on the relationship between suicide risk, trauma and retraumatization in its relevant ongoing training and policy efforts.

6.1.k. By December 2019, OHA will collaborate with three communities to implement the best-practice CONNECT Program to provide a locally developed framework for postvention and community connectedness for children, youth and young adults.

Objective 6.2: Provide training to mental health and substance abuse providers on the recognition, assessment and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

6.2.a. By March 2017, OHA Public Health and Health Systems divisions will engage the Health Quality Committee and Health Quality Outcomes Committee to review suicide as a health outcome, identify behavioral health needs and discuss options for CCO engagement.

6.2.b. OHA will develop a plan to meet the training needs for behavioral and health care providers, including an analysis of Washington State statutes, to identify, intervene, assess, provide means safety counseling, treat and manage patients with suicidal thoughts and behaviors by January 2017.

6.2.c. OHA will assess the needs of publicly funded health systems, clinics and hospitals to require training for health care workers to identify suicide risk, conduct means safety counseling, refer to care, treat and follow up with patients at risk of suicide by December 2019.

6.2.d. The Association of Oregon Community Mental Health Programs (AOCMHP) will host at least 11 regional trainings in geographically diverse areas of Oregon for at least 550 mental health professionals in Assessing and Managing Suicide Risk (AMSR) by September 2019.

Objective 6.3: Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, peer/family support providers and others on effective strategies for communicating and collaboratively managing suicide risk.

6.3.a. Beginning September 2016, OHA Health Systems Division will collaborate with behavioral health clinicians, primary care providers, clinical supervisors, first responders, crisis staff, peer/family support providers, care coordinators, case managers, and others to identify and implement strategies for timeliness and continuity across systems of care for individuals aged 24 years and younger.

6.3.b. By December 2019, at least eight counties will initiate and/or increase collaboration among behavioral and physical health providers and health systems to effectively identify, refer, treat and manage youth at risk of suicide.

Strategic direction 3: Treatment and support services

Goal 7. Promote suicide prevention as a core component of health care services.

Objective 7.1: Promote the adoption of Zero Suicide as an aspirational goal by health care and community support systems that provide continuity of care and support a defined patient population.

7.1.a. Beginning January 2016, OHA will collaborate with partners on outreach to health systems to educate them about and provide tools for Zero Suicide in their patient safety initiatives.

7.1.b. Washington County will comprehensively implement Goals 8 and 9 of the National Strategy for Suicide Prevention to reduce rates of suicidal ideation, suicide attempts and suicide deaths in its service area by September 30, 2019. OHA will track and disseminate outcomes by March 2020.

7.1.c. Washington County will share strategies, successes, barriers and recommendations for adopting Zero Suicide with all counties participating in the Garrett Lee Smith grant project on an ongoing basis through September 2019. OHA will track and disseminate results statewide by March 2020.

Objective 7.2: Strengthen efforts to improve timely delivery of effective programs and continuity of care for individuals at heightened risk for suicide, including those with mental health and substance use disorders.

7.2.a. Beginning January 2016, OHA will collaborate with Health Systems Emergency Department Diversion Pilot Project sites to collect, analyze and disseminate results statewide on customized local approaches to provide safe nonhospital care alternatives for youth in mental health or suicide crisis.

7.2.b. By January 2017, Trauma Informed Oregon will collaborate with early childhood agencies and other stakeholders to identify and document best-practice education programs and services addressing the relationship between early childhood trauma and suicide risk.

Objective 7.3: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments, hospital inpatient units and primary care.

7.3.a. By March 2017, OHA will collaborate with hospitals, primary care providers, families, youth and young adults and other stakeholders to identify and disseminate standardized health literacy materials for distribution by physical health providers to patients, families and families of choice, including aftercare instructions and risk reduction strategies for caring for individuals 10–24 years of age who have attempted or are at risk for suicide.

7.3.b. By March 2019, OHA will collaborate with Oregon emergency departments and community mental health programs to determine which suicide risk assessments are being used, the level of training clinical staff receive to administer them and develop a plan for distributing best practice assessment tools, providing technical assistance consultations and meeting training needs.

7.3.c. By March 2019, OHA will collaborate with the Alliance to create a legislative agenda that includes provision of suicide risk assessment and crisis counseling, at the in-network level of benefits, delivered by community mental health programs or other providers. Provision of suicide risk assessment and crisis counseling should be considered an essential health benefit that cannot be denied due to provider panel restrictions, pre-authorization requirements or other administrative functions.

7.3.d. By March 2017, OHA and the Children's System Advisory Committee (CSAC) will collaborate with peer-run organizations and other subject matter experts to identify opportunities and make recommendations to OHA for the use of peer and family support services to children, youth or young adults who are discharged from inpatient/ residential behavioral health care or health care facilities and are at heightened risk of suicide.

7.3.e. Deschutes, Jackson, Josephine and Washington counties will pilot use of best practice guidelines for continuity of care for youth released from emergency departments and inpatient psychiatric units by September 30, 2017. OHA will track and disseminate outcomes by March 2018.

7.3.f. Deschutes, Jackson, Josephine, Washington, Klamath, Linn/Benton, and Umatilla counties will pilot and update their system-wide crisis response plans by December 31, 2017, and monitor quarterly thereafter. OHA will track and disseminate outcomes by June 2018.

7.3.g. OHA and at least eight counties will partner with the Oregon Department of Veterans Affairs and the U.S. Department of Veterans Affairs to increase the identification of at-risk veterans, provide referrals and treatment, and improve continuity of care for those military and military families living in each catchment area by September 2019.

7.3.h. Counties participating in the Garrett Lee Smith grant will convene a team of decision-makers from physical and behavioral health care systems, including representatives from emergency departments and inpatient psychiatric units, to assess current practice guidelines for continuity of care, including follow-up care for youth leaving the emergency department or stay in an inpatient psychiatric unit after a suicide attempt, using the Suicide Care in Systems Framework. OHA will collaborate with counties to assess current practices and report to the Alliance by September 2017.

7.3.i. Counties participating in the Garrett Lee Smith grant will revise guidelines and establish policies and procedures to promote the safety and well-being of all patients treated for suicide risk, execute memoranda of understanding or other interagency agreements, adopt and monitor guidelines, including means safety counseling, among emergency departments, hospital inpatient units and primary care by September 29, 2017. OHA will compile the results and disseminate them statewide by March 2018.

Objective 7.4: Develop collaborations between emergency departments and other health care providers to pilot programs and disseminate results for alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow up after discharge.

7.4.a. By March 2019, OHA will recommend protocols for emergency departments to notify CCOs and private insurers upon release of individuals aged 24 years and younger who have been treated for a suicide attempt or are assessed at high or moderate risk for suicide.

7.4.b. By March 2019, OHA and the Alliance will collaborate with youth and young adults, families, public and private insurers, emergency departments, behavioral health providers and other subject matter experts to recommend protocols and implementation strategies for conducting check-ins within 48 hours of release from the emergency department of patients aged 10–24 years at risk of suicide. Check-ins will cover patient safety, family welfare and links to follow-up care. Options for entities conducting check-ins may include insurers or emergency departments, or under contract with peers, crisis lines, community mental health programs or by electronic means.

7.4.c. By March 2019, the Alliance and stakeholders will explore options and recommend strategies for emergency departments to adopt best practices for planning at release for patients aged 24 years and younger in mental health or suicide crisis.

- Protocols will include standards from the Joint Commission (Sentinel Event Alert #46, 11/17/2010; National Patient Safety Goals Goal 15, 1/1/2015) and the Suicide Prevention Resource Center (Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments, 2015).

- Additionally, the Alliance will consider standards for emergency departments to inform the patient, the parent, guardian or other individual selected by the patient who will act to support aftercare to:

  - Keep the patient safe at home or next care setting;

  - Understand medication side effects;

  - Follow discharge instructions;

  - Resolve barriers to effective care post discharge;

  - Link the patient and family to peer supports, when available; and

  - Assess the patient's and caregiver's capacity to follow up on aftercare plans.

Goal 8. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objective 8.1: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

8.1.a. By December 2017, OHA, in collaboration with CSAC, will work with behavioral health and primary care health providers, peers, prevention specialists, faith-based communities and suicide prevention advocates to identify and establish model guidelines to provide peer support for parents, family of choice and siblings of persons with suicidal ideation or who attempt suicide. OHA will identify or develop a guidebook to assist families, families of choice, friends and siblings of children/youth/young adults who are experiencing suicidal ideation or who attempt suicide.

8.1.b. Subject matter experts will convene a group, including youth/young adults and their families or families of choice, to help them identify and distribute guiding documents for physical and behavioral health care providers, addressing release of patient information among providers and to families, families of choice and caregivers under the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part

2 (Confidentiality of Alcohol and Drug Abuse Patient Records), Family Educational Rights and Privacy Act (FERPA), and Oregon House Bill 2948 (2014).

Objective 8.2: Collaborate with behavioral health providers to identify policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use conditions.

8.2.a. Integration of behavioral health and primary care services is key to successful screening and intervention for those at risk of suicide. OHA will continue to address this issue through ongoing collaboration with stakeholders to develop and implement standards for integration of behavioral health services and physical health services in patient-centered primary care homes (PCPCH) and behavioral health homes.

8.2.b. OHA will identify best practices and existing resources, and convene a group of behavioral health and primary care providers to identify, develop and disseminate model Oregon policies, procedures and training programs that define how to assess for suicide risk, intervene and treat suicidal patients aged 10–24 years, and to promote safety among children, youth and young adults receiving care for mental health and/or substance use conditions.

Goal 9. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

Objective 9.1: Engage suicide attempt and loss survivors in suicide prevention planning, including support services, treatment, community suicide prevention education and the development of guidelines and protocols for support groups.

9.1.a. By June 2018, OHA will collaborate with stakeholders to use electronic means to distribute resources for attempt and loss survivors, including information on national, state and local organizations that provide support groups, how to access support services, and communication tools for individuals and communities seeking to assist people who have lost a friend, family or community member to suicide.

9.1.b. Beginning January 2016, OHA will monitor national efforts in the emerging suicide attempt survivor movement and disseminate information about recommended and best practice programs as they become available, including information to encourage development of support groups for attempt survivors in Oregon.

9.1.c. By April 30, 2017, Trauma Informed Oregon will identify and disseminate tools to link survivors of trauma with resources and information to more effectively live with the challenges they experience and how to access appropriate support when their ability to cope is reduced.

9.1.d. By June 2019, OHA will collaborate with loss and attempt survivors and their advocates to identify and disseminate trauma-informed information on self-care for physical and behavioral health providers, first responders, medical examiners, funeral directors, clergy, school and university staff and students, volunteers, and others who offer services and supports to attempt and loss survivors.

9.1.e. By September 2019, OHA will collaborate with loss and attempt survivors and their advocates to identify training and information-sharing opportunities for support group facilitators, both electronically and in easily accessible locations statewide.

9.1.f. By January 2018, OHA will collaborate with Oregon groups and agencies representing and serving attempt and loss survivors to promote services and supports available for attempt and loss survivors. Partners include, but are not limited to, Lines For Life, the Dougy Center, the American Foundation for Suicide Prevention Oregon chapter, survivor support group facilitators and volunteer supports statewide.

> Loss and attempt survivors are individuals with lived experience with suicide. A survivor of suicide loss (also called "loss survivor" or "bereavement survivor") is an individual who has experienced the death of a family member, friend, loved one or individual with whom the survivor had an emotional or social connection. An attempt survivor is an individual who has lived experience along the continuum from seriously considering suicide, making plans that were not carried out or making an overt attempt, often requiring medical care.

9.1.g. Beginning March 2016, OHA and the Alliance will actively recruit members who are loss and attempt survivors and their advocates and include them in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for support groups.

Objective 9.2: Adopt, disseminate, implement and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training and consultation.

9.2.a. Beginning January 2016, OHA will identify and disseminate best practice guidelines and tools to schools; law enforcement; medical examiners; media; counties; community coalitions; clergy; agencies that serve children, youth and young adults; and other gatekeepers on effective response to suicides, including use of peers and volunteer supports, and the latest evidence for activities to reduce potential contagion.

9.2.b. Beginning January 2016, OHA will engage with communities and offer technical assistance, education and training on best practice response to suicide clusters and contagion.

Strategic direction 4: Surveillance, research and evaluation

Goal 10. Increase the timeliness and usefulness of surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.

Objective 10.1: Improve and expand the state's capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.

10.1.a. OHA Health Analytics and Policy Division will obtain emergency department data necessary to track and monitor suicide attempts treated in emergency departments.

10.1.b. The Public Health Division will obtain emergency department data from the OHA Health Analytics and Policy Division for tracking and monitoring suicide attempts treated in emergency departments, developing incidence and prevalence rates, and linking emergency department data with hospitalization and death data to identify trends and create annual reports.

10.1.c. The Public Health Division will obtain and analyze all relevant suicide, suicide attempt and other relevant data, produce data files and develop a web-based dashboard able to be queried to disseminate data.

10.1.d. The Public Health Division will develop quantitative methods to conduct epidemiologic investigation of how suicide affects minority populations with disproportionately high rates of suicide and gather information on what culturally relevant intervention and prevention messages could be used.

Goal 11. Evaluate the impact and effectiveness of suicide prevention interventions and systems, and synthesize and disseminate findings.

Objective 11.1: Disseminate the evidence in support of suicide prevention interventions.

11.1.a. OHA will collect data from Garrett Lee Smith grantees in Oregon, compile the results and report on outcomes by January 2019.

11.1.b. Beginning January 2016, OHA will convene an evaluation committee of internal and external subject matter experts, including families and youth, to identify performance measures and indicators to monitor the implementation of the Youth Suicide Intervention and Prevention Plan.

Appendix I: Comparison of Oregon and five states with lowest suicide rates

This section addresses the legislative requirement that the plan include an analysis of suicide prevention activities in the states with the five lowest suicide rates.

The CDC ranked Oregon's suicide rate in 2012–2013 as the 14th highest in the nation, with 166 deaths and a rate for those aged 10–24 years per 100,000 population at 10.99. Other states in the top 10 were Alaska, Wyoming, North Dakota, South Dakota, Montana, Idaho, New Mexico, Colorado, Utah and Oklahoma. In 2013, the states with the lowest suicide rates among those aged 10–24 years were New Jersey, New York, California, Rhode Island and Connecticut.

Table 3: Suicide rates among youth aged 10–24 years by state, U.S. 2012–2013

Rates are deaths per 100,000.

State	Deaths	Crude Rate	State	Deaths	Crude Rate
1. Alaska	82	25.36	27. Minnesota	196	9.13
2. Wyoming	45	19.23	28. Nebraska	68	8.76
3. North Dakota	58	18.5	29. Pennsylvania	433	8.61
4. South Dakota	63	18.28	30. South Carolina	163	8.41
5. Montana	67	16.84	31. Tennessee	213	8.17
6. Idaho	107	15.48	32. Nevada	89	8.1
7. New Mexico	129	14.79	33. Virginia	267	8.07
8. Colorado	283	13.4	34. Ohio	377	8.05
9. Utah	182	12.88	35. Alabama	159	7.99
10. Oklahoma	205	12.76	36. Louisiana	152	7.87
11. Arkansas	141	11.64	37. Texas	901	7.79
12. Kansas	143	11.57	38. New Hampshire	39	7.51
13. Maine	53	11.07	39. North Carolina	299	7.46
14. Oregon	**166**	**10.99**	40. Florida	535	7.39
15. Kentucky	189	10.73	41. Mississippi	92	7.15
16. Hawaii	56	10.49	42. Georgia	300	7.03
17. Washington	279	10.18	43. Maryland	162	6.91
18. Arizona	282	10.17	44. Illinois	340	6.42
19. Iowa	130	10.16	45. Massachusetts	164	6.12
20. West Virginia	68	9.82	46. California	918	5.64
21. Missouri	240	9.79	47. District of Columbia	13	5.31
22. Michigan	395	9.55	48. New Jersey	181	5.25
23. Vermont	24	9.53	49. New York	406	5.18
24. Wisconsin	215	9.3	50. Connecticut	70	4.85
25. Indiana	254	9.16	51. Rhode Island	15	3.41
26. Indiana	254	9.16			

Source: CDC WISQARS

Although there is limited research, a variety of factors have been explored as possible contributors to high suicide rates in many western states, including:

1. Lack of availability of behavioral health services;

2. A self-reliant culture and stigma about mental health conditions, creating associated barriers to help-seeking;

3. Lack of providers and long distances to care;

4. Access to lethal means;

5. Weather and climate; and

6. Limited widespread knowledge about mental health and substance use conditions, including warning signs for individuals at risk of suicide.

Oregon is working on many efforts to address these matters, including telemedicine, integrated care, school-based behavioral health services and gatekeeper education, such as Mental Health First Aid, QPR (Question, Persuade, Refer), ASIST (Applied Suicide Intervention Skills Training) and others.

Means safety programs and large anti-stigma campaigns have been initiated in other states to raise general awareness that mental health is essential to overall health and to increase help-seeking. States with the lowest suicide rates also have created an infrastructure for suicide prevention involving a state-level public-private council or coalition leading prevention efforts; state staff to carry out initiatives, provide technical assistance and community outreach through state resource centers; and developed interconnected networks of regional or county suicide prevention coalitions to undertake efforts at the grassroots level. States also address social determinants of health and ACEs as suicide risk factors through their prevention efforts.

States with low youth suicide rates have significant financial resources, both state and federal. Massachusetts, for example, rated as the fifth or sixth lowest rate for youth nationally depending on the year, has been the recipient of multiple grants from SAMHSA. These grants were for in-home therapy for traumatized children, increasing community capacity for recognizing mental health needs of school-age children, services to court-involved youth, services for families of youth with behavioral health challenges, and programs to improve access to effective and culturally relevant trauma-informed care. In Oregon, specific and targeted youth suicide prevention programs have been funded in large part by SAMHSA Garrett Lee Smith grants to the OHA Public Health Division and to Oregon tribes and other programs serving Native Americans. In addition, other state and federal funding has been available in Oregon for programs to address social determinants of health and ACEs. Additional work is needed to break down silos and incorporate suicide intervention and prevention into all programs that touch the lives of children, youth and young adults.

Selected highlights from states with the lowest youth suicide rates (ages 10–24) in 2012–2013 follow.

California

The California Office of Suicide Prevention integrates resources and activities to support state agencies and county systems. The 2008 Strategic Plan on Suicide Prevention:

1. Integrates suicide prevention into existing community settings and service to use key points of contact with at-risk individuals;

2. Addresses cultural and health disparity issues;

3. Co-locates and integrates behavioral health and primary care;

4. Ensures counties have well-coordinated crisis response services;

5. Ensures services after emergency department release;

6. Uses peer support models;

7. Ensures early intervention and treatment at the earliest onset of mental health conditions; and

8. Shares information among systems.

> **" To align with the call to action that 'Every Californian is Part of the Solution,' it is critical that long-term partnerships be developed with a broad range of partners that transcend the traditional mental health system. "**
>
> –California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution, 2008

Connecticut

Organized suicide prevention efforts in Connecticut date to 1969 when the legislature mandated creation of the state's Youth Suicide Advisory Board. Now the board includes public and private partners statewide. A priority of the Connecticut Suicide Prevention Plan 2020 is to develop a statewide network that links state and grassroots activities. A network of care currently includes 169 members representing 76 sectors from state and local agencies, profit and nonprofit agencies, community and faith-based organizations, hospitals, military, schools, higher education, towns, private citizens, students, loss survivors and advocates. The suicide prevention plan calls for all state agencies and nonprofits to include suicide prevention in their mission statements, and for agencies to train staff in suicide warning signs and incorporate language on suicide prevention/intervention in their contracts for delivery of services.

> **" Professional and peer helping relationships can strengthen the support and safety net for people with suicidal behaviors. "**
>
> –Connecticut Suicide Prevention Plan 2020

New Jersey

The New Jersey Youth Suicide Prevention Plan, 2011–2014, credits its "implementation of state regulations, policies, guidance and resources identified in the professional literature" in maintaining a low suicide rate among youth. Specifically, New Jersey has:

1. Strict laws restricting minor's access to guns;

2. Mandated training for school staff for suicide prevention and detection of warning signs;

3. Mandated psychiatric screening centers in every county that include crisis hotlines staffed 24/7 in community crisis intervention in situations where there may not yet be suicidal gestures, but are often significant risk factors; and

4. A statewide mobile response stabilization system for youth in each county, including services for up to eight weeks of immediate in-home/in-community therapeutic interventions.

New York

The New York Office of Mental Health advises that its early programs focused on "isolated events/projects that have not been incorporated into a statewide coordinated strategy model." Its suicide prevention plan now advocates for a broad coalition of state and community agencies statewide and concludes that, "The awareness, knowledge and skills related to successfully impacting upon suicide completion and attempts must be ingrained with the fabric of New York State's communities." The plan calls for training a cadre of individuals to provide postvention assistance on request. A postvention team would be available in each region to provide clinical, educational and other supports in the case of a traumatic event and for longer-term postvention to help loss survivors access needed supports. The state currently has a network of volunteer loss survivors who are available in some areas to meet the newly bereaved and offer support, and the plan anticipates adding clinical services for loss survivors. The postvention teams would establish collaborative relationships with public and private stakeholders and close working relationships between behavioral and physical health systems. The plan also suggests creation of a State Suicide Prevention Resource Center.

Rhode Island

Rhode Island's suicide prevention efforts for youth ages 15–24 dates back to the mid-1980s when the legislature mandated suicide education and prevention in public schools. After receiving initial training in suicide awareness and prevention, school staff integrated suicide prevention into the health curriculum and were prepared to recognize students experiencing risk factors and warning signs. Rhode Island's current Youth Suicide Prevention Project is funded by a Garrett Lee Smith grant. The program uses evidence-based suicide prevention education programs in specific public schools and community organizations in high-risk areas of the state. Negative social determinants of health and ACEs are key aspects of the selected communities, including high rates of children and youth involved with the justice and child welfare systems, child abuse, neglect and domestic violence, witnessing domestic violence, incarcerated parents and homelessness. The state's suicide prevention initiative also includes a student assistance service in schools to provide a safety net for at-risk youth through screening, identification and referral protocols, gatekeeper training and a media campaign about who is at risk and how to respond. The assistance service also works to enhance

resiliency of adolescents whose parents are substance abusers; delay adolescents' initial use of alcohol, tobacco and other drugs; and decrease adolescents' use of alcohol, tobacco and other drugs. Student assistance counselors are available in schools and conduct group sessions for at-risk youth.

Appendix II: Glossary

Applied Suicide Intervention Skills Training or ASIST: An interactive, experiential, two-day suicide intervention skills training, developed by Living Works Education, to recognize signs of suicidal thoughts and behaviors, intervene and get help for the suicidal person. SPRC Best Practice Registry: www.sprc.org/bpr/section-III/applied-suicide-intervention-skills-training-asist.

Assessing and Managing Suicide Risk (AMSR) is a one-day, research-based workshop for mental health professionals, including social workers, licensed counselors, psychologists and psychiatrists to teach them to assess and manage ongoing suicide risk in their clients. SPRC Best Practice Registry: www.sprc.org/bpr/section-III/assessing-and-managing-suicide-risk-core-competencies-mental-health-professionals-am.

Attempt survivor: An individual who has lived experience along the continuum from seriously considering suicide, making plans that were not carried out or making an overt attempt.

Behavioral health: The term encompasses all contributions to mental wellness including substances and their abuse, behavior, habits, and other external forces. Insight Telepsychiatry, accessed December 7, 2015 from http://www.insighttelepsychiatry.com/resources-2/consumer-resource-center/wellness/definition-of-behavioral-health/.

Best practices: For the purposes of this plan, programs, practices, policies, protocols and informational materials must be either evidence-based or best practices, as identified by the Best Practice Registry (www.sprc.org/bpr/using-bpr), SAMHSA (www.samhsa.gov/data/evidence-based-programs-nrepp), the National Action Alliance for Suicide Prevention (http://actionallianceforsuicideprevention.org/), or Zero Suicide in Health and Behavioral Health Care (http://zerosuicide.actionallianceforsuicideprevention.org/).

Best Practices Registry (BPR): SPRC's Best Practice Registry lists programs, practices, policies, protocols and informational materials with content reviewed according to current program development standards and recommendations. This listing includes only materials submitted and reviewed according to BPR criteria and is not a comprehensive inventory of all suicide prevention practices. The BPR has three sections: Evidence-based practices, Expert/Consensus statements and Adherence to standards. See www.sprc.org/bpr/using-bpr.

Evidence-based practices: Evidence-based means "based on scientific research." A common use of this term is in the phrase evidence-based programs, which are interventions that have been rigorously evaluated and demonstrated positive outcomes. For suicide prevention, positive outcomes are reductions in suicidal behaviors or changes in suicide-related risk and protective factors. It is accurate to say that evidence-based programs are "effective" for the populations and settings in which they were tested. Definition from SPRC Best Practices Registry: www.sprc.org/bpr/using-bpr.

Kognito At-Risk for High School Educators©: A one-hour, online, interactive gatekeeper training program that prepares high school teachers and other school personnel to identify, approach and refer students who are exhibiting signs of psychological distress such as depression, anxiety, substance abuse and suicidal ideation. Through a self-paced, narrative-driven experience, participants build knowledge, skills and confidence to connect at-risk students to counseling, mental health or crisis support services. SAMHSA National Registry of Evidence-Based Program & Practices (NREPP): www.sprc.org/bpr/section-III/risk-high-school-educators.

Kognito At-Risk in the ED©: Screening and brief intervention for patients in emergency departments. Online, interactive role-play simulation for ED personnel, eligible for CME/CNE credits. SPRC Best Practice Registry: www.kognito.com/products/er/.

Kognito At-Risk in Primary Care©: Screening and brief intervention for patients in primary care. Online, interactive role-play simulation for primary care providers, eligible for CME/CNE credits. SPRC Best Practice Registry: www.sprc.org/bpr/section-III/risk-primary-care.

Kognito Step In, Speak Up!: Online, interactive, professional development for educators to recognize signs of distress and connect students to help; training simulations to support LGBTQ youth. SPRC Best Practice Registry: www.sprc.org/bpr/section-III/step-speak-supporting-lgbtq-students.

Loss survivor: A loss survivor (also called a survivor of suicide loss or bereavement survivor) is an individual who has experienced the death of a family member, friend, loved one or individual with whom the survivor had an emotional or social connection.

Military member, veterans and their families: For the purposes of this plan, the working definition is: Anyone who has ever served in the U.S. military, Coast Guard, National Guard or Reserves and their family members, whether they were honorably discharged or not. This also includes those currently in ROTC (Reserve Officer Training Corps) and their family members.

National Strategy for Suicide Prevention: Goals and Objectives for Action 2012 (NSSP): U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. www.actionallianceforsuicideprevention.org/NSSP.

Oregon Violent Death Reporting System: A public health surveillance system funded by the Centers for Disease Control and Prevention and housed in the Injury and Violence Prevention Section in the Public Health Division in the Oregon Health Authority. This system collects police reports, medical examiner reports and death certificates on all deaths due to suicide, homicide, undetermined deaths, legal interventions, and firearm deaths occurring in Oregon. http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/nvdrs.aspx.

Postvention: For purposes of this plan, postvention refers to activities and programs that occur after a suicide, including immediate crisis response and longer-term interventions to reduce risks of contagion. Postvention supports bereaved family, friends, professionals and peers who are at risk of suicide themselves.

Question, Persuade, Refer (QPR): The QPR Gatekeeper Training for Suicide Prevention is a brief educational program designed to teach "gatekeepers" — those who are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers) — the warning signs of a suicide crisis and how to respond. SAMHSA National Registry of Evidence-Based Program & Practices (NREPP): http://legacy.nreppadmin.net/ViewIntervention.aspx?id=299.

REACHOUT.COM: An online resource designed to help youth strengthen mental wellness through technology-driven resources and peer support. http://us.reachout.com/about-us/what-we-do/.

RESPONSE: A comprehensive, school-based suicide prevention program that develops procedures/guidelines for handling suicidal students, has at least two ASIST-trained staff as the "go-to" people, trains all staff in intervention skills, and teaches four classroom lessons to high school students. SPRC Best Practice Registry: www.sprc.org/bpr/section-III/response-comprehensive-high-school-based-suicide-awareness-program-2nd-edition.

Appendix III: Youth M.O.V.E. focus group results

Youth Suicide Prevention/Intervention Focus Work Group Report

Youth M.O.V.E. Oregon

Youth M.O.V.E. Oregon (YMO) is a statewide, youth-led nonprofit organization that helps young adults successfully transition into adulthood. YMO also advocates for suicide awareness around the state, both in person, through daily interactions with young people and on social media, through an online campaign that delivers messages of hope to youth who may be struggling. Their staff are trained to provide in-the-moment crisis support to youth, as well as safety planning for youth as they stabilize.

During March and April 2015, YMO held three youth focus groups in Salem, Milwaukie and Clackamas. Twenty-two youth participated in the study; all were between 12 and 24 years of age. The groups were led by a YMO peer staff member and had two components: a series of questions about suicide prevention followed by a discussion. During the focus groups, additional staff were on site to offer extra support to those who needed it. Resources such as the National Suicide Prevention Hotline and the peer staff contact information were given to each member of the group at the end of the discussion. Additionally, the YMO peer staff member made sure to check in with each youth the week after the focus group to ensure they had access to emotional support if they needed it. The group environment itself was designed to be as supportive as possible. It included fidgets, snacks, a peer facilitator the youth were familiar with, an extra staff member for additional support, and, most importantly, an opportunity to be heard.

Below are the questions asked during the focus groups and the youth's responses:

1. Does a teen you know have mental health challenges that might make them seem depressed, unhappy, anxious or overly upset to the point that you're worried about them?

   20/22 YES   **1/22** NO   **1/22** Chose not to answer

2. What kinds of behaviors did you notice in them?

- Depressed/overly sad: **19/22**

- Worried or anxious: **12/22**

- Withdrawn/distancing/not spending time with or making friends: **15/22**

- Self-harm: **13/22**

- Trouble attending or doing school related things: **14/22**

- Relationship challenges with peers: **15/22**

- Family challenges: **16/22**

3. How do you see adults reacting when someone says they have a mental health problem and is there anything you'd like to see change? (**Personally, on TV, news, social media, etc.**)

Some youth said: "Some adults don't even care or 'tough love'"; "How can you have disability at your age?"; "They only portray the worst case scenario"; "They think that mental health challenge means you will end up homeless and unable to work"; "They think less of the person."

4. Has a youth you know thought about suicide?

    21/22 YES   **0 /22** NO   **1/22** Chose not to answer

5. Has a youth you know attempted suicide themselves?

    18/22 YES   **1/22** NO   **3/22** Chose not to answer

6. Has a youth you know completed suicide?

    10/22 YES   **6/22** NO   **6/22** Chose not to answer

7. Among young people you know who thought about suicide, what kinds of things do you think could have helped them?

Some youth said: "Having someone talk to me and just listen"; "Having a safe place like a YMO drop in center"; "Not having to feel embarrassed at school"; "Having more options outside of the county system"; "Getting on medication".

8. How can social media help youth/young adults who are thinking about attempting suicide and/or support friends when someone confides in them?

Some youth said: "It can raise awareness around suicide and mental health"; "It gives me/us a place to go and have other people to talk to who have gone through it too"; "It makes us feel not alone"; "It allows me to post about what's going on so my friends can see it without me having to bug them"; "Positive videos on Facebook help"; "Sometimes it's just a place for bullies".

9. What would you tell a youth/young adult to do when a friend confides in them about being suicidal?

Some youth said: "Come and talk to me"; "I would ask them to see how they are handling it and how it is making them feel"; "Refer them to the hotlines"; "Sometimes hotlines don't always work because you are put on hold so it's better to be there for them"; "Ask if they are comfortable talk to me or talking to me through their friend".

10. What kinds of help do youth/young adults need when they or a friend of theirs is in crisis or struggling with some of the challenges we discussed earlier?

Some youth said: "Support"; "Hugs"; "Food"; "Music and video games"; "Distractions"; "Friends"; "Exercise"; "People you know"; "Peer to peer support helps"; "A place not to be judged like the YMO drop"; "Peer support in schools"; "Police who understand the difference between mental health and committing a crime"; "Someone you can trust".

11. What do you think help young people cope with challenges in healthy ways?

Some youth said: "Use coping boxes"; "Chew gum"; "Music and dancing"; "Sports"; "Crafting, poetry, cooking, collections"; "Hobbies"; "Eat food"; "Take a drive"; "Take a walk"; "Playing with animals"; "Doing things I enjoy like getting a tattoo"; "Being around someone who makes me feel comfortable".

12. What are the key things you want adults to know about suicide among youth/young adults?

Some youth said: "I want them to know how often it happens"; "To have an open mind"; "To ask young adults questions"; "Take their time, pay attention to them, and be attentive"; "Don't be judgmental"; "Take youth seriously"; It's preventable".

13. What are key things you want adults to DO about suicide among youth?

Some youth said: "Take it seriously"; "Take interest in helping"; "Make counseling centers less confusing"; "Make meetings like AA but for intervention groups for people in crisis"; "To step outside of their comfort zone, be less uptight and make the youth feel comfortable"; "Educate other adults about it"; "Resources for people to have one on one support for suicide"; "Services should be more people friendly and have more helpful signs with instructions and directions".

14. Is there anything else you want to tell us that we haven't asked about?

Some youth said: "Everyone who plays a part in this can make a change but you have to put in the leg work. You have to step up and do/say something. You can always do something"; "I don't feel like I'm ever going to get help when the evaluator doesn't think I'm in crisis"; "Someone advocating for me helped most"; "We need someone on your side when doctors are siding with your parents"; "I want to see peer support staff in emergency rooms, full time".

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