2016

# Youth Suicide Intervention and Prevention Plan Annual Report

Oregon Health Authority

HEALTH SYSTEMS DIVISION

# Contents

# Executive summary

Youth suicide is a tragedy we can and must prevent. In 2016, the Director of the Oregon Health Authority chartered and launched an agency-wide suicide prevention initiative. Its goal is to collaborate with the Alliance to Prevent Suicide to elevate public understanding about suicide and dramatically reduce the incidence of youth suicide in Oregon. Staff guiding the initiative began meeting monthly in January 2016. The initiative uses data and measurement strategies to focus, monitor and coordinate progress in collaboration with the Alliance data and evaluation committee. An online data dashboard of suicide information by county provided local partners with information to shape prevention and post-suicide intervention (postvention) programs.

The following is a summary of the actions OHA took in 2016 to meet the goals of the legislatively mandated Youth Suicide Intervention and Prevention Plan:

- **Training in risk assessments:** OHA initiated a legislative concept for training physical and behavioral health providers and school counselors in best practices for suicide risk assessment, management and treatment.
- **Transition support for suicidal youth and families:** OHA provided technical assistance to a work group led by Rep. Alissa Keny-Guyer to develop legislative concepts for providing services and supports to suicidal youth and their families when the youth are released from emergency departments.
- **Best practices for community providers:** OHA promulgated rules for psychiatric emergency services and crisis response services by community mental health programs (CMHPs) to include best practices in suicide risk assessment, lethal means counseling and safety planning.
- **Education for families:** The Children's System Advisory Council began developing health literacy materials for families whose children go to emergency departments for suicide crises and are discharged to their homes.
- **Understanding impact of trauma:** Trauma Informed Oregon began work on materials analyzing impacts of trauma and suicide. The organization expects to update its trainings to include trauma and suicide in 2017.

- **Training for pediatricians:** The Oregon Pediatric Society began expanding its START provider training program to include suicide risk assessment, safety planning and lethal means counseling in classroom trainings and webinars in 2017–2019.
- **Safe online spaces:** Through a contract with OHA, Lines for Life, Youth MOVE Oregon, Reachout.com, a team of youth and other stakeholders began developing a youth-informed strategic plan, due by September 2017, to promote safe online spaces for youth.
- **Reporting and information-sharing:** SB 561 (2015), which mandates post-suicide information-sharing and response activities in all Oregon counties, was implemented. Rules were promulgated in 2016. Forty-four suicides of individuals 24 years of age and younger were reported to OHA within seven days of death in 2016, as required by law. As the program ramped up in 2016, OHA identified communities with disproportionate suicide rates and provided technical assistance, including funding for Sources of Strength and CONNECT:
    - Two pilots of the Sources of Strength peer-led school prevention and resiliency program began in the Albany and North Clackamas school districts with OHA funding.
    - Three pilot sites were identified and funded for the CONNECT suicide postvention training program: Linn-Benton-Lincoln, Umatilla and Malheur counties. All three sites will implement CONNECT by fall 2017 and will evaluate the pilots' effectiveness.
- **Raising public awareness:** OHA's county grantees and CCOs have offered a range of trainings to parents, communities and physical and behavioral health providers to increase awareness about youth suicide and build skills in working with at-risk youth.

# Introduction and background

## Background

Alarmed with the trend of increasing youth suicide rates since 2011, the Oregon Legislature in 2014 passed House Bill 4124 (ORS 418.704). This bill mandated a new five-year Youth Suicide Intervention and Prevention Plan, with updates every five years. In addition, the bill created a new position of youth suicide intervention and prevention coordinator in the Oregon Health Authority (OHA) Health Systems Division. This report fulfills the requirement that OHA submit an annual report to the Legislature each year.

## Youth Suicide Intervention and Prevention Plan

One hundred experts in suicide prevention and intervention worked with OHA to develop a plan for 2016–2020 to address the risk and protective factors that influence youth suicide. The plan was modeled after the research-based National Strategy for Suicide Prevention (NSSP), and has the aspiration goal of Zero Suicide. The plan is customized to meet the unique needs of Oregonians. Building connections for youth with adults and peers, increasing resilience, promoting life-affirming decision-making skills, and improving access to quality care are all included in the design. Those that made up the 100 stakeholders volunteering for the planning process include the following: parents and youth, behavioral and physical health providers and school-based health centers. Volunteers also include coordinated care organizations (CCOs) and private insurers, schools, hospitals, and OHA tribal liaisons. Volunteers were also made up of LGBTQ youth and young adults, representatives of minority communities, individuals who had attempted suicide, and individuals who had survived the loss of a loved one. Other agencies that worked with OHA were the Department of Human Services Child Welfare, Oregon Department of Education, Oregon Youth Authority, Oregon Department of Veteran Affairs, the U.S. Veterans Affairs Administration, and the Oregon Army and Air National Guards. The representatives of these groups and systems called for Zero Suicides in Oregon through collective action among health systems, schools, communities, parents and other systems that touch the lives of youth. A year into implementation, many activities have been undertaken by OHA as noted in this report. In addition, OHA has chartered an Alliance to Prevent Suicide, as called for in the plan, which began meeting in September 2016. The Youth Suicide Intervention and Prevention Plan is available at http://www.tinyurl.com/hr94228.

# Cultural relevance

The plan has specific recommendations to address the needs of individuals at disproportionate risk of suicide. This includes LGBTQ individuals as well as military members, veterans and their families. It also includes Native Americans and other minority populations, people with mental illnesses, people with chronic medical conditions, people bereaved by the loss of a loved one, and people who previously attempted suicide. Membership in the alliance includes all of these groups. A special ad hoc committee of the alliance is to review alliance recommendations starting in 2017 to ensure cultural responsiveness. Additionally, plans for 2017 include starting outreach to the affected groups and working with them to implement the recommendations they made in developing the plan. This report provides specific details.

# Suicide statistics

Oregon's rate of suicide is 16th highest among youth ages 10–24. This ranking is per 100,000 population among U.S. states in 2015. Oregon ranked number 12 highest in 2014. Oregon's rate of completed suicide among youth ages 10–24 remained stable in 2015. There was a slight decrease in overall deaths: from 97 in 2014 to 90 in 2015.* Data for 2016 is not yet available at the time of this report's preparation. Suicide numbers, rates and rankings by county or state fluctuate by year. The monitoring for trends across time is the most effective way to study the data. OHA will be monitoring youth suicide in future years to determine if this slight decline in 2015 is the beginning of a downward trend or a one-year dip in an overall increase across time.

## Addressing the risk of contagion

To reduce the risk of contagion, additional measures began in 2015. Contagion occurs when a suicide influences the suicidal behaviors of others. Research demonstrates that contagion risk is higher among youth than in older individuals. Senate Bill (SB) 561 (2015) directed OHA to develop a plan for Local Mental Health Authorities (LMHAs) to work with local partners in preparing information sharing and postvention protocols. In addition, the bill directed OHA to develop processes for reporting suspected suicides of individuals 24 years of age or younger to OHA within seven days of death. OHA issued the SB 561 plan in April 2016 and collaborated with LMHAs on developing rules, promulgated

* National Center for Health Statistics Vital Statistics System for numbers of deaths. Bureau of Census for population. Accessed 5/3/2017 at https://webappa.cdc.gov/sasweb/ncipc/mortrate.html

in November 2016. Minimum requirements for the LMHA protocols were included in the rules. LMHAs started ramping up reporting in 2016, with 44 suicides of individuals in the target age range reported to OHA by the end of the year. Six counties submitted their information-sharing and response protocols. Rules mandated submission of the protocols by April 2017. The law provides no enforcement authority to OHA, but the coordinator promoted submission of the protocols, offered technical assistance in preparing them, and reviewed the protocols submitted, offering comments and suggestions.

## Oregon Alliance to Prevent Suicide

The Oregon Alliance to Prevent Suicide is responsible for establishing a public policy agenda for suicide prevention and helping to implement the plan. Committees of the alliance launched on September 2016 and include:

- Continuity of Care
- Workforce Development
- Outreach and Awareness
- Policy and Legislation and
- Data and Evaluation.

A separate committee reviews alliance initiatives for cultural responsiveness to the needs of high-risk groups. Those high-risk groups include LGBTQ youth, military members, veterans and their families, Native Americans and other minorities. It also includes those who have lost a loved one to suicide (bereavement survivors) or those who have attempted suicide (attempt survivors), who are at high risk of suicide themselves. The alliance has started examining a public policy agenda. The Oregon Health Authority expects the first set of recommendations from the alliance in 2017.

Sixty-five subject matter experts from geographically diverse areas who volunteer for the alliance include:

- Parents and youth
- Suicide bereavement and attempt survivors
- Legislators
- Clergy
- Law enforcement

- Coordinated care organizations (CCOs) and private insurers
- Behavioral health and primary care providers
- Health systems and hospitals
- Foster parents
- Prevention specialists
- Substance abuse providers
- Adults living with behavioral health issues
- Community mental health programs
- Oregon Department of Education, education service districts and schools
- School-Based Health Centers (SBHCs)
- LGBTQ individuals
- Tribal members, African Americans and Latinos
- Oregon National Guard and the state Department of Veterans Affairs
- Oregon Department of Human Services, Child Welfare
- Oregon Youth Authority

# Report on OHA activities in 2016

Listed below are the legislatively mandated sections of the plan, followed by a bulleted list of action items completed or underway.

## Section 1

**Section 1 (2)(a): On Dec. 1, 2014, a suicide intervention and prevention coordinator was hired.**

**Status: Completed**

**Progress: Completed**

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

**Status: Ongoing**

**Progress:**

OHA continued collaborating with a wide range of special populations, including diverse members of the alliance (see categories of membership above). These high-risk groups include Native Americans and other minority populations, members of PRIDE ERG, and military members. OHA will convene committees in 2017 to address specific action items in the plan pertaining to groups at disproportionate risk of suicide, including LGBTQ individuals; military members, veterans and their families; Native Americans and minority populations; people who have attempted suicide (attempt survivors); and people who have lost a loved one to suicide (bereavement survivors).

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

**Status: Ongoing**

**Progress:**

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

This includes:

- **Improving discharge and safety planning for youth in emergency or inpatient care.**

  Oregon Health Authority enacted rules for psychiatric emergency services and community mental health program crisis services in 2016, including best practices in safety planning, lethal means counseling and risk assessment.

- **Competency and confidence in treating and managing suicidal patients.**

  OHA advanced legislation for the 2017 session relating to training for behavioral and physical health providers and school counselors in conducting timely best practice suicide risk assessments, treatment and management.

  The Oregon Pediatric Society and Trauma Informed Oregon began working on curriculum changes to include suicide best practice risk assessment, lethal means counseling and suicide safety planning.

- **Follow up after emergency department release.**

  The alliance continued examining barriers to welfare checks with youth and families within 48 hours after receiving care for suicidal ideation or an attempt.

  The expectation is for the alliance to make recommendations in 2017 on "caring contacts." These caring contacts are phone calls, emails, letters, etc., after discharge from an emergency department.

- **Determining the length of time between emergency department release and the initiation of outpatient therapies after assessments.**

  Work on this activity is pending results of evaluation work underway with OHA's Emergency Department Diversion pilot projects. Pilot projects across the state will test interventions that can divert suicidal youth and their families from repeated emergency department visits for suicidal ideation or attempts and facilitate transitions to outpatient care.

- **Establishing guidelines for use of peer and family support for at-risk youth.**

  The Children's System Advisory Council began preparing materials for families to ensure safety after their youth are released from an emergency department. The material also will provide guidance on transitions to outpatient care. The council plans to complete the materials in 2017.

  Once the above is completed, the Children's System Advisory Council plans to begin preparing proposed statewide protocols for use of family and peer support with suicidal youth and their families in outpatient care.

**Section 1 (2)(d): Technical assistance**

**Status: Ongoing**

**Progress:**

The suicide intervention coordinator provides technical assistance to state and local partners, communities, parents and suicide prevention advocates. Since December 2014, the coordinator has provided technical assistance on best practices to the Youth Suicide Prevention email list moderated by the Public Health Division, which reaches more than 300 individuals statewide. The coordinator offers technical assistance to community mental health programs with SB 561 (2015) and best practices in suicide postvention. Three pilots have been funded and will be evaluated for the CONNECT program to train communities in best practices in postvention. Additional technical assistance was provided to behavioral OHA health staff, providers, school districts, prevention specialists, parents, youth organizations, state programs, adults living with mental illnesses, attempt and bereavement survivor support group leaders, among others. The coordinator also provided technical assistance to the legislatively mandated Oregon Task Force on School Safety on its initiatives to intervene with youth who pose a threat to self or others.

# Section 2

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

**Status: Ongoing**

**Progress:**

- OHA has an Emergency Department Diversion pilot project (EDD) underway to follow up with youth and families after release from emergency departments in Multnomah, Clackamas, Marion and Deschutes counties. The pilot aims to ensure safety and warm handoffs to outpatient care and family support services and to avoid re-admittance to an emergency department in the future. The pilot will expand to Washington, Benton and Jackson counties and the Oregon Health & Science University will evaluate the pilots in 2017.
- OHA has assisted a diverse work group formed by Rep. Alissa Keny-Guyer to address discharge planning for suicidal patients at release from emergency departments.
- The Children's Systems Advisory Council Suicide Prevention Subcommittee began developing guidelines concerning use of peer and family supports in suicide intervention and treatment to ensure engagement in services.

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

**Status: Ongoing**

**Progress:**

- The alliance began work to establish priorities and a public policy agenda to guide implementation of the plan over five years, including recommendations for provision of standardized statewide use of best practice suicide risk assessment, lethal means counseling and safety planning interventions.
- An alliance committee was charged with reviewing all alliance recommendations for cultural appropriateness.
- Alliance work will begin in 2017 on activities to address needs of minority populations and groups at disproportionate risk of suicide, as identified in the plan.
- Trauma Informed Oregon began supplementing trauma-informed care with suicide prevention strategies.
- OHA advanced a legislative concept concerning training for physical and behavioral health providers for introduction in 2017.

- OHA worked with providers of youth peer and family support to expand the availability of services and supports in the behavioral and physical health systems.
- OHA funded a pilot project in Clatsop County to provide support services to families of youth at high risk of suicide in order to engage them in outpatient care and facilitate relationships with other child-serving agencies. Partners on this project were Lines for Life providing youth and parent school activities and Youth M.O.V.E. (Motivating Others through Voices of Experience) Oregon with youth peer support.

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

**Status: Ongoing**

**Progress:**

- The Oregon Pediatric Society's START trainings for primary care physicians on depression and substance use screening expanded to include best practices in risk assessment, safety planning and lethal means counseling.
- OHA examined rules for consistency with best practices in suicide risk assessment, lethal means counseling and safety planning. OHA will likely add suicide prevention over time as OHA rules open for updates.
- OHA funded a peer-delivered activity in Benton County by Youth M.O.V.E. Oregon to engage youth after a number of suicides occurred in 2016.
- OHA provided funding to Benton County School District 171 on a resiliency and positive school culture for Philomath High School.
- OHA funded two pilot projects of the Source of Strength program in the Albany and North Clackamas school districts. The peer-led resiliency-building program encourages youth to seek help with depression, suicidality and other behavioral health concerns.

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

**Status: Ongoing**

**Progress:**

- A work group began developing a youth-informed strategic plan, due by September 2017, for safe online spaces for youth. The group includes Lines for Life, Youth MOVE, Reachout.com, OHA, youth and other stakeholders.

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

**Status: Ongoing**

**Progress:**

- SB 561 rules were finalized and Local Mental Health Authorities (LMHAs) began working with local stakeholders to develop information-sharing and postvention protocols for standardized response to youth suicides.
- The youth suicide intervention and prevention coordinator provided technical assistance and disseminated best-practice guidelines on activities after a suicide (postvention) to schools, community groups and a wide range of community members.
- The coordinator worked with community mental health programs to establish information-sharing protocols at the local and state levels. These postvention activities (SB 561), included rulemaking and reporting deaths of individuals 24 years old or younger to OHA within seven days of the death.
- The Oregon medical examiner contacted all medical examiners in the state to encourage them to work with LMHAs on SB 561 implementation. LMHAs began forging relationships with their medical examiners to facilitate suicide death reporting requirements of SB 561.

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

**Status: Completed**

**Progress:**

- A comparison of Oregon's youth suicide rates and prevention strategies with other states was in the plan as required. Updated rankings are included in the statistics provided in Section 3 of this report.

**Section 2 Action items requiring additional resources to complete**

**Status: Underway**

**Progress:**

- The coordinator prepared budget proposals for resources needed to fully implement the plan. This was pending due to budget uncertainties at the time this report was published.

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

**Status: Ongoing**

**Progress:**

- The alliance and other stakeholders began examining laws on confidentiality to promote information sharing across systems (mental health, substance use treatment and schools) and with families and families of choice.
- OHA began working with the Oregon Athletic Coaches Association on a year-long program to raise awareness of suicide risk and warning signs among school coaches, athletic trainers and athletic directors.
- OHA worked with prevention and promotion grantees (including counties and CCOs) on suicide-related training and programs.
- The Oregon Pediatric Society START program trainings were offered to school-based health center staff.

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

**Status: Ongoing**

**Progress:**

- An analysis is needed to determine the types of risk assessments used in medical and behavioral health care settings and to disseminate best practices.
- A needs assessment should be done to determine the number of schools and colleges that have adopted suicide prevention and postvention protocols and to conduct an analysis of their incorporation of best practices.
- An evaluation plan for monitoring progress on plan implementation is needed and execution of a contract with a university is expected in 2017.
- Limited training is underway with federal grant funds and additional training, including continuing education, needed for medical and behavioral health providers in best practices for assessing, managing and treating individuals at risk for suicide or self-harm, and best practice risk assessment, safety planning and lethal means counseling. Currently, the counties participating in the Garrett Lee Smith suicide prevention grant are offering Assessing and Managing Suicide Risk (AMSR) trainings on assessment, management and treatment to clinicians.

# Section 3

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

**Status: Ongoing**

**Progress:**

The Public Health Division created a web-based platform for suicide data that includes death, hospitalizations and survey data. The platform also contains a storyboard that describes the problem of suicide. This platform was presented to Public Health and OHA leadership, and the alliance. There is potential to add additional data to this platform as data sources become available.

The following data analysis addresses Section 1 (3)(a–g) as specified in the legislation. The data below includes the number of youth and young adults ages 10 to 24 who had previously been in the hospital due to self-inflicted injury and who had died by suicide. Oregon's Violent Death Reporting System, funded by the Centers for Disease Control and Prevention since 2003, collects information on the demographics and circumstances, and risk factors surrounding all suicide deaths that occur in Oregon each year. More than 250 variables about these deaths are collected from police reports, medical examiner reports, and death certificates and entered into a web-based data system. The Oregon Association of Hospitals and Health Systems collects hospitalization data once a year that document a small set of demographic and diagnostic codes. They give the codes to OHA to monitor various health problems. There is no standardized emergency department data set available for use in monitoring various health problems in Oregon.

## Basic facts*,**

Suicide numbers, rates and rankings by county or state fluctuate by year. Monitoring for trends across time is the most effective way to study the data.

- Suicide was the second leading cause of death among youth ages 10 to 24 in Oregon in 2015.†
- Overall, Oregon suicide rates among youth ages 10–24 years were higher than the U.S. rates in the past decade; and Oregon suicide rates rose after 2011 (Figure 1).†

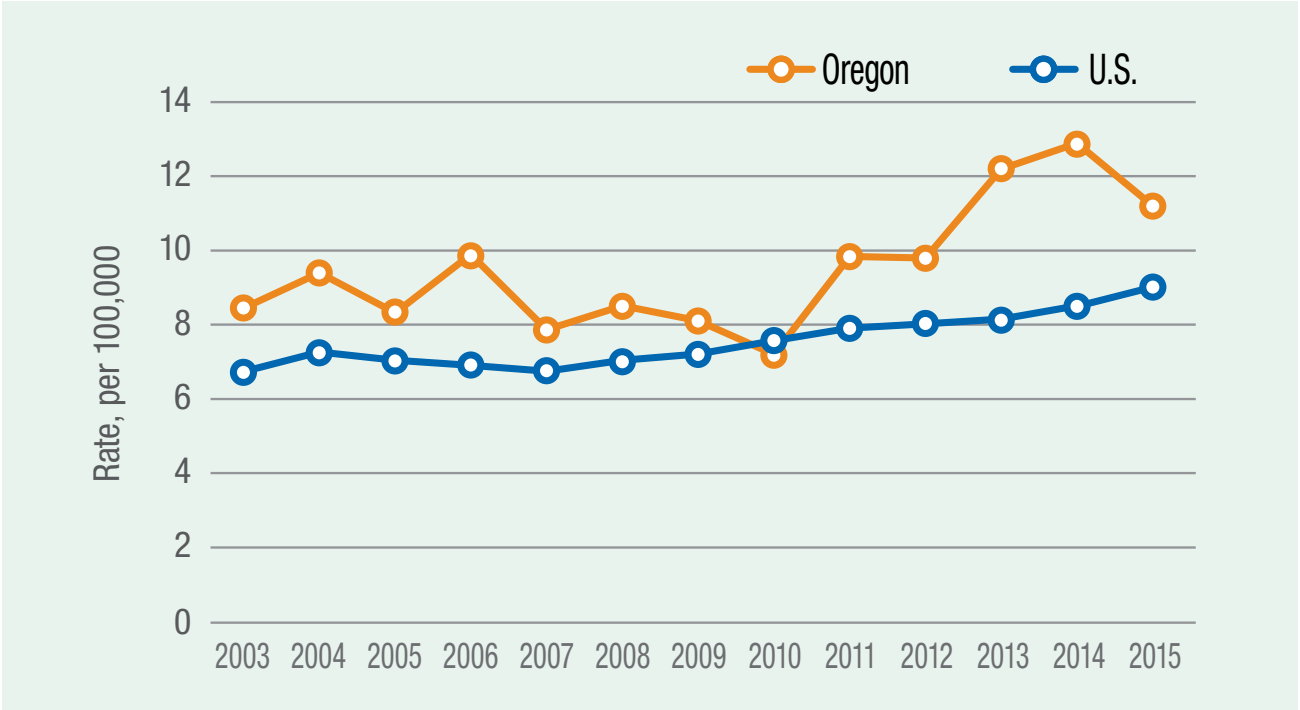
* Oregon Public Health Division, Oregon Violent Death Reporting System. Suicides in Oregon: Trends and Associated Factors, 2003-2012. Available from http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/Suicide%20in%20Oregon%202015%20report.pdf. Accessed 2017 June 6.

** The CDC WISQARS. Available from https://webappa.cdc.gov/sasweb/ncipc/mortrate.html.

† National Center for Health Statistics, Center for Disease Control and Prevention, WISQARS. Available from https://webappa.cdc.gov/sasweb/ncipc/mortrate.html. Accessed 2017 May 3.

- In 2015, the Oregon rate of suicide among youth ages 10–24 years improved to rank 16th among all U.S. states. This compares with the 12th highest state rate reported in 2014.*
- 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 ages 10–14 to 16.0 per 100,000 among youth ages 20–24 (2003-2012).**
- Suicide rates among male veterans were more than four times higher than non-veteran males (the most recent data available, 2003-2012).**

## Figure 1. Suicide rates among youth ages 10–24, United States and Oregon, 2003–2015*




* National Center for Health Statistics, Center for Disease Control and Prevention, WISQARS. Available from https://webappa.cdc.gov/sasweb/ncipc/mortrate.html. Accessed 2017 May 3.

** Oregon Violent Death Reporting System. Available from https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/nvdrs.aspx. Accessed 2017 June 6.

## Table 1. Comparison of suicide completion rates per 100,000, Oregon and the U.S., 2003–2015*

| Year | Oregon | U.S. |
|---|---|---|
| 2003 | 8.4 | 6.74 |
| 2004 | 9.4 | 7.26 |
| 2005 | 8.3 | 7.04 |
| 2006 | 9.9 | 6.9 |
| 2007 | 7.9 | 6.75 |
| 2008 | 8.5 | 7.04 |
| 2009 | 8.1 | 7.21 |
| 2010 | 7.2 | 7.57 |
| 2011 | 9.8 | 7.91 |
| 2012 | 9.8 | 8.02 |
| 2013 | 12.2 | 8.15 |
| 2014 | 12.9 | 8.51 |
| 2015 | 11.2 | 9.15 |

Common risk factors:

- 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

* National Center for Health Statistics, Center for Disease Control and Prevention, WISQARS. Available from https://webappa.cdc.gov/sasweb/ncipc/mortrate.html. Accessed 2017 May 3.

## Table 2. Common circumstances surrounding suicide incidents, Oregon, 2013–2014*

| Circumstance | Count | % |
|---|---|---|
| **Mental health status** | | |
| Mentioned mental health problems** | 139 | 76 |
| Diagnosed mental disorder | 80 | 44 |
| Problem with alcohol | 18 | 10 |
| Problem with other substance | 34 | 19 |
| Current depressed mood | 107 | 58 |
| Current treatment for mental health problem† | 51 | 28 |
| **Interpersonal relationship problems** | | |
| Broken up with boy/girlfriend, intimate partner problem | 59 | 32 |
| Suicide of family member or friend within past five years | 5 | 3 |
| Family stressor(s) | 38 | 21 |
| History of abuse as a child | 10 | 5 |
| **Life stressors** | | |
| A crisis in the past two weeks | 53 | 29 |
| Job problem | 15 | 8 |
| Recent criminal legal problem | 17 | 9 |
| School problem | 14 | 8 |
| **Suicidal behaviors** | | |
| History of expressed suicidal thought or plan | 74 | 40 |
| Recently disclosed intent to die by suicide | 49 | 27 |
| Left a suicide note | 59 | 32 |
| History of suicide attempt | 43 | 23 |

* Oregon Violent Death Reporting System, Injury and Violence Prevention Program. Available from https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/nvdrs.aspx. Accessed 2017 June 6.

** Include diagnosed mental disorder, problem with alcohol and/or other substance, and/or depressed mood.

† Includes treatment for problems with alcohol or other substance.

## Data for 2015:

Data for 2015 was the latest available at the time of this report.

- Ninety suicides occurred among Oregon youth ages 10–24.*
- The majority of suicides occurred among males (77%), White (80%) and those ages 20–24 (55%). Thirty-eight of them were elementary, middle school and high school students.*
- Firearms, suffocation (hanging) and poisoning are the most frequently observed mechanisms of injury in suicide deaths. Firearms alone accounted for 48% of deaths.*

### Table 3. Characteristics of suicide completions among youth aged 10 to 24, Oregon, 2014*

| | | | |
|---|---|---|---|
| **Age** | 10–14 | 5 | 6% |
| | 15–19 | 33 | 39% |
| | 20–24 | 46 | 55% |
| **Sex** | Male | 65 | 77% |
| | Female | 19 | 23% |
| **Race/ethnicity** | White | 67 | 80% |
| | African American | 4 | 5% |
| | American Indian/Native Alaskan | 3 | 4% |
| | Asian/Pacific Islander | 6 | 7% |
| | Multirace | 4 | 5% |
| | Other/unknown | 0 | 0% |
| | Hispanic | 6 | 7% |
| **Student status** | Middle school | 4 | 5% |
| | High school | 14 | 17% |
| **Mechanism of death** | Firearm | 40 | 48% |
| | Hanging/suffocation | 29 | 35% |
| | Poisoning | 5 | 6% |
| | Other | 10 | 12% |
| **Other** | Veteran | 5 | 6% |

* Oregon Violent Death Reporting System, Injury and Violence Prevention Program. Available from https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/nvdrs.aspx. Accessed 2017 June 6.

## Suicide attempts*

- Each year, more than 500 Oregon youth ages 10–24 are hospitalized for self-inflicted injury/attempted suicide. There were 695 youth hospitalizations in 2015 (Table 4).**
- In contrast to completed suicide, females were far more likely to be hospitalized for suicide attempts than males.**

### Table 4. Numbers and percentage of self-harm hospitalizations and completed suicide deaths among youth ages 10–24, by county and statewide, Oregon, 2015†

| County | Hospitalizations‡ | | Deaths§ | |
|---|---|---|---|---|
| | Count | % of total | Count | % |
| Baker | 2 | 0.3 | 1 | 1.2 |
| Benton | 11 | 1.6 | 3 | 3.6 |
| Clackamas | 70 | 10.1 | 10 | 11.9 |
| Clatsop | 9 | 1.3 | 0 | 0.0 |
| Columbia | 11 | 1.6 | 0 | 0.0 |
| Coos | 14 | 2.0 | 2 | 2.4 |
| Crook | 4 | 0.6 | 1 | 1.2 |
| Curry | 2 | 0.3 | 1 | 1.2 |
| Deschutes | 35 | 5.0 | 3 | 3.6 |
| Douglas | 10 | 1.4 | 2 | 2.4 |
| Gilliam | 0 | 0.0 | 0 | 0.0 |
| Grant | 0 | 0.0 | 0 | 0.0 |
| Harney | 1 | 0.1 | 1 | 1.2 |
| Hood River | 1 | 0.1 | 0 | 0.0 |
| Jackson | 39 | 5.6 | 9 | 10.7 |
| Jefferson | 2 | 0.3 | 1 | 1.2 |
| Josephine | 15 | 2.2 | 2 | 2.4 |
| Klamath | 11 | 1.6 | 3 | 3.6 |
| Lake | 1 | 0.1 | 0 | 0.0 |

* Oregon Public Health Division, Injury and Violence Prevention Program.

** Oregon Association of Hospitals and Health Systems. Oregon hospital discharge index. Unpublished data.

† Injury and Violence Prevention Program, Oregon Public Health Division. Oregon Hospital Discharge Index.

‡ ICD codes were switched from ICD-9 to ICD-10 CM after Oct. 1, 2015.

§ Out-of-state deaths may not be included.

| County | Hospitalizations‡ | | Deaths§ | |
|---|---|---|---|---|
| | Count | % of total | Count | % |
| Lane | 66 | 9.5 | 3 | 3.6 |
| Lincoln | 10 | 1.4 | 2 | 2.4 |
| Linn | 18 | 2.6 | 3 | 3.6 |
| Malheur | 0 | 0.0 | 2 | 2.4 |
| Marion | 63 | 9.1 | 6 | 7.1 |
| Morrow | 5 | 0.7 | 1 | 1.2 |
| Multnomah | 147 | 21.2 | 17 | 20.2 |
| Polk | 17 | 2.4 | 0 | 0.0 |
| Sherman | 0 | 0.0 | 0 | 0.0 |
| Tillamook | 1 | 0.1 | 1 | 1.2 |
| Umatilla | 7 | 1.0 | 0 | 0.0 |
| Union | 1 | 0.1 | 2 | 2.4 |
| Wallowa | 1 | 0.1 | 0 | 0.0 |
| Wasco | 4 | 0.6 | 0 | 0.0 |
| Washington | 94 | 13.5 | 6 | 7.1 |
| Wheeler | 0 | 0.0 | 0 | 0.0 |
| Yamhill | 23 | 3.2 | 2 | 2.4 |
| *State* | *695* | *N/A* | *84* | *N/A* |

## Suicidal ideation*

- Approximately 16 percent of eighth graders and 11th graders reported seriously considering suicide in the past 12 months in 2015.**
- Nearly 8% of eighth graders and 6% of 11th graders self-reported having attempted suicide one or more times in the previous 12 months in 2015.**

* Oregon Health Authority, Addictions and Mental Health Division. 2014 Student Wellness Survey. Available from https://oregon.pridesurveys.com/regions.php?year=2013. Accessed 2017 June 6.

** Oregon Healthy Teens Survey, Center for Health Statistics, Public Health Division, OHA, administered to eighth and 12th graders every two years. Available from https://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx. Accessed 2017 June 6.

## Table 5: Suicide rates among youth aged 10 to 24 years by state, U.S. 2015*

| State | Deaths | Crude Rate |
|---|---|---|
| Alaska | 60 | 37.61 |
| South Dakota | 44 | 25.22 |
| Wyoming | 27 | 23.22 |
| New Mexico | 80 | 18.74 |
| Colorado | 183 | 16.69 |
| Utah | 123 | 16.66 |
| Montana | 33 | 16.4 |
| Idaho | 56 | 15.9 |
| Hawaii | 41 | 15.31 |
| Oklahoma | 105 | 12.93 |
| Nebraska | 50 | 12.53 |
| Arizona | 170 | 12.09 |
| Iowa | 78 | 12.03 |
| Vermont | 15 | 11.98 |
| Kentucky | 105 | 11.96 |
| **Oregon** | **90** | **11.95** |
| Washington | 161 | 11.71 |
| Delaware | 21 | 11.66 |
| Missouri | 140 | 11.51 |
| Nevada | 63 | 11.4 |
| Kansas | 70 | 11.22 |
| Mississippi | 68 | 10.78 |
| Minnesota | 116 | 10.74 |
| Wisconsin | 122 | 10.54 |
| Michigan | 209 | 10.32 |
| Arkansas | 61 | 10.15 |
| Louisiana | 96 | 10.14 |
| Tennessee | 131 | 10.04 |
| South Carolina | 96 | 9.91 |
| Indiana | 137 | 9.87 |
| Ohio | 224 | 9.74 |
| Alabama | 93 | 9.56 |

* Oregon Health Authority, Addictions and Mental Health Division. 2014 Student Wellness Survey. Available from https://oregon.pridesurveys.com/regions.php?year=2013. Accessed 2017 June 6.

| State | Deaths | Crude Rate |
|---|---|---|
| Georgia | 198 | 9.18 |
| Virginia | 152 | 9.16 |
| Maine | 21 | 9.04 |
| Pennsylvania | 219 | 8.96 |
| West Virginia | 30 | 8.88 |
| Texas | 504 | 8.44 |
| Florida | 303 | 8.35 |
| Illinois | 211 | 8.14 |
| North Carolina | 165 | 8.12 |
| North Dakota | 13 | 7.81 |
| New Hampshire | 20 | 7.76 |
| Rhode Island | 15 | 7.01 |
| California | 506 | 6.32 |
| Massachusetts | 82 | 6.09 |
| New Jersey | 95 | 5.54 |
| Maryland | 64 | 5.52 |
| Connecticut | 38 | 5.26 |
| New York | 191 | 4.99 |
| District of Columbia | <10 | Not available |

## Limitations of data used for suicide surveillance

Oregon monitors and tracks suicide using a variety of existing administrative data sets, surveys and active surveillance efforts. Administrative data sets include death certificates collected by local health departments and sent to the Center for Health Statistics at the Oregon Public Health Division and hospitalization discharge data from the Oregon Association of Hospitals and Health Systems. Survey data come from the Oregon Healthy Teens Survey, the National Survey on Drug Use and Health, and the American Community Survey. The Oregon Violent Death Reporting System and the Oregon Child Fatality Review Data Systems collect active surveillance data.

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 students' sexual orientation, transgender status, school, primary spoken language and foster care status. Another limitation that affects data availability is funding and staff resources to conduct systematic ongoing

suicide surveillance. Routine suicide surveillance does not include requests for depression-related intervention services in the past 12 months, previous attempts, emergency department visits or hospitalizations in the last 12 months. Producing these complex analyses of large administrative data sets would involve linking, deduplication and analysis tasks. They would also require additional funding and position authority. Other data components would require active in-person case investigation, data entry and database management. All of the above would require significant resources and planning.

The Oregon Health Authority Public Health Division has asked Health Analytics and Policy for a complete standardized set of emergency department discharge data from the Oregon Association of Hospitals and Health Systems. These data are one of the major missing pieces for 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 OHA. Data on suicide attempts are not available. This also points to the need for a standardized emergency department data set to monitor health problems among Oregonians. During the 2017 legislative session, OHA plans to introduce a bill to require the hospital association to compile data and provide them to OHA. If the bill does not pass, OHA will continue its efforts in 2019.

OHA will also plan to assess agency-wide need from various programs for emergency department data.

Additionally, death certificates and medical examiner reports do not contain some variables mandated by HB 4124. These include the following for youth who died by suicide in the past 12 months:

- The school attended
- Previous admissions or treatment for depression or suicidality
- Primary spoken language
- Sexual orientation or foster care status

Implementation of SB 561 by the LMHAs may allow for collection of data regarding school attended, whether the youth was in treatment, and whether the youth was in the custody of an agency, if that information is available to the LMHA.

# Appendix I

## Garrett Lee Smith Grant activities

The Oregon Health Authority, Public Health Division, administers the Oregon Caring Connections Youth Suicide Prevention Initiative with funding through the Substance Abuse and Mental Health Services Administration (SAMHSA). Congress appropriates funding 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. In 2014, Oregon received $736,000 a year for five years (2014–2019) from SAMHSA to implement activities defined in the federal guidance document and aligned with the National Strategy for Suicide Prevention. As noted above, the Oregon Health Authority used the National Strategy for Suicide Prevention as a framework as it developed Oregon's mandated Youth Suicide Intervention and Prevention Plan. This ensured all state and local efforts, including those funded by GLSMA, would align with the national strategy. It also positions the state to be competitive for funding requiring a state plan that mirrors the national strategy.

**Action items from the Oregon Caring Connections Initiative are included in the state plan to reflect the work of communities across Oregon during the life of the plan.** The Oregon Caring Connections Initiative 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. This occurs 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 five 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 youth representing sexual minorities. SAMHSA's required 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 aligned with the National Strategy for Suicide Prevention.

OHA identified counties for funding using a process managed in partnership with the Association of Oregon Community Mental Health Programs. The process included a request for a letter of intent from counties and three steps:

- OHA ranked counties for funding using data that identified counties with the highest burden of suicide and suicide attempts.
- Counties submitted a letter of interest for funding that documented their suicide and suicide attempt rates, their completion of a county health assessment plan that included suicide, and documentation of an existing suicide prevention coalition or steering committee.
- The county behavioral health program's license to provide mental health services was documented.

Eight counties applied for funding. These eight counties were ranked in order of the burden and their readiness to implement funding activities. Four counties received funding in the first two years to implement a set of prevention strategies. The four Oregon Caring Connections Initiative (OCCI)-funded counties include Deschutes, Jackson, Josephine and Washington. A fifth county, Umatilla, joined the initiative Oct. 1, 2016.

The objectives in the SAMHSA grant were created in direct response to the requirements in the funding opportunity announcement. These objectives are aligned with strategic direction 2 and strategic direction 4 of the Youth Suicide Intervention and Prevention Plan. The grant objectives include:

- 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 annual safeTALK trainings to community members;
- Establishing RESPONSE in half of the high schools in three CMHP catchments areas;
- Providing Kognito At-Risk for High School Educators and Step In, Speak Up!, the LGBTQ module, training to 20,000 educators and school staff;
- Providing 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 in Primary Care;

- Training emergency department staff in all four Portland metro health systems on Kognito At-Risk in the 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;
- Improving county crisis response plans for full wraparound services;
- Implementing comprehensively goals 8 and 9 of the National Strategy for Suicide Prevention 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.
- Promoting the National Suicide Prevention Lifeline and project evaluation with all partners.

## Year two grant activities

The following section reports on activities completed in year two of the five-year SAMHSA Garrett Lee Smith Memorial Act Youth Suicide Prevention and Early Intervention grant to Oregon. It is divided by the strategic directions and objectives listed in the Youth Suicide Intervention and Prevention Plan.

OCCI-funded projects provide gatekeeper training consistent with goal 6 of the Oregon Youth Suicide Intervention and Prevention Plan. Those trainings include:

- Applied Suicide Intervention Skills Training (ASIST)
- Question, Persuade and Refer (QPR) and
- A web-based training known as Kognito.

Gatekeeper training is an evidence-based practice to prepare lay people and professionals to identify and refer persons at risk for suicide to care. This activity is an objective in the national suicide prevention plan and Objective 6.1 under strategic direction 2 in Oregon's Youth Suicide Intervention and Prevention Plan.

Funded counties achieved and exceeded the target for implementing one gatekeeper training per quarter (Table 6. below) in 2015–2016.

| Table 6. Counties and completed QPR, ASIST and safeTALK trainings and persons trained in year | | | | |
|---|---|---|---|---|
| **County** | **QPR** | **ASIST** | **safeTALK** | **Total** |
| Deschutes | 10 (376) | 2 (74) | | 12 (450) |
| Jackson | 14 (358) | 9 (205)* | 1 (17) | 24 (580) |
| Josephine | 2 (42) | 3 (61) | | 5 (103) |
| Washington | | | | *Funded by other sources* |
| **Total** | **26 trainings (776 people)** | **14 trainings (340 people)** | **1 training (17 people)** | **41 trainings (1,133 people)** |

* Includes one ASIST training of trainers with 15 participants

OHA provided through the grant an opportunity for professionals to use a web-based gatekeeper training that individuals working in schools, emergency departments, primary care and school-based health centers could complete online. This training is known as Kognito. Table 7 provides data on the settings, locations, licenses activated and users who completed Kognito training.

| Table 7. Implementation and completion of Kognito gatekeeper training by setting, 2015–2016 | | | |
|---|---|---|---|
| **Type of setting** | **Locations** | **Licenses activated** | **Users completed training** |
| Schools (Y1 & 2) | 16+ | 341 | 234 |
| Emergency departments (Y2) | 3 | 5 | 4 |
| Primary care providers/school-based health centers (Y2) | 5+ | 31 | 17 |
| **Total** | **24+** | **377** | **255** |

County projects completed other types of trainings in prevention and early intervention skills for persons who work with youth at risk for suicide.

| Table 8. County implementation of CALM, School-based RESPONSE, Mental Health First Aid, 2015–2016 | | | | |
|---|---|---|---|---|
| | Type of training | | | |
| County | CALM | School-based RESPONSE | Mental Health First Aid | Year 2 total |
| Jackson | 1 (22) | | Data collection not complete | 1 (22) |
| Josephine | 1 (30) | 11 (376) | | 12 (406) |
| Washington | 2 (38) | | | 2 (38) |
| Other | 2 (50)* | | | 2 (50) |
| **Total** | **6 (140)** | **11 (376)** | | **17 trainings (516 people)** |

* Includes one CALM training of trainers with 32 participants.

## Clinical professionals training in Assessing and Managing Suicide Risk (AMSR)

The OCCI required funded counties to implement a clinical training designed for mental health service providers known as Assessing and Managing Suicide Risk. Table 4 includes information that documents the county-level implementation of AMSR training.

| Table 9. AMSR trainings implemented by county, 2015–2016 | | |
|---|---|---|
| Training date | Training location | Clinicians trained |
| 07/12/2016 | Deschutes | 49 |
| 10/30/2015 | Jackson | 42 |
| 03/30/2016 | Josephine | 41 |
| 08/05/16 | Malheur | 47 |
| 09/16/2016 | Lane | 51 |
| 09/22/2016 | Multnomah | 46 |
| **Year 2 Total** | **6** | **(276)** |
| 2/27/2015 | Washington | 49 |
| **Total to date** | **7** | **325** |

**Target: Complete 11 trainings and involve 550 participants by Dec. 29, 2019.**

## Youth Suicide Prevention Conference

SAMHSA gave the project permission in June 2016 to redirect unspent funds from the first year of the grant to host a statewide youth suicide prevention conference held over two days in Portland, Oregon on Sept. 22 and 23, 2016. The conference was sited in Portland to coincide with the Oregon Alliance to Prevent Suicide's first meeting held that week. This enabled Oregon Alliance to Prevent Suicide members who were both participants and presenters at the conference to attend both events. The conference was a way to broaden the training and outreach to counties throughout Oregon. Prioritized conference sessions included:

- Training required by the SAMHSA funding opportunity
- Training on the implementation of SB 561
- Inclusion of sessions led by teens and Native Americans and family members who had survived a loss and
- Introduction of the systems-level approach to suicide prevention known as Zero Suicide

Every session in the conference aligned with the National Strategy, the State Plan, and the GLS grant requirements. There were 16 sessions held during the conference with 591 participants.

| Statewide Youth Suicide Prevention Conference participants per session (16 sessions) | |
|---|---|
| | **Participants** |
| Zero Suicide | 140 |
| Youth Voices: Hearing from Young People on the Front Lines | 51 |
| Lessons from Teens After a Suicide | 49 |
| AMSR | 46 |
| School & Mental Health Suicidal Ideation Protocol | 41 |
| Connect: Suicide Postvention | 38 |
| CALM Training of Trainers | 32 |
| Senate Bill 561 | 27 |
| Dialectic Behavioral Therapy | 25 |
| Safety Planning & Means Restriction | 24 |

| Statewide Youth Suicide Prevention Conference participants per session (16 sessions) | |
|---|---|
| | **Participants** |
| Intervention Skills Training: ASIST, QPR, RESPONSE, Youth MHFA | 24 |
| Native American Evidence Based Practices | 21 |
| Zero Suicide: Boots on the Ground, a Local Perspective | 19 |
| Providers & Family Communicating to Save Lives | 19 |
| CALM | 18 |
| QPR | 17 |
| **Cumulative total** | **591** |

## Summary of the Oregon Caring Connections Initiative activities

The Garrett Lee Smith Memorial Act Caring Connections Youth Suicide Prevention Initiative cumulative accomplishments from October 2014 through September 2016 include work in five key strategies:

- **Gatekeeper trainings:**
  - ASIST, QPR, safeTALK: 1,333 gatekeepers at 41 trainings
  - Kognito: 255+ gatekeepers at 24 schools, emergency departments and school-based health centers
  - Other: Counseling on Access to Lethal Means (CALM), RESPONSE, Mental Health First Aid, Youth Suicide Prevention Conference
- **Clinical trainings:**
  - AMSR: 278 clinicians at 6 locations
- **Crisis response and continuity of care:**
  - Enhancing plans and systems in 4+ counties
- **Zero Suicide:**
  - Being implemented in one large urban county and elsewhere around state
- **National Suicide Prevention Lifeline (NSPL):**
  - Ongoing promotion in multiple venues around state

The impact of the GLS grant spans a variety of service delivery systems. Two GLS counties have embedded mental health professionals in hospitals, schools and, in one case, primary care clinics to ensure youth identification, treatment and follow-up of those who are at risk of suicide. Another has implemented intensive follow-up care for youth seen in an ED for suicide attempts, and for their families. LifeWorks Northwest, the behavioral health agency for Washington County, is implementing Zero Suicide. Grant-funded counties are ensuring that suicidal patients have counseling to reduce access to lethal means. A grant-funded education consultant is working with schools statewide to increase implementation of suicide prevention protocols, guidelines, training and education. Hospitals and behavioral health agencies in funded regions have implemented evidence-based screening tools. Grant funding has paid for ASIST trainings and AMSR trainings that have been offered statewide to increase the ability and confidence among mental health professionals to recognize, treat and manage suicidal patients (education and training for suicide prevention frequently is not offered in graduate programs for mental health and social work). The Garret Lee Smith Memorial Act grant funding used by counties to implement needed evidence-based practices across health systems in funded regions has also reached to other counties and the state level.

As called for in the plan, OHA will collect data from Garrett Lee Smith grantees, compile the results and report on outcomes by January 2019. The Public Health Division has completed an annual report that summarizes the results to date and shared that report with funded counties, the AOCMHP, HSD and the suicide prevention listserv.

# Appendix II

## Glossary

**Applied Suicide Intervention Skills Training (ASIST):** Through a two-day workshop, ASIST teaches participants to recognize when people may have thoughts of suicide and work with them to create a plan that will support their immediate safety. Although health care providers widely use ASIST, participants don't need any formal training to attend the workshop — anyone 16 or older can learn and use the ASIST model.

**Assessing and Managing for Suicide Risk (AMSR):** AMSR is a one-day training workshop for behavioral health professionals. The 6.5-hour training, based on the latest research, helps participants provide safer suicide care.

**Attempt survivor:** An individual who has attempted suicide or has other lived experience with suicide.

**Bereavement survivor:** Also called "loss survivor," an individual who has lost a loved one, friend or community member to suicide.

**Completed suicide:** Used interchangeably with "died by suicide" to denote when an intentionally lethal act of self-injury leads to death.

**CONNECT:** A best practice program from the National Alliance on Mental Illness New Hampshire affiliate that trains communities on best practices in responding to suicides (postvention).

**Contagion:** Sometimes called "copycat" suicide, contagion occurs when an individual's suicide causes others to attempt or complete suicide.

**Counseling on Access to Lethal Means (CALM):** A best practice free online course for providers who counsel suicidal patients on effective safety skills. CALM is for providers who counsel people at risk for suicide, including behavioral and physical health providers.

**Kognito:** Online, interactive best practice courses for educators, students, medical and behavioral health providers to develop skills to talk to youth and adults about behavioral health and suicide risk.

**Mental Health First Aid (MHFA):** A best practice program to teach the skills to respond to the signs of mental illness and substance use. Courses are customized to identify and respond to youth and adults with mental health concerns.

**Postvention:** Used interchangeably with "post-suicide intervention," best practice postvention refers to the activities undertaken after a suicide occurs to assist bereavement survivors with grief and reduce the risk of contagion.

**Question, Persuade, Refer (QPR):** QPR is a best practice that teaches how to recognize the warning signs of a suicide crisis and how to question, persuade and refer someone to help. Online and in-person gatekeeper trainings are available and there is a module for behavioral and physical health providers.

**RESPONSE:** A comprehensive high school-based program that increases awareness about suicide among high school staff, students and parents. The program components heighten sensitivity to depression and suicidal ideation, as well as offer response procedures to refer a student at risk for suicide. The program includes technical assistance for key staff to ensure that schools sustain suicide prevention efforts.

**safeTALK:** A half-day alertness training that prepares anyone over the age of 15, regardless of prior experience or training, to become a suicide-alert helper. Most people with thoughts of suicide don't truly want to die, but are struggling with the pain in their lives. Through their words and actions, they invite help to stay alive. safeTALK-trained helpers can recognize these invitations and take action by connecting them with life-saving intervention resources, such as caregivers trained in ASIST.

**Sources of Strength:** A best practice youth suicide prevention project that uses the power of peer social networks to change unhealthy norms and culture, ultimately preventing suicide, bullying and substance abuse.

**Zero Suicide:** The aspirational goal of the Oregon Youth Suicide Intervention and Prevention Plan, Zero Suicide also is a set of interrelated activities that health systems can implement with the goal of reducing suicides among their patients to zero.

Oregon Health Authority

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