

>> Adult Suicide Intervention and Prevention Plan



How to use this document

The Adult Suicide Intervention and Prevention Plan (ASIPP) was created to serve as a resource for all who have a role to play in suicide prevention. As such, it is not expected or necessary to read the document in its entirety. Instead, use this document as it applies to the work you do. We recommend exploring the [Table of contents \(TOC\)](#) in a digital format as all sections are hyperlinked for easy access. Please refer to [Bookmarks](#) on the left for easy maneuverability. It is highly recommended that everyone read the sections on [Addressing equity](#) and [Voices of lived experience](#) which centers the work to create this document and is integrated into all other sections. Additionally, it is **highly recommended** that you read Appendix 15 [Terms defined](#). This will assist you with understanding commonly used terms and definitions throughout this document.

There are two main sections:

- Section one:
 - Details the state plan including the framework, goals, initiatives, etc., and
 - Details statewide data, ASIPP development methodology and the Oregon Suicide Prevention Framework and Initiatives.
- Section two:
 - Details the rationale and justification for the choices made in Section one
 - Details of the results of focus groups and surveys
 - Provides extensive information about several chosen priority populations including:
 - ✦ literature review
 - ✦ data
 - ✦ means
 - ✦ risk and protective factors
 - ✦ circumstances surrounding the suicide
 - ✦ inter-sectional identities
 - ✦ recommendations
 - ✦ work underway
 - ✦ focus group feedback and summary, and
 - Can be used as a resource.

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Dear Oregonians,

Suicide remains a persistent, pervasive, and yet largely preventable cause of death. Every death by suicide in Oregon carries a substantial and long-lasting ripple effect in our communities. The majority of the suicide prevention work in Oregon has been focused on youth with promising results. Yet the suicide rate for adults is consistently and substantially higher than the youth rate. This is why adult suicide prevention (ages 18+) has become a top priority for OHA. This work includes initiatives as broad as creating meaningful connections and as narrow as training providers to treat suicide ideation confidently and effectively.

This document is the first Oregon Adult Suicide Intervention and Prevention Plan (ASIPP). The plan builds upon the work included in the Youth Suicide Intervention and Prevention Plan (YSIPP) 2016–2020 and 2021–2025 while focusing on the unique needs of adults rather than youth. Since 2016, a robust amount of work has been done to increase safety for Oregon's children and youth. Now it is time to expand that focus to our adult population. Oregon has seen some positive momentum in the fight against youth suicide, thus ASIPP has been modeled after YSIPP with the necessary modifications to accommodate the developmental differences and challenges among the youth and adult populations. This body of work also commits to reducing health disparities and advancing health equity as promised by Governor Kotek by focusing on populations that have disparate rates of suicide or populations that have been historically underserved.

The process of building the first Oregon ASIPP included input from over a hundred people throughout the state. Input came from many with relevant lived experience, providers of behavioral and primary health services, content experts, evidence-informed practices, and a rigorous research review.

The Oregon Suicide Prevention Framework, shared by both youth and adult plans, will serve as a roadmap for meaningful progress over the next five years. Most importantly, this plan is centered on lived experience and equity and both were imbedded into the process of creating the plan. We hope this framework will be adopted by counties and municipalities. We know more than ever about what is protective against suicide. ASIPP 2023–2027 outlines ways to increase protective factors and consider upstream measures.

If you or someone you know is struggling or in crisis, help is available. Call or text 988 or chat [988lifeline.org](https://www.988lifeline.org). The 988 Suicide and Crisis Lifeline is available 24/7 for people experiencing a behavioral health crisis to call, text or chat online at [988lifeline.org](https://www.988lifeline.org). Calls are taken in English or Spanish. Text and online chat are currently only available in English.

Respectfully,

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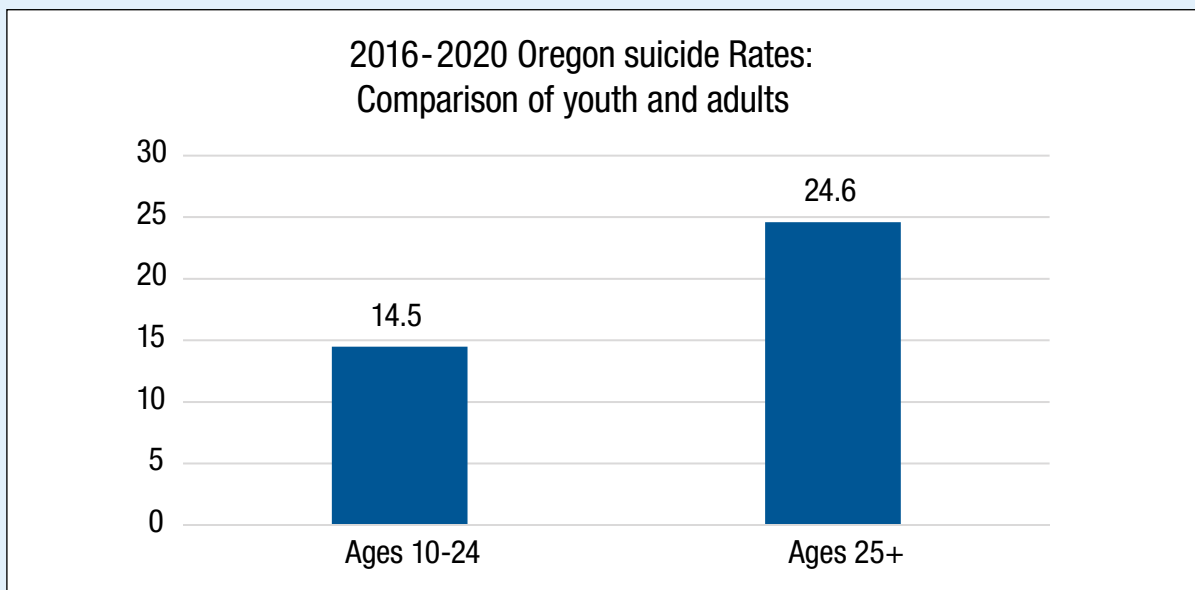
Executive summary

Need for the Adult Suicide Intervention and Prevention Plan (ASIPP)

In many ways, Oregon is leading the nation when it comes to suicide prevention. Statewide, our strength is evident in the 21 regional suicide prevention coalitions across the state, a dedicated and effective [Alliance to Prevent Suicide](#), a team of five Oregon Health Authority (OHA) suicide prevention coordinators, strong county suicide prevention coordinators, and state legislation promoting suicide prevention, intervention and postvention. We have legislation regarding postvention response (after a suicide death) which ensures that communities and families who experience the devastating loss of a young person to suicide receive outreach and resources. We have unique legislation that mandates that behavioral health workers become better trained in suicide prevention, intervention and postvention through continuing education. We adjusted quickly to the unique needs COVID-19 brought to our work of suicide prevention. Many of our contractors and advocates put in many hours to create as much protection as possible for people in Oregon. The number of suicides in 2020 did not increase from 2019 they decreased from 908 in 2019 to 835 in 2020.

Yet our work is far from done, especially on adult suicide prevention. Much of the work in suicide prevention in Oregon has been targeted toward youth defined as 0-24 years old. Oregon is well above the national average for youth suicide rates. We saw rising suicide rates from 2011 to 2018. In 2019 and 2020, Oregon's youth suicide rate decreased – the first two-year decrease since 2008. Also, the preliminary data for 2021 points to a decrease in youth. However, as true nationally, the adult suicide rate is substantially higher than the youth rate (Figure 1). There is much-continued work to be done and this document, the first Oregon ASIPP will help organize and facilitate this work. ASIPP is designed to address equity by focusing on populations that either have disparate rates of suicide or that have been historically underserved.

Figure 1. Number of deaths by suicide per 100,000 people from 2016–2020 for Oregonians stratified by age group (10-24 years old vs. 25 and older).



Source: Oregon Violent Death Reporting System

This document includes the overarching five-year plan, an executive summary of the plan, and a year-one plan. There will be an annual plan every year hereafter (2024, 2025, 2026, 2027) that will supply the new statewide strategic priority initiatives and outcomes from the previous year.

Broad overview of the methodology

ASIPP was developed over two years with much of the work centered on gathering community and partner input with a series of feedback loops. Over 130 people in Oregon helped to create this plan. Input and feedback were gathered from across Oregon through:

- A large and engaged group of 130 partners representing 68 organizations met monthly. In terms of race and ethnicity, the group was more representative than the state's populations for people of color and American Indian or Alaska Native persons, although still 82% White persons. Other demographics were much more diverse such as sexual orientation and gender identification, and formal education. For more detail on group demographics please see [Appendix 1](#).
- Several small workgroups were predominately made up of members from the large partner group (70% of large partner group members took part in one or more small workgroups and approximately 10% of the small workgroup participants did not attend the large group meetings). The small workgroups were based on populations that have disparate rates of suicide or populations previously disenfranchised and underserved. Those groups include:
 - LGBTQIA2S+
 - Ages 18–24
 - People employed in the construction industry
 - Veterans and military-connected personnel
 - Older adults
 - People with disabilities and chronic illness
 - People who are Black, Indigenous and people of color
 - People who are American Indians and Alaska Natives
 - Men, and
 - People living in rural and remote areas.

Four other small workgroups were not population-based including:

- Equity (see below)
- Lived experience (see below)
- Mental health systems, and
- Means matter.

- **Focus groups** included:
 - LGBTQIA2S+
 - Persons with chronic illness or disability
 - Attempt survivors
 - Persons residing in rural communities
 - Persons experiencing housing insecurities
 - Older adults, and
 - Veterans.
- Two **surveys** included:
 - County suicide prevention coordinators
 - Members of suicide prevention coalitions and councils throughout the state.
- The offer of **Tribal consultation** — A letter detailing the ASIPP development was sent out in an ongoing effort to consult with Oregon’s nine Federally Recognized Tribes and confer with the Urban Indian Health Program on issues that may affect the Tribes and the health of their members.

The lived experience small workgroup and the equity small workgroup were central to ASIPP development.

1. They created a values and principles document to share and be adhered to by all other small workgroups.
2. They reviewed all recommendations from the other small workgroups to ensure the values and principles of lived experience and equity remained paramount. Both groups met for several months. Their resulting documents were distributed to all small workgroup participants.

Summary results of small workgroups with a focus on priority populations: common threads

Complete reports from small workgroups are in Appendix 2.

1. We cannot have a “one size fits all” approach to suicide prevention, intervention and postvention.
2. We must approach different cultures with cultural humility and seek to gain knowledge about how we can be helpful within that population rather than trying to change that population to fit into the dominant culture’s idea about what “should” be helpful.
3. We must not only “invite other cultures to sit at our table” but seek out opportunities to “sit at their table.”
4. We need to move away from suicide prevention efforts normed and created for and by the dominant culture and seek alternatives better suited to specific cultures.
5. Suicide prevention needs to be culturally specific. To do otherwise is not only “not helpful” but can be “hurtful.”
6. Health disparities, including suicide, are the result of a long history of white supremacy, homo- and transphobia and gender inequities in this nation and Oregon. We must consider these influences as we proceed with the work of suicide prevention.

Summary results of focus groups

Complete reports from focus groups are in Appendix 3.

1. Provide peer-run drop-in centers that have short-term housing, and provide safety (from others and suicide). Also, provide respite for persons of concern without them having to be hospitalized or incarcerated.
2. Fund more mobile crisis teams such as the Portland Street Response and CAHOOTS (Crisis Assistance Helping Out On The Streets) models.
3. Provide respite care for caregivers and family members.
4. Increase the visibility of resources. Compile and centralize resources so information is consistent. Fund navigation assistance. Make accessing services “clear and easy.”
5. Conduct outreach to isolated seniors and those experiencing houselessness.
6. Provide transportation, especially to older adults and rural residents.
7. Address co-occurring substance use, opioid use, gambling addictions, etc. with accessible treatment services.
8. Train police and first responders.

Summary results of surveys

Both the Coalition and Council Survey and County Suicide Prevention Coordinator Survey had very similar themes.

1. The need for greater funding, particularly in rural and tribal communities.
2. The focus should be veterans, LGBTQIA2S+ and those who have alcohol and other drug (AOD) issues.
3. The need for OHA to be a clearinghouse for all things suicide. However, the actual work and decisions need to be on a local level.
4. The need for greater access to care and workforce development (not only access to care but adequate care).

Overview of the Oregon Suicide Prevention Framework

The Oregon Suicide Prevention Framework is the foundation for both ASIPP and YSIPP (Youth Suicide Intervention and Prevention Plan). This framework was developed in close collaboration with the University of Oregon Suicide Prevention Lab under the leadership of Dr. John Seeley. It is grounded in the strategies developed by the National Action Alliance For Suicide Prevention and the Centers for Disease Control 2017 publication “Preventing Suicide: A Technical Package of Policies, Programs and Practice”. The framework was informed by the San Diego County Suicide Prevention Action Plan and hundreds of pieces of feedback from partners across Oregon.

How will other suicide prevention coordinators within OHA use the framework to inform their suicide prevention plans?

OHA’s suicide prevention team currently includes five dedicated coordinators working on youth suicide, adult suicide and Zero Suicide initiatives in health care settings. Each of these coordinators within OHA will use the framework’s centering values, foundation, strategic pillars and goals as the baseline for their suicide prevention work. These sections of the framework are the long-term vision for suicide prevention in our state. Each coordinator (adult, youth and Zero Suicide in health care settings) within OHA will develop specific strategic pathways and corresponding strategic priority initiatives within their scope of work.

How does the framework inform the actual adult suicide prevention plan?

Although both YSIPP and ASIPP share the Oregon Suicide Prevention Framework, the specific strategic pathways and strategic priority initiatives included are adult focused and outline the state plan for addressing adult suicide. Strategic pathways are not likely to change over the five-year lifespan of this document. The strategic priority initiatives will be adjusted, refined and added to each year in collaboration with an advisory body and informed by ongoing evaluation. Each prioritized yearly initiative will have a work plan with roles and responsibilities assigned and metrics for evaluation and progress monitoring. The strategic pathways and strategic priority initiatives together make up the five-year ASIPP. The strategic goals, strategic pillars, center and base are the foundation on which the five-year plan is built.

Levels of interventions and strategies

Universal or primary level – These interventions have broad, community-wide reach. All people in Oregon will receive or benefit from these interventions.

Selected or secondary level – These interventions are for specific, targeted sectors or populations to maximize their benefit. These interventions happen in addition to universal interventions.

Indicated or tertiary level – These interventions are given to a very narrow scope of people, sectors or populations when risk or need for more intervention is indicated. This level includes treatment for suicidal thoughts, care coordination between levels of care and other interventions and supports. These are in addition to all other levels of intervention.

Strategic pillars

Strategic pillars are the first level of the suicide prevention framework. These closely match the National Strategy for Suicide Prevention (NSSP) with the exception that the NSSP has four pillars with the fourth pillar being Surveillance, Research, and Evaluation. The fourth pillar was removed from Oregon Suicide Prevention Framework and placed at the foundation of the framework intended to represent the concept that the whole framework is supported and grounded in these efforts. The pillars and foundation do not change over time. The strategic pillars in ASIPP 2023-2027 are:

- Healthy and empowered individuals, families and communities — universal interventions defined as activities designed to prevent negative health outcomes in an entire population regardless of the risk status of members of that population
- Clinical and community prevention services — selected intervention defined as activities targeting a group whose members are generally at higher-than-average risk for an adverse health condition regardless of whether individual members of the group display symptoms or have been screened for the condition
- Treatment and support services — indicated interventions defined as activities that target individuals who exhibit symptoms or have been identified by screening or assessment as being at risk for suicidal behavior

Strategic goals

Each pillar has three to four strategic goals embedded within it. These goals are not likely to change over time. The goals are based on the National Strategy for Suicide Prevention, the Centers for Disease Control 2017 publication “Preventing Suicide: A Technical Package of Policies, Programs and Practice, and Oregon’s suicide prevention landscape. Without the next level down (strategic pathways), they are not easily measured – they are “what” needs to happen. The strategic pathways are “how” we will do this work.

Strategic pathways

This is the measurable way we will know we’ve achieved success for the strategic goals. Each goal has two to five strategic pathways. For example, under the goal of “means reduction,” one pathway is, “All people of Oregon experiencing behavioral health problems will have access to safe storage of lethal means.” Strategic pathways may change over time, or new strategic pathways may be added over time, based on the success of implementation and the effectiveness of the efforts. These pathways were chosen based on the themes that emerged from feedback gathered, the literature reviewed and best practices.

Strategic priority initiatives

These are the project plan for how Oregon will achieve success within each strategic pathway. What steps will we take? These will be SMART (specific, measurable, achievable, realistic and timely). These should reflect what’s needed next to meet the moment. These will change over time. Likely they will be edited yearly based on implementation success and new needs and resources

Oregon Suicide Prevention Framework



Policy • Funding • Data • Evaluation

How to use the framework:

Preventing suicide cannot be done by one group, government or sector. OHA believes that the most effective suicide prevention happens in communities at the local level. Statewide infrastructure and equitable access to programs and resources are vital to local efforts. The intention of creating a statewide framework for Oregon is to equip various sectors and groups for the important work of suicide prevention and organize it to maximize collective impact.

Choosing annual strategic priority initiatives:

One death by suicide is one too many. Therefore, the work of suicide prevention is never done. The intent of choosing annual strategic priority initiatives is to enable folks doing the work to focus their time, energy and resources strategically to make meaningful progress.

“We can do anything, but not everything.”

- David Allen, author

Annual strategic priority initiatives are chosen using the following criteria:

- What is working that needs to be sustained?
- What is the data telling us we need to focus on improving?
- What is new legislatively mandated work that needs to be done?
- What previous legislative initiatives need improvements, monitoring or support?
- What did interested parties and partners identify as important next steps?

Each annual strategic priority initiative chosen will ideally have the following:

- An assigned agency or organization taking the lead
- An assigned lead person within that agency or organization
- A work plan that outlines tasks to be completed, target dates for completion and people responsible for each task
- A metric for evaluating progress toward completion, and
- A metric for evaluating the effectiveness of the initiative.

The framework can guide organizing suicide prevention work and choosing annual priorities that align with the needs of their community, government or organization. OHA encourages local teams to determine their annual strategic priority initiatives. OHA acknowledges that local priorities may not be the same as the statewide annual strategic priority initiatives. Some will likely match and some communities might have readiness or need for a different area of focus within the framework’s pillars, goals and pathways.

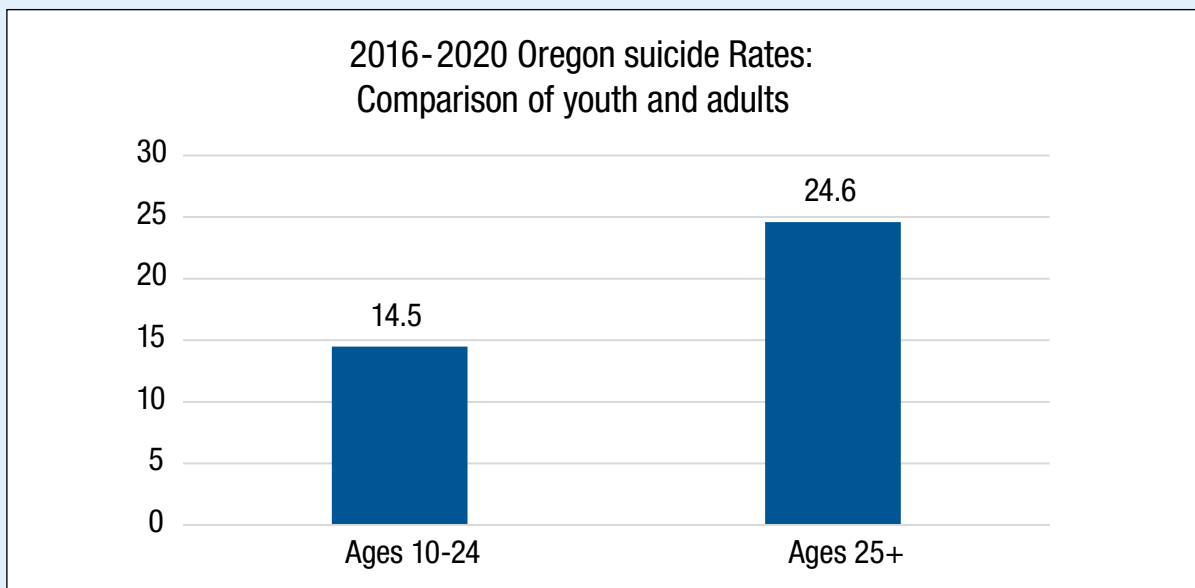
**Section 1: Oregon Suicide
Prevention Framework –
building the plan**

Introduction and need

In many ways, Oregon is leading the nation when it comes to suicide prevention. Statewide, our strength is evident in the 21 regional suicide prevention coalitions across the state, a dedicated and effective [Alliance to Prevent Suicide](#), a team of five Oregon Health Authority (OHA) suicide prevention coordinators, strong county suicide prevention coordinators, and state legislation promoting suicide prevention, intervention, and postvention. We have unique legislation that mandates that behavioral health workers become better trained in suicide prevention, intervention and postvention through continuing education. We adjusted quickly to the unique needs COVID-19 brought to our work of suicide prevention. Many of our contractors and advocates put in many hours to create as much protection as possible for people in Oregon. As a result of the work put in, the number of suicides in 2020 did not increase from 2019 they decreased from 908 in 2019 to 835 in 2020.

But our work is far from done, especially on adult suicide prevention. Much of the work in suicide prevention in Oregon has been targeted toward youth defined as 0-24 years old. Oregon started from a place of being well above the national average for youth suicide rates. We saw rising suicide rates from 2011 to 2018. In 2019 and 2020, Oregon’s youth suicide rate decreased – the first two-year decrease since 2008 and the preliminary data for 2021 also points to a decrease for youth. However, as true nationally, the Oregon adult suicide rate is substantially higher than the youth rate. There is much-continued work to be done and this document, the first Oregon Adult Suicide Intervention and Prevention Plan will help organize and facilitate this work. ASIPP is designed to address equity by focusing on populations that either have disparate rates of suicide or that have been historically underserved.

Figure 1. Number of deaths by suicide per 100,000 people from 2016–2020 for Oregonians stratified by age group (10-24 years old vs. 25 and older).



Source: Oregon Violent Death Reporting System

Methodology brief

This document is intended as a five-year+ plan. It includes an executive summary and a year-one plan. There will be an annual plan every year hereafter (2024, 2025, 2026, 2027). The plan will provide the new statewide strategic priority initiatives and outcomes from the previous year. For greater detail about the methodology involved in creating the ASIPP please see [Appendix 4](#).

ASIPP was developed over approximately one year with much of the work centered on gathering community and partner input with a series of feedback loops. Over 130 people in Oregon representing 68 organizations helped to create this plan. Input and feedback were gathered from across Oregon through:

- A large and engaged group of 130 partners that met monthly. In terms of race and ethnicity, the group was more representative than the state’s populations for people of color and American Indian and Alaska Native persons, though still 82% White persons. Other demographics were much more diverse such as sexual orientation and gender identification, and formal education. For more detail on group demographics please see [Appendix 1](#).
- Several small workgroups were predominately made up of members from the large partner group. The majority of small workgroups were based on populations that have disparate rates of suicide or populations previously disenfranchised and underserved. Those groups include:
 - LGBTQIA2S+
 - Ages 18–24
 - People employed in the construction industry
 - Veterans and military-connected personnel
 - Older adults
 - People with disabilities and chronic illness
 - People who are Black, Indigenous and people of color
 - People who are American Indians and Alaska Natives
 - Men, and
 - People living in rural and remote areas.
- Four other small workgroups were not population-based including:
 - Equity (see below)
 - Lived experience (see below)
 - Mental health systems, and
 - Means matter.
- **Focus groups** included:
 - LGBTQIA2S+
 - Persons with chronic illness or disability

- Attempt survivors
 - Persons residing in rural communities
 - Persons experiencing housing insecurities
 - Older adults, and
 - Veterans.
- Two **surveys** included:
 - County suicide prevention coordinators
 - Members of suicide prevention coalitions and councils throughout the state.
 - The offer of **Tribal consultation** — A letter detailing the ASIPP development was sent out in an ongoing effort to consult with Oregon’s nine Federally Recognized Tribes and confer with the Urban Indian Health Program on issues that may affect the Tribes and the health of their members.

The lived experience workgroup and the equity group were central to ASIPP development. Both groups played two vital roles:

1. They created a values and principles document to share and be adhered to by all other small workgroups.
2. They reviewed all recommendations from the other small workgroups to ensure the values and principles of lived experience and equity remained paramount. Both groups meet for several months. Their resulting documents were distributed to all small workgroup participants.

Voices of lived experience

The voices of those with lived experience were a vital part of the ASIPP development and were woven throughout this process. Lived experience refers to people who experience or have experienced suicidal ideation, suicide attempt survivors, and someone who has lost a loved one to suicide. Those with lived experience were encouraged and supported to join in all development activities and in addition, two ASIPP activities were intentionally focused on those with lived experience—the lived experience workgroup (an ongoing working committee) and the lived experience focus group (a one-time input gathering space).

- A.) **The lived experience workgroup** — From the lived experience workgroup a full report was created and is in [Appendix 5](#). The heart of that report is shared in these value statements.

Lived experience values

1. Nothing about us without us.
2. Self-determination. We have autonomy and choice around our treatment. For example, I am able to decide who I choose to see and am receiving the treatment I selected.
3. We are respected as the expert in our life; we’re believed when we share our story. For example, no gaslighting. No condescension.
4. Right to confidentiality. Our information is only shared with who we choose, how we choose and when we choose to share.

5. We have the right to access and preserve our charts and notes. We want to be able to review and annotate our chart to ensure accuracy.
 6. We have the right to receive support and treatment without judgment. People are seen as individuals and not their diagnosis. I may have schizophrenia but I'm not "a schizophrenic". I'm many things and although I may be impacted by my diagnosis, I'm not my diagnosis.
 7. Our identities are respected, and services are individually and culturally responsive.
 8. Services should be accessible and equitable to all. For example, materials should be offered in different formats and languages, and plain language. When technical terms must be used, a glossary should be included. We need physical access to services for those with physical, cognitive and other disabilities.
 9. Providers and programs are trauma-informed, trauma-free, and trauma-responsive. Safe spaces should be created for people to share their experiences and truth.
 10. The harm-reduction approach should be widely implemented among providers. We should not be excluded from treatment or services due to any substance use concerns. We should not be excluded from services for "not getting better" on "your timeline".
- B.) **The lived experience focus group** — Several focus groups were held (details throughout this document), one being an attempt survivor group. Below are some key messages heard in those focus groups.

"Everyone is different and so having resources is good but being the best fit for the individual is complicated. Therefore, I think multiple industries should be working together for the common good to have the biggest impact."

"The state needs to prioritize hiring folks with lived experience and those connected with them. Nothing for us without us. With that, inevitably we would see the focus turn away from law enforcement involved response and many of the other forgotten elements of pre and postvention."

"It seems like a common theme that they need follow-up of some kind. Rather than closing a case and moving on, it seems productive to be checking in on the person. It also seems like listening to the needs of the person helps the most. So, if they don't require follow-up then they should say so themselves rather than just taking it away."

"Prevention of suicide, as well as intervention, should be peer lead, peer focused, and peer intensive. Those with lived experience should be a part of every level of decision-making, supervision, and ground-level interactions."

Addressing equity

1. ASIPP is designed to address equity by focusing on populations that either have disparate rates of suicide or that have been historically underserved.
2. Equity is further centered in the ASIPP development since all small workgroups used the Equity Toolkit developed by the ASIPP equity small workgroup as a guide in developing recommendations. In addition, the equity small workgroup reviewed and vetted all recommendations made by other small workgroups. There was a collaborative feedback loop between the equity small workgroup and all other small workgroups.
3. One small workgroup was the BIPOC AI/AN workgroup, and all members of that Small Workgroup were members of that community by design. The recommendations and report were created by members of that community, exclusively.
4. When prioritizing (voting on) recommendations that transformed into initiatives, the BIPOC AI/AN and LGBTQIA2S+ groups were allowed more votes than the other groups. This “weighted” the scoring to ensure recommendations from these small workgroups would be likely selected. This was to further prioritize these historically underserved populations.
5. Although small workgroups focused on specific identities based on disparate populations or historically underserved populations, the small workgroups worked together to include the reality of intersectional identities. As human beings, we are never one identity but a multitude of identities. All small workgroups consulted with, attended meetings, etc., with other small workgroups. Many resulting recommendations made by the small groups focused on intersectional identities. For example, the LGBTQIA2S+ group made six recommendations specific to LGBTQIA2S+ living in rural areas. The older adult small workgroup made a recommendation specific to older adults that were also LGBTQIA2S+.

The equity workgroup developed a unique toolkit that not only looked at issues of equity but equity specific to suicide prevention. The full report and toolkit are in [Appendix 6](#). Below is a summary of that report.

Equity assessment for Oregon’s Adult Suicide Intervention And Prevention Plan (ASIPP)

The equity assessment for Oregon’s first Adult Suicide Intervention and Prevention Plan (ASIPP) is a toolkit designed for small groups to assess how power in society affects populations identified with the highest rates of suicide. The equity small workgroup sets forth four basic principles about equity as it relates to suicide prevention, providing a tool for assessing each small group’s decision-making, recommendations and resource allocations. It is a set of principles and reflective questions that will help ASIPP small groups to:

1. Move from universal, one-size-fits-all approaches focused on people through the lens of the dominant culture to more contextual approaches, and
2. Recommend policies and practices addressing environments and social conditions that lead to suicide.

The ASIPP equity group, in alignment with the Oregon State Health Improvement Plan (OSHIP), seeks to make Oregon a place where suicide reduction and suicide prevention are achieved for people of all:

- Races
- Ethnicities
- Disabilities
- Genders
- Sexual orientations
- Socioeconomic status
- Nationalities, and
- Geographic locations.

Acknowledging the impact of white supremacy and multiple forms of oppression, the equity assessment was developed with the following core concepts in mind.

Core concepts

- The reasons people die by suicide are complex and rooted in the context of the dominant culture.
- Suicide prevention is about changing our beliefs, values, practices and policies from a person’s lens on suicide to a culturally contextualized lens.
- Disparities strongly and systematically exist for people and groups with certain social identities, group characteristics, or both.
- Social identities are:
 - Gender
 - Race
 - Ethnicity
 - Social class
 - Wealth
 - Educational attainment
 - Religion
 - Sexual orientation
 - Ability
 - Age
 - Language
 - Housing status
 - Immigration status
 - Veteran status
 - Geographical location, and
 - Specific professions, for example, military or service members, police officers or first responders, etc.
- While high-risk populations may be identified as the groups with the largest represented demographic in suicide, it is not the same as identifying groups affected by forms of oppression, including racism, sexism, classism, ageism, ableism, homo- and transphobia and linguicism.
- Most importantly, from an equity lens, we must consider high-risk populations in the context of their social identities and systems that have affected their risk for suicide, rather than a person’s characteristics alone.

The Oregon Suicide Prevention Framework

The Oregon Suicide Prevention Framework is the foundation for both ASIPP and YSIPP ([Youth Suicide Intervention and Prevention Plan](#)). This framework was developed in close collaboration with the University of Oregon Suicide Prevention Lab under the leadership of Dr. John Seeley. It is grounded in the strategies developed by the [National Action Alliance For Suicide Prevention](#) and the Centers for Disease Control 2017 publication [Preventing Suicide: A Technical Package of Policies, Programs and Practice](#). The framework was informed by the [San Diego County Suicide Prevention Action Plan](#) and hundreds of pieces of feedback from partners across Oregon.

How will other suicide prevention coordinators within OHA use the framework to inform their suicide prevention plans?

The coordinated work of suicide prevention within OHA has expanded since legislative investments in 2019. OHA's suicide prevention team currently includes five dedicated coordinators working on youth suicide, adult suicide and Zero Suicide initiatives in health care settings. Each of these coordinators within OHA will use the framework's centering values, foundation, strategic pillars and goals as the baseline for their suicide prevention work. These sections of the framework are the long-term vision for suicide prevention in our state. Each coordinator (adult, youth, and Zero Suicide in health care settings) within OHA will develop specific strategic pathways and corresponding strategic priority initiatives within their scope of work.

How does the framework inform the actual adult suicide prevention plan?

Although both YSIPP and ASIPP share the Oregon Suicide Prevention Framework the specific strategic pathways and strategic priority initiatives are adult focused and outline the state plan for addressing adult suicide. Strategic pathways are not likely to change over the five-year lifespan of this document. The strategic priority initiatives will be adjusted, refined and added to each year in collaboration with an advisory body and informed by ongoing evaluation. Each prioritized yearly initiative will have a work plan with roles and responsibilities assigned, and metrics for evaluation and progress monitoring. The strategic pathways and strategic priority initiatives together make up the five-year ASIPP. The strategic goals, strategic pillars, center, and base are the foundation on which the five-year plan is built.

Levels of interventions and strategies

Universal or primary level — These interventions have broad, community-wide reach. All people in Oregon will receive or benefit from these interventions.

Selected or secondary level — These interventions for specific, targeted sectors or populations to maximize their benefit. These interventions happen in addition to universal interventions.

Indicated or tertiary level — These interventions are given to a very narrow scope of people, sectors, or populations when risk or need for more intervention is indicated. This level includes treatment for suicidal thoughts, care coordination between levels of care, and other interventions and supports. These are in addition to all other levels of intervention.

Strategic pillars

Strategic pillars are the first level of the suicide prevention framework. These closely match the National Strategy for Suicide Prevention (NSSP) with the exception that the NSSP has four pillars with the fourth pillar being Surveillance, Research, and Evaluation. The fourth pillar was removed from Oregon Suicide Prevention Framework and placed at the foundation of the framework intended to represent the concept that the whole framework is supported and grounded in these efforts. The pillars and foundation do not change over time. The strategic pillars in ASIPP 2023-2027 are:

- Healthy and empowered individuals, families and communities — universal interventions defined as activities designed to prevent negative health outcomes in an entire population regardless of the risk status of members of that population
- Clinical and community prevention services — selected intervention defined as activities targeting a group whose members are generally at higher-than-average risk for an adverse health condition regardless of whether individual members of the group display symptoms or have been screened for the condition
- Treatment and support services — indicated interventions defined as activities that target individuals who exhibit symptoms or have been identified by screening or assessment as being at risk for suicidal behavior

Strategic goals

Each pillar has three to four strategic goals embedded within it. These goals are not likely to change over time. They are based on the National Strategy for Suicide Prevention, CDC Preventing Suicide: A Technical Package of Policy, Programs, and Practices Package for suicide prevention and Oregon’s suicide prevention landscape. Without the strategic pathways, they are not easily measured – they are “what” needs to happen. The Strategic Pathways are “how” we will do this work.

Strategic pathways

This is the measurable way we will know we’ve achieved success for the strategic objectives. Each Goal has two to five Strategic Pathways. For example, under the goal of “means reduction”, one pathway is “people of Oregon experiencing behavioral health problems will have access to safe storage of lethal means.” Strategic pathways may change over time, or new strategic pathways may be added over time, based on the success of implementation and the effectiveness of the efforts.

Strategic priority initiatives

These are the project plan for how Oregon will achieve success within each Strategic Pathway. What steps will we take? These will be SMART (specific, measurable, achievable, realistic and timely). These should reflect what’s needed next to meet the moment. These will change over time. Likely they will be edited yearly based on implementation success, new needs and resources. For example, a strategic initiative might be “Every local mental health authority will receive information on the availability of low or no-cost medicine lock boxes and gun safes through the Association of Oregon Community Mental Health Programs (AOCMHP) by Dec. 15, 2021.”

Oregon Suicide Prevention Framework



Policy • Funding • Data • Evaluation

How to use the framework

Preventing suicide cannot be done by one group, government, or sector. OHA believes that the most effective suicide prevention happens in communities at the local level. Statewide infrastructure and equitable access to programs and resources are vital to local efforts. The intention of creating a statewide framework for Oregon is to equip various sectors and groups for the important work of suicide prevention and organize it to maximize collective impact.

Choosing annual strategic priority initiatives:

One death by suicide is one too many. Therefore the work of suicide prevention is never done. The intent of choosing annual strategic priority initiatives is to enable the folks doing the work to focus their time, energy and resources strategically to make meaningful progress.

“We can do anything, but not everything.”

- *David Allen, Author*

Annual strategic priority initiatives are chosen using the following criteria:

- What is working that needs to be sustained?
- What is the data telling us we need to focus on improving?
- What is newly legislatively mandated work that needs to be done?
- What previous legislative initiatives need improvements, monitoring or support?
- What did interested parties and partners identify as important next steps?

Each statewide annual priority initiative chosen will ideally have the following:

- An assigned agency or organization taking the lead
- An assigned lead person within that agency or organization
- A work plan that outlines tasks to complete, target dates for completion, and people responsible for each task
- A metric for evaluating progress toward completion, and
- A metric for evaluating the effectiveness of the initiative

The framework can guide organizing suicide prevention work and choosing annual priorities that align with the needs of their community, government, or organization. OHA encourages local teams to determine their annual strategic priority initiatives. OHA acknowledges that local priorities may not be the same as the statewide annual strategic priority initiatives. Some will likely match and some communities might have readiness or need for a different area of focus within the framework’s pillars, goals and pathways.

Statewide strategic priority initiatives 2023–2027 (to be updated annually)

The ASIPP small workgroups developed a thorough list of over 263 excellent recommendations for reducing suicide and increasing wellness for people in Oregon. The next step in the process was narrowing those recommendations down to a tenable number of initiatives that align with the Oregon Suicide Prevention Framework.

The initiatives emerged in a collaborative, community-rooted process via the following steps:

1. The small workgroups created 263 recommendations.
2. The results of the surveys and focus groups were integrated into the recommendations.
3. Through a series of several large group partner feedback loops and an ease impact analysis, they agreed upon 12 themes and 59 initiatives. Those can be viewed in [Appendix 7](#).
4. The final step was to insert those initiatives into the partner agreed upon Oregon Suicide Prevention Framework. This is the same framework used by YSIPP resulting in a lifespan approach to suicide prevention.
5. All of the selected Initiatives align with:
 - 2012 National Strategy for Suicide Prevention put forth by the National Action Alliance for Suicide Prevention, or
 - Preventing Suicide: A Technical Package of Policy, Programs and Practices published by CDC in 2017.

Framework levels	ASIPP initiatives 2023–2027
1. Healthy & empowered individuals, families and communities	
Integrated & coordinated activities	
“Coordinated activities” Suicide prevention programming is coordinated between tribes, state, county, and local leaders to maximize reach & ensure equitable access for all Oregonians.	Coordinated activities: Increase coordination and collaboration between OHA’s suicide prevention plan and activities and counties’ plan and activities. OHA will serve as a clearinghouse on suicide prevention and provide timely information to counties throughout the state.
“Suicide prevention policies” Organizations and agencies have suicide prevention policies for clients and staff that are known and utilized.	Suicide prevention policies – TBD
“Coordinated organizations” Organizations and agencies are coordinated and understand their role in suicide prevention.	Coordinated organizations: Collaborate with and advise 988 implementations to address suicide prevention, assessment and treatment.
	Coordinated organizations: Increase collaboration and coordination among other prevention activities in categories such as Alcohol and other Drugs, tobacco, gambling, and violence.

Integrated & coordinated activities

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

Voice of lived experience: Positive Connections: Build active relationships through outreach with organizations of all types led by and working with Black, Indigenous, and People of Color to become fully embedded in the community.

“Equipped advisory groups” Advisory groups are well supported, equipped, and function efficiently to make meaningful change.

Equipped advisory groups: An advisory group will be established to monitor and advise the implementation of the ASIPP.

“Resourced coalitions” Regional Suicide Prevention Coalitions are informed and resourced to address their local needs and priorities.

Resourced coalitions: OHA will provide better supports to the statewide suicide prevention councils and coalitions.

Media and communication

“Safe messaging” All Oregonians receive safe messaging about suicide and self-injury.

Safe messaging: OHA will develop media and communication campaigns that promote hope, healing, and wellness and portray suicide as both a public health and behavioral health issue.

Safe messaging: All media campaigns include diversity in terms of ethnicity, sexual orientation, age, and gender expression.

Safe messaging: Any media campaign will portray diversity and media campaigns will include mental health, stigma and suicide for disenfranchised populations.

Safe messaging: OHA will implement rural-specific outreach and communication strategies for creating safety for LGBTQIA2S+ communities in rural and remote areas.

“Promoting wellness” Organizations and agencies routinely and strategically promote wellness, emotional strength, mutual aid examples, and protective factors.

Promoting wellness: Implement a sustained male-specific public awareness campaign that demonstrates an alternative, healthy set of masculine norms.

Promoting wellness: Create media campaigns that promote hope, healing and wellness and portray suicide as both a public health and behavioral health issue.

Promoting wellness: Create media campaigns that combat ageism and actively confront the stigma associated with aging.

Media and communication

“Information dissemination” Suicide Prevention Programming, information and resources are widely advertised and centrally located on one website. Information is kept up to date.

Information dissemination: Increase outreach and communication regarding services and ensure that the information is correct.

Information dissemination: OHA will serve as a clearinghouse for suicide prevention activities and provide timely information to counties throughout the state.

“Informed leaders” Key decision-makers are kept well informed & up to date about suicide activity and prevention efforts (i.e., legislators, Oregon Health Authority leaders, Oregon Department of Education leaders, and county commissioners).

Informed leaders: Each year an ASIPP Annual Report will be created and widely distributed. The report will include outcomes for the previous year and new strategic initiatives for the upcoming year.

Social determinants of health

“Clear links” The link between economic factors and the risk of suicide is highlighted outside of typical suicide prevention work.

Clear links: TBD

“Supporting partners” Suicide prevention advocates and experts support the work of those decreasing health disparities and inequities.

Supporting partners: Increase proactive forms of outreach about mental health in activities such as street outreach.

Coping and connection

“Positive connections” All Oregonians should have access to meaningful places and spaces to experience positive connections & promote mutual aid.

Positive connections: Strategically engage men during major life transitions such as retirement, unemployment, separation, death of a spouse, moving from military to civilian, transitioning from foster care, divorce, or exit from criminal justice systems.

Positive connections: Increase points of care by integrating and coordinating older adult suicide prevention activities across multiple sectors, settings and points of care and connection.

Positive connections: Increase opportunities and programming to reduce social isolation with older adults.

“Coping strategies” All Oregonians understand and have access to what helps them to cope with hardship as an individual and within their community including culturally specific strategies.

Coping strategies: Promote and support programs such as Program to Encourage Active, Rewarding Lives (PEARLS) Options for People for Alternatives to Loneliness and Connection Planning for older adults.

“Support roles” People, family and caregivers understand and feel equipped to fulfill their role and understand their important impact on suicidality.

Support roles: Provide educational opportunities for caregivers of adults experiencing a mental health crisis, suicide thoughts or suicide behaviors.

Framework levels	ASIPP initiatives 2023–2027
2. Clinical & community prevention services	
Frontline & Gatekeeper Training	
<p>“Appropriately trained community” (including the peer support workforce) Oregonians receive the appropriate level of training for suicide prevention (basic awareness, enhanced, and/or advanced) and are retrained appropriately.</p>	<p>Appropriately trained community: Increase suicide prevention training for family and friends of Older Adults and Veterans.</p>
	<p>Appropriately trained community: OHA should promote suicide prevention gatekeeper training for employment sectors with disparate rates of suicide.</p>
	<p>Appropriately trained community: Create recommendations to incorporate mental health promotion and suicide prevention resources and information into regularly scheduled safety meetings for industries that employ high-risk populations.</p>
<p>“Supported training options” Suicide prevention frontline and gatekeeper training is widely available at low or no cost for Oregon communities.</p>	<p>Supported training options: OHA will fund suicide prevention gatekeeper training for employment sectors with disparate rates of suicide.</p>
	<p>Supported training options: OHA will fund and promote suicide prevention training (QPR) as a part of all Crisis Intervention Training statewide.</p>
	<p>Supported training options: Promote and provide Counseling on Access to Lethal Means (CALM) training to gatekeepers and health care professionals.</p>
<p>“Representative trainers” The trainer pool in Oregon for suicide prevention programming represents the cultural and linguistic diversity of the communities in which they train.</p>	<p>Representative trainers: Increase the number of suicide prevention trainers in rural and remote areas.</p>
<p>“Culturally relevant Training” Suicide prevention programming is regularly evaluated and updated to ensure equity, cultural relevance and responsiveness, and linguistic needs are addressed.</p>	<p>Culturally relevant training: OHA will increase gatekeeper training and outreach for black youth ages 18–24 or those who work with black youth ages 18–24.</p>
Means reduction	
<p>“Safe storage access” All Oregonians experiencing a behavioral health crisis should have access to safe storage for medicine and firearms.</p>	<p>Safe storage access: Develop and distribute a list of entities that are willing and able to temporarily hold guns for safe storage.</p>
	<p>Safe storage access: Develop guidelines and requirements for assisted living facilities and older adult communities that allow gun owners to have safe storage facilities in place.</p>

Means reduction

<p>“Means reduction education” Oregon communities are equipped with means reduction strategies and resources.</p>	<p>Means reduction education: Partner with Gun Safety instructors to develop and distribute a suicide prevention module that complements existing firearm safety and Concealed Handgun License education.</p>
	<p>Means reduction education: Counseling on Access to Lethal Means (CALM) is available online at no cost.</p>
	<p>Means reduction education: OHA will increase the availability of Oregon CALM (in-person).</p>
<p>“Means reduction promotion” Means reduction practices are promoted regularly in Oregon and are linked to suicide prevention.</p>	<p>Means reduction promotion: Promote safe storage of medicine and firearms to the general population with a focus on older adults.</p>

Protective programming

<p>“Population-focused programming” People within populations at greater risk for suicide have access to positive and protective programming in their community.</p>	<p>Population-focused programming: OHA will implement peer-delivered services for youth transitioning out of foster programs.</p>
	<p>Population-focused programming: OHA will support the workforce by providing peer programs, especially to industries with high suicide rates or companies that have had suicide clusters.</p>
	<p>Population-focused programming: OHA will implement rural-specific outreach and communication strategies for creating safety for LGBTQIA2S+ communities in rural and remote areas.</p>
	<p>Population-focused programming: OHA will identify and widely distribute available supports for older LGBTQIA2S+ adults and issue recommendations for addressing gaps in services.</p>
	<p>Population-focused programming: Increase proactive forms of outreach by providing drop-in centers.</p>
<p>“Population-focused programming” People within populations at greater risk for suicide have access to positive and protective programming in their community.</p>	<p>Population-focused programming: OHA and people who identify as LGBTQIA2S+ will develop a toolkit/training on how to create services that are safe and inclusive.</p>
	<p>Population-focused programming: OHA will support veteran and veteran family peer-delivered services.</p>

Protective programming

“Available support” Oregonians who need immediate support or crisis intervention have access to it.

Available support: OHA will develop a 24/7 TELEHEALTH CRISIS RESPONSE TEAM designed for and by LGBTQIA2S+.

Available support: Provide respite opportunities for caregivers of adults experiencing mental health crises.

“Protective policies” Adult serving entities have policies and procedures that increase protection against suicide risk (including passive risk, active risk, and crisis intervention) and those policies are implemented.

Protective policies: Improve identification of suicide risk and lethal means assessments targeting older adults, IDD patients, men, and post-partum patients in primary health care settings.

Protective policies: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Protective policies: OHA will encourage health care systems to develop and maintain policies and procedures for completing a suicide risk assessment following a serious (terminal, chronic, life-threatening) physical health diagnosis.

Protective policies: OHA will encourage health care systems to develop and maintain policies and procedures for follow-up care after a suicidal crisis.

Protective policies: Health care systems including emergency departments will have policies that promote smooth transitions of care.

Protective policies: Health care organizations employing Traditional Health Workers (including Peer Support Specialists) will have clear policies that include peer supervision and support for Traditional Health Workers (including Peer Support Specialists) to prevent and mitigate vicarious/secondary trauma, compassion fatigue and burnout.

Protective policies: Develop guidelines and requirements for assisted living facilities and older adult communities that allow gun ownership to have safe storage facilities in place.

Protective policies: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicide.

Framework levels	ASIPP initiatives 2023–2027
<p>3. Treatment and support services — OHA staff will issue a crosswalk between the current Zero Suicide grant objectives and the Oregon Suicide Prevention Framework.</p>	
<p>Health care capacity</p>	
<p>“Accessible services” Oregonians can access the appropriate services on the continuum of behavioral health care at the right time for the right amount of time, regardless of health insurance.</p>	<p>Accessible services: Increase proactive forms of outreach which may include mobile crisis, home-based care, street outreach, drop-in centers, and Program to Encourage Active, Rewarding Lives (PEARLS) programs.</p> <p>Accessible services: Ensure that all behavioral health services are culturally and linguistically appropriate for Black, Indigenous, People of Color, American Indian/Alaska Native, and LGBTQIA2S+ people.</p> <p>Accessible services: OHA will support veteran and veteran family peer-delivered services.</p> <p>Accessible services: OHA will support the implementation of Peer Delivered services for LGBTQIA2S+ adults who are experiencing suicidal thoughts or behaviors with a target population of those experiencing housing insecurities or financial distress.</p> <p>Accessible services: Increase proactive care by focusing on home-based mental health services.</p> <p>Accessible services: Increase availability of culturally and linguistically appropriate and relevant approaches to treatment.</p>
<p>“Right-sized workforce” There is adequate behavioral health care to meet the need.</p>	<p>Right-sized workforce: Support debt forgiveness programs for health care providers serving in the veteran community.</p> <p>Right-sized workforce: Attract and retain behavioral health care providers in rural areas by offering scholarship field placements, living stipends, loan repayment, educational opportunities, etc.</p> <p>Right-sized workforce: Actively support diverse behavioral workforce professionals by offering internships or mentorships for historically excluded populations.</p>

Health care coordination	
<p>“Coordinated transitions” All Oregonians who access health care for behavioral health crises or suicidal ideation receive coordinated care in transitions between levels of care.</p>	<p>Coordinated transitions: Support HB3090 and 3091 efforts regarding caring contact billing codes.</p>
	<p>Coordinated transitions: Identify infrastructure needs for mobile crisis and stabilization services statewide.</p>
	<p>Coordinated transitions: Develop caring contact billing codes and disseminate information statewide.</p>
<p>“Appropriate communication” There is a formal communication between health care providers, behavioral health care providers</p>	<p>Appropriate communication: TBD</p>
<p>“Substance use services” substance use disorder and Mental Health services are integrated when possible and coordinated when not fully integrated.</p>	<p>Substance use services: OHA suicide prevention will increase collaboration and coordination with entities that provide substance use disorder treatment and other behavioral health treatment activities.</p>
<p>“Integrated care” Oregonians will receive integrated care between primary care and behavioral health care</p>	<p>Integrated care: TBD</p>
Appropriate treatment & management of suicidality	
<p>“Equipped and well workforce” The health care workforce is well-equipped to support Oregonians with suicidality (including understanding variations of risk and protective factors and current risk and protective conditions).</p>	<p>Equipped workforce: OHA will ensure that behavioral health providers, certified peer support specialists and traditional health workers have access to and receive low or no cost role appropriate education around suicide prevention, intervention, treatment and postvention.</p>
	<p>Equipped workforce: OHA and LGBTQIA2S+ community partners will develop a toolkit/training on how to create services that are more inclusive.</p>
	<p>Equipped workforce: All physicians and other medical professionals will be required to complete continuing education in suicide prevention.</p>
	<p>Equipped workforce: Increase Safety Planning training among health care professionals.</p>
	<p>Equipped workforce: Health care organizations employing Traditional Health Workers (including Peer Support Specialists) will have clear policies that include peer supervision and support for Traditional Health Workers (including Peer Support Specialists) to prevent and mitigate vicarious/secondary trauma, compassion fatigue and burnout.</p>

Appropriate treatment & management of suicidality	
<p>“Equipped and well workforce” The health care workforce is well-equipped to support Oregonians with suicidality (including understanding variations of risk and protective factors and current risk and protective conditions).</p>	<p>Equipped workforce: Increase availability of culturally and linguistically appropriate and relevant approaches to treatment.</p>
<p>“Voice and choice” Oregonians have a voice and choice in treatment.</p>	<p>Voice and choice: Encourage health care and behavioral health care providers to utilize the least restrictive options when providing services to someone who is having a suicidal crisis.</p>
<p>“Whole-person approaches” Whole-person approaches are used to enhance treatment for suicide and to increase the effectiveness of management of long-term symptoms.</p>	<p>Whole-person approaches: Support and fund behavioral health care services in settings that are non-traditional.</p>
	<p>Whole-person approaches: Support and fund culturally specific treatments such as sweat lodges and Eastern medicine.</p>
<p>“Equipped & resourced communities” Oregon communities are equipped to provide trauma-informed postvention care for those impacted by a suicide death.</p>	<p>Equipped and resourced communities: Increase culturally responsive postvention services across Oregon with a focus on Black, Indigenous, and People of Color, American Indian/Alaska Native people, people who identify as Lesbian, Gay, Bisexual, Transgender, and Queer+, veterans, and older adult populations.</p>
	<p>Equipped and resourced communities: OHA will support Connect: Postvention training by providing low or no-cost access to Train-the-Trainer events, statewide coordination for local training needs, evaluation support and limited course support.</p>
<p>“Postvention response leads” Postvention Response Leads (PRLs) and teams are supported and equipped to fulfill their legislative mandates.</p>	<p>TBD</p>
<p>“Fatality data” Suicide fatality data is gathered, analyzed, and used for system improvements and prevention efforts.</p>	<p>Fatality data: OHA to encourage statewide best practices in suicide death investigation for Medical Examiners and Medical-Legal Death Investigators to collect more specific and inclusive data.</p>
	<p>Fatality data: Increase the number of psychological autopsies performed.</p>

Framework levels	ASIPP initiatives 2023–2027
4. Foundations and centering lenses	
Data and research	Data needs: Partner with pertinent organizations to collect data to better understand the impact of illness/disabilities on mental health, including suicide.
	Data needs: OHA will contract with a university to conduct research to implement the ASIPP
	Data needs: Public Health Division Suicide-related Surveillance Report is released monthly by OHA and includes emergency department data, urgent care centers data, calls to poison control and calls to LifeLine.
Evaluation	Evaluation: OHA will monitor and report patient satisfaction with mental health and crisis response services and work to achieve consistent and continuous empathic and effective mental health care.
	Evaluation: OHA will design an evaluation plan, including a contract for services, to monitor ASIPP progress.
Policy needs and gaps	Policy needs and gaps: OHA will develop policies, procedures, and requirements (including appropriate billing codes) that promote Medicaid reimbursement of outreach, caring contacts, follow-up services, non-traditional therapies, therapy in non-traditional places, and peer-delivered services.
Funding needs	Funding needs: OHA's Suicide Prevention team will maintain a list of funding needs related to ASIPP strategic initiatives.
	Funding needs: OHA's Suicide Prevention team will propose a Policy Options Package to management in February 2022 for consideration to be included in OHA's 2023/2025 budget to address suicide prevention funding needs. The POP will include requests for both the ASIPP and YSIPP.
Equity Principles of Equity are promoted throughout many other Goals and Pathways	Equity: Promote programming, partnerships, and funding for historically underserved communities and higher-risk populations (e.g. people who are, rural, Latinx, Tribal, LGBTQIA2S+, young adults, people with schizophrenia, people with substance use disorders, people with depression, and people who identify as male).
	Equity: Promote a system-wide use of an anti-racist, integrated public health framework to address systemic inequality by decreasing barriers to culturally responsive health care and using culturally adaptive assessment tools.
	Equity: Ensure that all behavioral health services and outreach services are culturally and linguistically appropriate for Black, Indigenous and People of Color and American Indian/ Alaska Native populations and the LGBTQIA2S+ populations.
	Equity: The ASIPP Equity Toolkit will be revised and widely distributed to Local Public Health Programs and Local Mental Health Programs, 988 centers, and Measure 110 Centers.

Framework levels	ASIPP initiatives 2023–2027
4. Foundations and centering lenses	
<p>Lived experience voice Trauma-informed practices are promoted throughout this document The Voices of lived experience are promoted throughout many other goals and pathways</p>	
Collaboration	

Year One (2023–2024) will be largely unfunded. Therefore, much of the first year will focus on funding acquisition and creating the infrastructure to implement, monitor and evaluate the plan years 2024–2027. Outcome and process measures have yet to be developed. However, they will be developed once the ASIPP is funded allowing these services to be contracted.

Year One (23–24) ASIPP initiatives

Framework levels	ASIPP initiatives 2023–2024
1. Healthy & empowered individuals, families and communities	
Integrated & coordinated activities	
<p>“Coordinated activities” Suicide prevention programming is coordinated between tribes, state, county, and local leaders to maximize reach & ensure equitable access for all Oregonians.</p>	<p>Coordinated activities: Increase coordination and collaboration between OHA’s suicide prevention plan and activities and counties’ plans and activities. OHA will serve as a clearinghouse on suicide prevention and provide timely information to counties throughout the state.</p>
<p>“Coordinated organizations” Organizations and agencies are coordinated and understand their role in suicide prevention.</p>	<p>Coordinate organizations: Collaborate with and advise 988 implementations to address suicide prevention, assessment, and treatment.</p>
	<p>Coordinated organizations: Increase collaboration and coordination among other prevention activities in categories such as Alcohol and other Drugs, tobacco, gambling, and violence.</p>
<p>“Equipped Advisory Groups” Advisory groups are well supported, equipped, and function efficiently to make meaningful change.</p>	<p>Equipped advisory groups: An advisory group will be established to monitor and advise the implementation of the ASIPP.</p>
<p>“Resourced coalitions” Regional Suicide Prevention Coalitions are informed and resourced to address their local needs and priorities.</p>	<p>Resourced coalitions: OHA will provide better supports to the statewide suicide prevention councils and coalitions.</p>

Media and communication

“Informed leaders” Key decision-makers are kept well informed & up to date about suicide activity and prevention efforts (i.e., legislators, Oregon Health Authority leaders, Oregon Department of Education leaders, and county commissioners).

Informed leaders: Each year an ASIPP Annual Report will be created and widely distributed. The report will include outcomes for the previous year and new strategic initiatives for the upcoming year.

Coping and connection

“Coping strategies” All Oregonians understand and have access to what helps them to cope with hardship as an individual and within their community including culturally specific strategies.

Coping strategies: Promote and support programs such as Program to Encourage Active, Rewarding Lives (PEARLS) OPAL for older adults.

Framework levels

ASIPP initiatives 2023–2024

2. Clinical & community prevention services

Frontline & Gatekeeper Training

“Appropriately trained community” (including the peer support workforce) Oregonians receive the appropriate level of training for suicide prevention (basic awareness, enhanced, and/or advanced) and are retrained appropriately.

Appropriately trained community: Increase suicide prevention training for family and friends of Older Adults and Veterans.

“Supported training options” Suicide prevention frontline and gatekeeper training is widely available at low or no cost for Oregon communities.

Supported training options: Promote and provide Counseling on Access to Lethal Means (CALM) training to gatekeepers and health care professionals.

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

Representative trainers: Increase the number of suicide prevention trainers in rural and remote areas.

Framework levels

ASIPP initiatives 2023–2024

3. Treatment and support services — OHA staff will issue a crosswalk between the current Zero Suicide grant objectives and the Oregon Suicide Prevention Framework.

Health care capacity

“Accessible services” Oregonians can access the appropriate services on the continuum of behavioral health care at the right time for the right amount of time, regardless of health insurance.

Accessible services: Increase proactive forms of outreach which may include Mobile crisis, Home-based care, Street outreach, Drop-in centers, and Program to Encourage Active, Rewarding Lives (PEARLS) programs.

Health care capacity

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

Coordinated transitions: Support HB 3090 3091 efforts

Framework levels

ASIPP initiatives 2023–2024

4. Foundations and centering lenses

Data and research

Data needs: Partner with pertinent organizations to collect data to better understand the impact of illness/disabilities on mental health, including suicide.

Data needs: OHA will contract with a university to conduct research to implement the ASIPP.

Data needs: Public Health Division Suicide-related Surveillance Report is released monthly by OHA and includes emergency department data, urgent care centers data, calls to poison control and calls to Lines for Life.

Evaluation

Evaluation: OHA will design an evaluation plan, including a contract for services, to monitor ASIPP progress.

Funding needs

Funding needs: OHA's Suicide Prevention team will maintain a list of funding needs related to ASIPP strategic initiatives.

Funding needs: OHA's Suicide Prevention team will propose a Policy Options Package to management in February 2022 for consideration to be included in OHA's 2023/2025 budget to address suicide prevention funding needs. The POP will include requests for both the ASIPP and YSIPP.

Equity

Principles of equity are promoted throughout many other Goals and Pathways

Trauma-Informed Practices are promoted throughout this document

Equity: The ASIPP Equity Toolkit will be revised and widely distributed to Local Public Health Programs and Local Mental Health Programs, 988 Centers, and Measure 110 Centers.

Lived experience voice

The Voices of Lived Experience are promoted throughout many other Goals and Pathways

Collaboration

The collaboration is promoted throughout many other Goals and Pathways

Grounded in data: Statistics on adult suicide in Oregon

We can't look to reduce the rate of suicide attempts or deaths without first understanding the scope of the problem. The following data is to help quantify what suicide and suicidal ideation look like in Oregon.

Data used for suicide surveillance

OHA identified suicide prevention as one of its top priority issues. Suicide is a complex behavior and is associated with many factors, including:

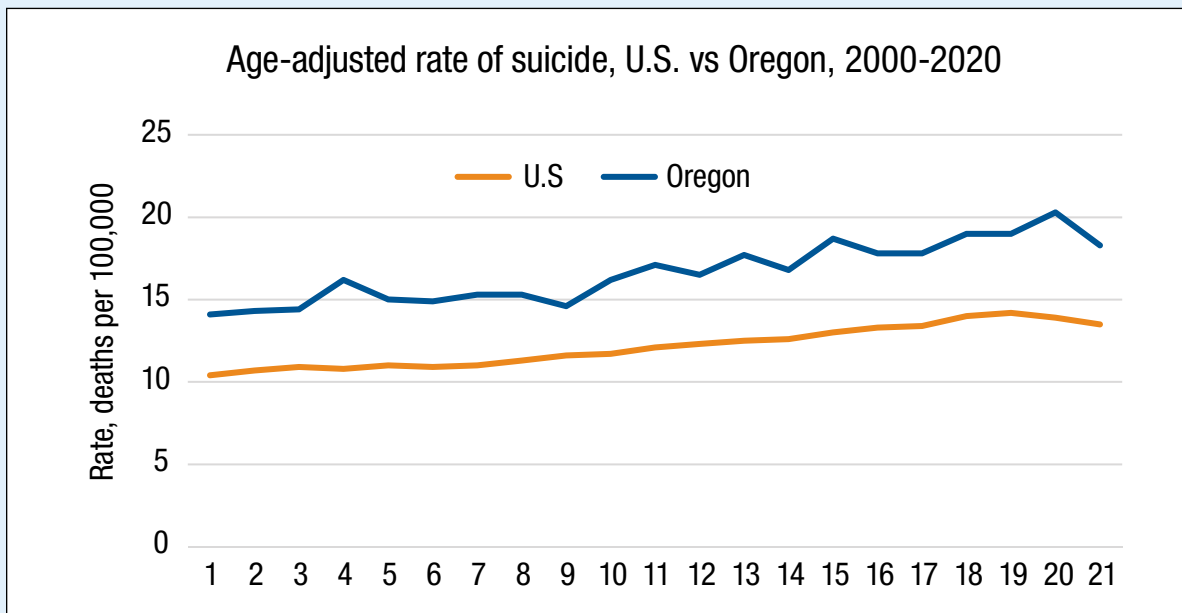
- Mental health
- Substance use
- Physical health
- Relationships
- Life events
- Isolation
- Social connectivity
- Stress
- Other environmental and societal conditions
- Adverse childhood experiences, and
- Lack of access to mental and behavioral health services

To monitor and track suicide as well as some risk and protective factors that lead to or prevent suicide, Oregon uses various existing administrative data sets, surveys and active surveillance efforts. While data tell us much, it is imperfect. For more information about data limitations for suicide surveillance please see [Appendix 8](#) and use the [Injury and Violence Prevention Program \(IVPP\) Data Glossary](#).

Statistics on suicide in Oregon

Figure 2 compares the age-adjusted rate of suicide between the national rate and the rate in Oregon. In 2020, the national age-adjusted rate of suicide was 13.5 per 100,000, whereas the age-adjusted rate of suicide in Oregon for the same period was 18.3 per 100,000 (CDC). This makes the age-adjusted rate of suicide in Oregon 36% greater than the national rate. Oregon's rate has stayed well above the national rate since 2000. Oregon lost 835 persons to suicide in 2020 (Oregon Public Health Assessment Tool (OPHAT)). Despite some predictions that suicide would skyrocket during the COVID-19 crisis, this did not happen in Oregon. The suicide rate decreased by nearly 10%, a statistically significant decrease in the age-adjusted rate of suicide between 2019-2020 (Ehman, et al., 2022).

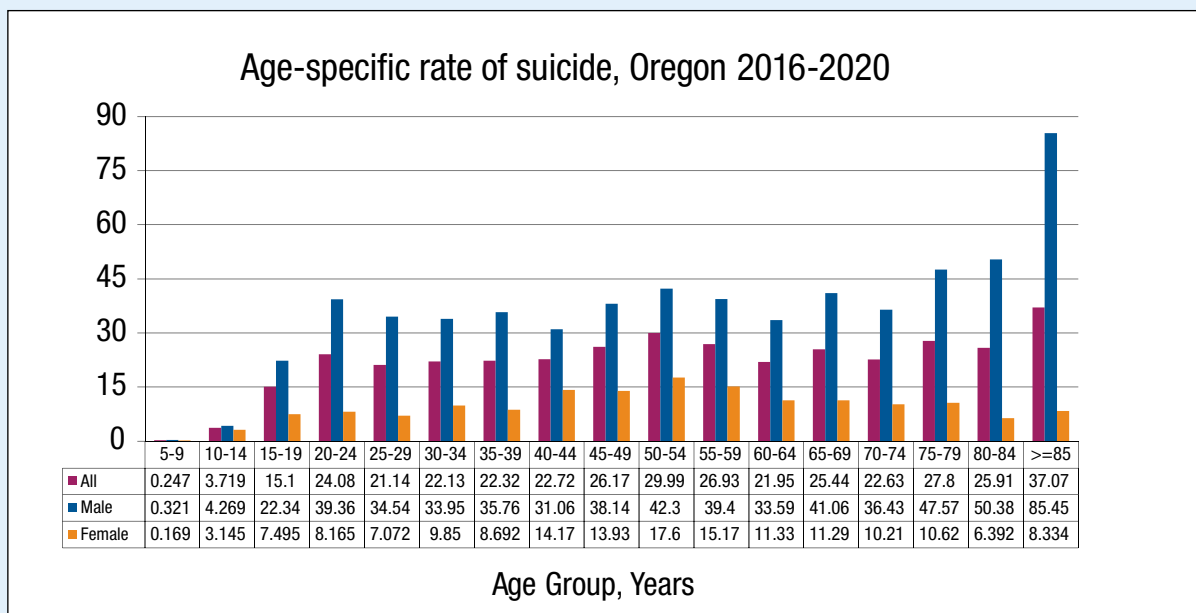
Figure 2. Number of deaths by suicide per 100,000 people adjusted for age from 2000-2020 for Oregonians compared to the entire United States population.



N=493 (2000) N=685 (2010) N=833 (2020)
 Source: CDC WISQARs

Figure 3 shows the age-adjusted rates of suicide in Oregon by sex and age between 2016–2020. The rates of suicide for males are higher than for females throughout the lifespan with older males (75+) having the highest rates of suicide.

Figure 3. Number of deaths by suicide per 100,000 population stratified by age bracket and sex from 2016–2020.



Source: CDC WISQARs

Figure 4 shows the age-adjusted rates of suicide in Oregon by race, ethnicity, and gender between 2016–2020. Non-Hispanic white and non-Hispanic American Indians and Alaska Natives have the highest suicide rates.

Figure 4. Number of deaths by suicide per 100,000 population stratified by race, ethnicity and sex from 2016–2020.

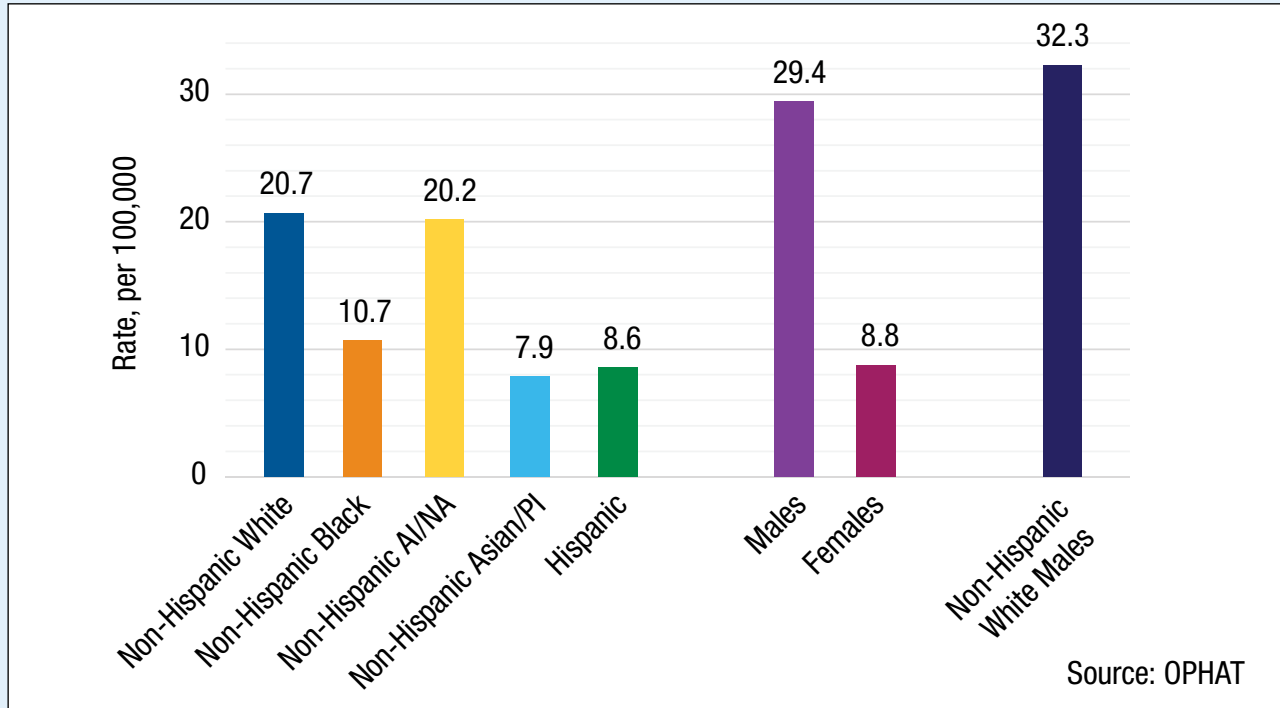


Figure 5 shows the stratification of methods across all ages and by sex from 2016–2020. Firearms, suffocation or hanging, and poisoning were the most often observed mechanisms for suicide death.

Figure 5. Occurrence of methods across all ages and by sex from 2015–2020.

2015–2020: Methods of Suicide in Oregon (all ages)

Mechanism of injury	All		Males		Females	
	Percent	Count	Percent	Count	Percent	Count
Firearm	52%	2223	58%	1911	31%	312
Hanging or suffocation	26%	1108	25%	825	28%	282
Poisoning	13%	561	8%	266	30%	293
Fall	3%	126	3%	88	4%	38
Motor vehicle or train	2%	76	2%	58	2%	22
Sharp instrument	2%	80	2%	60	2%	16
*Other or unknown	2%	88	2%	59	3%	30
Total	100%	4263	100%	3267	100%	993

*Other Includes: Fire or burn and drowning

Source: ORVDRS

Circumstances surrounding suicide incidents

Oregon collects circumstances surrounding suicide incidents reported as the percentage of suicides that had a certain circumstance. The most recent report is from 2016–2020 and has three age data points:

- 18–24
- 25–54, and
- 55+

Across all ages, a high percentage reported having a current depressed mood or diagnosed underlying mental health condition. The full chart is in [Appendix 9](#).

Suicidal thoughts and behaviors

Suicide deaths tell only part of the picture. Suicide typically begins with unbearable psychological pain, often precipitated by loss, or losses with little hope of recovering from those losses which can lead to thoughts about ending one’s life ([Ducasse et., al 2017](#)). The similarities and differences between those who do and those who do not experience suicidal ideation are complicated and multifaceted. During 2017–2019, among adults 18 and older in Oregon, when asked about “serious thoughts of suicide within the past year” 5.9% endorsed this item, which is higher than the national average of 4.5% ([SAMHSA](#)). The overwhelming majority of people who think about suicide never attempt or die by suicide. [CDC’s 2022 Surveillance Summaries report](#) states that 4.3% of the adult United States population have experienced suicidal thoughts within the past year and 1.3 % made a plan with .06% attempting. Although the majority of people who die by suicide think about it before, the majority of people who experience suicidal ideation never die by suicide. However, it is often difficult to discern the differences between those that think about suicide and do not make an attempt and those who think about suicide and make an attempt. That is why it’s important to take all thoughts of suicide seriously.

According to the [American Foundation for Suicide Prevention \(AFSP\)](#) it is estimated that 1.38 million Americans attempted suicide in 2019, which is a rate of 420 per 100,000. Females are much more likely to think about suicide and make a suicide attempt (three times more likely). However, men are more likely (four times more likely) to die of suicide. Although the majority of those who make a suicide attempt do not end up dying by suicide, and most never repeat an attempt, 5.4% of previous attempters die by suicide ([Bostwick et. al, 2016](#)), which is why having made a suicide attempt in one’s lifetime is a risk factor for suicide.

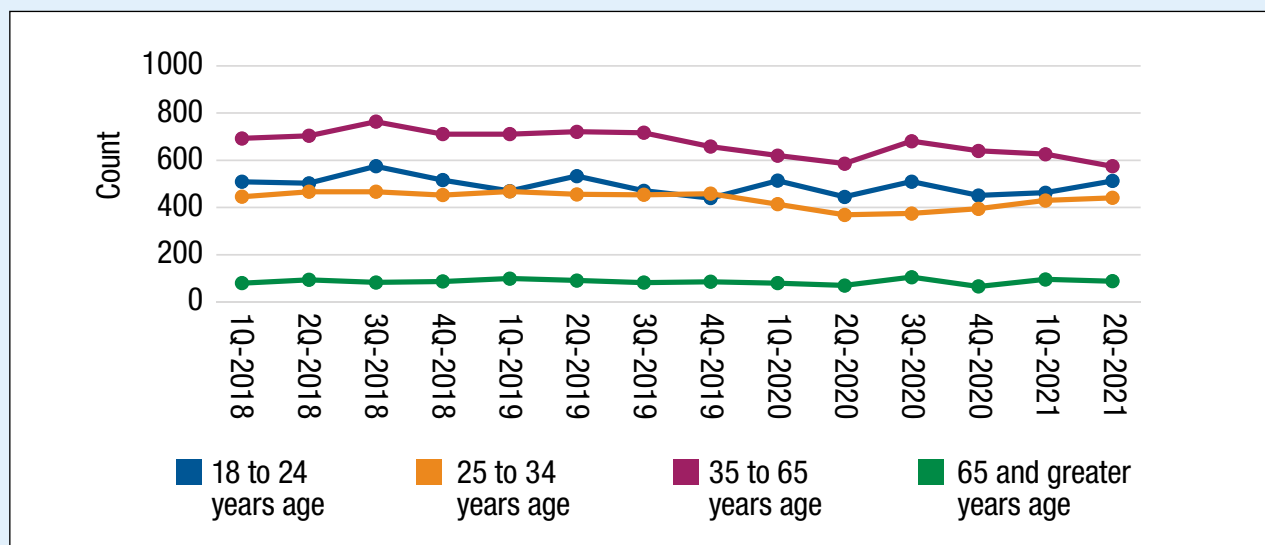
In addition to putting one at greater risk for suicide death, making a suicide attempt can create immediate and long-term difficulties such as job loss, financial burden, emotional turmoil for loved ones and even permanent disability. Suicide prevention should be more than preventing death, but helping others thinking about suicide to live lives worth living. [Bryan \(2022\)](#), a clinician and suicide prevention researcher, has suggested the following strategies that could prevent suicide by improving the well-being and quality of life:

1. Enhance financial security.
2. Preserve the health and attractiveness of our natural environments making it easier for those to enjoy and appreciate nature’s beauty.
3. Expand access to health care.
4. Improve affordability of health care.
5. Design neighborhoods and communities that facilitate social connections.
6. Support and encourage the expression of gratitude and appreciation within social groups.

For more about the relationship between suicidal ideation, behavior and death, see [Appendix 10](#).

Oregon does have limited data points that shed some light on ideation and attempts. However, it's important to remember that ideation and attempts are likely under-reported. The following figures show data from the Oregon Association of Hospital and Health Systems (OAHS) and Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) which together help create a fuller picture of suicide ideation and attempts.

Figure 6. Number of self-harm, suicide ideation, or suicide attempt emergency department (ED) and hospitalization admissions by age bracket from Quarter 1 of 2018 – Quarter 2 of 2021.

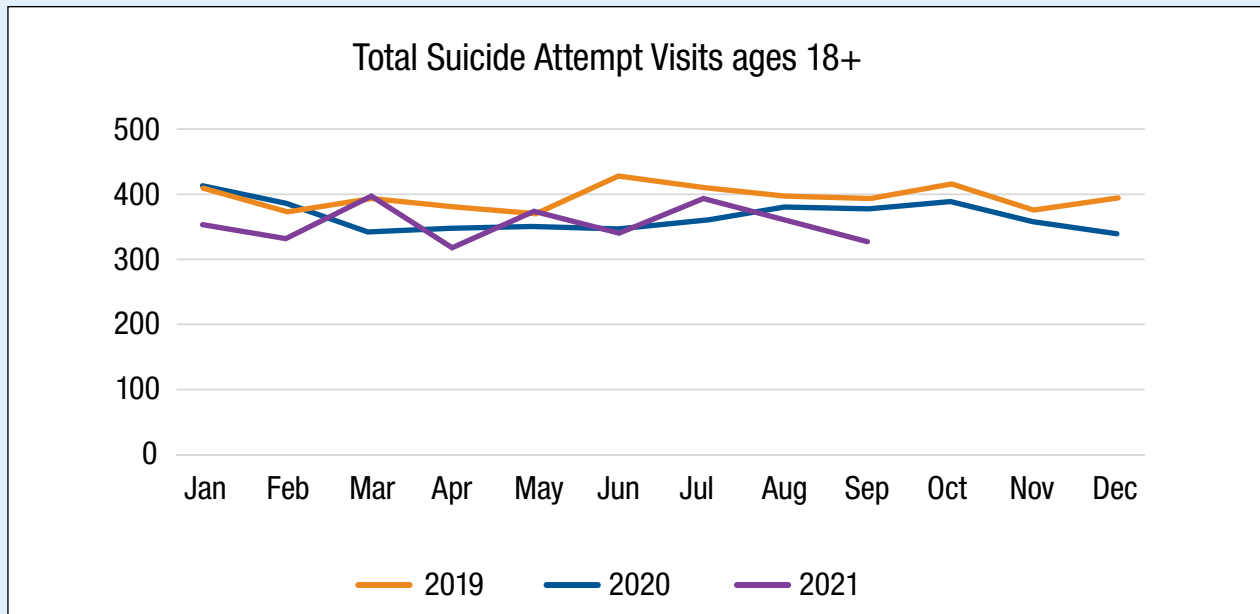


Source: Oregon Association of Hospital and Health Systems (OAHS)

From 2018 through June 2021, there was little variation in the overall emergency department and hospital admissions related to self-harm, suicide ideation and suicide attempt per age bracket (Figure 6). It is important to know the age groups are not uniform in the ranges covered above. The overall Oregon population within the age groups is different with a larger age range having a greater population and potentially more potential emergency department and hospitalization visits. With 18–24 years old, only a seven-year range is covered yet the overall counts are not much less compared to the age group 35–64 years old (approximately 30-year range) indicating higher rates for the population. This is also similar for the age group 25–34 years old (only a 10-year range). Population rates were not appropriate for this type of graph since there was a priority to report by quarter due to COVID-19 instead of yearly rates. An admission rate could be used as a denominator for calculating rates, especially during the COVID-19 years Quarter 2 of 2020 going forward due to a significant difference in the emergency department and hospitalization rates in previous years.

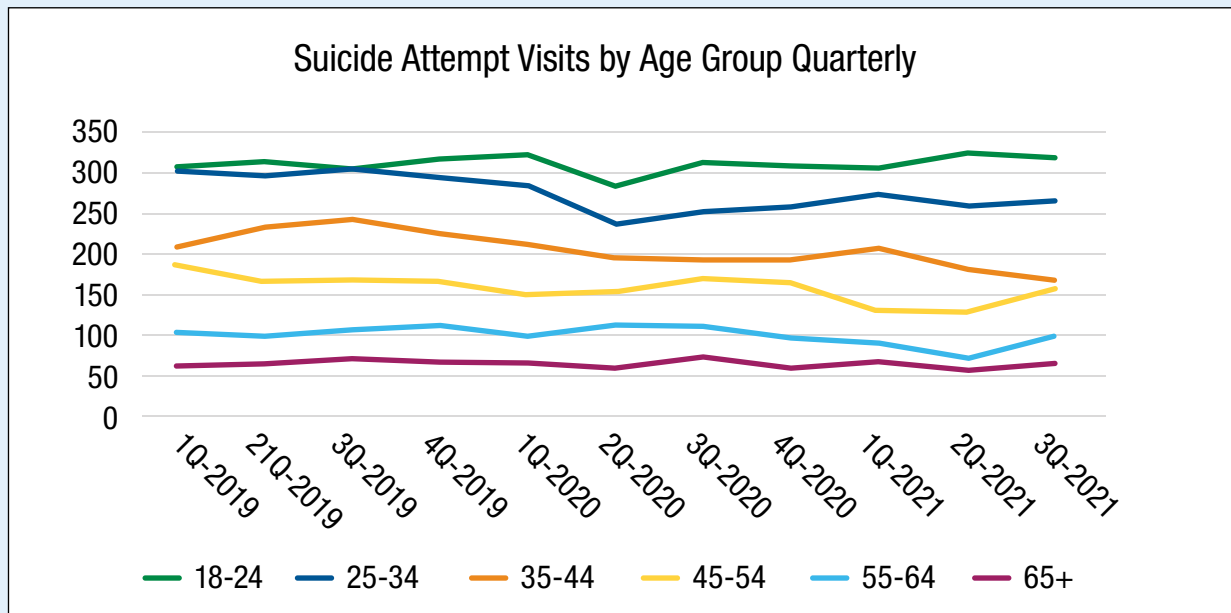
Emergency departments and participating urgent care centers in Oregon share de-identified information on visits to monitor health-related activity including suicide attempts. ESSENCE captures this data in real time and reports it multiple times per day to approved entities. The number of suicide attempt visits in adults 18 and older is similar from 2019–2021 (Figure 7).

Figure 7. Total number of suicide attempt emergency department and urgent care visits for adults from 2019-2021 by month.



Source: ESSENCE 2019-2021

Figure 8. Total number of suicide attempt ED and UCC visits for adults by age bracket from Quarter 1 of 2019 – Quarter 3 of 2021.

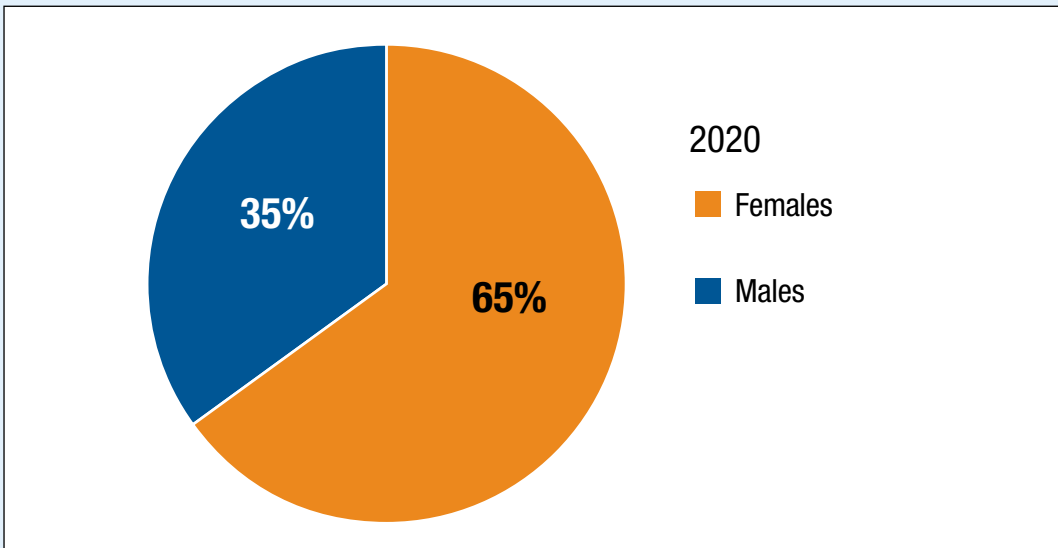


Source: ESSENCE 2019-2021

Adults ages 18–24 have the highest number of suicide attempt visits, while adults ages 65 and older have the lowest (Figure 8). Figure 8 represents counts and not rates. Therefore, it's not possible to draw an exact comparison of rates of suicide attempts from this data.

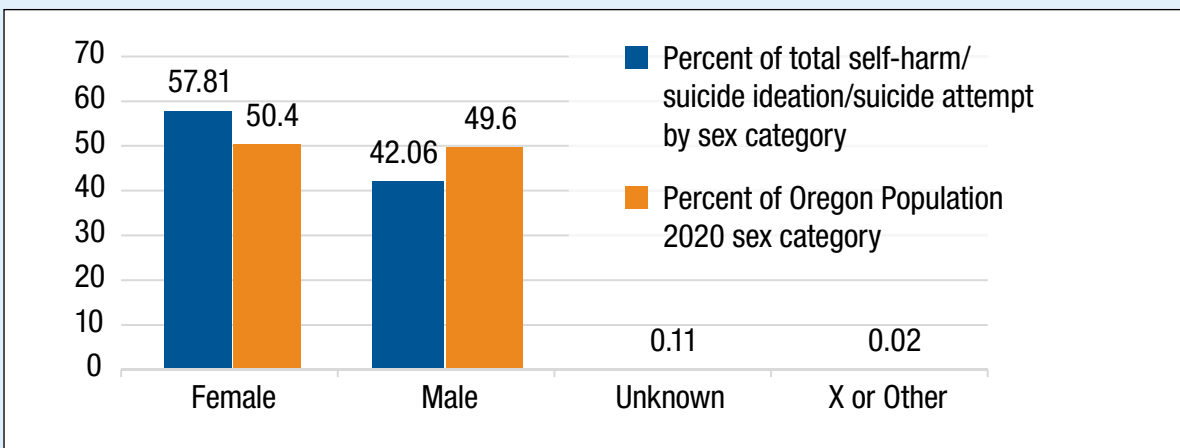
As is also true nationally, in Oregon females are much more likely to attempt suicide (Figure 9); whereas males are much more likely to die by suicide. Finalized data from 2019 and preliminary data from 2021 show nearly the same proportion of suicide attempts by sex as finalized 2020 data.

Figure 9. Proportion of suicide attempt ED and UCC visits by sex in 2020.



Source: ESSENCE 2020

Figure 10. Percent of total self-harm, suicide ideation, suicide attempt and percent of the population by sex from 2018-June 2021.



Source: Oregon Association of Hospital and Health Systems (OAHHS) & 2020 Census

Overall, females show a higher percentage of self-harm, suicide ideation or suicide attempt compared to their percentage of the population in the Oregon 2020 census (Figure 10). Other categories of unknown and X or other represent those not necessarily female or male (total of 32) which most likely experience health and societal inequities and systemic pressures of not identifying as female or male. OHA highly suspects many who identify as transgender reported within male and female categories, leading to more of an often under-reported population. More efforts are needed to better report and represent groups other than male and female groups.

Passive suicidal ideation and behaviors:

Passive suicidal ideation is defined as having thoughts that life is not worth living or believing that one is better off dead without any conscious plan of actively killing oneself. Passive suicidal ideation can lead to passive suicidal behaviors such as:

- Misuse of alcohol and drugs
- Engaging in high-risk behavior
- Not taking prescribed medications for life-threatening conditions
- Not wearing a seatbelt or helmet
- Smoking, and
- Refusing to eat.

To be clear, not everyone who engages in the above behaviors is experiencing a passive wish to die. There are many reasons for the above behaviors. However, a study comparing people with active suicidal ideation and a passive desire for death found that the highest rate of lifetime suicide attempts (25.9%), was found in the group that experienced both active and passive suicidal ideation compared to either active or passive alone ([Baca-Garcia, et al., 2011](#)).

Risk and protective factors

There are many risks and protective factors that could increase or decrease the likelihood that someone may attempt to take their own life. [CDC](#) lists the following as risk factors and protective factors for the general adult population:

- Previous suicide attempt
- Mental illness, such as depression
- Social isolation
- Criminal problems
- Financial problems
- Impulsive or aggressive tendencies
- Job problems or loss
- Legal problems
- Serious illness
- Substance use disorder
- Child abuse and neglect
- Bullying
- Family history of suicide
- Relationship problems such as a breakup, violence or loss
- Being a victim of sexual violence
- Barriers to health care
- Cultural and religious beliefs such as the belief that suicide is a noble resolution of a personal problem
- Suicide cluster in the community
- The stigma associated with mental illness or help-seeking
- Easy access to lethal means among people at risk (for example, firearms), and
- Unsafe media portrayals of suicide

Protective factors

- Coping and problem-solving skills
- Cultural and religious beliefs that discourage suicide
- Connections to friends, family and community support
- Supportive relationships with care providers
- Availability of physical and mental health care, and
- Limited access to lethal means among people at risk

For more information about risk assessments and risk and protective factors, see [Appendix 11](#). A summary of risk and protective factors will be reviewed for each of the 10 priority populations, making note of when factors are unique for that specific population.

Section 2: Results of focus groups, surveys and small workgroups

Brief results of the focus groups

In addition to the large partner group and the 13 small workgroups, seven focus groups were held across the state. The full focus group report is in [Appendix 3](#). The seven focus groups were chosen by the large partner group based on populations that had disparate rates of suicide. The seven groups were:

- Attempt survivors
- Chronic illness and conditions
- Experience of houselessness
- LGBTQIA2S+
- Older adults
- Rural
- Veterans

The feedback and insight of these focus groups are woven throughout this document. Below are key recommendations from the focus groups.

1. Provide peer-run drop-in centers that have short-term housing and provide safety (from others and suicide). Also, provide respite for persons of concern without them having to be hospitalized or incarcerated.
2. Fund more mobile crisis teams such as the Portland Street Response and CAHOOTS models.
3. Provide respite care for caregivers and family members.
4. Increase the visibility of resources. Compile and centralize resources so information is consistent. Fund navigation assistance. Make accessing services “clear and easy.”
5. Conduct outreach to isolated seniors and those experiencing houselessness.
6. Provide transportation, especially to older adults and rural residents.
7. Address co-occurring substance use, opioid use, gambling addictions, etc. with accessible treatment services.
8. Train police and first responders.

Key takeaways of the focus groups:

Key takeaways were reiterated across multiple groups. To clarify, provider education, for example, is not listed, because one group (LGBTQIA2S+) discussed how even educated providers did not deliver acceptable care.

1. Everyone must be attuned to warning signs

The ability to identify warning signs was seen as a broad community responsibility. There was dismay at how often warning signs (in themselves and others) were disregarded, underestimated or missed. It was not OK to simply identify warning signs – it was important there was a follow-up plan and whoever helped to identify a warning sign continued to check in and follow up over time. Smaller, grassroots, and community organizations were seen as important and potential hosts for training such as Mental Health First Aid (MHFA) and Applied Suicide Intervention Skills Training (ASIST).

2. Implement changes that create intergenerational community connections

LGBTQIA2S+, older adults, and rural residents thought prevention, not just programs, but also urban, park and housing design would have the most effect and the greatest reach when young people (through school programming such as mentoring or community events) worked collaboratively with adult and older adult community members. Achieving the productive intergenerational dialogue envisioned may require training, facilitation and practice.

3. Raise awareness; improve visibility of services and resources; including those who use them

Participants commented they felt invisible and not heard – both as a member of their identity group and as a person with a mental health concern – it was important to see oneself represented, included and publicly visible in communications and improvement efforts. Another phrase a veteran used was “being put on a back burner.” When stigma and stereotypes did arise as public perceptions important to combat, participants prioritized a need for prominent communications that were accessible, understandable, educational and consistent (same message from all sources) for those seeking mental health assistance either for themselves or a friend or family member. Participants felt this information would be best communicated person-to-person by a peer who could help navigate, problem-solve and see them as people. Finally, many participants benefited from a psycho-educational understanding of their mental health condition. Many felt this understanding was one way to develop the “radical acceptance” they felt recovery required.

4. Expand the current behavioral health workforce with peer support specialists

Peer support services were consistently identified in all groups as most important for suicide prevention including crisis support, hospital visits, recovery, relapse prevention (including having a peer support specialist you are working with listed in your safety plan to call in a future crisis), and navigation or advocacy. Peers were also seen as providing ongoing group support to each other and helpful roles for those in recovery or managing chronic mental health concerns (it works “two-ways”) or both. The groups recommended that:

- The number of peer support specialists increase
- Services are easy to access at any point and free or covered by insurance, and
- Roles be defined to be protective of workers (flexible schedules, for example).

OHA should report on the number of active peers and their caseloads by geographic region to monitor for increased availability of their services.

The LGBTQIA2S+ and veterans’ groups espoused more informal, typically self-funded models of community-driven mutual aid as compared to formal peer specialists. Older adults preferred the term “mentor.” Peer support likely takes distinctly different forms to serve different communities.

5. Reward providers who stay in their roles, especially those working in rural areas

Nearly all groups mentioned provider burnout, turnover and subsequent care transitions as a problem. However, the rural group suggested providers be rewarded for staying in place and that these rewards should include both direct incentives (competitive salaries and flexible schedules) as well as indirect community-wide enhancements (more livable cities, better schools, improved green spaces) that made living in a location desirable. Such enhancements would have mental health benefits for all.

6. Expand community mobile crisis response teams and drop-in centers staffed by peers and mental health providers as alternatives to 911 and emergency rooms

All groups discussed poor experiences receiving treatment in emergency rooms and hospitals. Most groups also shared at least one experience related to the use of mobile crisis teams staffed by mental health providers that did or did not also include police as first responders. Mobile crisis response teams, as an example CAHOOTS in Eugene, were seen as more effective and less traumatizing alternatives to calling 911. While the rural group had examples of supportive involvement of police officers during a mental health crisis, other groups (attempt survivors, chronic conditions, older adults) expressed reluctance to involve police or negative experiences when police were involved.

7. Address mandatory hospitalization

Less restrictive alternatives to mandatory hospitalization (including peer respite care) should be more readily available. There were doubts raised as to the effectiveness of in-patient “mandatory holds” and a request by one participant to revisit policies followed for those in mental health crises to determine if those policies were helpful. The discussion focused on how even the thought of a mandatory hold was a barrier to seeking care. Nearly all who experienced a mandatory hold felt the commitment experience itself exacerbated, rather than addressed, the crisis. There were recommendations for:

- A utilization review that looks at re-admission and suicide rates after mandatory hold, and
- A forensic review of whether and when a mandatory hold might have prevented a completed suicide.

The OHA website should be updated to include links to NAMI and provide alternatives that might negate the need for in-patient, civil commitment.

8. Address houselessness before it occurs

- Increase the number and types of affordable housing available.
- Design affordable housing to foster community connection.
- Make safe, secure temporary housing available when needed for the short-term (even a few days can be restorative).
- Provide benefits that reduce the mental health consequences of housing transitions.

Safe, secure housing was described as four walls and a locked door (but even just a door would suffice). Suicide prevention requires people to have and retain a place to live; a goal of suicide prevention is to reduce the number of people currently or ever unsheltered in Oregon. Such efforts must be inclusive and supportive of those with substance use disorder. Once houselessness does occur, proactive services come to you and follow-up is required since barriers to self-help seeking for those houseless are numerous and overwhelming.

9. Expand follow-up care, post-crisis and beyond

Follow-up should occur after any mental health concern is raised with a provider, including caring contacts after hospitalization. Follow-up was identified as an important, effective strategy to check on people before a crisis happens and after a crisis occurs. Follow-up facilitates treatment engagement and supports long-term recovery: creating a healing connection and a mindset that sees care as continuous and not episodic or acute. Insurance coverage may need to change to support this broader, preventative continuum of care. It is recommended that:

- Peer specialists provide follow-up as possible and appropriate
- Follow-up be readily available upon request (not required) of a person, family member or provider and not limited to post-discharge, and
- Follow-up includes a safety plan that identifies and documents a service acceptable to the person to use in the future if needed.

These care preferences might be compiled to better align offerings to demand.

Summary of survey results

In addition to the working groups and focus groups outlined in the above sections, there were two local leaders' surveys — one survey of county suicide prevention coordinators and one survey of members of local suicide prevention coalitions and councils across the state.

The results of the surveys are interspersed throughout this document. A summary of recommendations and information gathered from the **Suicide Prevention Coalition and Councils Survey** is below.

1. Veterans, LGBTQIA2S+ and those addicted to alcohol and other drugs (AODs) are the top three adult populations that need greater focus.
2. Over two-thirds of respondents have been involved in their respective coalition or council for over a year, which provides a great sense of continuity to the meetings and reflects the level of sustained interest.
3. Ninety-seven percent of coalition and council members who responded to this survey have at least one type of suicide prevention training. Question, persuade, refer (QPR) was the number one training endorsed by 78% of the respondents. The two-day ASIST was the second most endorsed training with 43% of respondents completing ASIST.
4. Lack of funding was the number one challenge noted by coalition and council members.
5. When asked “What are some of the things that the state of Oregon is doing well with suicide prevention?” some responses included:
 - Data gathering and dissemination
 - Attention to youth suicide prevention
 - Making resources accessible
 - Giving the counties some funding for community-based projects (grants)

- Developing more effective programs
- Bringing folks together
- Free training including Training for Trainers (T4T)
- Suicide prevention laws, legislation
- Zero Suicide to create systems for suicide prevention
- OHA statewide coordinators (Megan Crane and Jill Baker) are “brilliant, thoughtful, strategic and collaborative”.

6. When asked “What are some of the statewide gaps in suicide prevention?” some responses included:

- Lack of fuller data gathering by doing more extensive and standardized interviews after suicides, such as psychological autopsies.
- Grants are released to communities well-funded already, rather than smaller rural and Tribal communities that do not have the public health infrastructure that larger counties have.
- There isn’t enough cohesive effort across the counties.
- What has worked in the past is not the most efficient. Need more out-of-the-box solutions that can be used in suicide prevention.
- There’s not been enough community engagement.
- Upstream efforts like housing, food, employment, etc.
- Access to care.
- More coordination between counties.
- Workforce development.
- Doing something about the role that firearms play in suicide.
- Not every region has a dedicated Suicide Prevention Coordinator. Funding is inconsistent. Needs more visibility.
- Addressing racial disparities and thinking about hiring staff who are bilingual or culturally identify with marginalized communities of color.
- More funding is needed to hire BIPOC workers to do ethnographic research about the perceptions of suicide in respective cultures. This could assist in developing culturally competent training.
- More attention needs to be given to males who have much higher rates of suicide than women.
- Older adults need more attention.
- The state hospital is inadequate.
- There is no real leader setting directions or goals.

Recommendations and information gathered from the **County Suicide Prevention Coordinator Survey** include:

1. Similar to the Coalition and Council Survey, veterans, LGBTQIA2S+, and those addicted to alcohol and drugs are the top three adult populations that need greater focus.
2. The strengths of Oregon's current work in suicide prevention are situated in its community, localized contexts and relationships with people that emerge in doing the work to provide resources, training and networking to address local-level change.
3. There is a need for sustainable, non-competitive funding for counties to maintain staff and suicide prevention coordination and strategies. In rural areas, suicide is one of many mental health imperatives that community health advocates address. Oregon needs a streamlined funding mechanism that does not require communities to piecemeal the work of suicide prevention, intervention and postvention.
4. There is a need for easy accessibility to a statewide data tracking system for reporting, maintaining and accessing information on suicide in Oregon. The database should include county or state-level data on suicide and suicide attempts by LGBTQIA2S+, people of color, rural communities, veterans, males, and higher-risk professions to assist in prevention, intervention and postvention.
5. To leverage the work in suicide across Oregon, OHA should act as a clearinghouse on all things suicide and provide timely information to locales throughout the state. As a part of a clearinghouse model, OHA should continue to advocate for more coalitions across Oregon and the coming together of communities to take part in those coalitions. Coalitions could be organized and focus on both sectors (veterans, adults, youth, schools, etc.) and interventions (lethal means reduction, gatekeeper training, etc.). Communities with fewer resources require support from OHA to create coalitions and connect localized areas with other locales statewide. Certain statewide initiatives such as QPR, MHFA and ASIST train-the-trainer are considered valuable and need to expand.

Both the Coalition and Council Survey and County Suicide Prevention Coordinator Survey had very similar themes, including:

1. The need for greater funding, particularly in rural and Tribal communities.
2. The population of focus should be veterans, LGBTQIA2S+ and those who misuse or abuse alcohol or other drugs.
3. OHA needs to be a “clearing house” for all things suicide. However, the actual work and decisions need to be on a local level.
4. The need for greater access to care and workforce development (not only access to care but adequate care).

Offer of Tribal consultation

As per OHA policy, an official Tribal consultation was submitted for this plan. In addition, a presentation about the ASIPP development was provided to Tribal suicide prevention coordinators with the opportunity for input and feedback. There was no official formal response from the Tribes. However, 4.3% of the large partner group self-identified as American Indian or Alaska Native. Self-identification does not necessarily mean that each person belongs to one of the nine federally recognized Oregon Tribes. The 4.3% of the large partner group who self-identified as American Indian or Alaska Native, is well over the 1.1% Oregon population. However, OHA knows this is not adequate. The next edition of the ASIPP promises to be more intentional about involving Tribes in the ASIPP development.

Results of small workgroups

The following populations were chosen as a high priority for ASIPP based upon disparate rates of suicide or populations historically disenfranchised or both:

- LGBTQIA2S+
- Ages 18–24
- Construction industry workers
- People who served in the military
- Older adults
- People with disabilities, chronic illnesses or both
- BIPOC, American Indians and Alaska Natives
- Men, and
- People who live in rural or remote areas.

In addition, there was a “means matter” group to address the means by which people die by suicide

In the sections below, each priority population is examined in depth with specific information about each topic including:

- Introduction, data and literature reviews
- Means and methods (when available)
- Circumstances surrounding suicide incidents, Oregon 2016–2020 (when available)
- Risk factors and protective factors, when different than CDC general population risk and protective factors
- Intersectional identities
- Recommendations from the small workgroups
- Input from the focus groups (if applicable)
- Suicide prevention work currently underway, and
- Summary

Intersectional identities and “at risk” or “high risk” populations:

Most people have multiple identities, some of which may further increase the risk of suicide. It is not the identity itself that increases the risk. Using an equity lens, high-risk populations must be considered in the context of their social identities and systems that have impacted their risk for suicide, rather than individual characteristics. For example, identifying as lesbian does not inherently make one more vulnerable to suicide; however, living in a society that shames, stigmatizes, marginalizes, and threatens a person does make one more vulnerable to many challenges, including suicide. It is also important to note that although the stated priority populations were chosen because they have disparate rates of suicide, there are many people within those populations, in fact, most, who do not experience suicidal thoughts or behaviors. In addition, for the work of the ASIPP, some population groups have been combined, based on sexual orientation, gender identity and expression (SOGIE) or race or ethnicity. These may have large differences among the subsets. LGBTQIA2S+ is not one population, but several populations. For example, gay men may have more in common with straight men than they do with lesbians. The commonality among LGBTQIA2S+ populations is oppression and marginalization because of homophobia and transphobia. Additionally, people of color, American Indians and Alaska Natives are not one population. The commonality among these populations is the oppression and marginalization experienced because of white supremacy.

Priority populations

Priority populations include:

- LGBTQIA2S+
- Ages 18–24
- Those employed in the construction industry
- Veterans and military-connected personnel
- Older adults
- Those with disabilities and chronic illness
- Black, Indigenous and people of color (BIPOC) and American Indian/Alaska Native (AI/AN)
- Men, and
- People who live in rural and remote areas.

LGBTQIA2S+

Introduction, data and literature review

There is a lack of research and data collection on adult LGBTQIA2S+ populations despite there being robust efforts for LGBTQIA2S+ youth. Most of our understanding is based on suicide attempters rather than those who die by suicide. This is because sexual orientation, gender identity and expression (SOGIE) data is not routinely collected at the time of death. The National Institute of Health (NIH) recently (November 2021) released the results of a [large-scale study](#) in which they collected data from 2015-2019 on 191,954 adult participants, 14,693 of who identified as lesbian, gay or bisexual. The results were as follows:

“In line with previous research, the NSDUH data showed that rates of all three suicide-related behaviors—thoughts, plans, and attempts—were generally higher among lesbian, gay, and bisexual adults than among heterosexual adults. After taking demographic factors into account, the researchers found that suicide risk was three to six times greater for lesbian, gay, and bisexual adults than for heterosexual adults across every age group and race/ethnicity category. Among gay and bisexual men, 12% to 17% had thought about taking their lives in the past year, 5% had made a suicide plan, and about 2% had made a suicide attempt. Among lesbian or gay women and bisexual women, 11% to 20% had experienced thoughts of suicide, 7% had made a suicide plan, and about 3% had made a suicide attempt. Among gay and bisexual men, the data showed no differences in suicide risk according to race/ethnicity. However, among lesbian or gay and bisexual women, the data indicated that Black women had lower risk of suicidal thoughts and plans relative to white women.”

When the researchers looked at the specific intersection between minority sexual identity and race and ethnicity, they found White and Black women who identified as bisexual were more likely to report suicidal thoughts compared to White and Black women who identified as lesbian or gay.

Looking at the intersection between minority sexual identity and age, the researchers found suicidal thoughts were also relatively higher among bisexual women in the 35-64 group compared with lesbian or gay women in the same age group.

In Oregon, from 2016–2020, 56 people (less than 1%) who died by suicide were identified as lesbian, gay, bisexual, or transgender (OVDRS). Compared to more rigorous studies on LGBTQIA2S+ and suicide risk, it is likely that there is a dramatic underreporting of SOGIE demographics in Oregon. The data available is very difficult to interpret due to the lack of adequate collection of this specific demographic.

Excerpts from the small workgroup regarding this at-risk population: [\(link to full report\)](#)

Lesbian, bisexual, gay, transgender, transsexual, queer, questioning, intersex, asexual, ally, pansexual and two-spirit (LGBTQQIAAP2S, referred to in this report as LGBTQIA2S+) is an expansive group with a variety of terms to identify themselves and their communities. However, being a part of a sexual minority group increases vulnerability to social stigma and health inequities ([Hottes, et. al, 2016](#)). The LGBTQIA2S+ community consists of many social identities, sexual orientations and expressions of gender ([NAMI](#)). LGBTQIA2S+ people can have multiple identities (that is, race, ethnicity, family, geographic, socioeconomic and age). They also vary widely in the importance they attach to their sexual orientation, gender identity and the sense of community they share with other LGBTQIA2S+ people. Many people in the LGBTQIA2S+

community view their sexual orientation or gender identity as extremely or very important to their overall identity. However, others say it carries relatively little weight. LGBTQIA2S+ people also differ in:

- How much they have in common with other subgroups within the LGBTQIA2S+ population or community
- How much they take part in activities such as pride events and rallies, and
- How big a role they believe venues such as LGBTQIA2S+ neighborhoods and bars should play in the future as the community gains more acceptance by the larger society.

Many factors contribute to a person's health. Due to perceived, direct and self-stigma many people in the LGBTQIA2S+ community struggle in silence and face poorer health outcomes as a result including:

- Rates of violence
- Sexually transmitted infections (STIs)
- Substance or tobacco use
- Depression
- Anxiety, and
- Suicide-related behavior ([Hottes](#), et. al, 2016).

Lesbian, gay and bisexual adults are twice as likely to experience mental health conditions compared to heterosexual adults ([NAMI](#)).

Suicide is a top public health concern and those who identify as LGBTQIA2S+ are at increased risk for suicidal behavior and death by suicide ([Kaniuka](#), et. al, 2019). In the United States, there is no systematic way of collecting information about sexual orientation, gender identity and expression (SOGIE) at the time of death. Therefore, suicide rates for LGBTQIA2S+ people are unknown ([Haas](#), et., al, 2019). There is also a lack of representation and diversity in research on LGBTQIA2S+ people, especially people of color. Previous research has predominantly engaged with youth and cisgender people, White, gay and lesbian people. Therefore, the findings are skewed and not representative of the community as a whole.

The loss of any person to suicide cannot typically be explained by a single factor. Suicide reflects a complex interaction of factors that place stresses on LGBTQIA2S+ people at the societal, community, familial, relational and personal levels. Beyond the complex interaction of multiple and dynamic risk factors, certain suicide risk factors meaningfully affect the LGBTQIA2S+ community. A complex interaction of multiple and dynamic risk factors, power dynamics and social identities affect the interpersonal, community and societal experiences of the LGBTQIA2S+ community and meaningfully affect certain suicide risk factors of the LGBTQIA2S+ community.

LGBTQIA2S+ risk factors

- Stress from prejudice, discrimination, and violence, historical and generational trauma – particularly in communities of people of color.
- Social isolation and ostracized from family and peers.
- Chronic physical health concerns and inequity in health care services, including HIV or AIDS diagnosis and lack of culturally responsive and appropriate behavioral and physical health care providers.

- Coming out – There have been positive shifts in acceptance. However, this can affect social experiences, relationships and mental health for those not in supportive environments.
- Internalized anti-LGBTQIA2S+ attitudes and beliefs.
- Laws and polices that encourage stigma and discrimination or a lack of laws and polices that protect against stigma and discrimination
- Ages 18–24
- Gender: transgender male

LGBTQIA2S+ protective factors

- The LGBTQIA2S+ community is tight-knit and more connected due to shared oppression and exclusion
- Family acceptance
- Sense of safety

Intersectional identities that may increase risks for LGBTQIA2S+ populations

In 2021, the [Oregon LGBTQIA2S+ Older Adult Survey](#) was published. The community survey was completed by 1,402 demographically diverse LGBTQIA2S+ adults aged 55 and older. Twenty-one percent of participants experienced suicidal ideation within the past year. This figure is significantly higher than the general population of the United States with only 4.3% reporting suicidal thoughts within the past year (Asha, et. al., 2022).

People at the greatest elevated risk of suicidal ideation are:

- Black or African Americans, Asian and Pacific Islanders, Native Americans and Alaska Natives
- Aged 55-64
- Living with lower incomes
- Living in rural and remote areas
- Gay men

Recommendations from the LGBTQIA2S+ small workgroups

1. Rural

- a.) Expand research and data collection on LGBTQIA2S+ people in rural areas, including adding questions about sexual orientation and gender identity to surveys. This will allow for improvements in understanding how many LGBTQIA2S+ people live in Oregon and rural areas to better improve outreach efforts and services.
- b.) There are fewer people, including LGBTQIA2S+, living in rural areas in Oregon. Around 33% of Oregon's population lives in rural areas and 2% in frontier⁹. People living in rural areas may be less familiar with LGBTQIA2S+ people and issues. OHA should implement rural-specific outreach and communication strategies for improving rural communities' understanding of LGBTQIA2S+ people and issues. Materials and communications should represent a diverse range of identities, orientations, races, ethnicity and expressions of gender.

- c.) OHA builds and strengthens existing relationships with community organizations and behavioral health providers to promote LGBTQIA2S+ wellness and education. For example, promoting communication and connection points for LGBTQIA2S+ suicide prevention such as the grantee meetings for the LGBTQIA2S+ mini-grants, where several rurally-located grantees were able to collaborate and support each other's work.
- d.) Invest in infrastructure in rural areas such as high-speed internet and access, improved transportation and health centers for LGBTQIA2S+ people.
- e.) Allocate funding to improve LGBTQIA2S+ inclusivity with community partners and state-funded agencies.
- f.) Signal commitment to inclusion in rural communities by updating marketing materials that are diverse and culturally responsive to the community in its images of LGBTQIA2S+ patients. Also, by displaying inclusive and culturally responsive (considering the makeup of each community) with posters and stickers in visible parts of the office or workplace.

2. Outreach, training and education

- a.) Cultural competency training for providers of care:
 - 1. Encourage and incentivize evidence-based professional development in workplaces regarding LGBTQIA2S+ inclusion. Behavioral health and primary care physicians should use the LGBT training curricula from the Substance Abuse and Mental Health Services Administration (SAMHSA).
 - 2. Develop a toolkit and training around how to create services more inclusive of LGBTQIA2S+ people and the intersectionality of other identities they hold.
 - 3. Incentive and encourage LGBTQIA2S+ persons to become certified or licensed as providers. This would be a strategic partnership with local community colleges and universities.
 - 4. It would be interesting to create a system for providers, for example:
 - a.) First year: training all staff up is optional, but encouraged
 - b.) Second year: require certain job profiles to have the training, although all staff is encouraged, and
 - c.) Third year: require all staff at the organization to have training with annual in-service thereafter.
- b.) Develop, implement and promote suicide prevention training specific for the LGBTQIA2S+ population and the intersectionality of LGBTQIA2S+ and other identities. Encourage all the [Big River programs](#) and their staff to have supplemental training. This will enhance their understanding and competency to create LGBTQIA2S+ suicide prevention training for LGBTQIA2S+ adults.
- c.) Design materials and other deliverables with the LGBTQIA2S+ community present and meaningfully involved. Include different gender identities and sexual orientations, as well as allies, family members and suicide loss survivors. Advocate for unique perspectives from those with different intersectionalities to create robust and inclusive messaging.

3. Policy:

- a.) OHA to adopt an equity tool or lens policy similar to the one used in the ASIPP. Then, apply that tool to all OHS policies and contracts. Based on findings, adjust policies to be more inclusive and culturally responsive to communities throughout Oregon.
- b.) Replicate this process for the Oregon Legislature to affect policymaking.

4. Data collection

- a.) Encourage training for medical examiners and coroners to collect more specific and inclusive data, drawing on learnings and methods from the [LGBT Mortality project](#). This can inform strategies at local, county and state levels.
- b.) Psychological autopsies were conducted in all counties throughout Oregon.
- c.) SOGIE data collection: Alongside provider education of LGBTQIA2S+ community and care, encouraging health care providers to safely and securely collect sexual orientation and gender identity information to use to improve health care for those with specific identities. Additionally, encourage health care providers to safely and securely collect and use pronoun information in health care settings. Provide science-based education to providers so they fully understand the need for and importance of these data as well as trauma-informed ways to counsel patients and collect this information.
- d.) Increase research efforts.

5. Inclusion Practices

- a.) Encourage health care systems to have employees' pronouns printed on their nametags to normalize gender identity in health care. This signals inclusivity and could open up conversations between patient and doctor. Everyone has a gender identity. It's not something you can assume by looking at someone.
- b.) Signal commitment to inclusion by:
 - 1. Updating marketing materials with diverse, culturally responsive and appropriate for the community images of LGBTQIA2S+ patients, and
 - 2. Displaying LGBTQIA2S+ inclusive posters and stickers in visible parts of the office or workplace.

6. Increasing access and availability of services

- a.) Create culturally specific programming in communities where LGBTQIA2S+ population numbers warrant. Either a safety net type organization for the LGBTQIA2S+ community that provides all types of social services or culturally specific programs if that makes more sense for the number of LGBTQIA2S+ people in a community. A direct and strategic partnership with LGBTQIA2S+ organizations such as the Human Rights Campaign (HRC), [Our House of Portland](#) (Our House) and the [Q Center](#) (or a similar model) for consultation, partnership and potential expansion into rural areas of our community.
- b.) Organizations that contract with OHA must have non-discrimination policies that include LGBTQIA2S+ protections explicitly, with a commitment to training staff and reassuring a friendly, welcoming and inclusive service.
- c.) Encourage bills similar to California's [Assembly Bill No. 2218 – Transgender Wellness and Equity Fund](#). This bill establishes funds for organizations serving people who identify as transgender, gender non-conforming, or intersex, to create or fund specific housing programs and partnerships with hospitals, health care clinics and other providers.

7. Postvention training on death by suicide

- a.) Mandate that all behavioral health care providers and staff get CONNECT or similar postvention training. Update the CONNECT training with more specific information about LGBTQIA2S+ suicide death and grieving. Pay special attention given to the history of death and grief in the community and the resilience of survivors who often end up in informal peer support roles after a loss.

8. Incentive health and wellness and peer support villages

- a.) Incentivize a peer support specialist training program to appeal to more people and drive more people to become peer support specialists from the LGBTQIA2S+ community.
- b.) Create a toolkit on peer support villages that speaks to how to create and maintain them.
- c.) Create a mini-grant program to assist communities with getting peer support villages off the ground and functioning.
- d.) OHA provides funding for LGBTQIA2S+ people to get behavioral health screenings, HIV testing, etc.e. OHA provides funding to conduct and to offer stipends/incentives for LGBTQIA2S+ health education groups that speak to how to increase resiliency, positive health practices, behavioral health, etc.
- e.) Evaluation of these initiatives by using evaluation programs through local colleges and universities.

9. Older LGBTQIA2S+ adults

- a.) LGBTQIA2S+ community is living longer, especially when considering discrimination, violence and disproportionate health burdens. OHA should meaningfully advocate for intergenerational approaches to support mental health across the lifespan. The creation of materials, initiatives and education around aging in the LGBTQIA2S+ is a critical protective factor as seeing a future for oneself is important in reducing suicide.
- b.) Use training, literature, and evidence-based practices from CONNECT and AARP to create sustainable efforts for older adult LGBTQIA2S+ persons.

LGBTQIA2S+ focus group

In addition to the input from the LGBTQIA2S+ small workgroup the following input was gathered during the LGBTQIA2S+ focus group (link to complete report):

Being misgendered, not being called by their chosen name, receiving insensitive physical or mental health assessments, having their identity pathologized and not having family support to access services were all raised as commonplace and evident barriers to help-seeking. These were some concrete examples of what the group identified as “systemic marginalization” and what it meant to be: uniquely antagonized in our society – there is not a lot of structural support for the kind of mental strain that puts on the [LGBTQIA2S+] community. Later this same participant talked about the heaviness of being an LGBTQIA2S+ person in our culture (LGBTQIA2S+).

Some other comments included:

“Any suicide prevention/intervention work for the LGBTQIA2S+ population is done against the backdrop of large-scale cultural disenfranchisement. Work and efforts in this realm would be best served by being community-led, where possible, to fully address the reality of many people in the LGBTQIA2S community.”

Empowering community-led organizations to do this work is going to be one of the most impactful ways to enact any policy around suicide prevention.”

“therapist[s] should be educated or have life experience with LGBTQIA2S+ population as most therapist are not helping people when they look for therapy in fact therapist are traumatizing people because of the lack of knowledge in the field. Peer support mentors in this specific population is needed.”

“The people in power need to sort out how the system is oppressive and built for straight people and do the work to change it without making queer people figure out all the answers”

“Basically, it’s nice to feel like a contributing member of the community, whose identity and unique experience are being acknowledged, embraced and specifically valued. Being seen and given a seat at the table, as highly marginalized, “fringe” members of society, is paramount to addressing the unique issues we face.

LGBTQIA2S+ suicide prevention work underway

In 2020, OHA awarded a total of \$215,000, spread across 18 LGBTQIA2S+ community organizations, to reduce suicidal behaviors among LGBTQIA2S+ people with priority given to Black, Tribal, Latinx, other communities of color, rural and disabled populations. The goal of the grants was to build protective factors by increasing opportunities for life-affirming connection, resources, and health care to vulnerable and isolated LGBTQIA2S+ youth and adults. The 18 funded projects included a wide range of creative and community-centered approaches, such as:

- Increasing access to gender-affirming care
- Expanding positive youth development activities
- Creating community-wide collaborative efforts, and
- Creating a podcast to elevate LGBTQIA2S+ voices.

LGBTQIA2S+ summary

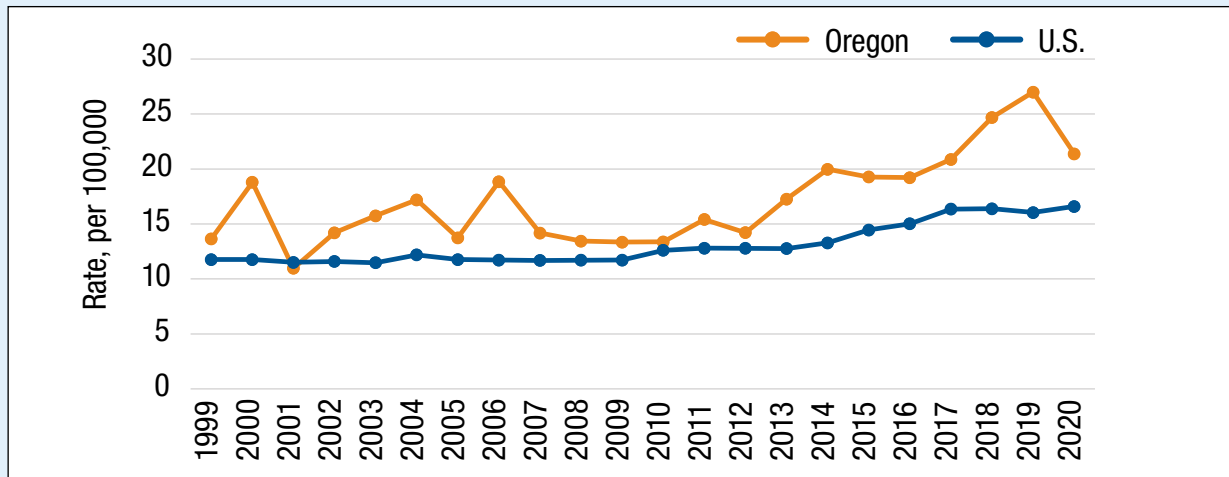
Being LGBTQIA2S+ does not inherently put a person at greater risk for suicide. Living in a culture that oppresses, marginalizes and disenfranchises those with that identity does put those at greater risk for suicide. Thus, additional focus, funding, efforts, etc. should be placed on reducing suicides and improving the quality of life for LGBTQIA2S+ populations, who have been historically oppressed and underserved. Results from the recent [2021 Oregon LGBTQIA2S+ Older Adult Survey](#) suggest that concerted efforts should be made with cross-sectional identities within the LGBTQIA2S+ population including older adults, people of color, American Indians, Alaska Natives, gay men, those with low incomes and living in rural areas.

Ages 18–24

Introduction data and literature review

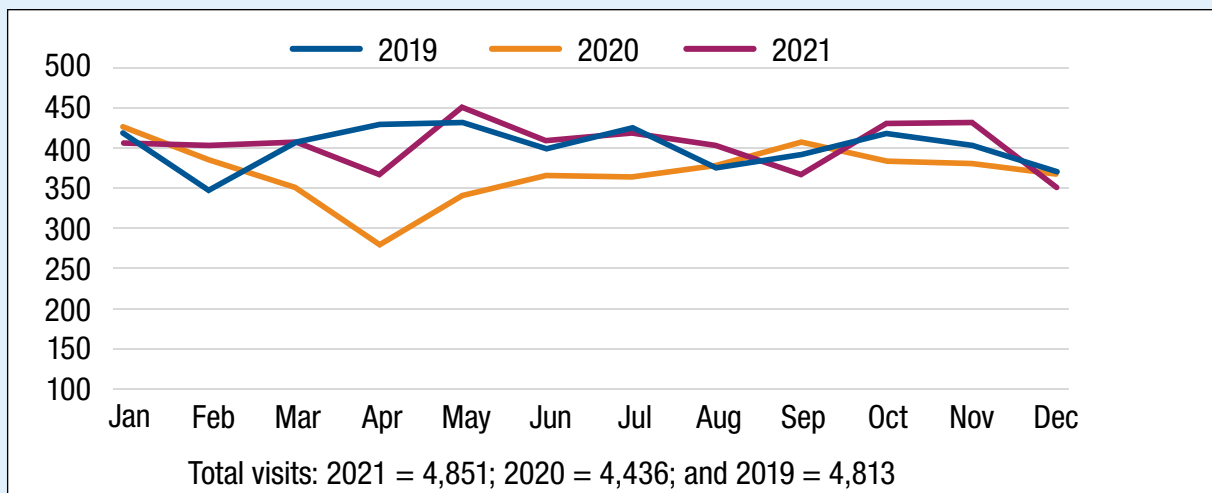
In Oregon, the suicide rate for young adults aged 18–24 has been on a steady incline since 2012 and is well above the national rate. In 2020, the national rate for this age group was 16.6 per 100K versus Oregon with a rate of 21.4 per 100K (Figure 11). In 2020, there were 77 suicides in Oregon within this age group. Oregon saw a decrease in the suicide rate for this age group between 2019 and 2020. Multiple-year data are needed to determine if there is a decreasing trend beyond year-to-year variation. The figures below describe suicide rates for this group specifically along with race and ethnicity, mechanism of death and life circumstances before death.

Figure 11. Comparison of Suicide Rates Between US and Oregon youth aged 18–24 from 1999–2020.



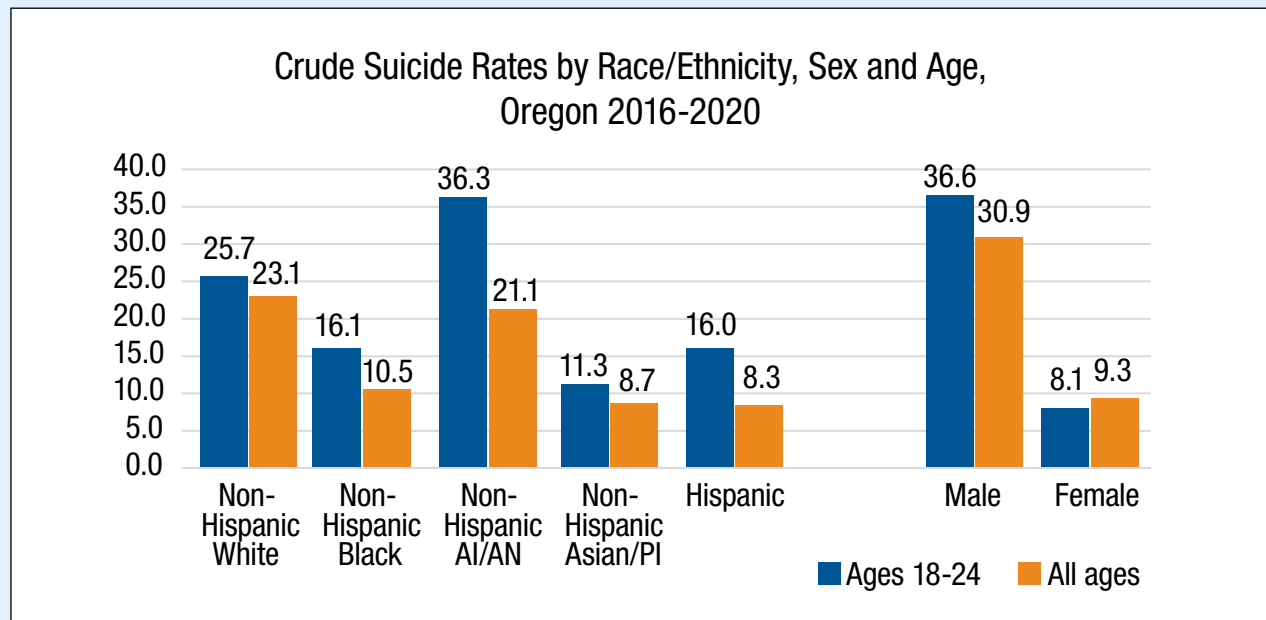
Source: CDC WISQARs

Figure 12. Number of ED and UCC suicide-related visits by month from 2019–2021.



Source: ESSENCE

Figure 13. Crude suicide rates per 100,000 population by race and ethnicity, sex, and age for people in Oregon from 2016–2020.



Source: CDC WISQARs

Consistent with other national and state data, males are much more likely to die by suicide than females. Males ages 18–24 are over four times more likely to die by suicide than females in the same age group (Figure 13). In terms of race and ethnicity, the highest rate of suicide for this age group is non-Hispanic American Indian and Alaska Native (36.3) followed by non-Hispanic White (25.7).

Means and methods

Figure 14. Percent mechanism of suicide for ages 18–24 in Oregon Between 2016–2020

18–24 Mechanism of injury	ALL		Males		Females	
	Percent	Count	Percent	Count	Percent	Count
Firearm	51%	219	58%	205	19%	14
Hanging or suffocation	29%	126	26%	94	44%	32
Poisoning	8%	34	5%	19	21%	15
Fall	4%	19	5%	16	4%	3
Motor vehicle or train	2%	7	1%	5	3%	2
Sharp instrument	4%	15	3%	10	7%	5
*Other or unknown	2%	8	2%	6	3%	2
Total	100%	428	100%	355	100%	73

Source: ORVDRS

With numbers this alarming, the OHA Suicide Prevention Team decided to include this group in the ASIPP despite being included in the [YSIPP](#). The decision to “double team” this age group was also based on the degree of developmental variability within this group. Some 18–24-year-olds may be married with children, while others may still be in high school or college and living at home with their parents. YSIPP focuses on 18–24-year-olds in the latter group. Unfortunately, others may be struggling with housing insecurities, drug dependence or even incarceration.

Circumstances surrounding suicide incidents

For this age group (18–24) the top circumstance found in suicide deaths is a diagnosed mental disorder (Figure 15). The top five most prevalent circumstances are found in Figure 15. For a complete list of circumstances please see [Appendix 9](#).

Figure 15. Circumstances of suicides in ages 18–24 from 2016–2020.

Ages 18–24 circumstances (2016–2020)	% of total suicides
Diagnosed mental disorder	33.2
History of expressed suicidal thoughts or plan	31.5
Left a suicide note	30.6
Current depressed mood	26.2
Intimate partner problem	22.9

Source: ORVDRS

Age 18–24 risk factors

- Exposure to violence, abuse, or other trauma, either chronic or acute
- Losing a family member through death or divorce
- Conflict within relationships
- Starting or changing psychotropic medications
- Feeling stigmatized

Additional insight into potential risk factors for Oregon youth ages 18–24 are included in the [2020 YSIPP Annual Report](#):

- Mental health problems
- Broken up with an intimate partner
- Crisis in the past two weeks
- History of suicidal thoughts or behaviors

Age 18–24 protective factors

The following [protective factors](#) come from the Suicide Prevention Resource Center (SPRC) and Substance Abuse and Mental Health Services Administration (SAMHSA): *Treatment for Suicidal Ideation, Self-harm, and Suicide Attempts Among Youth*. (SAMHSA Publication No. PEP20-06-01-002 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020).

- Problem-solving skills
- Adaptability
- Cultural and religious beliefs that discourage suicide

Intersectional identities that may increase risk

- Being male
- Being LGBTQIA2S+
- Being White, American Indian or Alaska Native
- Being a veteran
- Being a construction worker
- Living in rural or remote areas

Recommendations from the Age 18–24 small workgroup: (see full report)

1. Life skills and socioeconomic risk reduction

- a.) Universities and trade schools should offer transitional life skills programming or education during students' numerous time points, including during late high school, the first year, last year and during the graduate or post-grad period (budgeting, insurance, home-buying, job-seeking, etc.).
- b.) Expansion of current peer-based programming or development of a collective statewide system that draws on organizations already doing the work should be pursued with increased availability of centrally located centers of communal resources, such as found in the Oxford House or independent living skills models, for biopsychosocial, developmental and economic skill building and support.
- c.) Resources and services of focus should include:
 1. Independent living skills development
 2. Mental health counseling and medication management
 3. Case management
 4. Peer support
 5. Employment skill building and assistance
 6. Parenting skills and support, and
 7. Parental respite care.

2. **Inter-program and interagency collaboration**

- a.) Universities and trade schools should support and promote accessible, safe communication of incidents, concerns or issues related to campus climate with campus administration and have an effective response system (JED Foundation).
- b.) Universities should create open and supportive opportunities to engage around national and international issues and events (JED Foundation).
- c.) Behavioral health, physical health and disability services on university and trade school campuses should collaborate to create and reinforce consistent, but appropriately targeted messaging about suicide and mental health.
- d.) All post-secondary institutions should take part in resource and information sharing (within and between schools) (JED Foundation).

3. **Advocacy**

- a.) OHA should actively support the establishment of a youth action board in every county. This is important as it allows for the voices of 14–15-year-olds to be heard about their experience and needs, as well as the specific needs and available resources of each unique county within the state. Clackamas County Youth Action Board, as supported in development by True Colors United, can provide an example for this implementation and act as a framework for the development of each county's board.
- b.) At least one member of a county youth action board shall be designated as the representative at all state-level systems of care meetings, councils or both. Given the diversity of the needs of counties across the state, the inclusion of more than one representative would be of critical consideration.

4. **Knowing services exist**

- a.) Post-secondary institutions should help students learn about suicide prevention programs and mental health services by advertising and promoting them through multiple channels (JED Foundation).
- b.) Potential online platforms to consider:
 - 1. Twitch
 - 2. Discord
 - 3. TikTok
 - 4. Instagram

Successful interfacing with this population demonstrated by current organizations, such as Youth Era, can provide feedback about the most effective channels. Therefore, they can be similarly used by higher education systems to achieve this aim of greater awareness of programming.

- c.) Non-social media and non-electronic modalities should also be used, including:
 - 1. Billboards
 - 2. In-school bulletin boards or other postings in communal areas

3. Hotline and campus mental health number on student IDs
4. As part of graduate student orientation, and
5. In cultural centers and athletic complexes.
6. Information about resources and programming for perinatal, post-partum and paternal mental health should be mandatory to expectant and current parents, regardless of age, gender, marital status, or type of health care and prenatal care sought.
7. Universal screenings should include mental health items, such as a Columbia-Suicide Severity Rating Scale (C-SSRS), and screenings for problematic substance use, for all expectant and new parents.

5. Accessing services

- a.) OHA and ODHS should collaborate in establishing and conducting a peer-based system of services outside of the Independent Living Program (ILP) for all transitioning age youth ages 18–24 engaged in ODHS services, regardless of qualifying for ILP, to develop and support skills for emerging adulthood and mental wellness.
- b.) A statewide program of low-cost or free culturally-sensitive and trauma-informed prenatal and post-partum services targeting younger adults should be pursued, including services or groups specifically for sexual assault survivors, single parents, pregnancy-after-loss and fathers. While some community resources exist to specifically address post-partum depression or mental health, such as those connected with hospitals or clinics (for example, Hope for Mothers – Samaritan Health Services), these are limited in accessibility and are general in scope. This results in underutilization for numerous reasons, including feeling unwelcomed or judged due to parental age, gender, race, or marital status as these aspects may be underrepresented or completely absent within the generally homogenous groups.
- c.) OHA should develop and implement staff-client ratio requirements for staffing and caseload for ODHS caseworkers to be adjusted based on acuity rather than the total number of clients to supply care and services sensitive to the people’s needs and lagging skills and increase opportunities for early intervention in increasing distress.

6. Diversity and equity

- a.) Post-secondary institutions should supply a variety of different structures and culturally relevant program types (mentor networks, discussion groups, workshops, etc.) focused on supporting the mental health and well-being of students (JED Foundation).
- b.) Post-secondary institutions should identify and promote the mental health and well-being of all students, with intentional cultural responsiveness for students of color, as a campus-wide priority (JED Foundation).
- c.) Create dedicated roles to support the well-being and success of people of color, LGBTQIA2S+, veterans, military service members, students with seen or unseen disabilities or both, and other student populations who may be disproportionately affected by suicide (JED Foundation).
- d.) Post-secondary institutions should actively recruit, train, and retain a diverse and culturally competent workforce, particularly those who have “frontline” experiences with students, to support active and open help-seeking behaviors (JED Foundation).

- e.) Post-secondary institutions should consider partnering specific cultural groups with mental health professionals who identify within those cultural groups to promote help-seeking behaviors. Professional organizations and their specific sub-groups, should be used as resources for accessing professional resources and sources of employment recruitment, examples are:
 - 1. National Association of Social Workers
 - 2. American Association of Marriage and Family Therapists
 - 3. American Psychological Association, and
 - 4. American Counseling Association.
- f.) Actively pursue professional pipelines to increase diversity and cultural competency of the professions. This may include educational or living stipends for serving rural populations, educational assistance, loan repayment, scholarships for military or military-connected persons, people of color and LGBTQIA2S+ communities to pursue careers in mental health.

7. Training

- a.) Statewide free or low-cost gatekeeper training online modules should be made available to and be required by universities or trade schools for all students and their faculty, staff and administrators (see example in California of contracting with [LivingWorks](#) to provide Start for all K-12 students)
- b.) Develop robust programming and resources for peer-focused training and services, particularly targeting community college and trade school programs and campuses using the structure already present on many four-year campuses.
- c.) Universities and trade schools should consider contracting with training agencies to provide education on suicide prevention, intervention and postvention to support the creation of a network of safety for students
- d.) Develop and implement robust programming for training available for peer-focused and delivered services, including training in:
 - 1. Trauma-informed care
 - 2. Adulthood
 - 3. Tokenism (Tri-Force), and
 - 4. Mental Health First Aid.
 - 5. All physicians and other medical professionals, including OB/GYNs, certified nurse-midwives and nurses, should have suicide prevention as a mandatory portion of required continuing education. Also, this mandate should be considered for the required training of employees of public and private family planning and reproductive health agencies, employment, other state social service programs and mentoring-focused services.

8. Postvention

- a.) Post-secondary institutions should develop a suicide postvention plan to adequately respond if a student attempts or dies by suicide (see CONNECT training format and Action Alliance 10 Steps to Handling Aftermath of a Suicide). A uniform response across all state universities, ultimately all post-secondary institutions within the state, should be considered with people institutions adding to or adjusting to the needs of each specific campus or institution – reflect [Adi's Act](#) (SB52, 2019 Session) in construction and framework (SB52, 2019 Session).

9. Research and data

- a.) Post-secondary institutions should regularly and systematically conduct surveys and focus groups with students to understand their needs and challenges around mental health, emotional well-being and campus climate, including a specific focus on students of color ([JED Foundation](#)). These survey initiatives should be supported and potentially funded by the state to improve adherence and implementation across all campuses.
- b.) Post-secondary institutions should identify and use culturally relevant and promising programs and practices and collect data on effectiveness (JED Foundation).
- c.) The currently ongoing statewide assessment for homelessness should be used as a resource for data that bear influence on risk within the young adult and student populations.
- d.) Establish a unified method for data collection and analysis of mental health incidence, prevalence and suicide, whether on or off academic campus, mandated and guided by OHA.

Input from the small workgroup supported by OVDRS data suggests this is a very vulnerable population, particularly for males with a suicide rate of 36.6 per 100,00 (2016–2020), which is more than twice the national rate of suicide for 2019 (13.9). In terms of ethnicity, White, American Indian and Alaska Native populations have the highest rates of suicide for this age group.

Ages 18–24 suicide prevention work underway

Dedicated work in the [YSIPP](#) that supports the ages 18–24 population:

- Stipends for youth representatives and people with lived experience are now paid to attend state advisory committees.
- The Alliance will maintain youth representatives on each committee and ensure the following populations are represented whenever larger feedback is gathered:
 - Members ages 18 or younger
 - Rural youth
 - Youth of color
 - LGBTQIA2S+ youth
- OHA will require diverse youth engagement and a meaningful feedback loop in all relevant OHA suicide prevention contracts.

- OHA will contract specifically for youth engagement and meaningful feedback including Youth and Young Adult Engagement Advisory (YYEA), focus group stipends and facilitation, including in program planning and evaluation efforts.
- YYEA receives OHA support for .5 full-time equivalent staff.
- Sources of Strength programming will be available statewide for all students from third grade to post-secondary.
- [YouthERA](#), [Youthline](#) and Oregon Family Support Network ([OFSN](#)) are available and advertised widely.
- Statewide partners in building positive youth connections are identified and receive communication from OHA suicide prevention coordinators and the Alliance, including:
 - Oregon After School & Summer for Kids Network
 - ODHS
 - Oregon Foster Youth Connection
 - Oregon Alliance for Safe Kids
 - Healthy Families
 - Strong Communities
- OHA will support the development of Youth SAVE for young adults (ages 18–24). Oregon Pediatric Society will add the development of Youth SAVE training modules for those serving young adults (ages 18–24) and for primary care providers.
- Behavioral health providers (including peer support workforce) in Oregon have access to low or no-cost courses in evidence-based treatment of suicidality that address various levels of risk of suicide and teach interventions.

Ages 18–24 summary

The decision to “double team” this age group in both YSIPP and ASIPP seems well-grounded. This “age of transition” between youth and adulthood seems to be a vulnerable period for suicidal thoughts and behaviors. Oregon-specific data shows a clear upward trend in the suicide rate for this vulnerable population.

Construction industry

Introduction, data and literature review

Similar to national rates for occupational groups, Oregon has an alarming rate of suicide for construction and extraction occupations with a rate of 93 per 100,000 (2016–2020). This group ranks #2 for suicide deaths by an occupational group with farming, fishing and forestry occupations ranking #1 with a rate of 101.3 (Figure 16).

Figure 16. Suicide deaths and rates among suicide victims aged 16 to 64 years by occupational group, Oregon, 2016–2020

Standard Occupational Classification code (2010)	Major occupational group	Deaths	Rate per 100,000
45	Farming, fishing and forestry	70	101.3
47	Construction and extraction	359	93
27	Arts, design, entertainment, sports and media	110	76.1
49	Installation, maintenance and repair	158	49
53	Transportation and material moving	253	38.8

Note: Rates are per 100,000 civilian, noninstitutionalized working persons aged 16–64 years

Source: ORVDRS and U.S. Department of Labor, Occupational Employment Statistics

Construction industry risk factors

The construction industry small workgroup created a list of variables that may contribute to the increased risk of suicide for this industry: ([see full report](#))

Risk Factor #1: Construction demographics are comprised mostly of populations that intersect with other high-priority populations such as men and veterans.

Risk Factor #2: Too tough and silent – the construction industry is a male-dominated field where “toughness” is a gauge of success. This culture contributes to mental health stigma which can reduce help-seeking behaviors.

Risk Factor #3: Action and reaction – the construction industry is an unobstructed high-performance industry driven by tight schedules and even tighter budgets. The construction industry is fraught with stress leading to the possibility of unhealthy coping mechanisms such as alcohol and substance misuse, unhealthy relationships, etc.

Risk Factor #4: Layoffs and working ourselves out of a job – The projects we work on are, for the most part, scope-driven and finite contract work. Layoffs and gaps in employment are common in the construction industry which also affects access to health care benefits and financial stability.

Risk Factor #5: Pain management – physical labor can lead to serious injury which increases the likelihood of opioid addiction.

Risk Factor #6: Isolation and separation – the construction industry often involves some degree of migratory work. It's common for construction workers to spend long periods living away from home, family and friends. Even when living at home the work hours are often long with 10-hour shifts common.

Risk Factor #7: Access to lethal means – the construction Industry, is a high-risk industry with many exposures to lethal means a person in crisis has access to.

Construction industry protective factors

- Connection to others, family, friends and community
- Sense of purpose and contribution to others
- Interpersonal relationship skills
- Job assistance and stability
- Spirituality or faith orientation
- Support from the “industry” employer
- Problem-solving skills

Construction worker intersecting identities that may increase risk

- Men, particularly those who adhere to stereotypical masculine “tough guy” ideals
- Veterans
- People with easy access to lethal means
- People who live in rural and remote communities
- People with chronic illness, disability or chronic pain

Recommendations from the construction industry small workgroup: ([Link to full report](#))

1. Training which should include QPR and CALM
2. Integration of suicide prevention into Occupational Safety and Health Administration (OSHA) outreach
3. Reducing and treating opioid addiction and other forms of addiction
4. Shifting the culture of “toughness” to empathy and inclusion
5. Equity, inclusion and diversity training
6. Companies should have suicide prevention, intervention and postvention plans
7. Increase suicide prevention outreach efforts specific to the industry which should include the distribution of resources
8. Policy changes that make it easier for construction workers to seek help, such as:
 - a.) Sick pay
 - b.) Increased employee assistance program
 - c.) Health insurance for non-union workers
 - d.) Focus on help rather than disciplinary actions, and
 - e.) Identifying and reducing barriers to help-seeking behaviors.

9. Peer support
10. Postvention services
11. Promote proactive well-being including mental health and reducing stigma
12. Promote communication strategies and campaign strategies specific to the construction industry

Construction industry suicide prevention work underway

Fortunately, there are already substantial efforts nationally and throughout the Oregon construction industry to address the issue of suicide which include:

Nationally:

1. The Construction Industry Alliance for Suicide Prevention (<https://preventconstructionsuicide.com/>)
2. Construction Financial Management Group (<https://cfma.org/suicideprevention>)
3. Workplace Suicide Prevention (<https://workplacesuicideprevention.com/>)

Oregon specifically:

1. Construction Suicide Prevention Partnership in Portland has a Strategic Plan, Action Guide and provides resources (<https://www.linesforlife.org/construction/>)
2. Several local general contractors have launched suicide prevention initiatives.
3. Several local unions conduct QPR training and have peer support programs.
4. Suicide prevention and mental well-being are discussed during Safety Week in May, Suicide Prevention Month in September and through the leaders in our safety community. OHA has addressed this topic with safety organizations and trade associations, such as:
 - a.) The National Association of Women in Construction (NAWIC)
 - b.) Oregon Association of Minority Entrepreneurs (OAME)
 - c.) Associated General Contractors (AGC)
 - d.) Associated Builders and Contractors (ABC)
 - e.) American Society of Safety Professionals (ASSP), and
 - f.) The Oregon Construction Safety Summit (CSS).

Several national conferences also have allowed us to present this topic.

Construction industry summary

The construction industry small workgroup concluded the following:

There are many factors that we have discussed and solutions that we have offered. We ask that the focus of our efforts is centered around a cultural shift and resource availability.

We ask that the ASIPP reinforce the following:

- *Quality of communication, information sharing (whether it be data or story-driven).*
- *Identifying and removing obstacles for people who need to reach out for help.*
- *Promoting and participating in healthful activities.*
- *Providing resources and support for one another proactively and in a time of need.*
- *Creating, maintaining and reinforcing a culture of acceptance, inclusion and of care and concern that redefines what it means to be tough and work in the construction industry.*

Through policy and programs, the construction industry can begin to require that suicide prevention and mental well-being be integrated into existing safety programs, outreach, training and culture. For our final recommendation, we would like to see the ASIPP formalize workforce development initiatives. There are many that tie to DEI and are effective in illustrating a framework and excellent example. We can begin to formalize a culture of care and formalize workforce development.

Engrained in these efforts, Diversity Equity and Inclusion shall be the underlying current that gives the energy for this culture to grow. Finally, having multilingual and multicultural resources will have a unifying impact.

“When we think about the high rate of suicide in the construction industry, particularly here in Oregon, we need to consider the enormity of the number of families whom the construction industry touches. The improvements we can make will not only have a cultural life-saving effect to our immediate industry but can begin to shape and grow our society.” Steve Frost

The construction industry has accomplished remarkable work around suicide and the construction industry. However, this vulnerable population, with its many high-risk intersecting identities, needs to continue to be a focus of suicide prevention efforts throughout the state.

Veterans and military-connected personnel

Introduction, data and literature reviews

The layperson often uses the term “veteran” to refer to anyone who has served in the United States Armed Forces or a reserve component of the armed forces. “Veteran” as related to access to care and other earned benefits has been defined by state and federal entities, as well as the Oregon Constitution. Self-identification as a military veteran is frequently associated with discharge status, time served in the U.S. Armed Forces, or lived experience. In practice, the word “veteran” means different things to different people. It is not uncommon for women veterans, survivors of Military Sexual Trauma (MST), those discharged under the policy “Don’t Ask, Don’t Tell” (DADT), or those who did not serve active-duty to not identify as a veterans. When asked if they are a veteran, a person may decline to identify as such. However, when asked if they served in the military, they may answer affirmatively. Recognizing these nuances and how they related to increased risk for suicide is important when developing a comprehensive ASIPP. To be inclusive of all military personnel, their families, and caregivers, we chose language reflecting this decision and use “veterans and military-connected personnel.” **From this point on in the ASIPP, persons who served in any capacity for any length of time in the United States Armed Forces or reserve components of the armed forces will be referred to as veterans.**

About this data:

When analyzing data specific to veterans, there are several sources available to reference. Depending on what data and what timeframe is being analyzed, one source may be more appropriate than another. Reports you may have seen, or see in the future, could reference data from one or more of the following sources:

- United States Department of Veterans Affairs (USDVA)
- Department of Defense (DoD)
- National Violent Death Reporting System (NVDRS)
- Oregon Violent Death Reporting System (ODVRS), and
- Oregon Vital Records, from the Oregon Center for Health Statistics.

The information in the tables and paragraphs below uses two sources:

1. Vital statistics veteran death data provided by the Oregon Center for Health Statistics.
2. Veteran population data from USDVA reports and used when calculating rates. Currently, only projected population data is publicly available.

The veteran status associated with the vital statistics death data is based on information on the death certificate. Vital statistics veteran status has not been validated with DoD. Currently, only USDVA can conduct that kind of validation. Depending on which reports and data sources you review, this means there might be slight variations in numbers. However, OHA believes our analysis regularly matches the same themes observed at the federal level.

By using vital statistics data in this summary:

- OHA can conduct analysis which may allow for more detail and more up-to-date information than publicly available through USDVA.
- OHA can align with the analysis provided in the 2019 Veterans Behavioral Health Improvement Study.

Sometimes different systems break down suicide death data using different age groupings. To align with the two different age groupings used by OHA produced reports and USDVA reports, there are two different tables for each year. The same data was utilized to produce each table.

Figure 17. Rate of veteran suicides by OHA ASIPP age-bracket from 2018–2020. Summary by year (2018–2020)

Veteran suicide deaths (OHA age grouping)								
Year	Total 18+		18–24		25–54		55+	
	No	Rate	No	Rate	No	Rate	No	Rate
2018	169	55.2	*	97.1	43	46.6	123	58.4
2019	158	52.6	*	92.7	45	49.8	110	53.1
2020	160	53.9	*	90	49	55.4	108	53.1

*Rates based on fewer than ten events are unreliable.

Source: Oregon Center for Health Statistics.

Figure 18. Rate of veteran suicides by VA/DoD age bracket from 2018–2020.

Veterans suicide numbers and rates (VA/DoD age grouping)										
Year	Total 18+		18–34		35–54		55–74		75+	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
2018	169	55.2	14	57.7	32	45	71	52.3	52	69.23
2019	158	52.6	22	92.2	26	37.3	60	45.6	50	66.4
2020	160	53.9	13	55.5	39	57	64	50.2	44	57.9

Source: Oregon Center for Health Statistics.

2018 summary

Of 9,209 veteran deaths in Oregon in 2018, 169 (1.84%) were identified as deaths by suicide. Of those deaths identified as veteran suicides, the vast majority were identified as men. Fewer than 10 women veterans died by suicide in 2018.

Approximately 28% of veterans who died by suicide in 2018 were identified as combat veterans. None of the combat veterans were identified as women. Of the 118 veteran suicides involving firearms, approximately 30% resulted in the death of a combat veteran. As with the rest of this data, details about a veteran’s military service are unknown (branch, time served in a reserve component, deployment status, etc.)

2019 summary

Of 9,404 veteran deaths in Oregon in 2019, 158 (1.68%) were identified as deaths by suicide. Of those deaths identified as veteran suicides, the vast majority were identified as men. Fewer than 10 women veterans died by suicide in 2019.

Approximately 25% of veterans who died by suicide in 2019 were identified as combat veterans. Of the 105 suicides involving firearms, approximately 30% resulted in the death of a combat veteran. As with the rest of this data, details about a veteran's military service are unknown (branch, time served in a reserve component, deployment status, etc.)

2020 summary

Of 9,631 veteran deaths in Oregon in 2020, 160 (1.66%) were identified as deaths by suicide. Of those deaths identified as veteran suicides, the vast majority were identified as men. Fewer than 10 women veterans died by suicide in 2020.

Approximately 24% of veterans who died by suicide in 2020 were identified as combat veterans. None of the combat veterans were identified as women. Of the 110 suicides involving firearms, approximately 22% resulted in the death of a combat veteran. As with the rest of this data, details about a veteran's military service are unknown (branch, time served in a reserve component, deployment status, etc.)

Means and methods

Figure 19. Most commonly used means of suicide by combat status and sex compared to all Oregonian suicide means.

Most frequently used lethal means					
Year	All veterans	All combat veterans	Male veterans	Female veterans	All Oregon suicides
2018	Firearms 69.9%	Firearms 74.5%	Firearms 69.7%	**Firearms	Firearms 51%
2019	Firearms 66.5%	Firearms 80%	Firearms 67.3%	**Firearms	Firearms 51%
2020	Firearms 68.8%	Firearms 61.54%	Firearms 67.5%	*Poisoning	Firearms 55%

* Includes carbon monoxide and acute substance abuse

**Numbers are too small to analyze

Firearms are the means used more often by veterans than the general population.

Source: CHS

2018–2020 summary

Looking at data over the three years of 2018–2020, OHA made the following observations:

- A.) **Based on the number alone, there were fewer combat veteran suicides, than non-combat veteran suicides.** The data used in making this observation does not include veterans where combat status was listed as “unknown”. Unknown status ranged from 4 in 2018 to 30 in 2019, and 20 in 2020. This statistic is puzzling. Based on Joiner's Interpersonal-Psychological Theory of Suicide in which increased capability if necessary (although not sufficient) for suicide; and being in combat would increase capability via exposure to death, fearlessness and

pain tolerance, one would expect that combat veterans would have a much higher suicide rate than non-combat veterans. Other research has shown that deployed veterans are no more likely to die by suicide than non-deployed veterans. [Bryan \(2022\)](#) did a meta-analysis of several studies on suicide and deployment versus non-deployment. Bryan found very conflicting results, likely due to the definition of deployment used in the study. Bryan concluded that deployment was not correlated with suicide. Bryan also compared civilians who had multiple suicide attempts (less fear of death) with military personnel regardless of deployment status. Bryan found that military personnel had even less of a fear of death than civilians who had multiple suicide attempts. Is it possible those that who sign up to be in the military may have some traits that make suicide more likely in the first place and being in the military exacerbates those traits? There is empirical evidence those in the military have total higher adverse child experiences (ACEs) scores than civilians ([Kanton, et., al 2015](#)). Higher ACEs scores are also associated with a higher risk of suicide attempts ([Choi, et., al 2017](#)).

- B.) **Significantly more veteran men than veteran women died by suicide between 2018–2020.**
- C.) **Each year, firearms were the most often used form of lethal means.** As determined by ICD10 coding in the data set, handguns were the most frequently used form of firearm in all three years. Between 70%-88% of all veteran suicides using firearms were associated with a handgun. This was determined by looking at the ICD10 coding provided in the vital statistics data set.
- D.) As mirrored by national-level data sets, the rate of veteran suicide in Oregon is higher than the rate of suicide in the general population.
- E.) The rate of veteran suicide (per 100,000 people) may fluctuate among age groups. However, **the highest number of veteran suicides tends to occur in people 55+.** When comparing vital statistics data against the 2018 and 2019 VA State Fact Sheets, it is clear both the rate and number of veteran suicides in Oregon are higher than the national average as well as the western region's average for veteran suicide.
- F.) **Veterans are more likely to use firearms to die by suicide than non-veterans** (69.82% in 2018; 66.46% in 2019, and 68.75% in 2020). **The firearms are usually handguns.**

In 2019, a report was produced by the Rede Group for OHA and the Oregon Department of Veterans Affairs [Oregon Veterans' Behavioral Health Services Improvement Study: Needs Assessment & Recommendation Report](#). **Many of the ASIPP veterans' small workgroup recommendations mirror findings from the 2019 study.**

Risk factors (meta-analysis of 22 studies by the VA)

- Prior attempt
- Depression
- Mental health symptoms
- Being White
- Alcohol and or drug abuse
- Traumatic brain injury
- Physical illness
- Severe pain
- Physical disability
- PTSD
- Being male
- Access to lethal means (U.S. Department of Veterans Affairs)
- A recent loss (U.S. Department of Veterans Affairs)
- Relationship issues (U.S. Department of Veterans Affairs)
- Unemployment (U.S. Department of Veterans Affairs)
- Homelessness (U.S. Department of Veterans Affairs)
- Military Sexual Trauma (MST) (U.S. Department of Veterans Affairs)
- LGBTQIA2S+ ([Matarazzo et al, 2014](#))

Protective factors

- Getting substance abuse help when needed
- Admission to a nursing facility when needed
- Having access to mental health resources and care
- Connection to others, especially other “like” veterans

Risk factors specific to women veterans

- Eating disorders
- Intimate partner violence (IPV) – veteran women are at a greater risk than civilian women to experience IPV
- ACEs (adverse childhood experiences)
- Non-suicidal self-injury (NSSI)

Intersecting identities that may increase risk

- LGBTQIA2S+
- Men
- Disability or chronic illness
- Easy access to a lethal means
- Living in rural or remote areas

Guiding principles developed by ASIPP veteran and military workgroup

- Upon implementation, all recommendations must consider the need for training on military cultural awareness for military-connected families, communities and the health care provider network.
- All recommendations must recognize different identities and key populations within the veteran and military community.
- To recognize and prioritize continuity of care, implementation efforts should include process improvement methodologies.
- The recommendations intend to support and address the needs of all veterans and military service members.
- These recommendations were developed and are being submitted as a part of a larger plan, but are intended to respond to an immediate need, requiring urgent implementation efforts

Recommendations from the veterans small workgroup: ([Link to full report](#))

An asterisk is placed next to those recommendations that closely mirror the 2019 Veterans Behavioral Health Improvement Study Recommendations.

- *1. Oregon Health Authority (OHA) should encourage all health care providers to complete standardized suicide prevention training inclusive of a military cultural lens. This training should be part of their training, ongoing learning or both. This training should be a requirement for any health care provider receiving referrals from the Veterans Health Administration (VHA) or Department of Defense (DoD).
2. OHA should promote screening efforts for early identification of suicide risk and connection to services based on the risk identified.
3. OHA should consider leveraging existing resources and training available through the VHA. Also, engage county and Tribal veteran service officers (CVSOs, TVSOs) when planning for different training opportunities.
- *4. OHA should coordinate or partner with organizations offering military cultural training to create culturally specific training and resource lists focusing on key populations within the military community, such as:
 - a.) Black, Indigenous, and people of color
 - b.) Women
 - c.) Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQIA2S+), and
 - d.) Tribal veterans and military service members.

An example of this is OHA continuing to partner with Lines for Life to provide more cultural training inclusive of content specific to key populations present in the military community.

- *5. OHA should coordinate with external partners to create, support or fund a social media campaign promoting visual awareness and inclusivity of key populations within the military community, such as:
 - a.) People of color
 - b.) Women
 - c.) LGBTQIA2S+, and
 - d.) Tribal veterans and military service members.
6. OHA should consider process improvement methodologies when engaging in new work or partnerships designed to support key populations within the military community.
- *7. OHA should promote inclusion and representation of key populations in advisory groups and decision-making bodies (borrow the consumer language of “nothing about us without us”).
8. To support veterans and their families, OHA should coordinate with ODVA’s family representative and the ODVA-funded campus veteran coordinators to collaborate on training, offering educational opportunities and the development of resource materials.

9. OHA should partner with non-profit and community-based organizations, such as National Alliance on Mental Illness (NAMI) to provide education to families and promote resource sharing.
10. OHA should partner with a university or other appropriate educational institution to bring in support programs.
- *11. OHA should provide peer-delivered services focusing on the unmet needs of military families and military spouses.
12. OHA should make suicide prevention gatekeeper training widely accessible to military families.
13. OHA should partner with organizations such as the American Foundation for Suicide Prevention (AFSP) Oregon Chapter to offer educational opportunities, such as safe gun storage, to community organizations statewide, with a particular emphasis on rural and frontier communities.
14. OHA should coordinate with ODVA's Aging Veterans Services to provide educational materials to Oregon's aging veterans to promote information, resources, and learning opportunities about potential eligibility for services.
15. OHA should offer VSOs training in specific behavioral health topics such as Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), compassion fatigue, etc.
16. After conducting a resource inventory, OHA should support efforts at increased collaboration between federal Veterans Affairs offices and civilian organizations.
17. OHA should partner with other sectors (county, city, state, federal) to gather information to inform a centralized resource list with resources and specialized points of contact.
18. OHA should focus on breaking down silos by leveraging existing resources such as 211 or being at the table to contribute to the development of new systems, such as 988.
19. OHA should engage with federal Veterans Affairs ombudspersons and United States personnel to bring awareness and attention to the ASIPP and other state-level efforts affecting the behavioral health of veterans in Oregon.
20. OHA should promote the use of national consultation programs such as the Suicide Risk Management (SRM) Consultation Program and the National Center for PTSD Consultation Program.
- *21. OHA should create and coordinate a scholarship program to assist with field placements for behavioral health professionals in rural and remote areas experiencing workforce shortages.
22. OHA should explore options to coordinate with OHSU (Oregon Health & Science University) or other educational institutions to incentivize or allow for debt forgiveness of health care providers serving the veteran community.
23. OHA should explore opportunities to address non-financial incentives affecting clinician retention and professional workforce shortages. Examples may include addressing workplace culture, caseload counts, educational opportunities or other benefits.

-
- *24. OHA should recognize the unique role private practices have in serving the veteran and military community while understanding their limited ability and resources to become fully certified outpatient clinics.
 - *25. OHA should help veterans and military service members who fall into service gaps when requirements of discharge status, length of service or service type or deployment criteria are put in place.
 26. OHA should explore establishing different levels of care or tiers of services in response to gaps or delays the veteran and military community may experience when accessing person-centered behavioral health care.
 27. OHA should develop messaging to address the misconception that the federal government takes care of all behavioral health needs of the National Guard.
 28. OHA should partner with organizations to identify and address opportunities and challenges associated with post-military service veteran employment (for example, veteran meet-ups, stand-downs and employer recruiting events).
 29. OHA should coordinate with the Oregon Employment Department and the Oregon Supported Employment Center for Excellence to discuss supporting veteran-specific job development and placement strategies.
 30. OHA should conduct immediate outreach and engagement with nonprofit and community-based organizations such as Transition Projects (TPI) in Portland to maximize and leverage existing community supports currently focusing on the veteran and military population.
 31. OHA should create a rapid response team to address the immediate behavioral health needs of high-risk veteran and military populations who may be uninsured or under-insured and do not have service-connected eligibility determined.
 - *32. OHA should partner with organizations that offer peer-delivered services (PDS).
 - *33. OHA should emphasize PDS and recognize the unique ability of veteran peers to serve veterans and military service members within and outside the traditional VA health care system.
 - *34. OHA should explore opportunities to expand peer support models (both training and delivery of PDS) across sectors to develop an established veteran peer support community outside the four walls.

Veterans focus group ([link to report](#)):

Below are statements collected from the veterans' focus group.

“There needs to be more holistic approaches to mental and physical health care”

“OHA needs to include Military Culture and POC Culture awareness in their planning/trainings”

“We need to do a better job at reaching out to the homeless”

“Connection and community are key”

“OHA needs to understand military culture. They need to know that throwing pamphlets at a veteran isn't the answer nor is a zoom call. Veteran suicide is an epidemic on its own and needs to be treated with the same care as you would any other epidemic.”

Veterans and military-connected personnel suicide prevention work underway

OHA has made an earnest effort to address Oregon veteran suicides and the recommendations brought forth by ASIPP are intended as an adjunct to these efforts. OHA has a full-time veterans behavioral health liaison who focuses on many aspects of assisting veterans who may be experiencing behavioral health concerns including suicidal thoughts and behaviors. Some accomplishments include:

1. During the 2019-2021 biennium, OHA contracted with Lines for Life to deliver a series of suicide prevention and military culture training to health care providers. The training was open to other military-connected service providers. The contract required the development of specific content focusing on LGBTQIA2S+, women and Tribal veterans.
2. Beginning in 2016, OHA became a supporting partner in the promotion of the Star Behavioral Health Providers Training. The training was, in part, used to meet requirements associated with the certified community behavioral health clinic (CCBHC) demonstration program. OHA continues to be a supporting partner in this training.
3. In 2020, OHA coordinated with ODVA to contribute content to and promote, the Veteran Resource Navigator.
4. Between 2018–2019, OHA launched a veteran behavioral health listserv and a veteran and military behavioral health website.
5. Beginning in 2021, OHA set aside funding to support the behavioral health needs of Tribal veterans.
6. In the 2021-2023 biennium, OHA contracted with NAMI Multnomah to support a variety of military-specific programming, including the support of a NAMI family member and caregiver support group and mental health awareness presentations (via NAMI Multnomah's Evening with the Experts model).
7. Beginning in 2019, OHA contracted with the Association of Oregon Community Mental Health Programs ([AOCMHP](#)) to financially support veteran and military-specific MHFA training in Oregon.

8. OHA was a fiscal sponsor of the 2019 Veterans + Military Suicide Prevention Conference, hosted by Lines for Life.
9. OHA was a fiscal sponsor of the veterans and military track of the 2021 Oregon Suicide Prevention Conference.
10. Beginning in 2020, OHA awarded funds to support the efforts of community-based organizations and rural and frontier providers in serving veteran and military populations.
11. Between 2019-2021, OHA piloted a veteran behavioral health peer support specialist (VBHPSS) program at three community mental health programs (CMHPs) in Oregon. The model leveraged the unique experiences of traditional health workers who identified as consumers of behavioral health services and had lived experience in the military. OHA continues to support and further develop the VBHPSS work in the 2021-2023 biennium.
12. In 2020 and 2022, OHA set aside funds to support scholarships to cover registration fees for the Mental Health & Addiction Association of Oregon (MHA AO) Peerpocalypse Conference.

Veterans and military-connected personnel summary

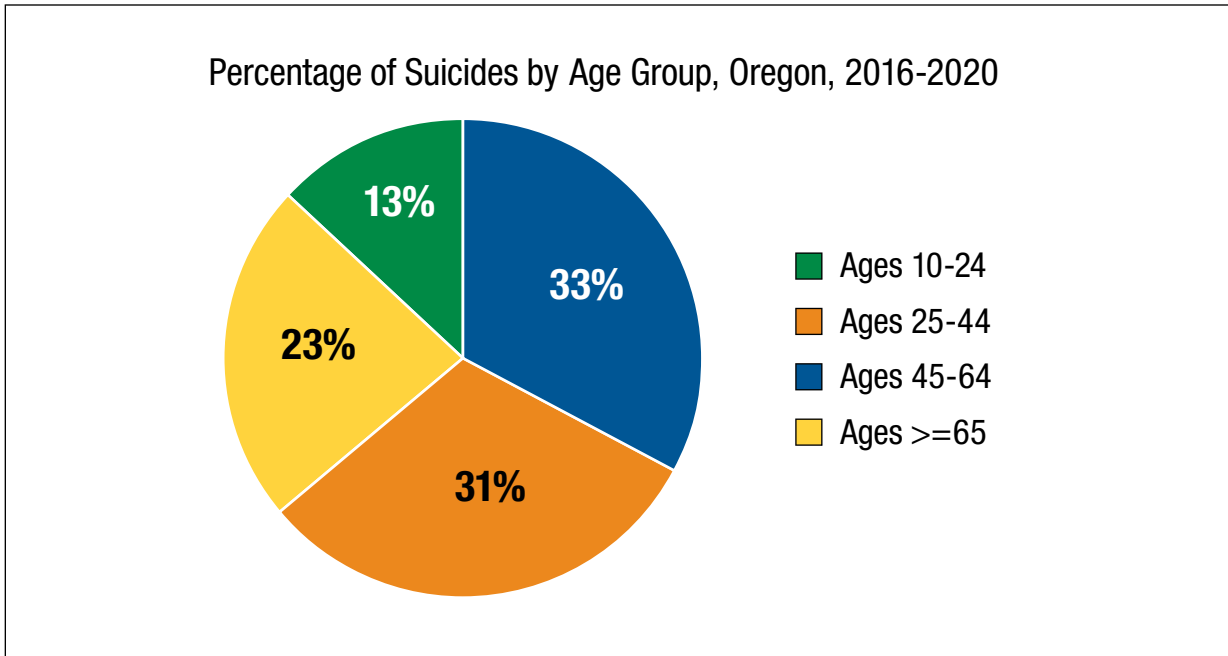
The suicide rate for veterans is substantially higher than the general population in every age group. The majority of persons in the armed forces are men. Men make up 75% of all suicides. However, the suicide rate for both male and female vets is still substantially higher than the general population. Veterans are much more likely to use firearms as a method of suicide than the general population. However, firearms are the most frequent method of suicide for both veterans and non-veterans (ranked at 1). It appears as though the majority of veteran suicides are not combat veterans. OHA, OVDA and VA have made substantial efforts to reduce suicide among veteran populations. Some of the recommendations from the comprehensive 2019 Veterans Behavioral Health Improvement Study have already been initiated or completed despite the substantial disruption caused by the COVID-19 pandemic. The ASIPP veteran small workgroup, which consisted mostly of veterans, made several thoughtful recommendations, some similar to the 2019 Study and should be given careful consideration. As a society, we need to better protect those who protected us.

Older adults

Introduction, data and literature review

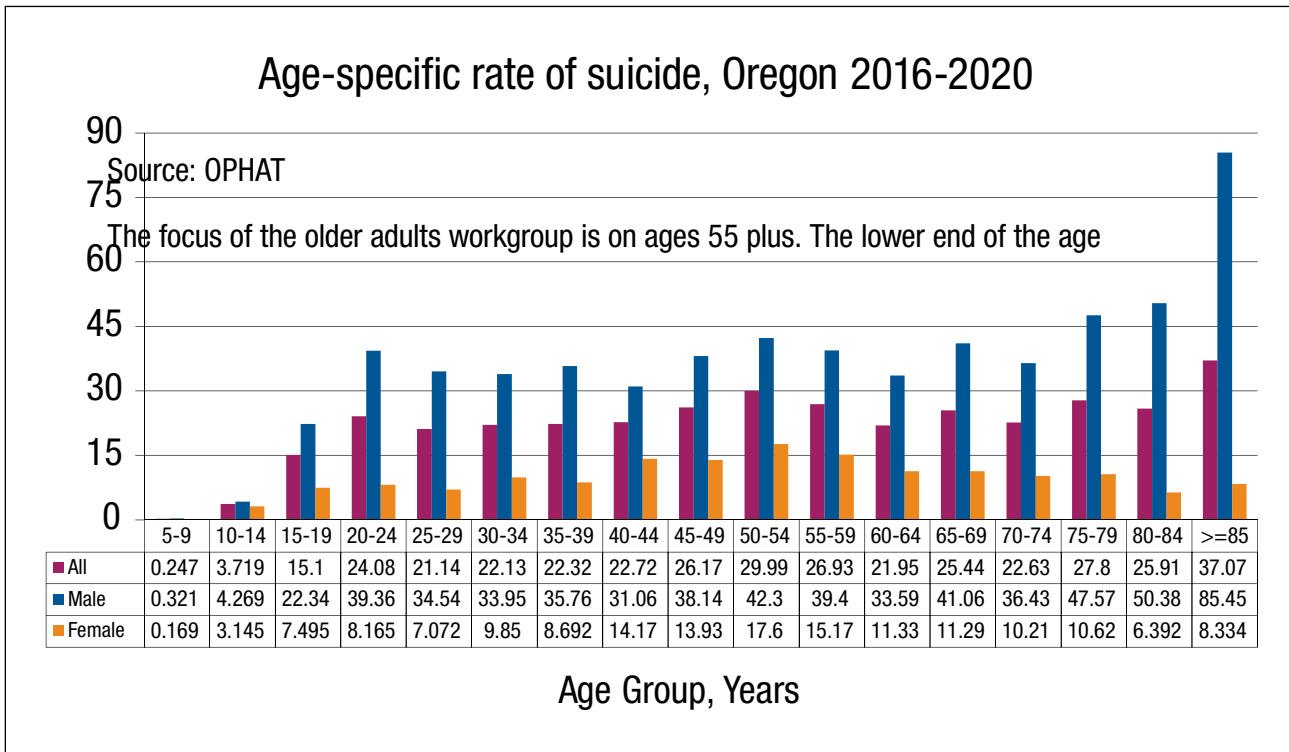
The majority of Oregon's suicide prevention efforts are with youth. However, the majority of suicides (56%) are by those 45 and older (Figure 20).

Figure 20. Percentage of suicides by age group from 2016–2020 in Oregon.



Generally, as age increases, so does suicide with males being at a much greater risk than females throughout their lifespan (Figure 21).

Figure 21. Rate of suicides by sex and age group from 2016–2020 in Oregon.



focus (55) was chosen because of the potential developmental commonalities potentially beginning at age 55 such as retirement, illness, “empty nest syndrome,” etc.

As Figure 21 indicates, the most dramatic increase in suicide is with males moving from a rate of

36.43 at age 70-74 to a rate of 85.45 by age 85+ (more than doubling the rate from age 70 to age 85+). There is a decrease in the rate of suicide for women from age 55-59 (15.17) to age 85+ (8.33).

The mechanism of death changes a bit as age increases with 63% of all suicides for the 55+ age group being firearms compared to across the lifespan with 52% using firearms (Figure 22, Figure

5). Female older adults are as likely to die by poisoning compared to

firearms.

Means and methods

Figure 22. Mechanism of suicide deaths in older adults (55+) by sex from 2016–2020.

Mechanism of injury among suicide deaths, 55+, Oregon, 2016–2020						
55+	ALL		Males		Females	
Mechanism of injury	Percent	Count	Percent	Count	Percent	Count
Firearm	63%	1043	71%	908	35%	135
Hanging or suffocation	15%	254	14%	182	19%	72
Poisoning	14%	239	8%	106	35%	133
Fall	3%	44	2%	26	5%	18
Motor vehicle or train	1%	23	1%	18	1%	5
Sharp instrument	1%	12	1%	9	1%	3
*Other or unknown	2%	39	2%	21	5%	18
Total	100%	1654	100%	1270	100%	384

Although youth suicide is extremely tragic and efforts to reduce the rate of suicide are a worthy goal, the same efforts are not seen for older adults in Oregon or across the nation. Whether conscious or not, there seems to be a notion in our society that older adults are somehow expendable.

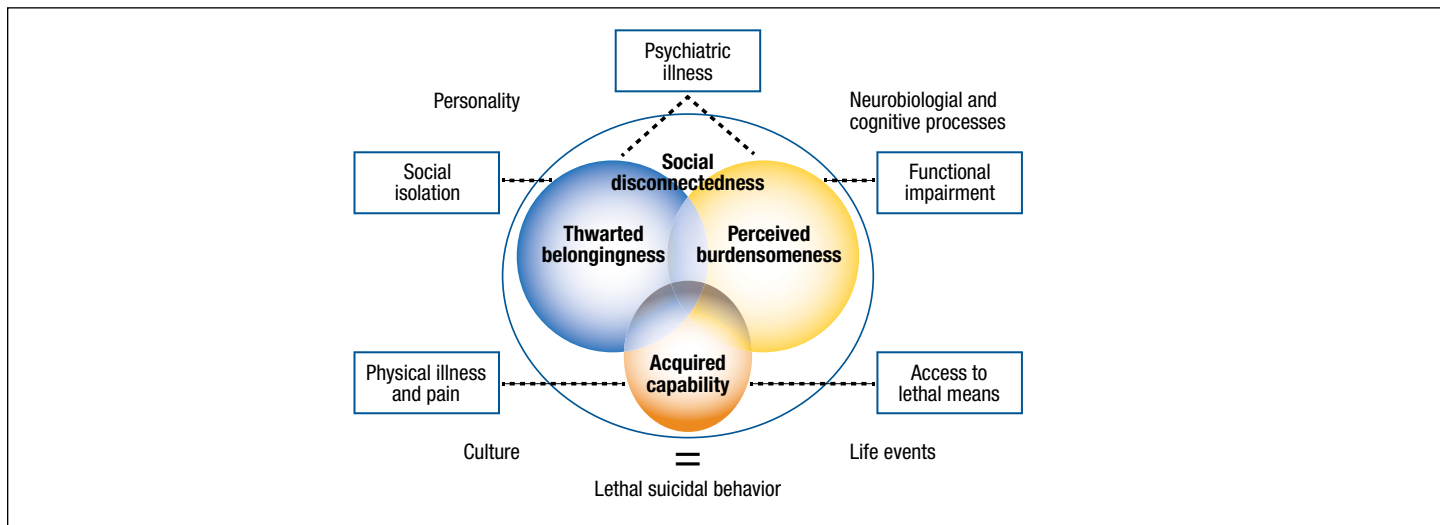
Interpersonal theory of suicide and older adult suicide

[Thomas Joiners Interpersonal Theory of Suicide](#) seems especially applicable to older adults. The theory consists of three potential causative factors when combined increases the risk for suicidal behavior which includes:

1. An increasing sense of thwarted belonging
2. Perceived burdensomeness, and
3. An acquired capability to kill oneself.

Joiners' theory contends that we are not born with the "ability" to die by suicide. Our instinct is to remain alive (survival instincts). The ability to die by suicide must be acquired over lifetime experiences that desensitize us to pain and death. It seems as though older adults, particularly those physically ill and perhaps in chronic pain would seem vulnerable to all three of Joiners' causative factors ([Van Orden et., al 2011](#)).

Figure 23. The Interpersonal Theory of Suicide applied to late life.



Source: Reference – [Van Orden](#)

Note that the three inner-colored circles represent the three key constructs posited to cause suicide according to the Interpersonal Theory of Suicide. The five boxes represent key risk factors for late-life suicide derived from psychological autopsy studies. The dotted lines from these risk factors to one of the inner circles indicate hypothesized psychological mechanisms (derived from the Interpersonal Theory of Suicide) whereby risk factors elevate the risk of late-life suicide.

Circumstances surrounding suicide incidents

For this age group (55+) the top five circumstances surrounding a suicide include:

Figure 24. Circumstances of suicides in ages 55+ from 2016–2020.

55+ Circumstances (2016–2020)	% of total suicides
Physical health problem	33.5
Diagnosed mental disorder	31.5
Left a suicide note	31.3
History of expressed suicidal thoughts or plan	30.2
Current depressed mood	30.2

Source: ORVDRS

For a complete list of circumstances please see [Appendix 9](#).

Figure 24 is congruent with the Interpersonal Theory of Suicide as applied to older adults with psychiatric and physical illnesses leading the way.

Older adults’ risk factors

1. Physical illness, disability and pain
2. Social isolation
3. Being male
4. Being unmarried

Older adults' protective factors

- Receiving adequate care for mental and physical health problems
- Social connectedness
- Skills in coping and adapting to change
- Having religious or spiritual beliefs

Intersectional identities that may increase risk for older adults

- Men
- LGBTQIA2S+
- Veterans
- Those living in rural or remote areas
- Those experiencing disabilities, chronic illness or both

Recommendations from older adults small workgroup: ([Link to complete report](#))

1. Increase points of care

Integrate and coordinate older adult suicide prevention activities across multiple sectors, settings and points of care and connection including:

- | | | |
|--------------------------------|---------------------------------|---|
| ▪ Community and senior centers | ▪ Faith communities | ▪ Gatekeepers |
| ▪ Libraries | ▪ Community-based care settings | ▪ Financial systems |
| ▪ Social groups or clubs | ▪ Auxiliary services | ▪ Local older adult-serving businesses |
| ▪ Social media | ▪ Barbershops and salons | ▪ Peer settings |
| ▪ Health care settings | ▪ Mail and meal delivery | ▪ Affinity groups |
| ▪ Natural systems of support | ▪ Transportation | ▪ Culturally specific organizations, etc. |

2. Increase awareness and education

Provide training to community and clinical service providers on the prevention of suicide and related behaviors. Implement evidence-based, evidence-informed and practice-based education and awareness efforts designed for older adult mental health promotion, such as:

- a.) Older Adult Question, Persuade, Refer (OAQPR)
- b.) Military-connected [QPR](#)
- c.) QPR for faith communities
- d.) Older Adult [Mental Health First Aid](#) (OAMHFA)

Develop culturally specific efforts and resources with older adult people of color, LGBTQIA2S+ communities and other marginalized communities.

3. Increase protective factors

Increase knowledge of factors that offer protection from suicidal behaviors in older adults and that promote wellness and recovery, such as:

- a.) Social connection
- b.) Social determinants of health
- c.) Limited access to means
- d.) Promotion of mental health and physical health (whole health) services and support

Increase culturally appropriate protective factors in older people of color, LGBTQIA2S+ and other marginalized communities. Promote activities that support the sense of community-wide belonging and inclusion. Reduce marginalization, discrimination and exclusion.

4. Increase community-based prevention programs

Implement programs that promote wellness and prevent suicide and related behaviors, such as:

- a.) Wellness Initiative for Senior Education ([WISE](#)) program
- b.) Aging Mastery Program® ([AMP](#))
- c.) Program to Encourage Active, Rewarding Lives ([PEARLS](#))
- d.) Oregon Senior Peer Outreach ([OSPO](#))
- e.) Peer-to-peer programs
- f.) [Senior Loneliness Line](#) and other effective tools and programs

Develop culturally specific programs with older people of color, LGBTQIA2S+ and other marginalized communities.

5. **Improve clinical strategies**

Promote suicide prevention and mental health services as a core component of health care services and delivery. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

6. **Promote means safety**

Promote efforts to address means of safety among older adults through educational efforts, such as:

- a.) Counseling on Access to Lethal Means ([CALM](#))
- b.) Conversations with care providers and other social or medical support persons
- c.) Firearm safety and locks programs
- d.) Outreach to veterans and military-connected communities and families, care partners, rural and isolated older adults, and other groups with a propensity towards gun ownership.

7. **Improve postvention planning and response**

Increase postvention education, preparation and support for older adult congregate settings, such as:

- a.) Senior living communities
- b.) Senior and community centers
- c.) Congregate meal and activity sites
- d.) Villages (virtual peer communities)
- e.) Care communities
- f.) Faith communities
- g.) Culturally specific organizations, etc.

8. **Improve suicide prevention equity**

Promote research around the causes and impacts of disparities in suicide rates among older adult groups, such as:

- a.) LGBTQIA2S+
- b.) People of color
- c.) White men
- d.) Income level
- e.) Gender, etc.

Implement new strategies based on research outcomes.

Older adult focus group

In addition to the input from the older adult small workgroup the following input was gathered during the older adult focus group ([link to complete report](#)):

“[If] people don’t feel their life is at least sometimes worthwhile or pleasant, then they’re more likely to be looking at leaving the earth”

“We are all human and want connection”

“That one-on-one talking is very important in preventing depression and possibly suicide. Online help will assist, but for actual situations, a friend or relative is also very important”.

“Connection. Humans need connection just after food and shelter as a basic necessity. We need to create meaning and belonging among generations and communities”

Suicide Prevention Work Currently Underway for Older Adults

1. In 2015, OHA created a 1.0 FTE (older adult behavioral health services lead) devoted to providing increased behavioral health care, including suicide prevention, for older adults.
2. OHA holds annual summits on older adults with a focus on loneliness and commotion.
3. OHA has added services for older adults in Eastern Oregon using the PEARLS model (pilot project).
4. There has been QPR and Older Adult Mental Health training throughout the state for older adults and those who work closely with older adults.
5. In 2020, OHA began contracting with Lines for Life to provide the “Senior Loneliness Line”, a call line for seniors feeling lonely and who just need somebody to talk to. They do not have to be in a crisis or suicidal.
6. In 2015, OHA provided funding and the infrastructure to provide 25 older adult behavioral health specialists in 36 counties (some smaller counties share the FTE).

Older adults summary

OHA has a great foundation and infrastructure to continue to build upon its suicide prevention, intervention and postvention efforts with older adults who have alarmingly high rates of suicide, especially older men. This work needs to be done across sectors, with an emphasis on health care professionals since health care is a major “touch point” for older adults. Older adults should continue to be involved in the planning and implementation of suicide prevention work. Upstream measures, such as the Senior Loneliness Line and building social connections should continue to be supported.

Disabilities and chronic illness

Introduction, data and literature review

As mentioned previously this small workgroup had a difficult time coming to fruition. Thus, this section will be somewhat sparse and incomplete. Fortunately, we did have a focus group for this population which will add to our knowledge.

What we do know from completing a literature review on the topic of disabilities and or chronic illness and suicide is that having disabilities or chronic illness can increase the risk of suicide. [Khazem](#) (2018) completed a meta-analysis on this topic and found:

“Those with disabilities, including physical disabilities, were three times as likely than those without disabilities to have endorsed past-year suicidal ideation, after controlling for age, sex, and psychiatric comorbidity. Compared to those without disabilities, individuals with some form of disability impacting ADL (Activities of Daily Living) were observed as being four times more likely to have attempted suicide in the past 12 months; those with multiple disabilities were eight times as likely to have attempted suicide in the same period.”

Khazem (2018) suggested the mechanisms contributing to this heightened risk for suicide are their perceived sense of burdensomeness and pain. As mentioned in the Older Adult section, [Thomas Joiners Interpersonal Theory](#) of Suicide seems especially applicable to those experiencing disability, chronic illness or both. The theory consists of three potential causative factors that when combined increases the risk for suicidal behavior which includes:

1. An increasing sense of thwarted belonging
2. Perceived burdensomeness, and
3. An acquired capability to kill oneself.

It seems as though those experiencing disability, chronic illness, or both would seem vulnerable to all three of Joiners' causative factors, especially perceived burdensomeness, and pain desensitization.

Khazem (2018) states:

“A meta-analysis of individuals with physical pain indicated that these individuals were more likely to endorse suicidal ideation and history of suicide attempts and to die by suicide. According to the ITS, individuals' capability for making a lethal suicide attempt is acquired partly through habituation to pain and developing a fearlessness about death. For those with chronic pain conditions and suicidal ideation, their physical pain may facilitate the capability for suicide.”

Disabilities and chronic illness risk factors

A literature review did not reveal any risk and protective factors specific to those with disabilities, chronic illness or both. However, there are some risk factors related to chronic pain. CDC states the following for the general population. *There is an asterisk next to those more likely to be true for this population focus:*

[CDC](#) states the following risk factors:

- Previous suicide attempt
- Mental illness, such as depression
- Social isolation*
- Criminal problems
- Financial problems*
- Impulsive or aggressive tendencies
- Job problems or loss*
- Legal problems
- Serious illness*
- Substance use disorder
- Child abuse and neglect
- Bullying*
- Family history of suicide
- Relationship problems such as a breakup, violence, or loss
- Being a victim of sexual violence
- Barriers to health care*
- Cultural and religious beliefs such as the belief that suicide is a noble resolution of a personal problem
- Suicide cluster in the community
- The stigma associated with mental illness or help-seeking
- Easy access to lethal means among people at risk (e.g. firearms, medications) *
- Unsafe media portrayals of suicide

*Additional specific risk factors for those in chronic pain: (Ilgen et., al 2008)

- Longer pain duration
- Insomnia
- Abdominal pain
- Headache / Migraine
- Presence of multiple pain conditions
- Receipt of workers' compensation/pursuit of a legal claim

Disabilities and Chronic Illness Protective Factors

- Coping and problem-solving skills
- Cultural and religious beliefs that discourage suicide
- Connections to friends, family, and community support
- Supportive relationships with care providers
- Availability of physical and mental health care
- Limited access to lethal means among people at risk

Intersectional Identities That May Increase Risk for Disabilities and Chronic Illness

- LGBTQIA2S+
- Veterans
- Living in Rural or Remote areas
- Older Adults
- BIPOC and AI/AN

Recommendations from the Disabilities and Chronic Illness small workgroup

Unfortunately, this Small Workgroup never quite came to fruition in the manner that the other Small Workgroups were able to. Despite meeting 3-4 times, the attendance was poor. Despite recruitment attempts, the right people were not at the table, and it did not result in a formal report. However, there were a few recommendations that were formulated which include:

1. Conduct a landscape analysis, which outlines strengths, resources, and needs, with the goal of gaining a better understanding of the relationship between suicide and disabilities/chronic illness specific to Oregon and explicitly engage Disability groups in this process.
2. Encourage hospitals and physicians to complete a suicide risk assessment following a serious diagnosis.

Input from the Disabilities and Chronic Illness focus group (full report is in [Appendix 3](#))

Fortunately, Disabilities and Serious Illness was a population that was chosen to be one of the seven focus groups; thus, we were able to ascertain some perspectives on the disparate population, despite having a limited Small Workgroup. Some of the feedback included:

“We need affordable, accessible housing. We need affordable, accessible health care, including prevention services for physical and mental health. We need providers to be trained and paid appropriately when accepting OHP/Medicaid.”

“There needs to be more access to resources (ie. Peer services, housing assistance programs, etc.) There needs to be a more consistent way of resource sharing within counties/regions, that clients and providers can access. Often times I have been told to use 211 only to be led to all dead ends.”

“I think that the most important thing to keep in mind is that even though people who struggle with suicide can be (or are) in crisis that they still need to be able to have a say in their plans. Also, DO NOT EVER SEND POLICE FOR A MENTAL HEALTH CRISIS.”

“Basic human needs and rights are violated every day by “helping professionals” and it needs to stop. People deserve to have their basic needs secured, food and housing and access to care and community services is a must. This is a multi-layered issue that is going to take leadership in all areas to address the underlying sickness in our communities, not just individuals experiencing it. We need community gardens, support for families struggling, less access to alcohol and dangerous prescription drugs and more access to nature, leisure time, spiritual services, and exercise. We need to stop criminalizing mental health behaviors and start training people to be ready to support those who experience mental health challenges and help them be successful in jobs and community activities.”

“Peers need to continue to be added to these conversations—we are the experts of our lives and we know best what we need to thrive!”

Suicide Prevention Work Currently Underway

There has been little or no suicide prevention work that has been completed or underway with this specific population despite being a population that has disparate rates of suicide.

Summary

As mentioned above, this is a population that has received little or no suicide prevention efforts. However, there has been some focus via the Veterans, Construction, and Older Adult Workgroups. The difficulty in gathering a Small Workgroup for the ASIPP focusing on this population is further attestation of the degree to which this population has been “forgotten” and marginalized which needs to be addressed throughout the ASIPP 5-year plan.

Black, Indigenous, people of color and American Indian or Alaska Native

Introduction, data and literature review

The following is an excerpt from the ASIPP BIPOC AI/AN Small Workgroup: ([Full Report](#))

“Racism is a public health crisis. In Oregon, accessing safe, effective, and culturally informed behavioral health/health care often comes with increased burdens and barriers for BIPOC individuals seeking non-emergency and emergency care. The social determinants of health and intersectionality compound and multiply many of the struggles BIPOC communities encounter in receiving quality care, reducing suicide deaths, and deaths by “slow suicide” which can be more common in communities of color. Integrated, community-based health approaches and initiatives could greatly improve the quality of life and lifespan of BIPOC community members.”

Oregon is predominately White persons (82.6% according to the American Community Survey) and has a long history of racism with several examples of exclusionary laws regarding jobs, entertainment, and home ownership. Some of these laws existed into the 1960s and racist attitudes and behaviors have persisted into the present day.

OHA has more recently made a strong commitment to establishing health equities. The OHA 2020 – 2024 State Health Improvement Plan – Healthier Together Oregon (HTO) has named health equity as a top priority. The HTO states:

“HTO’s primary goal is to achieve health equity for BIPOC-AI/AN, people with low incomes, people with disabilities, people who identify as LGBTQIA2S+ and people who live in rural areas. These groups experience major health inequities because Oregon and U.S. systems that determine access to these resources are designed for people who typically identify as white, straight, English-speaking, able-bodied, cis-gendered and male. People at the intersection of more than one affected community, e.g., people who are Black and transgender, find these systems especially oppressive and hard to navigate. People in power positions may not be intentionally racist. However, our systems are racist because of implicit and institutional bias.”

“Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class or the intersections among these communities or identities or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address: the equitable distribution or redistributing of resources and power and recognizing, reconciling and rectifying historical and contemporary injustices.” (Oregon Health Policy Board – Health Equity Committee, 2019)

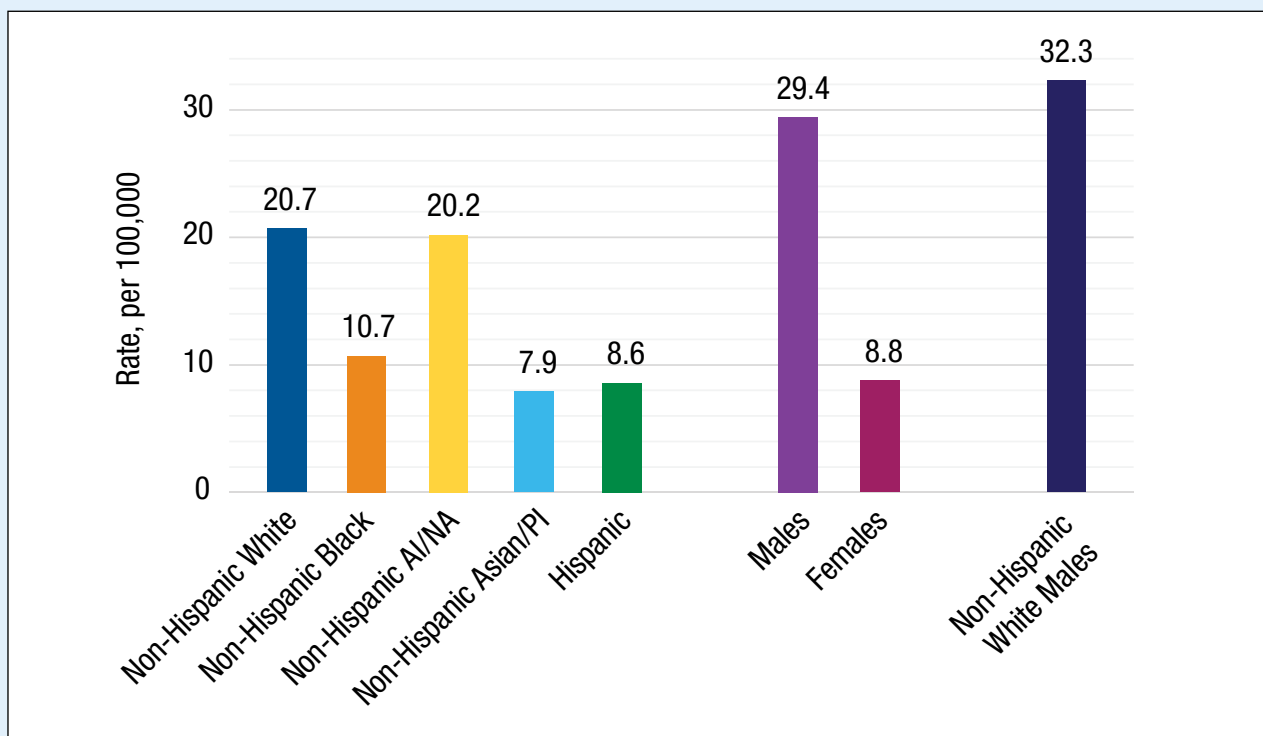
There are a few important implications that Oregon is predominately White persons as it relates to the interpretation of data and the development of the ASIPP. In terms of ASIPP development, the Small Workgroup named “BIPOC” AI/AN” is many different populations as is the LGBTQIA2S+ Small Workgroup. There are many differences within those populations but because of the low population numbers, we have combined them. The similarity is that all of the non-White populations

have been the target of systematic racism and marginalization by the dominant white culture which has negatively impacted health, including mental health and access to valuable resources.

The second implication of having a state that is predominately White persons is that data is difficult to interpret, particularly when trying to measure change within a small group of people. When the denominator is low interpretation becomes challenging. The change could be a “fluke” — a change that shows up due to small sample sizes but does not represent a real trend in the population. The larger the denominator the greater the likelihood that it is not a fluke.

Keep these limitations in mind while interpreting the following data.

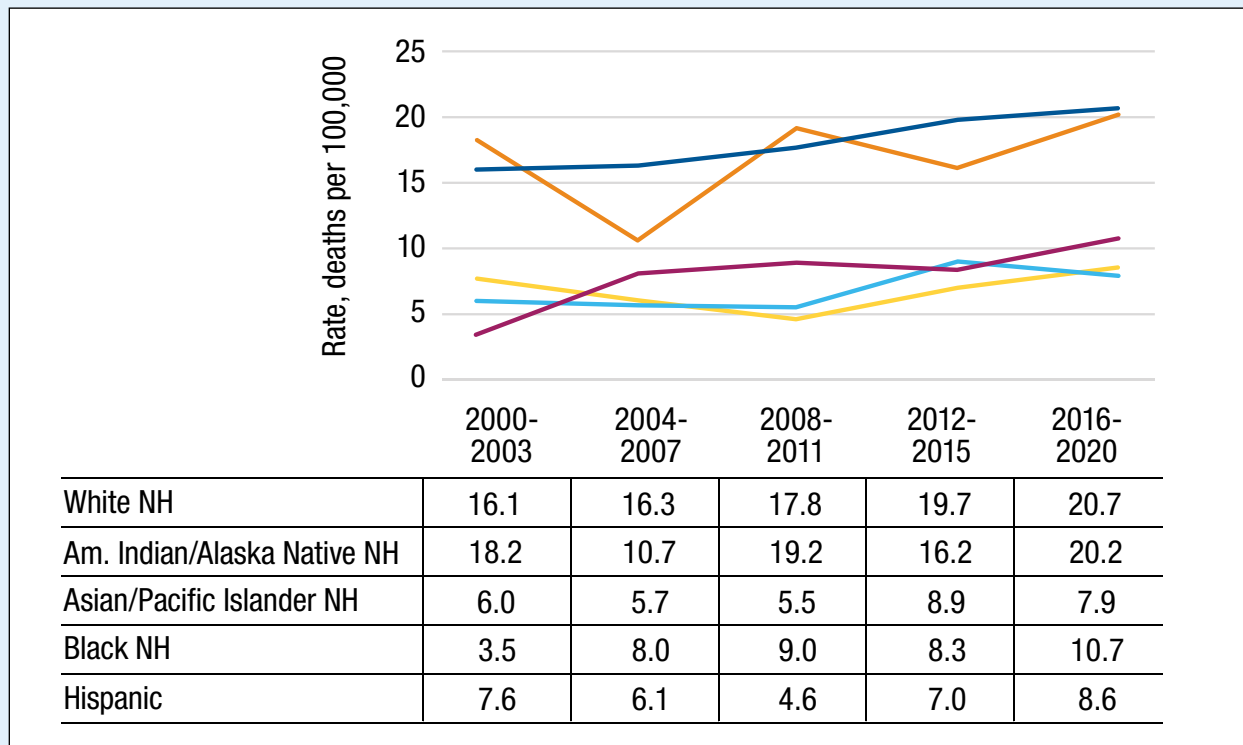
Figure 25. Age-adjusted suicide rate per 100,000 population by race/ethnicity and sex from 2016–2020.



Source: OPHAT (Oregon Public Health Assessment Tool)

Between 2016–2020 Non-Hispanic White and Non-Hispanic American Indians and Alaska Natives have the highest rates of suicide with rates of 20.7 and 20.2 respectively (Figure 25). Data from OPHAT also reports that all races have seen an increase in the suicide rate between 2000 and 2020 and of specific concern is the increase in the Non-Hispanic Black population with a rate of 3.5 from 2000-2003 to a rate of 10.7 from 2016–2020 (Figure 26). It would be a mistake to simply look at rates of suicide between Race/Ethnicity categories without considering increases in those rates within each population over time. All populations have seen an increase over the last 20 years.

Figure 26. Age-adjusted rate of suicide, by race/ethnicity in Oregon from 2000-2020



Source: OPHAT

Circumstances Surrounding Suicide Incidents

Figure 27. Circumstances of Suicide in Non-White* Populations from 2016–2020.

Non-White* Circumstances (2016–2020)	% of total suicides
Diagnosed mental disorder	39.9
Current depressed mood	30.8
History of expressed suicidal thought or plan	34.9
Intimate partner problem	30.0
Left a suicide note	28.6

* Non-White population includes people with Hispanic ethnicity regardless of race, multi-races, Black, American Indian or Native Alaskan, Asian and Pacific Islander.

Source: ORVDRS

The top five circumstances list looks similar to the 18–24 year and 55+ list except for “Intimate Partner Problem” which is at 30% (Figure 27). Intimate Partner Problem ranked 5th at 22.9% for 18–24-year old’s with nearly a quarter of that group having Intimate Partner Problems as a circumstance surrounding the suicide (Appendix 9). Intimate Partner Problem was a factor in only 10.5% of suicides for the 55+ population. Otherwise diagnosed mental disorder, depression, and a history of suicidal thoughts and or behaviors is a somewhat common circumstance among all three high-risk populations.

As mentioned, BIPOC AI/AN is not a uniform population. There are different specific risk and protective factors for each racial and ethnic population. The following Risk and Protective Factors are Racially/Ethnically Specific and come from the [SPRC](#):

Risk factors and protective factors

Risk Factors for Black populations (SPRC)

- Alcohol and drug abuse
- Mood and anxiety disorders
- Access to lethal means
- Prior suicide attempt(s)
- Relationship problems
- Work problems
- Financial hardships
- Legal difficulties
- Declining health
- Being Divorced
- Being Widowed
- Family Problems
- Acculturation into a White society which can include loss of family cohesion
- Hopelessness, racism, and discrimination
- Lack of Access and/or use of Mental Health Services or access to culturally appropriate services

Protective factors for Black populations

- Effective mental health care
- Connectedness to individuals, family, community, and social institutions
- Problem-solving skills
- Contacts with caregivers
- Religion
- Social and emotional support
- Community Connection
- Family Support
- Peer Support
- For women specifically, a strong sense of African American identity, heritage, and history

Risk Factors for AI/ AN populations (SPRC)

- Alcohol and drug abuse
- Mood and anxiety disorders
- Access to lethal means
- Prior suicide attempt(s)
- Relationship problems
- Work problems
- Financial hardships
- Legal difficulties
- Declining health
- **Historical trauma** – Attempts to eliminate AI/AN culture such as forced relocation, removal of children to boarding schools, prohibition of the practice of native language and cultural traditions, and outlawing of traditional religious practices have affected multiple generations of AI/AN people and contribute to high rates of suicide among them
- **Alienation** – causes a loss of well-being when the individual feels emotionally disconnected from their family of origin or culture
- **Acculturation** into white society
- **Discrimination** leading to poor self-esteem and depression
- **Being a victim of violence**
- Lack of Access and/or use of Mental Health Services or access to culturally appropriate services
- Suicide Contagion can occur when living in tight-knit communities such as reservations

Protective Factors for AI/ AN populations (SPRC)

- Effective mental health care
- Connectedness to individuals, family, community, and social institutions
- Problem-solving skills
- Contacts with caregivers
- Community Control such as sovereignty, land titles, and provision of services such as education, police, fire, health care, child and family services within the community and controlled by the community
- Cultural Identification and practices
- Commitment to tribal cultural spirituality
- Family connectedness

Risk Factors for Asian, Native Hawaiian and other Pacific Islander Populations (SPRC)

- Alcohol and drug abuse
- Mood and anxiety disorders
- Access to lethal means
- Prior suicide attempt(s)
- Relationship problems
- Work problems
- Financial hardships
- Legal difficulties
- Declining health
- Family Conflict
- Acculturation
- Discrimination
- Lack of Access and/or use of Mental Health Services or access to culturally appropriate services
- Poor academic achievement

Protective Factors for Asian, Native Hawaiian and other Pacific Islander Populations (SPRC)

- Effective mental health care
- Connectedness to individuals, family, community, and social institutions
- Problem-solving skills
- Contacts with caregivers
- Cultural Identification
- Strong family relationships
- Help-seeking with native healers

Risk Factors for Hispanic Populations (SPRC)

- Alcohol and drug abuse
- Mood and anxiety disorders
- Access to lethal means
- Prior suicide attempt(s)
- Relationship problems
- Work problems
- Financial hardships
- Legal difficulties
- Declining health
- Lack of Access and/or use of Mental Health Services or access to culturally appropriate services
- **Alienation** – causes a loss of well-being when the individual feels emotionally disconnected from their family of origin or culture
- Acculturation
- Hopelessness and fatalism
- Discrimination

Protective Factors for Hispanic Populations (SPRC)

- Effective mental health care
- Connectedness to individuals, family, community, and social institutions
- Problem-solving skills
- Contacts with caregivers
- Familism
- A strong sense of ethnic affiliation
- Religiosity that discourages suicide
- History of having caring mentors as adolescents

Intersectional Identities That May Increase Risk for BIPOC AI/AN Populations

- LGBTQIA2S+
- Veterans
- Older Adults
- Disability or Chronic Illness
- Rural and remote

Recommendations from the BIPOC AI/AN small workgroup (Full Report)

Areas of focus:

- Increasing BIPOC behavioral health providers and retaining them.
- Decreasing barriers for BIPOC communities accessing higher education in identified fields.
- Improving outcomes for BIPOC individuals who do engage in behavioral health services.
- Decreasing barriers to culturally responsive health care.
- Use an anti-racist, integrated public health framework to address systemic inequality.

Recommendations:

Education

- Loan forgiveness programs to complement federal programs.
- In-state scholarship opportunities for BIPOC AI/AN students seeking a health-related degree, generated in conjunction with public universities and community college grant opportunities.
- Internship opportunities specifically for BIPOC AI/AN Youth high school students to encourage them to join behavioral health-related fields.
- Provide free CEU training for all providers to understand and apply culturally adaptive assessment tools.

Community

- Build active relationships through outreach with racially and ethnically diverse organizations of all types to fully engage with the community and invite the community to partner in creating initiatives
- Provide comprehensive postvention services to all BIPOC AI/AN families experiencing suicide loss, working with county suicide specialists to create a sustainable postvention and outreach plan.

Integrated health

- Connect behavioral health initiatives to the Healthier Together Plan. All of the equity initiatives noted in the Healthier Together plan are also part of greater suicide prevention work.

BIPOC AI/AN Suicide Prevention Work Currently Underway

- In 2020, OHA awarded a total of \$215,000, spread across 18 LGBTQIA2S+ community organizations, to reduce suicide behaviors among LGBTQIA2S+ people with priority given to Black, Tribal, LatinX, other communities of color, rural and disabled populations. The goal of the grants was to build protective factors by increasing opportunities for life-affirming connection, resources and health care to vulnerable and isolated LGBTQIA2S+ youth and adults. The 18 funded projects included a wide range of creative and community-centered approaches such as increasing access to gender-affirming care, expanding positive youth development activities, creating community-wide collaborative efforts, and a podcast to elevate LGBTQIA2S+ voices.
- [Northwest Portland Area Indian Health Board](#) (NPAIHB) has robust suicide prevention efforts. The suicide prevention project at the NPAIHB is THRIVE which stands for Tribal Health: Reaching out InVolves Everyone. THRIVE works to reduce suicide rates among American Indians and Alaska Natives living in the Pacific Northwest by increasing tribal capacity to prevent suicide and by improving regional collaborations. Staff provides programmatic technical assistance, suicide prevention training, and resources to the Northwest Tribes. Specific project activities include: Zero Suicide, training, and presentations, media campaigns and an Annual THRIVE conference.
- In the summer of 2021, a summit, supported by the Oregon Alliance to Prevent Suicide and OHA was held titled, “Seeking Healing During COVID-19 for Black and Native American Communities”. The focus was on suicide. Approximately 75 people attended the conference from throughout the US; however, predominately people in Oregon attended.
- [Familias en Acción](#) began convening Oregon health professionals through an annual Latino/a/x health equity conference focused on Oregon’s Latino/a/x communities. Their 2018 conference, Strengthening Latino Mental and Emotional Health, highlighted understanding and integrating Latino/a/x psychology within health, mental health and social service systems.
- In 2020, Oregon Commission on Hispanic Affairs in partnership with OHA did an in-depth report, “[Crisis de Nuestro Bienestar: A Report on Latino Mental Health in Oregon](#)” that included several thoughtful recommendations.

BIPOC AI/AN Summary

OHA has a strong commitment to ending health disparities among the BIPOC AI/AN populations. Developing an ASIPP that has a clear focus on these populations is part of that larger commitment. As shown in the list of Risk Factors for these populations a normed “White-centric” approach to everything, including suicide prevention is clearly contraindicated. The majority of research on suicide is normed on White populations as is true for suicide prevention training which is also very White-centric. This approach is racist and causes further damage to people of color and American Indian and Alaska Native populations. The movement from a racist White-centric approach to suicide prevention to a more anti-racist one is formidable but absolutely necessary to become more helpful and less hurtful. The ASIPP BIPOC AI/AN Small Workgroup Recommendations will be focused on throughout the 2023-2027 five-year span.

Men

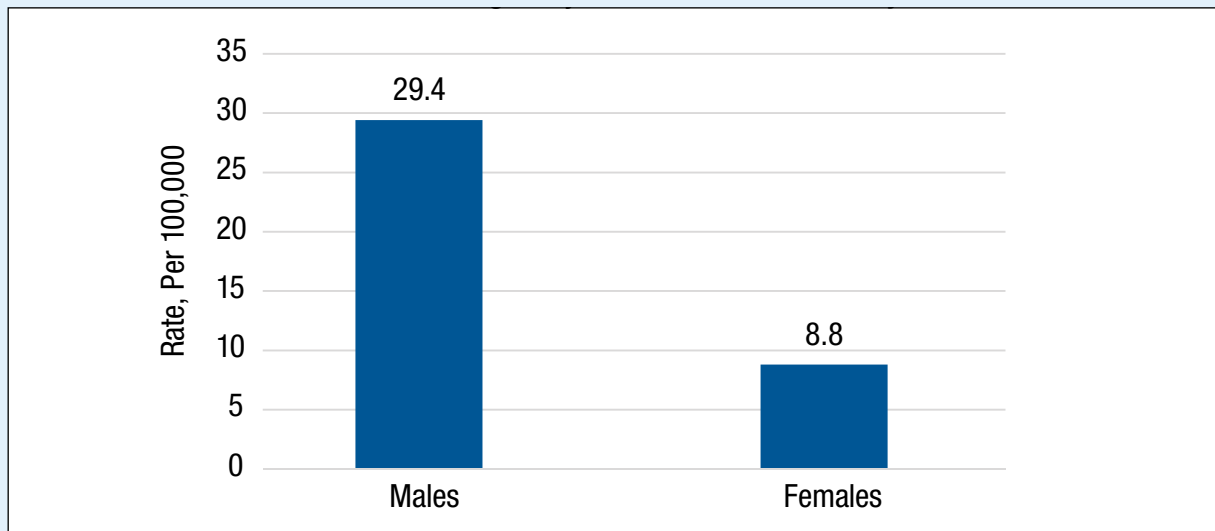
Introduction, Data and Literature Review

The following is an excerpt from the ASIPP Men’s Small Workgroup: ([Full Report](#))

“Roughly 75% of people who die by suicide in Oregon and the US are male. Between 2000 and 2020, 10,980 males died by suicide in the state of Oregon (OHA-Vital Statistics, 2021). In 2020 alone, 670 males died by suicide, compared to 163 females. In contrast to females, whose risk profile plateaus in mid-life, male suicide risk increases exponentially across the lifespan, making older adult males the population with the greatest suicide risk (Hedegaard et al., 2021). Oftentimes, men who die by suicide, die on their first attempt, leading to a case-fatality rate nearly 5 times that of women (Conner et al., 2019). The primary method of suicide for males is firearms and the rate of firearm suicide has been steadily increasing for over a decade (Curtin, Martinez 2019). Some suggest that men have higher suicide rates because they use firearms”.

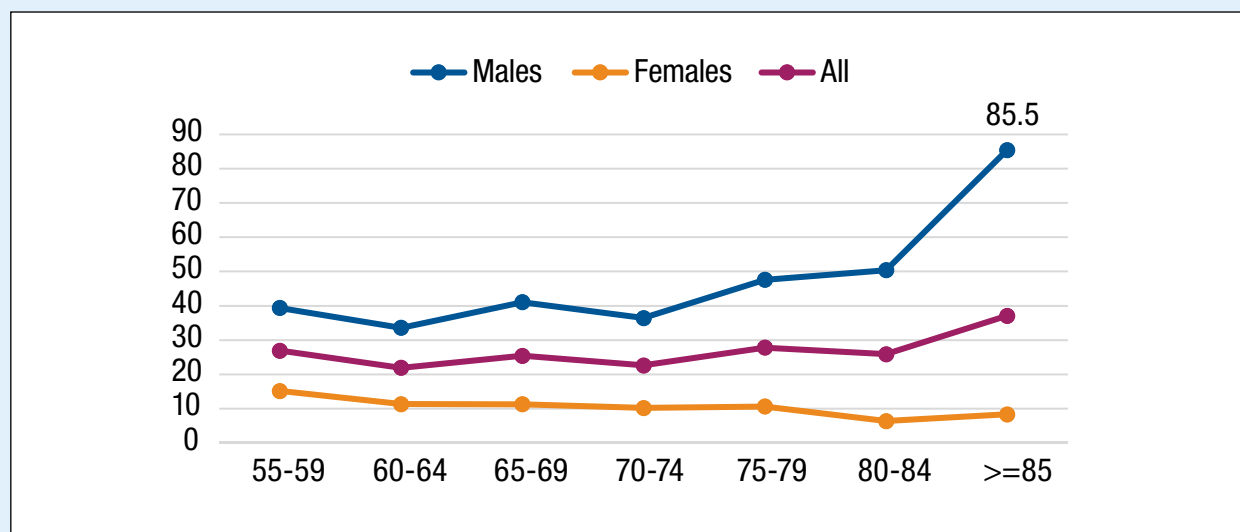
Across the lifespan, the age-adjusted rate of suicide is over three times as high for males (29.4/100,000) as compared to females (8.8/100,000) (Figure 28). For males, as age increases, the risk for suicide also increases with the highest rates of suicide seen in males ages 85 and older (85.5/100,000) (Figure 29).

Figure 28. Age-adjusted rate of suicide by sex from 2016–2020.



Source: ORVDRS

Figure 29. Age-specific rate of suicide in Oregonians ages 55+ by age category and sex from 2016–2020.



Source: ORVDRS

Means / Methods

Figure 30. Mechanism of injury amount suicide deaths by sex from 2016–2020.

Mechanism of injury	Males	Females
	Percent	Percent
Firearm	58%	31%
Hanging/suffocation	25%	28%
Poisoning	8%	30%
Fall	3%	4%
Motor Vehicle/Train	2%	2%
Sharp instrument	2%	2%
*Other/Unknown	2%	3%

Source: ORVDRS

In Oregon, the rate of suicide for males is over 3 times that of females (Figure 28). That schism becomes larger as age increases (Figure 29). The mechanism is also different between genders (Figure 30). Men are far more likely to use firearms (58% of deaths compared to 31% of deaths in females). Females are most likely to die by poisoning (30% of deaths compared to 8% of deaths in males). Hanging or suffocation is similar for both sexes.

Mortality data such as those above are often cited in suicide prevention literature to emphasize the crisis of male suicide, however, the complex reasons for these disparities are rarely discussed or addressed in most suicide prevention programming and policy in the US. The following information and recommendations below represent a portfolio of

programs, practices and policies that will engage men at risk of suicide and reduce the risk factors unique to men, leading to a reduction in the male suicide rate and the rate of suicide and traumatic sequelae in other populations. The Men’s Small Workgroup strongly urges the Oregon Health Authority to deliberately and explicitly address the crisis of suicide among men in the Oregon Adult Suicide Intervention and Prevention Plan. Commonly, epidemiologic data about suicide are recorded and reported in binary sex terminology (male and female) and rarely reflect the range of gender identities. In fact, the surveillance systems relevant to the vast majority of suicide mortality, attempt and ideation research in Oregon do not systematically record gender identity, relying solely on sex assigned at birth. The ASIPP Men’s Small Workgroup, while forced to cite these data, acknowledges that this binary classification is inadequate and fails to recognize the identities of transgender and non-binary people. Furthermore, we recognize that binary gender classifications and related cultural expectations actually contribute to increased suicide behavior. With these thoughts in mind, when we refer to “men” in this document, we are referring to people who identify as male or as a man regardless of the sex assigned at birth.

The ASIPP Men’s Small Workgroup detailed the complex reasons for the large suicide disparity between genders and can be found at link to [full report](#).

Circumstances Surrounding Suicide Incidents 2016–2020 for 18+ Men (Appendix 9)

The percentage of suicides that had various circumstances surrounding the death changes a bit with age for men with “Diagnosed Mental Disorder” being at the top of the rank for those 18-54 and “Physical Health Problems” being at the top of the rank for those men 55+. “Current Depressed Mood” is more prevalent for 25+ than for those under 25. Suicide notes were left approximately 32% of the time and there was no substantial difference with age. Women on the other hand left a suicide note nearly 44% of the time. This difference may reflect the utter isolation and certainty that men may experience as they prepare to die by suicide.

Male risk factors ([Freeman et., al 2017](#) and [Shwu-Hua et., al 2014](#))

- Military Service with or without combat
- End of a significant romantic relationship
- Financial Issues
- Legal Issues
- Illness
- Physical discomfort
- Conflict with family or friends
- Illness or death of a family member
- Loneliness
- Being single
- Retirement
- Unemployment
- History of suicide attempt
- History of physical or sexual abuse
- Having a mental health disorder
- Chronic Pain
- Terminal Illness
- Alcohol or drug misuse or abuse
- Easy access to lethal means
- Being gay, bisexual or transgender, and experiencing discrimination with little or no support from others
- A family history of mental illness, suicide or substance abuse

Male protective factors

Although there was nothing found in the literature regarding protective factors specific to males, there was information couched in “What interrupts the suicidal process in men?” ([Struszczyk et. al 2019](#))

- Men who are able to redefine help-seeking behavior as masculine
- Men who are able to consider the consequences of how their suicide may impact loved ones
- Men who are able to feel a sense of connection to other men who are thinking about suicide
- Men who were offered and used pragmatic self-regulation techniques to deal with strong emotions

Intersectional Identities for Men that Increase Risk

- LGBTQIA2S+
- Older White men
- Construction and Forestry Workers
- Veterans
- Men who live in rural communities
- Men who have disabilities / chronic illness

Recommendations from the Men’s small workgroups ([Link to complete report](#))

1. Strategically Engage Men During Major Life Transitions

Reason: When men encounter major life transitions, such as retirement, unemployment, separation and divorce, or exit the criminal justice system, their suicide risk and mental health vulnerability increases (Brenner & Barnes, 2012). Thus, it is essential to reach men prior to and during these transitions to provide support and resources about suicide risk and prevention (Yousaf, Grunfeld, & Hunter, 2016). Professionals who may be particularly well-suited to encounter and reach men during these transitions include clergy, social service and case workers, counselors and therapists, physicians, district attorneys and lawyers, retirement planners, bartenders, barbers, bankers and financial planners, and probation and parole and correctional officers.

Action Steps:

- a.) These above professionals should receive state-sponsored training in suicide risk for men during major life transitions that can be provided by local, state or contracted Big River Suicide Prevention Training Staff or other certified mental health providers. Consultants with whom OHA can partner to develop this type of programming include mental health professionals, social workers, trade organizations and unions and state and county governments.
- b.) Professionals in these settings should display and distribute suicide prevention resources for men and be able to help build awareness about men’s higher risk for suicide with all men they encounter. These OHA-sponsored resources can be developed in partnership with many of the groups mentioned above in collaboration with contracted marketing and design firms.

2. Provide behavioral health care services in non-therapeutic settings

Reason: Men's reluctance to seek help is a significant factor in men's high suicide rate. Despite the many stressors that men face, many men are reluctant to take part in traditional psychotherapy. Their reasons include shame about needing help, perceived loss of control in the therapy process, fear of being judged or being misunderstood, cost, and not knowing how to navigate connecting with a counselor. This dilemma has led some authors to recommend creating therapeutic opportunities in nontraditional settings as a way to address men's barriers to help-seeking. (Davies, Shen-Miller & Isacco, 2010). Telehealth has been shown to be popular among some men for its ability to provide services without experiencing the shame of going into an office. Psychoeducational and support groups that focus on depression management, life coping strategies and suicide prevention can offer men information without "outing" them as needing help.

Action Steps:

- a.) Promote and provide funding for programs that provide therapeutic opportunities for men in non-therapy settings
- b.) Advocate for the continuation and expansion of behavioral telehealth services
- c.) Educate service providers on the value of therapeutic services in non-therapeutic settings

3. Evolve masculine norms expansive, inclusive and lead to the health and safety of boys, men and communities.

Reason: Many American men are taught to hide their vulnerability, take risks, and be independent, unemotional, competitive, and aggressive. These rigid masculine standards have led many men to feel that they don't belong and don't measure up to being a man. Current norms discourage men from taking care of themselves and seeking help, lower their self-esteem and contribute to depression and high rates of male suicide. Additionally, these norms do not acknowledge differences in men's power and privilege due to their race, ethnicity, cultural background, sexual orientation, gender identity, or economic class. This makes it easier to ignore the effects of racism, classism, and homophobia on men and boys of color, and gay, bisexual, queer, or transgendered men. Racism and homophobia negatively impact mental health and can contribute to suicide.

To have healthier boys and men we must replace unhealthy norms with healthy ones. Changing gender norms requires a sustained effort by our entire community. One strategy is to engage and educate the community about masculinities and suicide prevention through community dialogues. These events bring mental health professionals, educators, concerned community members and diverse members of the general public together to talk about promoting healthy masculinities and reducing suicide. Community dialogues are an effective way to help community members identify and promote masculine norms that contribute to the health and safety of men and the reduction of male suicide.

Action Steps:

Provide support and incentives for organizations to provide community dialogues that

- a.) Promote the recognition, acceptance, and expansion of the diverse, healthy ways that men live their lives
- b.) Discuss the impact of race, culture, sexual orientation and gender identity upon one's identity as a man
- c.) Recognize how male socialization and role expectations can lead to sexual and other forms of interpersonal violence

- d.) Identify masculine norms that promote the health and safety of all people
- e.) Educate parents and mentors of boys and men about strategies to raise healthy boys and men.

4. Provide opportunities for civic engagement in which men can support their communities and find meaning and purpose

Reason: Studies have shown individuals experience improved quality of life when they consistently engage in civic activities (Pew Charitable Trust, 2021). Civic engagement can take many forms, from individual volunteerism to organizational involvement to electoral participation. It can include efforts to directly address an issue, work with others in a community to solve a problem or interact with the institutions of representative democracy. Civic engagement encompasses a range of specific activities such as working in a soup kitchen, serving on a neighborhood association, writing a letter to an elected official or voting. Social isolation is a significant risk factor for suicide and opportunities for civic engagement provide men a place to meet others, create relationships and even potentially find a sense of purpose and meaning.

Action Steps:

- a.) OHA should create diverse partnerships with nonprofits, and culturally specific community-facing agencies that have volunteer programs for men in various settings examples include: Big Brothers and Big Sisters and other mentoring organizations, Court Appointed Special Advocates, restorative justice programs, urban and land restoration initiatives, sports coaching associations, Kiwanis, Lion's Club, Rotary Club, etc.
- b.) OHA should provide men with the material, education, and means to create their own programs for civic engagement in their communities.
- c.) OHA should provide funds for agencies to expand their volunteer programs for new services and update already existing services specific to men and boys.
- d.) OHA and/or 211 should create a central location for information on civic engagement opportunities to allow interagency communication and improve citizenship.

5. Implement a sustained male-specific public awareness campaign that demonstrates an alternative, healthy set of masculine norms.

Reason: Health promotion campaigns are effective ways to raise community awareness of health issues, recruit people to get involved in advocacy and change health behavior. Universal mental health promotion and suicide prevention campaigns often do not meet the needs of men, especially in relation to language, content or cultural acknowledgment. Men's health needs and barriers are unique and should be addressed to effectively educate the public and reach men.

Action Steps:

- a.) OHA should develop a media and communication plan to empower men to get involved in their own mental health and support the mental health of other people. This campaign should be sensitive to the psychosocial traits of men of all ages and craft messages appropriate to their needs. A specific theme to highlight includes the value of social connection.
- b.) Campaign materials should be distributed online, in print, radio and television.

6. Improve the diagnosis and treatment of depression in men in health care settings

Reason: Many men present symptoms of depression not considered diagnostic of Major Depressive Disorder or Persistent Depressive Disorder (dysthymia) in the DSM-V or ICD-10. Men tend to experience and express depression with greater levels of irritability, anger, aggression and stress compared to women. Additionally, men who are diagnosed with depression in primary care settings tend to identify somatic rather than emotional symptoms of depression which are not addressed by most universal depression screening tools (Suh & Gallo, 1997). The inaccuracy of depression screening leads to an underdiagnosis of depression in men in both behavioral and primary health care settings and potentially greater suicides (Wilhelm & Parker, 1994)

Action Steps:

- a.) Promote the option of using male-specific depression scales when working with men in any primary or behavioral health care setting to ensure the accurate diagnosis of depression in men: Examples may include
 1. The Gotland Male Depression Scale
 2. The Diamond Male Depression Scale
 3. The Masculine Depression Scale
- b.) Promote the American Psychological Association Guidelines for Psychological Practice with Boys and Men with mental health professionals working with men regardless of licensure type.
- c.) OHA should develop training for clinicians working with men to educate service providers on how to create services congruent with the culture of men and masculinities. Primary care providers should particularly be trained in recognizing the external signs of depression in men.

7. Advocate for the development of billing codes that support follow-up care and outreach during times of life transition or crisis.

Reason: Outreach activities are those that involve a trained person proactively attempting to contact another person for behavioral health engagement or treatment. Outreach activities are regularly recommended as essential in suicide prevention and intervention since many people presumed to be at risk of suicide, do not seek treatment or support, especially immediately before their suicide behavior. Also, the period of days and weeks after discharge from the hospital after a suicide attempt are some of the most dangerous for the person to die by suicide. And this is especially important for men because they don't often pursue support or follow-up with clinical care and therefore more outreaches must occur.

Outreach activities usually include telephone, face-to-face, or written attempts to reach a person possibly at risk of suicide or behavioral health issues. It may require several failed attempts to reach the person and considerable drive time to do face-to-face outreach in the community. Unfortunately, Medicaid and private insurance billing codes only cover services in the presence (face-to-face or telephonic) of the person. It does not pay for failed attempts to reach the person or drive time.

Action Steps:

- a.) The Oregon Health Authority should immediately use its current expertise to draft Medicaid billing codes that would provide payment for Outreach Services and then request that the Centers for Medicare and Medicaid Services approve these codes for Oregon.
- b.) Oregon’s regulatory processes should require those private insurance companies operating in the state to pay for Outreach Services.

8. Improve state-level leadership and direction in men’s health

Reason: Universal health promotion information is generally ill-suited to the needs of men. In fact, men with adherence to Western masculine norms often have lower health literacy than men without (Milner et al. 2019). Health literacy is a core component of health access and serves as a vital bridge to well-being.

Action Steps:

- a.) OHA develop a men’s health advocate position, to increase providers’ awareness and knowledge of the impact of male socialization on men’s health and safety and the safety of the entire community.
- b.) This position should have the opportunity to review state literature with men’s needs in mind and develop materials that address the cultural realities of men’s health behavior.

Men’s Suicide Prevention Work Currently Underway

1. “[Elevate Him](#)” is a Portland-based program, that creates mental, emotional, and economic stability for men and advocates for suicide awareness specific to men.
2. “[McKenzie River Men’s Center](#)” is a program of the Center for Community Counseling in Eugene and specializes in men’s mental health issues. The McKenzie River Men’s Center provides counseling to men in non-traditional ways that help to ameliorate the stigma associated with seeking mental health services for men.
3. [Portland Men’s Shed](#) is dedicated to building a global movement of spaces where men can gather to find meaning, purpose, and friendship to enhance a greater sense of connection.

Men’s Summary

Nearly 3/4 of all suicides in Oregon are men. Although there has been some obvious “crossover” work such as with the construction industry and veterans there is still much-dedicated work that needs to be accomplished. The Men’s ASIPP Small Workgroup did an excellent job of guiding the way with recommendations based on an understanding of the complex etiology involved in male suicide. Just as we must have cultural competency regarding race/ethnicity, sexual orientation and gender Identification, Veteran Status, and Age, we must have cultural competency when providing suicide prevention strategies for men. It is clear that different populations need different interventions.

Rural and remote areas

Introduction, data and literature review

The suicide rate in Oregon is higher in rural and remote areas than in urban areas. Please note that the term “remote” is being used to replace the term “frontier” as requested by some tribal communities. The Oregon Office of Rural Health defines rural as all geographic areas in Oregon 10 or more miles from the centroid of a population center of 40,000 or more. Frontier (referred in the ASIPP as Remote) are those counties with fewer than 6 or fewer people per square mile as defined by the Oregon Areas of Unmet Health Care Report. The rate of suicide in rural and remote counties is higher than in urban counties (Figure 31).

Figure 31. Rate of suicide per 100,000 population by county classification from 2016–2020.

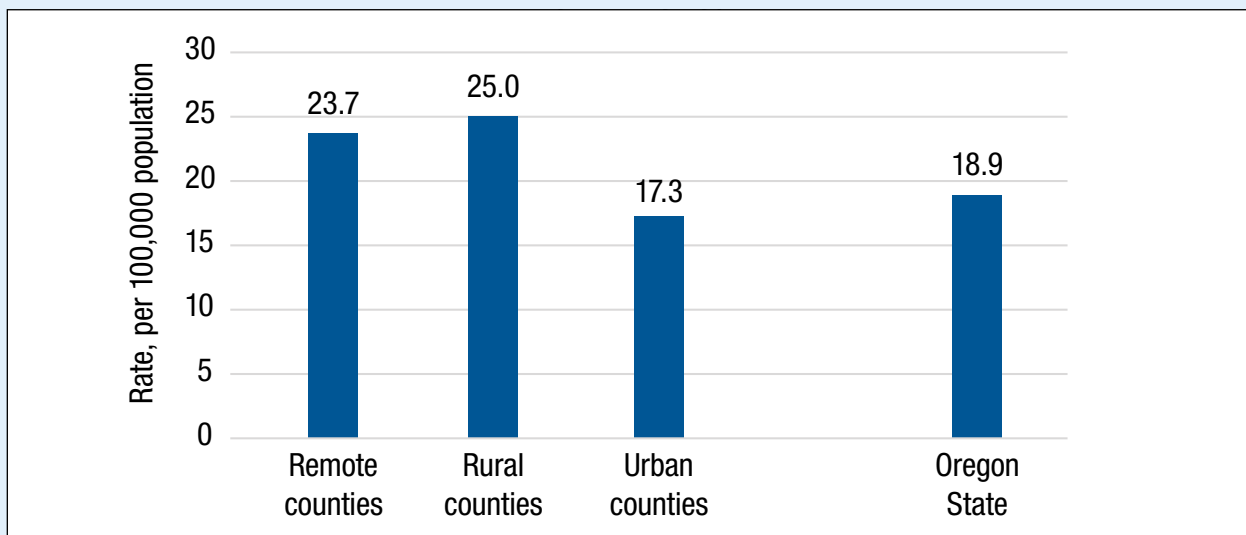
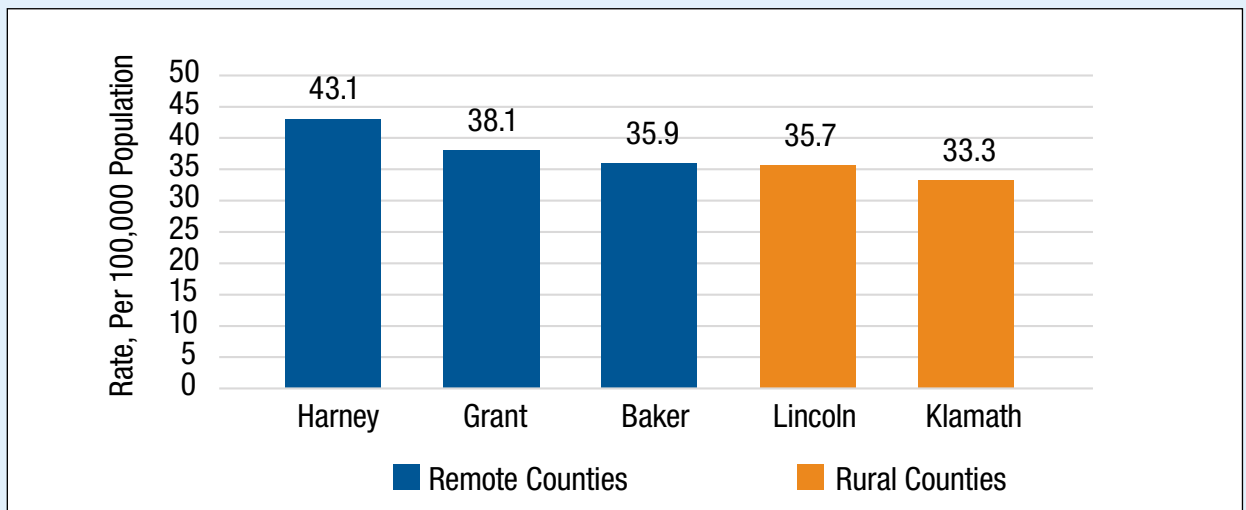


Figure 32. Top 5 highest rates of suicides per 100,000 population by county in Oregon from 2016–2020.



Source: OPHAT

As Figure 32 indicates the highest rates of suicide between 2016–2020 for counties are all either rural or remote counties. It's important to note that these rates include small numbers of deaths per county and may not be reliable. For a complete list of suicide rates by county please see [Appendix 12](#).

The schism between urban and rural suicide rates is a national trend and not unique to Oregon. CDC states that between 2000 and 2018 there has been a 48% increase in suicide rates in rural areas versus a 34% increase in urban areas.

So why is suicide so much higher in rural and remote areas than in urban areas? A literature review by [Hirsch](#) and Cukrowicz, (2014) found that the higher rates of suicide might be due to several factors such as:

1. Geographic isolation can create barriers in terms of resources.
2. Agricultural factors such as drought, flooding, etc., and unpredictable markets create financial instability.
3. Sociocultural factors such as gender conformity espousing a male-dominant, honor-based, rugged and individualistic life perspective.
4. Stigma regarding having mental health concerns and seeking help.
5. Physical health factors such as chronic pain or disability from years of performing labor-intensive work.
6. Environmental factors such as easy access to firearms and pesticide poisoning.

Risk factors and protective factors

Geographical risk factors

A literature review did not reveal any suicide risk or protective factors specific to rural communities. The [CDC provides a list of risks and protective](#) for adults and an asterisk is placed next to those that may be more likely for rural populations:

- Previous suicide attempt
- Mental illness, such as depression
- Social isolation*
- Criminal problems
- Financial problems*
- Impulsive or aggressive tendencies
- Job problems or loss*
- Legal problems
- Serious illness
- Substance use disorder
- Child abuse and neglect
- Bullying
- Family history of suicide
- Relationship problems such as a break-up, violence, or loss

- Being a victim of sexual violence
- Barriers to health care*
- Cultural and religious beliefs such as the belief that suicide is a noble resolution of a personal problem
- Suicide cluster in the community*
- The stigma associated with mental illness or help-seeking*
- Easy access to lethal means among people at risk* (eg. firearms, medications)
- Unsafe media portrayals of suicide

Geographical protective factors

- Coping and problem-solving skills
- Cultural and religious beliefs that discourage suicide
- Connections to friends, family, and community support
- Supportive relationships with care providers
- Availability of physical and mental health care
- Limited access to lethal means among people at risk

Intersectional identities for those living in rural and remote areas

- Men
- LGBTQIA2S+
- Veterans
- Chronic health conditions/disability
- Construction and forestry industries
- Older adults

Recommendations from the small workgroup ([Link to complete report](#))

1. Reduce the number of suicides completed by the use of firearms by collaborating with firearm dealers, shooting ranges and instructors to educate customers about firearms and suicide.
2. Increase the likelihood that people will seek help prior to, or while they are thinking about suicide by developing help-seeking campaigns specific to rural communities that reduce stigma and promote mental health and substance use resources.
3. Identify and utilize “hubs” in rural communities for targeted outreach with mental health promotion and suicide prevention resources to identify and fund already existing protective factors and enhance connectedness.
4. Promote messaging campaigns, information, and resources such as but not limited to “Ask the Question”
5. Use local law enforcement agencies to provide crisis intervention services since the officers are typically well-integrated into the community.

6. Advertise and provide gatekeeper training, especially in rural areas for parents and other community members.
7. Improve the usefulness and applicability of suicide-related data in rural areas by using additional data such as hospitalizations, death rates (suicide and overdose) and service access/utilization for smaller communities along with rates per 100, 000.
8. Determine opportunities to further support not only the recruitment of behavioral health providers to rural communities but also incentives to stay long-term by increasing salaries, providing regional high-speed internet, and suitable housing opportunities.
9. Develop a behavioral health workforce that is more competent to address suicidal ideation.
10. Provide infrastructure that promotes mental health, community connectedness, treatment access and quality of life by increasing social services, social-emotional learning programs, and educational opportunities that promote mental health wellness.
11. OHA should develop Medicaid billing/encounter codes that promote behavioral health outreach activities.
12. Address geographic inequity by allocating state funding to regions where there have the highest suicide rates and statistical risk (age, physical isolation, lack of mental health services, opioid usage, firearm access, and rurality).

Input from the Rural & Remote Focus groups: (full report can be found in [Appendix 3](#))

Below are statements collected from the Rural & Remote focus group

“The system is very hard to navigate”

“Decreasing stigma needs to be a priority”

“More training for law enforcement”

“Policy makers and decision makers should look at the organizations, coalitions and volunteers within communities to see what is working already, before implementing or changing things. In most cases, it is the funding or lack of paid employees that would make all the difference.”

“Please make sure that there is a broader dissemination of hotline access. For rural communities, also having transportation that is not an ambulance would be important especially since public transportation in general is nonexistent.”

“Suicide is an issue of justice (social, economic, personal). In addition to funding pre- or postvention, you need to address systemic issues that play such a large role in causing, increasing, and continuing the context for suicidal ideation and thoughts”

“How can we as smaller rural communities better serve each other to be the change? access to money for projects in community to enhance the quality of care from the people providing these services, recognition, prizes, trainings?”

Suicide prevention work currently underway for those living in rural and remote areas

1. There are approximately 21 suicide prevention councils/coalitions throughout the state of Oregon and over half of them are in rural or remote areas, thus there have been some concerted suicide prevention efforts throughout rural and remote areas.
2. Of the 36 counties in Oregon, nine have full-time dedicated Suicide Prevention Coordinators and five have Prevention Coordinators in which suicide prevention is a part of their work. Of these 14 counties that have positions performing suicide prevention work, six are in rural or remote counties.

Rural and Remote Summary

The suicide rate in rural and remote areas has a suicide rate of nearly twice that of those that live in urban areas. This is true not only in Oregon but across the United States. States that have large rural populations tend to have much higher rates of suicide such as New Mexico, Montana, Wyoming, Alaska, and Idaho whereas states with less rural areas have the lowest rates of suicide such as New Jersey, New York, Rhode Island, Massachusetts, and DC. The etiology of these differences is complex but what seems clear is there are cultural differences that need to be understood and respected. Suicide prevention in rural areas needs to involve those living in rural areas and be tailored to the needs of this population specifically.

Mental Health Systems Report

Preamble – Mental Health Conditions, Suicide and Stigma:

Although having a mental health condition puts one at greater risk for suicide, not everyone that dies by suicide has a mental health condition and the majority of people with a mental health condition do not die by suicide. [CDC data](#) demonstrates that life events, isolation and other environmental or societal factors can also contribute to suicide. Data collected by CDC in 2016 showed that more than half (56%) of people that died by suicide did not have a known mental health condition and that this was more likely to be true for males than females. However, men are less likely to receive a diagnosis for a mental health condition because men are less likely to seek help. Other factors contributing to suicide found by CDC included relationship problems, job and financial stresses, loss of housing, and physical health problems. The implications of this CDC report are profound in terms of suicide prevention. If we continue to focus predominately on the relationship between diagnosed mental health conditions and suicide, we will be missing about half of those who die by suicide.

Introduction, data and literature review

The Mental Health Systems Small Workgroup participants were a combination of behavioral health care workers (psychologists, counselors, therapists, social workers, etc.) and participants in behavioral health care. The group was tasked with making recommendations for the ASIPP regarding improving mental health care systems and practices in the state of Oregon. The full report can be found [here](#).

Mental Health Status: Review of needs and services

Before reviewing the Small Workgroup recommendations, it is important to have a general overview of “what is the mental health status of Oregon?”, both in terms of needs and services. There are several sources of data regarding the above question that will be reviewed. The web addresses are linked to the titles however a summary is provided below:

1. [Behavioral Health Barometer, Oregon, Volume 6](#) which are indicators through the 2019 National Survey on Drug and Health and the National Survey of Substance Abuse Treatment Services.
 - During 2017-2019, among adults 18 and older in Oregon, when asked about “serious **thoughts of suicide** within the past year” 5.9% endorsed this item, which is higher than the national average of 4.5%
 - During 2017-2019, among adults 18 and older in Oregon, the average prevalence of past year Serious Mental Illness (**SMI**) was 5.9% which is higher than the national average of 4.8%
 - During 2017–2019, the annual average prevalence of past-year mental health service use among those with Any Mental Illness (**AMI**) in Oregon was 42.6% (or 338,000), similar to the national average (43.6%).
2. [Healthier Together Oregon \(HTO/SHIP\)](#)
 - During 2019, 44.3% of adults reported 1 or more days of **poor mental health** within the last month
 - The **alcohol-related death** rate for 2019 was 43.6 per 100,000
 - The **drug overdose/poisoning death** rate for 2019 was 14.2 per 100,000
 - During 2018-2019 the percentage of the population ages 12+ with a **substance disorder** within the past year was 9.5

3. [Adult Behavioral Risk Survey \(BRFSS\)](#)

- During 2014-2017, the percentage of adult females, 18+ who had at least one episode of binge drinking (4+ drinks on one occasion) was 12.9
- During 2014-2017, the percentage of adult males, 18+ who had at least one episode of binge drinking (5+ drinks on one occasion) was 21.2
- During 2014-2017, the percentage of adult females, 18+ who had 1+ drinks of alcohol per day in the past 30 days was 7.8
- During 2014-2017, the percentage of adult males, 18+ who had 2+ drinks of alcohol per day in the past 30 days was 7.7
- The BRFSS survey in 2016 indicated that 59.9% of males and 50.2% of females used marijuana at some point in their lifetime and that 16.3% (sexes combined) have used marijuana in the past 30 days.
- The BRFSS survey in 2016 indicated that 17.6% of males and 31.2% of females have been diagnosed with depression at some point in their lifetime
- The BRFSS survey in 2016 indicated that 90.9% of Oregonians have some kind of health care coverage

4. [Oregon's Health Care Workforce February 2021](#)

- Oregon has one full-time licensed behavioral or mental health provider for every 655 people statewide with extreme variation at the county and local levels. For example, Polk County has one full-time licensed behavioral or mental health provider for every 350 residents while Sherman, Wheeler and Gilliam counties have no full-time licensed behavioral or mental health providers
- Professionals in Oregon's mental health system report low pay, inadequate support and training, and heavy workloads that compromise their ability to provide quality care (HSRI, 2018).
- A September 2018 report on Supply and Demand for Behavioral Health Occupations from the U.S. Health Resources and Services Agency (HRSA) indicated that to meet the current demand for behavioral health services, Oregon would need an additional workforce of 170 more psychiatrists (26% increase), 90 more psychologists (6% increase), 500 school counselors (48% increase), and 700 social workers (23% increase). For the other behavioral health professionals assessed in the HRSA report, including addiction counselors, mental health counselors, and marriage and family therapists, the supply of providers more closely matched the current demand.
- Urban areas average 1.54 licensed behavioral health provider FTE per 1,000 population compared with 0.54 FTE in rural/frontier areas, which is about 65% less than the urban ratio
- There are no licensed behavioral health providers in 21 rural and remote service areas
- The top workforce training needs identified in the MHACBO survey were trauma-informed care, co-occurring disorders (i.e., mental health and substance use disorder), motivational interviewing, and medication-assisted treatment
- People of color are underrepresented in all segments of Oregon's behavioral health workforce, and there is a need for providers who speak languages other than English

- In October 2020, 41% of behavioral health visits were by telehealth
- The [Governor’s Behavioral Health Advisory Council](#), established by executive order in October 2019, included representatives of behavioral health systems, consumers with lived experience, and clinicians. In October 2020, the Council released its recommendations:
 - ✦ Increasing funding for incentive programs for the recruitment and retention of behavioral health providers to increase the number of people of color, people from tribal communities, and rurally-based people in the behavioral health workforce
 - ✦ Support for culturally based practices, including equitable reimbursement for promising practices and practices outside of the conventional medical model
 - ✦ Training for the behavioral health workforce in trauma-informed care and workplaces, culturally and linguistically specific/responsive care, anti-racism, equity, interdisciplinary care (including working with peers), leadership and management development, and co-occurring disorders.

5. [2018 CCO Metrics DEEPER DIVE](#)

- More than a quarter (28 percent) of patients reported having recently felt stigmatized by their primary care provider. Patients who had experienced stigma had much worse health outcomes.
- Adults with a mental health diagnosis reported lower rates of “getting needed care” (primary) in all 15 CCOs

6. [Governor’s Behavioral Health Advisory Council Recommendations \(2020\)](#)

The GBHAC was established by Executive Order on Oct. 18, 2019 and was charged with “the development of recommendations aimed at improving access to effective behavioral health services and supports for all Oregon adults and transition-aged youth with serious mental illness or co-occurring mental illness and substance use disorders. Guiding the Council’s work were a number of principles and values:

- Health equity is advanced within the state’s behavioral health system.
- Mental health and substance use disorders are detected early and treated effectively.
- Youth and adults with serious mental illness have timely access to the full continuum of behavioral health care.
- Youth and adults with serious mental illness can receive treatment that is responsive to their individual needs and leads to meaningful improvements in their lives.
- People with serious mental illness have access to affordable housing that offers independence and is close to providers, community resources, and public transportation.
- People have ready access to a broad range of behavioral health workers who are well-trained to effectively engage them and provide care that is responsive to their needs and individual characteristics.

7. [OHA 2015-2018 Behavioral Health Strategic Plan](#)

“During these discussions, we heard some common themes. Our stakeholders told us that we must ensure that all Oregonians get:”

- **The right care** – Behavioral health care should be culturally appropriate, person-centered and trauma-informed.
- **In the right place** – People should have access to behavioral health services regardless of where they live, and they should receive services in their community whenever possible, keeping people out of emergency departments and the state hospital who do not need to be there.
- **At the right time** – In addition to making sure that appropriate services are available when people need them, we must strive to catch illnesses early and prevent behavioral conditions from developing in the first place, through promotion and early intervention, especially with children, youth and families.

The **guiding principles** reflected in the goals and strategies are:

- The full spectrum of Behavioral Health is applied – promotion, prevention, treatment and recovery.
- The recovery model is followed – “People get better! People recover!”
- Care is consistent with Culturally and Linguistically Appropriate Services standards.
- Health care disparities are addressed.
- Behavioral health care is self-directed.
- Families are supported and involved.
- Diverse community outreach, engagement and collaboration are essential for success.
- Geography impacts access and is a key factor in statewide planning.
- Care is based on evidence-based practices, promising practices and traditional culturally based practices.

8. [OCHA Oregon Commission on Hispanic Affairs: Crisis de Nuestro Bienestar: A Report on Latino Mental Health \(2020\)](#)

- One-third of Latino/a/x adults reported that their mental health was “not good” at least one of the past 30 days. Causes include stress, depression and problems with emotions.
- Latino/a/x adults in Oregon report on average 4.1 poor mental health days in the past 30, better than an average of 4.6 days for White adults, and 7.0 days for American Indian and Alaska Native adults.
- In addition to being less likely to receive mental health treatment, Latinos/as/x who do receive treatment are more likely to forego services sooner and tend to receive a lower quality of care (Voelker, 2017).
- The current mental health system’s focus on principles (independence and individuality) is in direct conflict with Latino/a/x cultural values of interdependence and community.
- Latinos/as/x account for approximately 10% of mental health encounters within the county mental health system in Oregon, despite making up a larger share of the population as a whole.
- In a review of 30 years of Oregon administrative data, only 11% of Latino/a/x adults and 24% of Latino/a/x

minors receiving treatment through the county mental health system discontinued treatment because it was considered complete; the most common reason for Latinos/as/x discontinuing treatment was needing short-term crisis services. This review also found Latinos/as/x in Oregon were also more likely than other groups to discontinue mental health care against their clinician's advice (Voelker, 2017).

- Latinos/as/x in Oregon who are more socially connected and born in the United States are more likely to access mental health care.
- Interviews with providers suggest fear of accessing mental health services is especially acute among Latino/a/x immigrants, particularly those without documentation of their immigration status.
- Factors negatively associated with the use of mental health services include being born outside the United States or having low acculturation, not knowing where to seek services, experiencing economic strain, and having a smaller network of social support (Cabassa et al., 2006).
- Notably, while police made 41% of all adult referrals to county mental health services in Oregon, police referred only 5% of Latino/a/x adults to county mental health services. Self-referrals and those made by health care providers, family and friends were much more likely for Latino/a/x adults than the general population (Voelker, 2017).
- In Latino/a/x Medicaid members, 9.2% experienced emotional symptoms in the past 30 days due to how they were treated based on their race or ethnicity (compared to 7.5% statewide) (Oregon Health Authority, Medicaid Behavioral Risk Factor Surveillance System).
- Barrier — Difficulties in communication, misunderstanding of rules and regulations, and inability to build an authentic relationship because of language and/or cultural differences all work directly against trust- and relationship-building.
- Licensed mental health workforce: Only 3% of the mental health workforce identified as Latino/a/x, significantly lower than Oregon's population.
- The mental health practitioner workforce, pipeline and credentialing process must be examined and strengthened to increase the number of mental health practitioners with essential training to practice and supervise trauma-informed, linguistically and culturally relevant, culturally specific treatment. Strengthening the mental health provider workforce will help increase access to effective, quality mental health care for all Oregonians.
- There is an urgency for Oregon to simultaneously train and develop more mental health providers qualified to serve the Latino/a/x community.
- Oregon's credentialing process for mental health professionals allows for a combination of education, certification, and experience, but lacks a robust process for transferring licenses or recertifying advanced mental health professionals from other countries.
- Establish as standard practice the appointment of practitioners of color and other historically marginalized groups on all licensing boards and the appointment of people of color and other historically marginalized groups on all public bodies.
- Integration of primary and mental health care combats stigma, a prominent barrier to mental health care for Latinos/as/x in Oregon. Providing direct access to mental health care in community centers or health

care venues (e.g., clinics, spiritual care) reduces some of the administrative systemic barriers that might foster stigma, fear and disengagement and help make getting mental health care more discreet.

- Resource and support developing and maintaining a Latino/a/x mental health task force and a larger culturally specific mental health task force. This Latino/a/x task force will be one of several task forces representing historically underserved groups in Oregon to comprise a larger culturally specific mental health task force.
- Mental health work environments do not account for cultural complexity in provider caseload or supervision and thereby contribute to inequitable workloads and provider burnout.

9. Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness (2016)

Oregon Health Authority Plan is intended to improve mental health services for adults with serious and persistent mental illness. The Plan was issued after lengthy discussions with the Civil Rights Division of the United States Department of Justice (USDOJ). In the Plan, OHA commits to several performance outcome measures and to further data gathering and study of certain issues. Oregon also commits to quality and performance improvement measures, and data reporting. These measures cover a broad array of subjects, including:

- Assertive Community Treatment Services
- Crisis services
- Supported housing
- Peer-delivered services
- Oregon State Hospital discharges and linkages to services
- Acute psychiatric care discharges and linkages to services
- Emergency department services
- Supported employment services
- Secure Residential Treatment Facility discharges
- Criminal Justice diversion
- Quality and performance improvement; and
- Data reporting

Circumstances Surrounding Suicide Incidents

Similar to the national data, although mental health concerns are pronounced, many individuals who died by suicide did not have mental health concerns demonstrating that the “reasons” for suicide are multi-factored and complex.

Figure 33. Circumstances of suicides by age bracket from 2016–2020 (full report Appendix 9)

Circumstances	Aged 18–24		
	All sexes	Males	Females
Diagnosed mental disorder	33.2%	29.0%	53.4%
Alcohol problem	10.7%	11.3%	8.2%
Non-alcohol substance use problem	17.8%	17.2%	20.5%
Current depressed mood	26.2%	25.4%	30.1%
Current treatment for mental health/ substance use problem	17.5%	14.9%	30.1%

Circumstances	Aged 25–54		
	All sexes	Males	Females
Diagnosed mental disorder	37.7%	34.1%	48.6%
Alcohol problem	19.9%	19.7%	20.5%
Non-alcohol substance use problem	18.3%	18.5%	17.9%
Current depressed mood	27.1%	26.9%	28.1%
Current treatment for mental health/ substance use problem	21.7%	19.2%	29.2%

Circumstances	Aged >= 55		
	All sexes	Males	Females
Diagnosed mental disorder	31.5%	27.3%	45.3%
Alcohol problem	14.3%	15.4%	10.7%
Non-alcohol substance use problem	5.1%	5.5%	3.9%
Current depressed mood	30.2%	30.0%	30.7%
Current treatment for mental health/ substance use problem	20.3%	17.5%	29.4%

Source: ORVDRS 2016–2020

Mental Health Conditions and Suicide:

- 60% of people who die by suicide have major depression (Ng, et., al 2017),
- 2% of people with chronic depression will die by suicide (National Institute for Mental Health)
- 4% of severe depression (need for hospitalization) will die by suicide (National Institute for Mental Health)
- The most frequent psychiatric illnesses associated with suicide or severe suicide attempt are mood and psychotic disorders (Sher and Kahn, 2019)
- Contemporary research studies indicate that the lifetime rate of suicide in individuals with schizophrenia is between 4% and 13%, while the modal rate is about 10% (Sher and Kahn, 2019)
- The reported rates of suicide attempts in patients with schizophrenia vary from 18% to 55% (Sher and Kahn, 2019)
- Suicide risk is significantly elevated during the first psychotic break (Sher and Kahn, 2019)
- Suicide Risk is greatest for those experiencing Bipolar-disorder (Dome et., al 2019))
- Those with Bipolar disorder have a 20-30% greater risk of suicide than the general population (Dome et., al 2019)
- Up to 20% (mostly untreated) of those with bipolar disorder end their life by suicide, and 20–60% attempt suicide at least once in their lifetime (Dome et., al 2019)
- Compared with the general population, individuals with alcohol dependence and persons who use drugs have a substantially increased risk of dying by suicide (Wilcox et al., 2004)
- Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior (Esang, et., al 2018)
- Persons with both alcohol use disorders and mood disorders have a greater risk of suicide attempts compared to those with a mood disorder alone (Esang et., al 2018)
- An especially dangerous time for suicidal risk is immediately following discharge from psychiatric hospitalization (Chung et., al 2017; Forte et., al 2019)

Stigma

The above-noted statistics regarding mental health conditions and suicide can be alarming for those that experience mental health conditions and for family members. However, please keep in mind that the vast majority of those with the above conditions do not die by suicide. Many of the negative consequences of being labeled as “mentally ill” such as shame, low-self-esteem, loneliness, hopelessness, etc., are also risk factors for suicide. In addition, stigma reduces the likelihood that individuals will seek help. A population-based study from several European countries reported that mental illness stigma levels were positively associated with national rates of suicide (Schomerus, et., al 2015). In a qualitative research study, participants reported that the discrimination that they experienced regarding having a mental health condition, contributed to their suicidal behavior (Farnelly et., al 2015). It seems clear, that it is not just the mental health condition itself that contributes to suicide, but the stigma associated with having a mental health condition.

Recommendations from the Mental Health Systems small workgroup ([Link to full report](#))

1. **Goal: Establish OHA Advisory Committee(s) for ongoing advising to OHA regarding adult suicide prevention** or join with an existing committee to align goals and expand the focus of suicide prevention across the lifespan. Options to consider include forming a group made up of representatives from the ASIPP and those with lived experience, and/or collaborating with the Oregon Alliance to Prevent Suicide or other related advisory committees.

2. **Goal: Implement and Expand Culturally Responsive and Linguistically Appropriate Services**

Reason: Traditional mental health services are primarily focused toward White persons, English-speaking, able-bodied consumers. Services that support those of other cultures, languages, and abilities help providers better respect and consider a client’s cultural background — from diagnosis to implementation of treatment, to long-term health outcomes. Respect and consideration of these needs lay a foundation of trust, and this allows organizations to better align their mental health services and infrastructure with best-practice care for these communities and populations.

Recommendations:

- a.) More culturally responsive approaches to suicide prevention, intervention, and postvention need to be integrated into day-to-day care
- b.) Mental Health services should strive to develop a more diverse workforce to reflect and support communities, including Mental Health professionals and peer-delivered services
- c.) Cultural activities should be emphasized (when clinically appropriate) and adequately funded/reimbursed as an integral part of treatment (i.e., sweat lodges with Native American population, Eastern medicine, etc.)

3. **Goal: Expand Peer-Delivered/Informed Services**

Reason: The Centers for Medicare and Medicaid Services (CMS) recognize peer-delivered services as a successful tool in the treatment of mental health disorders. Authentic engagement in peer-delivered services alongside mental health treatment helps create better outcomes, reduces the cost of care, expands the workforce, and gives credibility to outreach efforts. Peer-delivered recovery supports offer help, hope, and wellness to those experiencing mental health disorders.

Recommendations:

- a.) System barriers should be addressed to achieve broadly distributed, well-funded peer services that adhere to a fidelity model and include effective peer supervision
- b.) Peer services should reflect the community they are serving, and should not be siloed to specialized populations/organizations
- c.) Caring contacts and other informal, often peer-delivered services should be reimbursable through Medicaid and private insurance.

4. **Goal: Integrate and Coordinate Mental Health Activities Across Systems**

Reason: Mental health system partners, especially those who work with individuals experiencing Intellectual/Developmental Disabilities and Substance Use Disorders, should work collaboratively to cross-train staff and reduce barriers to accessing culturally responsive, trauma-informed, and peer-supported services. Effective and efficient integrated care should exist throughout the continuum of services. Services should include but are not limited to: outreach activities, communication with the individual and family, and connecting with natural supports. Incentives — including the elimination of legislative salary caps and payment for outreach activities — should be considered. Braiding funds across systems would allow access to services that would best fit an individual’s needs, regardless of geographic location, insurance, or other barriers.

Recommendations:

- a.) Medical and behavioral health agencies should proactively collaborate to address barriers to access and minimize duplication of services, and policies should be implemented to guide this collaboration and coordination
- b.) Coordination, education, and support should exist between Mental Health and criminal justice systems
- c.) “Siloed” systems i.e. intellectual and developmental disabilities (IDD), older adult mental health, substance use disorders (SUD)) may have funding/licensure/structural/training limitations that inhibit widespread access to Mental Health services (i.e. MH services are difficult to provide in I/DD residential settings due to non-transferable licensure/funding)
- d.) OHA should develop Medicaid billing codes that pay for outreach activities and propose these codes to the federal government.
- e.) Mental Health consumers should have specific, invested access to housing supports, including considerations for houseless populations.
- f.) Policies should delineate and clarify “next steps” following utilization of crisis services (i.e. connection to housing, outpatient services, etc.) in a way that is supportive of the individual and their dignity
- g.) “Diagnostic overshadowing” presents negative connotations and assumptions about suicidal behavior based on diagnosis (i.e. suicidal ideation can be seen as a need-seeking behavior among SUD/IDD individuals instead of a mental health crisis) and should be avoided to provide equitable, coordinated care
- h.) Standardized testing for anxiety/depression/suicide i.e., PHQ-9, GAD, etc., needs to be adapted for different abilities, communication styles, and cognitive differences, as they currently may present barriers to accessing adequate care.

5. Goal: Improve and Expand Workforce Development & Training

Reason: Oregon is facing a crisis in workforce development, especially for culturally responsive, trauma-informed, and suicide-safe-care-trained providers. Some of the barriers include low salaries, housing costs, retention and staff turnover issues, and lack of community infrastructure and support for Black, Indigenous, and People of Color. Robust training with adequate funding/incentive to support workforce development is needed for all types of behavioral health service providers, including peers, non-clinical care providers, and community members. Training must also address suicidality effectively without bias, stigma, or assumptions that could be harmful.

Recommendations:

- a.) Suicide awareness training is well-received in communities, so it should be marketed and pushed broadly across communities. Additional considerations should be made to target training for occupations/agencies that have direct contact with vulnerable populations i.e., food stamp offices, libraries, hotels, etc.
- b.) Non-MH providers and community members who have contact with individuals experiencing suicidal thoughts need more training around crisis intervention and safety planning to improve confidence and preparedness in conversations.
- c.) More understanding and training are needed in health care systems (and particularly in emergency services) regarding the intersection of MH with co-existing concerns/diagnoses, including I/DD diagnosis, substance use, pain management, trauma, and interpersonal violence. This will support matching the level of care for an individual to their level of need.
- d.) Providers need to understand that suicidal ideation can improve, but also can still be a serious issue for those who experience thoughts chronically.
- e.) Providers would benefit from more awareness about parasuicidal and passive suicidal behaviors i.e., restrictive eating, excessive risk-taking behaviors, etc.
- f.) Many mental health providers (including CADCs, Q.M.H.A.s, and peer support specialists) do not feel qualified or willing to work with actively suicidal individuals, so more understanding and training in direct intervention and safety planning is extremely important. All licensures/accreditations should have targeted, best-practice training specific to suicide care, and should be in alignment with the requirements of HB 2315.
- g.) ASIPP Advisory Committee should be involved in the implementation of HB 2315 to ensure that required training meet suicide risk assessment, treatment, and management best practices.
- h.) Insurance, waitlists, and other barriers exist for individuals attempting to access treatment modalities indicated for treating suicidal thoughts and behaviors i.e., DBT, CBT, etc.
- i.) Data around suicide attempts/non-fatal suicide outcomes needs further understanding for application in practice.
- j.) Organizations should actively reduce concerns around liability in suicide care through education and awareness for staff.

6. Goal: Identify Social Determinants of Health Among Mental Health Participants to Improve Outcomes

Reason: Research indicates that better health outcomes result from access to safe housing, food, jobs, and transportation. Poverty strongly predicts poor health, as an individual cannot adequately address their mental health concerns without access to basic needs. Poverty is also strongly related to inequitable services and practices within the mental health realm, such as high cost to access care, limitations on services provided through OHP/Medicaid, lack of access to services in rural communities, and lack of care coordination for individuals attempting to access services.

Recommendations:

- a.) Increase access to services that impact social determinants of health. Examples include added flexible funding, implementation of harm reduction models, such as Housing First, better nutrition, and increased awareness of resources, such as Non-emergency Medical Transportation.
- b.) Barriers to accessing mental health services, particularly along the lines of social determinants of health (i.e., poverty, homelessness, etc.) should be eliminated.
- c.) Resources for bilingual/bicultural consumers (translators, documents in spoken language, etc.) need to be improved.
- d.) “Psychological autopsy” policies for use in suicide postvention are needed to assess root causes of suicide, update our violent death data, and inform prevention efforts.
- e.) ASIPP Advisory Committee should inform practices of Healthier Together Oregon.

7. Goal: Emphasize the Use of Media and Communication to Promote Hope, Healing, and Wellness

Reason: Media plays a huge role in our society and culture and impacts many facets of public perception and general knowledge. To prevent suicide and promote mental wellness, we need to be able to talk about it openly — without fear or shame. How we talk about suicide and mental health matters, as conversations and messaging must be conveyed in ways that support safety, means reduction, wellness, and recovery. Media and communications, on both macro and micro scales, have an obligation to our communities to provide consistent, caring, and normalized messaging about suicide and mental health.

Recommendations:

- a.) Media should promote viewing suicide as both a public health issue for overall community health, as well as a behavioral health issue for people experiencing suicidality as a behavioral health challenge.
- b.) Agencies should fund/support campaigns that aim to reduce the stigma around suicide and access the right help at the right time.
- c.) Agencies and organizations should work with media outlets to promote gatekeeper training in communities to recognize signs of suicide, provide connection to appropriate service, and debunk common lay assumptions around suicide.
 - a.) Organizations need comprehensive postvention policies, including some form of sentinel event review to assess for systems barriers, trauma-informed supports for staff, and safe-messaging guidelines.

- d.) Requirements for postvention planning and communication should be expanded to the entire lifespan (similar to the guidelines and requirements in SB 561 for postvention response to youth suicide) to reduce the risk of suicide contagion and improve best practice responses to suicides.
- e.) All media and communications should consider accessibility needs, including language, alternate forms of distribution, and access to technology. In rural communities, communications should be tailored to the resources available in the area (i.e. flyers in a grocery store, resources at a meal site, etc.).

Summary of mental health systems

The shortage of behavioral health care workers in Oregon is a serious problem, leaving those in need on long waitlists. In terms of treatment for suicidal ideation and behaviors, many therapists acknowledge that they were not trained properly in graduate schools. Fortunately, passing HB 2315, which mandates some post-degree training in suicide prevention will be somewhat helpful in terms of this serious hindrance to getting not only timely help but the right kind of help. Another glaring challenge is the lack of ethnic and linguistic diversity in the Oregon behavioral health workforce which is being addressed by the OHA Healthcare Workforce Committee.

Means Matter

Introduction Data and Literature review

“...widespread adoption of suicide-focused treatment could, in best-case scenario, potentially reduce the national rate of suicide by up to 15-22%. Means restriction, by comparison, reduces suicide rates by margins that consistently range from 30% to nearly 60%...we focus so much of our efforts on trying to figure out who is going to kill themselves and trying to thwart the reasons why someone would want to kill themselves that we haven’t spent much time on how people kill themselves.” (Bryan, 2022)

This Small Workgroup is slightly different than the other Small Workgroups in that it does not have an “identity” in the same manner as gender, ethnicity, sexual orientation, etc.; however, it is true that firearm owners are at greater risk of suicide than non-firearm owners. Men who own handguns are 8 times more likely to die of suicide than men who do not own handguns. Women who own handguns are 35 times more likely to die of suicide than women who don’t own firearms. However, there are some competing explanations, i.e., do people who are seriously thinking about ending their life buy a firearm in preparation for suicide or does the pre-existing presence of a handgun in the home make it more likely that someone will impulsively use it during a suicidal crisis? A recent study published in the New England Journal of Medicine explored that question and found that both explanations are true. In this large-scale longitudinal study, 26.3 million male and female residents of California who were new handgun owners were followed for over 12 years in terms of mortality and suicide. Although 48% of the suicides by handgun occurred within a year of purchase, 52% occurred more than a year after acquisition (Studdent et., al 2020)

A firearm is the most prevalent manner of death by suicide. This is not true for attempts. This is true across the nation and in Oregon. Between 2016–2020, 52% of suicides in Oregon were via firearms, followed by 26% via suffocation (Figure 34).

Means and methods

Figure 34. Methods of Suicide in Oregon across the lifespan by sex from 2016–2020

Mechanism of injury	ALL		Males		Females	
	Percent	Count	Percent	Count	Percent	Count
Firearm	52%	2223	58%	1911	31%	312
Hanging/suffocation	26%	1108	25%	825	28%	282
Poisoning	13%	561	8%	266	30%	293
Fall	3%	126	3%	88	4%	38
Motor Vehicle/Train	2%	76	2%	58	2%	16
Sharp instrument	2%	80	2%	60	2%	22
*Other/Unknown	2%	88	2%	59	3%	30
Total	100%	4263	100%	3267	100%	993

Source: ORVDRS 2016–2020

In 2019, OHA collaborated with Lines for Life and State of Safety to further explore the relationship between suicide and firearms and in 2020 Lines for Life, OHA and the Oregon Alliance to Prevent Suicide collaborated and created an additional

report, *Input from Oregon Gun Owners on Firearm Safety and Suicide Prevention*, in which a series of focus groups with firearm owners were held. The major recommendations from that work include:

1. There needs to be a coalition with members from both suicide prevention experts and those who are firearm owners (there are individuals who are both). **
2. Integrate firearm safety information in all suicide prevention training and work from the assumption that firearm owners are increasingly represented among trainees.
3. Use co-design and message testing to further develop and test communication strategies suggested by these findings for a firearm owner-to-firearm-owner-focused communication campaign.
4. Develop print collateral for any communication campaign such as brochures, ads and cling stickers that gun retailers can put on purchases. Include information in existing print materials such as those produced by the state related to hunting, fishing, falconry, etc.
5. Emphasize direct and clear communication and preparation among gun owners to protect themselves and their loved ones in the event of a mental health issue. Encourage gun owners to designate a mental health safety buddy in advance of needing one.
6. Develop a firearm safety curriculum that demonstrates safety protocol and gear for parents and youth 12-16 that includes a suicide prevention component.

**This recommendation came from the State of Safety. All other recommendations came from Oregon Gun Owners on Firearm Safety and Suicide Prevention

[Wang](#) and colleagues (2020) analyzed suicide attempts and suicides among 10–74-year-olds between 2006-2015. They found firearms to be 90% fatal, suffocation at 51%, poisoning at 2%, and all other methods at 2%. The literature and data agree that firearms are a means in need of focus and prioritization.

The full report for the Means Matter Small Workgroup can be found [here](#). Excerpts and recommendations are as follows:

Risk Factors

The risk and protective factors for firearm owners are the same for any adult population with having easy access to a lethal means being the prominent risk factor. [CDC](#) states the following with regard to risk factors and protective factors:

- Previous suicide attempt
- Mental illness, such as depression
- Social isolation
- Criminal problems
- Financial problems
- Impulsive or aggressive tendencies
- Job problems or loss
- Legal problems
- Serious illness

- Substance use disorder
- Child abuse and neglect
- Bullying
- Family history of suicide
- Relationship problems such as a break-up, violence, or loss
- Being a victim of sexual violence
- Barriers to health care
- Cultural and religious beliefs such as the belief that suicide is a noble resolution of a personal problem
- Suicide cluster in the community
- The stigma associated with mental illness or help-seeking
- Easy access to lethal means among people at risk (e.g. firearms, medications)
- Unsafe media portrayals of suicide

Protective factors

- Coping and problem-solving skills
- Cultural and religious beliefs that discourage suicide
- Connections to friends, family, and community support
- Supportive relationships with care providers
- Availability of physical and mental health care
- Limited access to lethal means among people at risk

Intersectional identities

- Men
- Veterans
- Construction Workers
- Those living in rural and remote areas

Recommendations from the Means small workgroups ([link to full report](#))

1. Occupations

- a.) Incorporate mental health promotion and suicide prevention resources and information into regularly scheduled safety meetings for industries that employ high-risk populations.
- b.) Promote both safe firearm storage and prescription drug/opioid safety when discussing lethal means safety, as workplace injuries that require prescription drugs can be easily misused.

- c.) Promote lethal means safety practices on and off job sites, including distribution of materials for lethal means safety planning.
- d.) Promote and consider funding wellness programs for high-risk occupational groups that offer classes and/or counseling support for mental health, financial health, nutrition, cultural affiliations, environmental factors, and fitness.
- e.) Provide all employees who are issued a firearm by their employer, with a safe storage device and training on proper use.

2. Firearms training

- a.) Develop a module that complements existing firearm safety and Concealed Handgun License (CHL) curriculum that focuses on suicide prevention and includes safe storage concepts.
- b.) Incentivize firearm safety instructors to include the training module on mental health and suicide prevention awareness in their classes, with a focus on ways to keep oneself or a family member/friend safe if they develop a high risk for suicide.
- c.) Recommend that Oregon establish standardized training requirements (e.g., through OSP and/or DPSST) for CHL competency courses or other firearm-related courses.
- d.) Encourage gun shops and shooting ranges to communicate with new firearm owners (especially those who purchased during state COVID restrictions) on firearm safety training opportunities through ODFW, local law enforcement, or private trainers.

3. Veterans

- a.) Provide printed posters and brochures on suicide awareness and lethal means safety directly to firearm retailers, shooting ranges, gun shows, and other firearm-related businesses.
- b.) Provide Veteran specific digital and print resources and information to firearm safety instructors.
- c.) Implement HB 2315 (2021) to ensure that behavioral health providers are trained in lethal means safety (e.g., CALM training included in continuing education opportunities) as part of their suicide prevention, intervention, and treatment education.
- d.) Recommend that future legislation expand the requirements of HB 2315 (2021) to include physical health providers, and to explicitly require education that includes lethal means safety.

4. Older adults

- a.) Improve identification of suicide risk and lethal means access for older adults in primary health care settings.
- b.) Develop guidelines and requirements for assisted living facilities and older adult communities that allow gun ownership to have safe storage facilities in place.

5. Health care providers

- a.) Direct Oregon mental health clinicians to complete a cultural competency course and Counseling on Access to Lethal Means (CALM) training.
- b.) Provide funding and/or CEUs for behavioral health providers to attend firearms training courses to increase cultural competency, facilitate professional connections to establish referral pathways to behavioral health services, and promote suicide awareness training for range staff and instructors.
- c.) Educate health professionals on the function of and process for seeking an Extreme Risk Protective Order (ERPO).

6. Local firearm businesses

- a.) Prepare outreach materials for firearms community distribution.
- b.) Distribute outreach materials to gun shops using 2A-friendly people as messengers.
- c.) Consider developing a temporary offsite firearm storage process for Oregon gun owners to offload their firearms to trusted recipients when they or someone in their household is undergoing mental health challenges and add this information and contact information for local firearm dealers that wish to provide this service, to outreach materials.
- d.) Encourage Oregon firearms accessory manufacturers to include outreach materials (e.g., brochure, card) with their products.

7. Temporary offsite storage

- a.) OHA to formally request that the Oregon Department of Justice clarify ORS 166.435 to describe the process and requirements that gun owners must abide by to transfer firearms to licensed firearm dealers, family members, friends, and other entities.
- b.) Ensure that temporary firearm transfers are done with confidentiality so that transferors will not be marked as mentally ill or suicidal.
- c.) Develop a list of gun-related businesses, local law enforcement agencies, national guard facilities, and other entities who are willing to hold onto guns temporarily and develop a database or visual map of these participating businesses for the public to view.
- d.) Create grant fund for gun shops to purchase large gun safes for storage of customer firearms, to pay for attorney fees incurred in review of the shop's consignment return process agreement (and potential contracts with Hold My Guns), and to purchase general liability insurance.

8. Race/Ethnicity and LGBTQIA2S+

- a.) Develop Sexual Orientation and Gender Identity data tracking process for suicide deaths and suicide attempts to better understand lethal means data specific to this group.
- b.) Conduct outreach on lethal means safety and suicide awareness at pride events and culturally specific community events across the state.
- c.) Engage with organizations that represent specific high-risk identity groups (e.g., BIPOC, LGBTQIA2S+) to increase the promotion of suicide awareness and lethal means safety concepts at gun shows and related events.

9. Substance Abuse

- a.) Facilitate coordination between the Oregon Poison Center and county health departments to enhance substance addiction prevention and postvention work as it relates to intentional overdose response work and connecting to services.
- b.) Develop or provide grant funding for a coordinated response to nonfatal, intentional overdose cases, to reduce future risk of overdose and/or suicide.
- c.) Ensure that Oregon's Drug Takeback Program provides and promotes safe medication disposal sites proximal to workplaces with higher risk for overdose and/or suicide (e.g., construction sites, manufacturing, and logistics warehouses).
- d.) Combine firearm safe storage and medication-safe storage (including prescription drug takeback program information) in suicide prevention outreach efforts and training (e.g., MHFA, ASIST, CALM, QPR).
- e.) Encourage the inclusion of basic naloxone administration skills in CPR training to increase community bystander first-aid capacity and awareness.

Additional notes:

General Older Adult Recommendations

- Provide additional support to local health systems for a timely response in supporting individuals who have been identified at risk for suicide by primary care professionals.
- Expand the amount of Medicare-certified behavioral health providers. Solution may involve expanding telehealth access to certified behavioral health providers in rural areas of Oregon.
- Teach older adults how to use modern forms of technology and software to help them stay connected to friends/family.

General Equity/LGBTQIA2S+ Recommendations

- Ensure that behavioral health services and other outreach services (e.g., street outreach for houseless people) are culturally appropriate for BIPOC and LGBTQIA2S+ people – (aligns with HB2949 relating to diversifying the behavioral health workforce through incentive and pipeline programs and HB2086 relating to culturally specific behavioral health services for BIPOC).
- Use medical examiner data, law enforcement data, and other sources to develop more targeted changes to the care and service system and address equity

General Construction Recommendations

- Explore funding options for the development of a program to augment worker incomes in trades or employers with very limited sick leave or strict drug policies, such that workers feel less fear of potentially being terminated from work for seeking addiction treatment. Especially construction, extraction, hospitality, food/drive service, and logistics industries.

Survivor/Postvention Recommendations

- Include site-specific physical protections and communications for locations that become suicide hot spots.
- Ensure counties have the resources necessary to respond and monitor locations, and if not make resources available.
- Support safety planning and lethal means counseling after a suicide attempt.

Means Suicide Prevention Work Currently Underway

1. Washington County competed in a two-month pilot program in which a contractor with expertise in both suicide and firearms visited all gun shops and pawn shops within the county to provide outreach and resources such as brochures. All gun shops, except for one, agreed to distribute resources to customers.
2. The VA in Portland distributed unsolicited mailers to gun ranges throughout Oregon with resources and information regarding suicide and firearms.
3. Hundreds of people have received CALM training.
4. Gun locks have been distributed throughout the state through the Association of Oregon Community Health Programs (ACOMHP) as per a contract with OHA.
5. OHA contracted with Oregon State University (OSU)-Cascades and other experts to develop and distribute a CME (Continuing Medical Education) accredited course for Health Care Providers regarding "[Addressing Firearm Safety in Your Suicidal Patient](#)".
6. OHA contracted with OSU-Cascades and other experts to design a [brochure](#) regarding firearms and suicide prevention.
7. The Oregon Firearm Safety Coalition (OFSC) has over 60 members who represent the firearm community, the suicide prevention community, and public health. They have formed partnerships with the Oregon State Shooting Association and Oregon Association of Shooting Ranges created [suicide prevention modules](#) for gun clubs and collaborated with American Foundation for Suicide Prevention (AFSP) to create an Oregon Firearm Suicide Prevention video.
8. The Coalition to Prevent Suicide in Clackamas County has formally partnered with the OFSC to work collaboratively to create relationships with Clackamas County gun owners, clubs, ranges, retail stores and others to reduce suicide deaths, and provide safe storage for any Clackamas County Residents experiencing a behavioral health-related crisis.
9. Clackamas County's largest gun club is offering QPR training quarterly to members and their families. This is in addition to suicide prevention being added to their new member orientation. In addition, they are developing cultural competence training designed to better equip and inform mental health professionals on gun culture and conversations around gun ownership. This training will be taught by the firearm community and is in partnership with Clackamas County.
10. The Oregon State Shooting Association and the OFSC developed posters to highlight the importance of safety and wellness in the firearm community. Posters emphasize safety in secure storage with an emphasis on safety within families and the community. These posters were paid for by OHA and will be distributed to all 27 gun clubs in the state.

11. Douglas Ridge Rifle Club, the OFSC and Clackamas County are partnering to create videos of Clackamas County gun owners to normalize gun ownership and to hear the voice of lived experience surrounding what suicide prevention means as a gun owner.
12. In 2020, OHA contracted with Lines for Life to conduct and [report virtual focus groups](#) with experts from OSU-Cascades.
13. The [Oregon Alliance to Prevent Suicide](#) has an ongoing “workgroup” focused on monitoring and addressing suicide issues related to lethal means including firearms.
14. The Portland VA analyzed VA health care records in Oregon for 162 Veterans where treatment for firearm injury was provided, finding that 20% of injuries were intentionally inflicted. Using national VA records, the team also found that 5.5% of Veterans treated by the VA for a firearm injury subsequently died from suicide.
15. The Portland VA is conducting a series of interviews with veterans and VA providers about addressing responsible firearm ownership during health care visits.
16. The VA and OHSU are partnering on a project to record interviews of veterans who have been injured by firearms; interviews will be curated and presented on a public-facing website.
17. OHSU and OHA are partnering on an analysis of all firearm injuries treated in EDs across the state; a substantial portion of ED encounters are due to self-directed injury. The team is conducting interviews with community partners working to prevent intentional and unintentional firearm injury to determine best practices for sharing firearm injury data from Eds.
18. OHSU is conducting an analysis of extreme risk protection order (ERPO) petitions across the state; in tandem, they are surveying health care providers across the state to assess knowledge of – and counseling about – the state’s ERPO law for patients at risk of firearm injury.

Means summary

Oregon, particularly the counties within the state, has made substantial efforts with means reduction suicide prevention work. This work can be especially difficult in terms of political climates, and it is imperative that firearm owners and advocates are an integral part of this work, which has been mostly true thus far. Most people who own firearms care deeply about suicide and have championed this work. Firearms are not the only lethal means of suicide. An overdose of medication can also be lethal without medical intervention. The difference is the opportunity to be rescued. An overdose allows a window of time for potential rescue whereas a gunshot rarely does. For some, suicide is a well-thought-out measured plan, but for many, it is an impulsive act. Impulsivity combined with easy access to a lethal means dramatically increases the potentiality for a suicide death and thus we need to continue to work on means reduction diligently and thoughtfully, involving the right people at the table.

Summary: All small workgroup recommendations

The Small Workgroups provided integral feedback in the completion of the ASIPP. The ASIPP would not be complete without their thorough input and collaboration on this process. The summaries above only begin to touch on the work the committees did to make the ASIPP happen. Full reports from each Small Workgroup can be found in [Appendix 2](#). We are eternally grateful for their guidance. There were a number of common threads among the Small Workgroups outlined below.

1. We cannot have a “one size fits all” approach to suicide prevention, intervention and postvention.
2. We must approach different cultures with cultural humility and seek to gain knowledge about how we can be helpful within that population rather than trying to change that population to fit into the dominant culture’s idea about what “should” be helpful.
3. We must not only “invite other cultures to sit at our table” but seek out opportunities to “sit at their table”.
4. We need to move away from suicide prevention efforts normed and created for and by the dominant culture and seek alternatives better suited to specific cultures.
5. Suicide prevention needs to be culturally specific. To do otherwise is not only “not helpful” but can be “hurtful.”
6. Health disparities, including suicide, are the result of a long history of white supremacy, homo- and transphobia and gender inequities in this nation and Oregon. We must consider these influences as we proceed with the work of suicide prevention.

Appendix 1

Demographics of large partner group

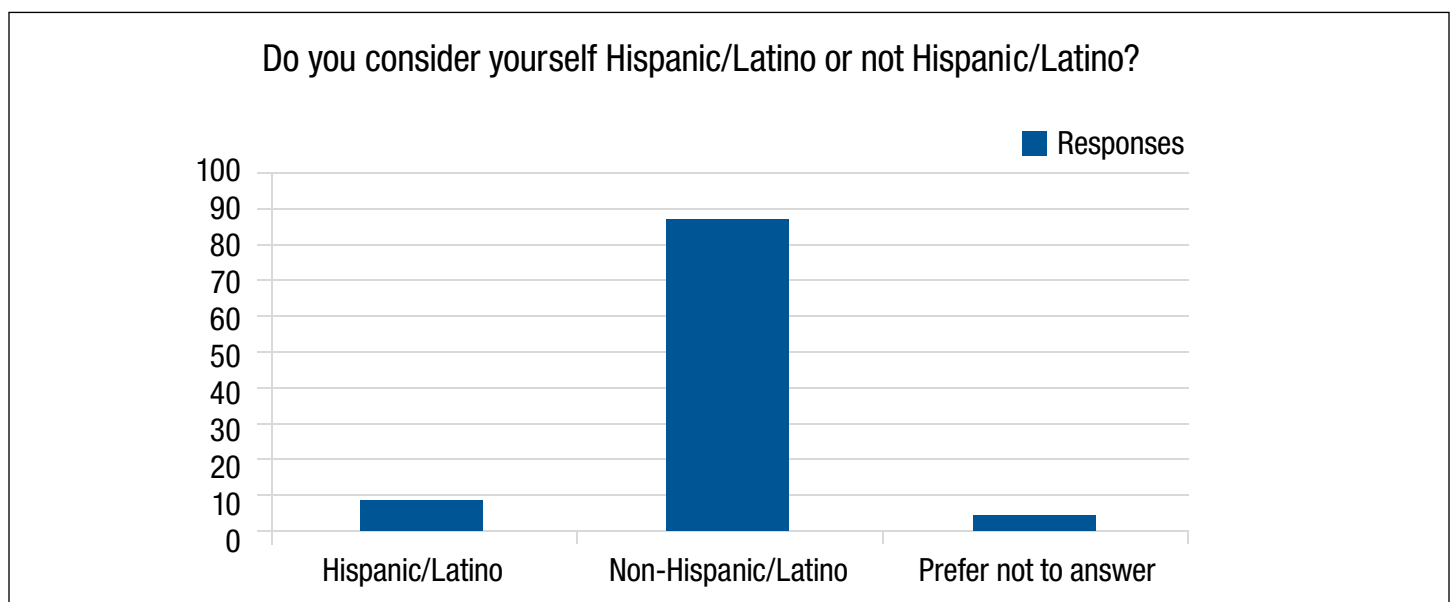
Summary of results

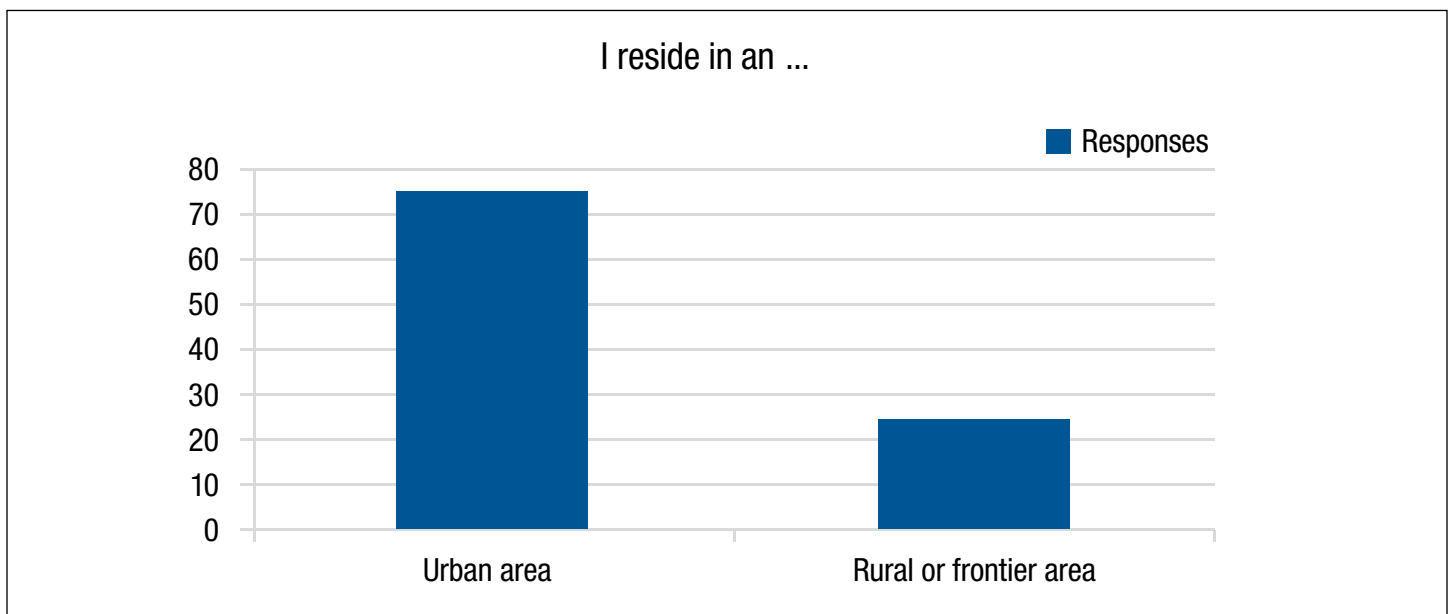
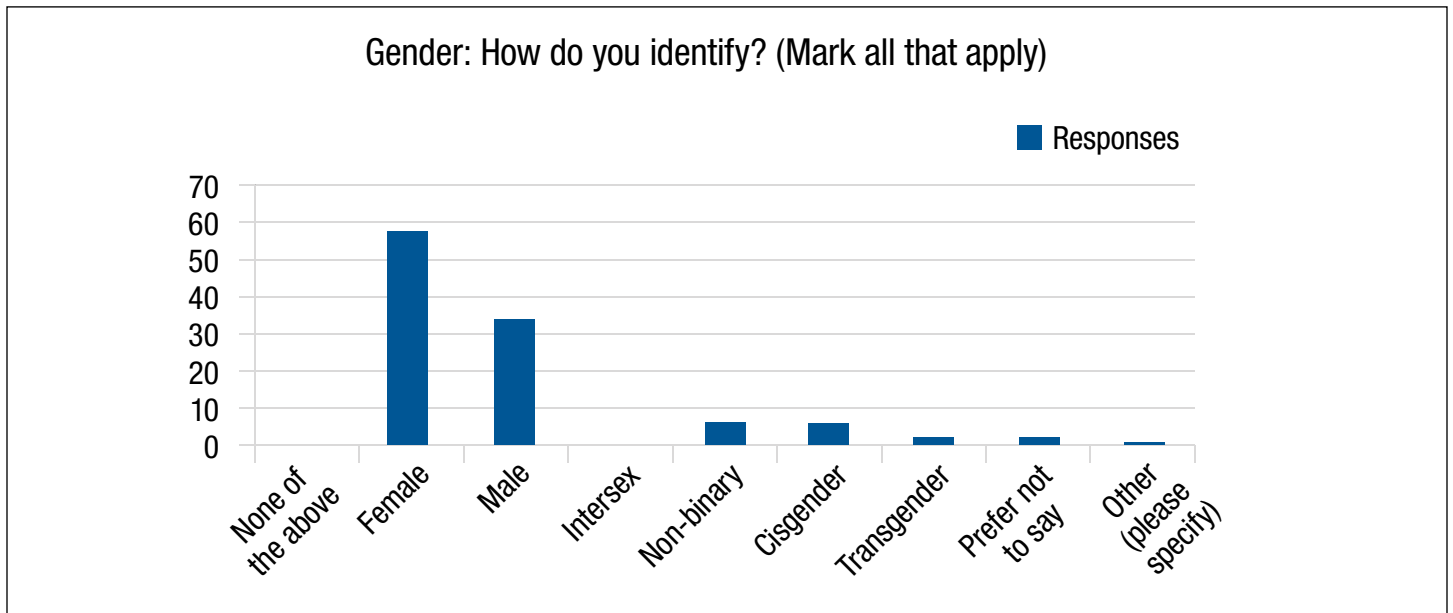
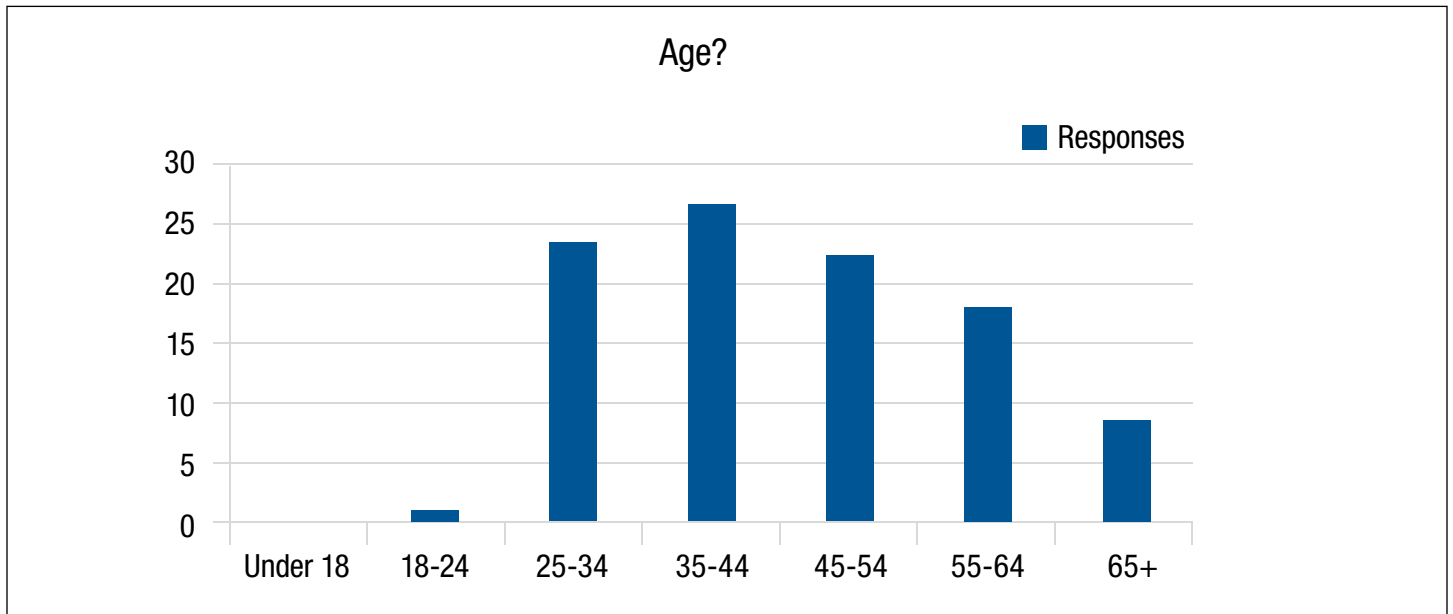
1. The response rate for this survey was 72 percent
2. 50 percent of all counties were represented in terms of participation
3. 57 percent of the population identified as heterosexual or straight which means that there was a remarkable representation from the LGBTQIA2S+ community
4. 13 percent of participants served in the military
5. 83 percent of the participants had a bachelor's degree or greater (MA, Ph.D.)

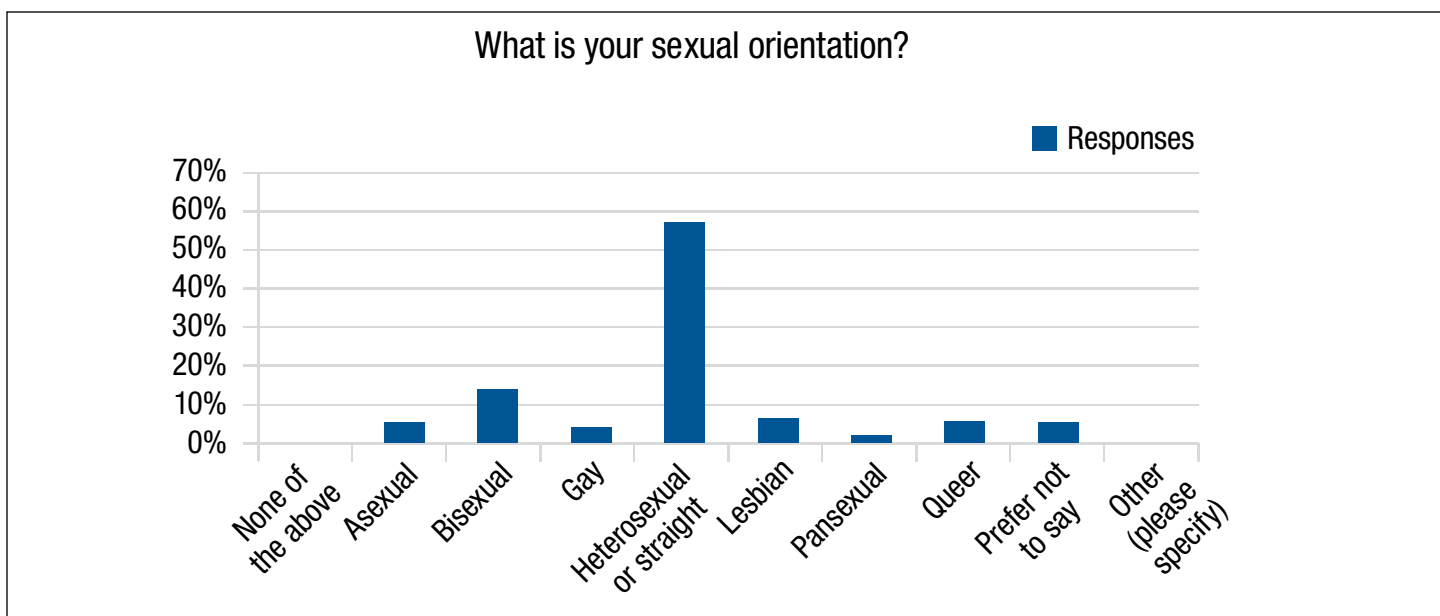
The table below is a comparison of the 2020 Oregon American Community Survey (ACS) (population demographics of the state) and the large partner group regarding ethnicity. Two questions were asked differently on the two different surveys which made it impossible to compare and those were left as question marks.

	ACS 2020	Large partner group
White	82.59%	82%
Two or more	6.18%	*
Asian or Asian American	4.50%	7.40%
Other race	3.36%	0
Black African American	1.89%	5.30%
American Indian/AN	1.09%	4.20%
Native Hawaiian/PI	0.39%	3.10%
Hispanic or Latino	*	8.70%
Prefer not to answer	*	3.10%

*Questions were not in the surveys

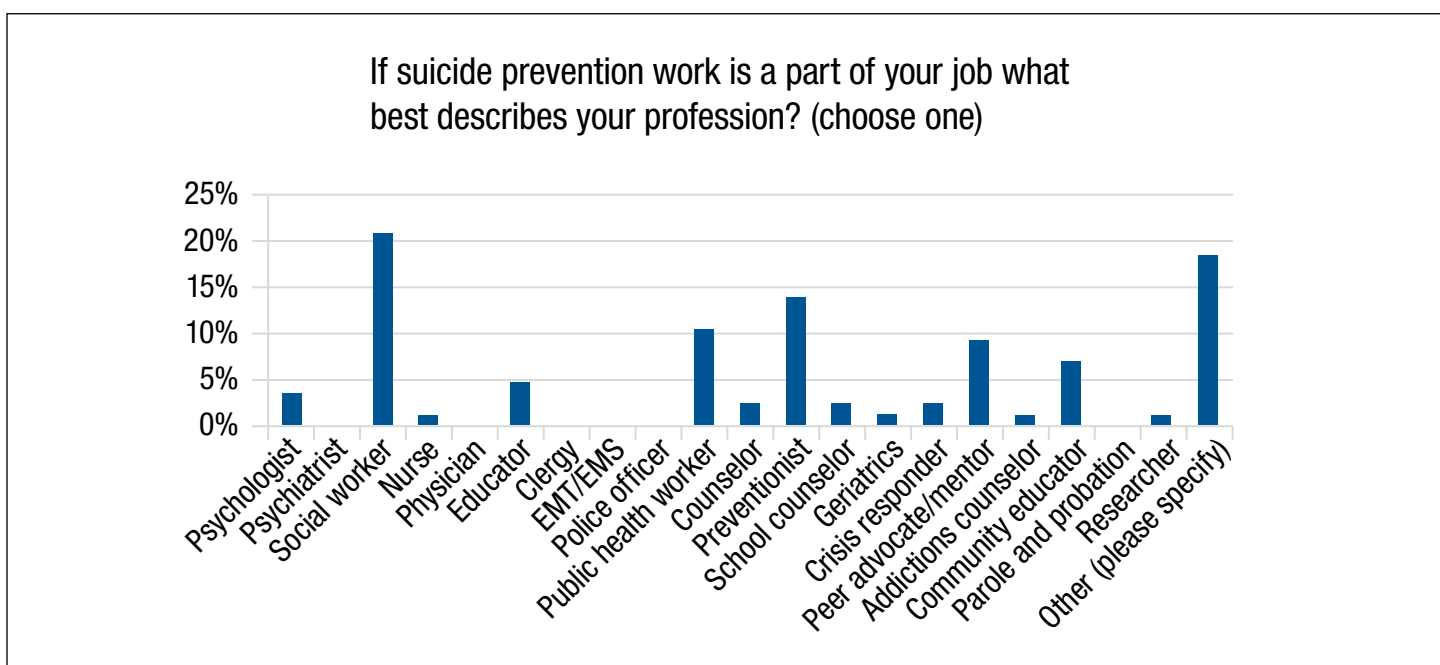






What are the reasons that you are involved with suicide prevention work? Select all that apply.

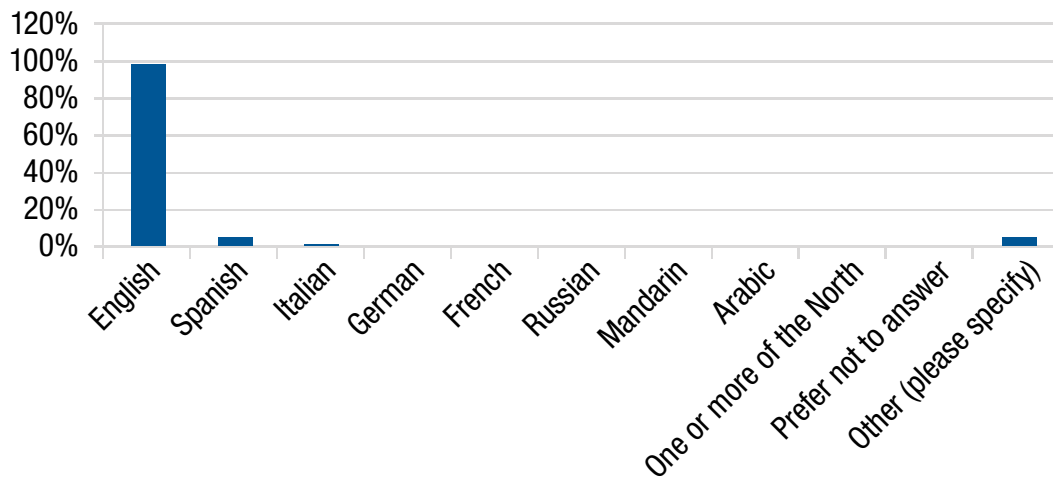
Answer choices	Responses	
It is a part of my professional work duties	76.60%	72
I am a loss survivor (lost a close relationship in my life to suicide)	36.17%	34
I am an attempt survivor (I made a previous suicide attempt sometime in my life)	34.04%	32
I am a student and this work is a part of my educational experience	3.19%	3
Other (please specify)	24.47%	23
	Answered	94
	Skipped	0



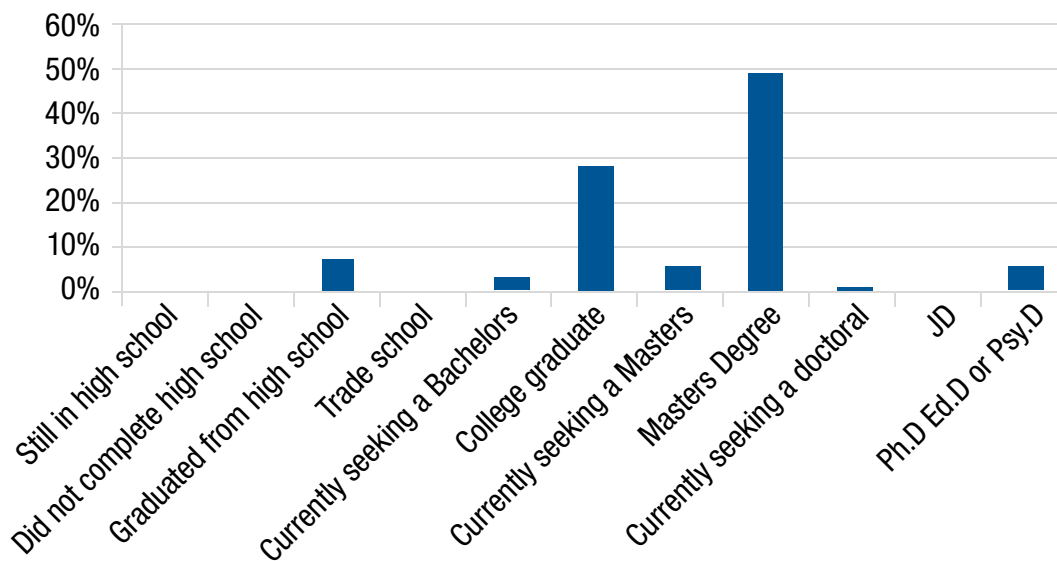
Which ASIPP small workgroups are you signed up for (even if the first meeting has yet to occur)?
Mark all that apply.

Answer Choices	Responses	
LGBTQIA2S+	15.22%	14
18–24 age range	14.13%	13
Focus Groups	6.52%	6
Policy	6.52%	6
Construction Industry	8.70%	8
Persons Who Have Served in the Military	14.13%	13
Means Matter	6.52%	6
Equity Group	10.87%	10
Persons with Lived Experience	9.78%	9
Older Adults	9.78%	9
Housing Insecurities	2.17%	2
Disabilities & Chronic Illness	8.70%	8
SPMI	7.61%	7
BIPOC AI/AN	5.43%	5
Men	9.78%	9
Rural	8.70%	8
I am not signed up for a small workgroup	15.22%	14
	Answered	92
	Skipped	2

What languages do you speak fluently?
(Select all that apply)



What is your level of formal education?



Appendix 2

Complete Reports from ASIPP small workgroups

Adult Suicide Intervention and Prevention Plan

LGBTQIA2S+Workgroup Recommendations

Background

The Oregon Health Authority (OHA) has put together workgroups of volunteers to help inform the Adult Suicide Intervention Prevention Plan (ASIPP). The following document outlines recommendations from the LGBTQIA2S+ workgroup. The workgroup was composed of advocates, allies, and members of the LGBTQIA2S+ community. The workgroup did not consist of all identities in the LGBTQIA2S+ community but took into account other identities and expressions when researching and forming recommendations.

Members:

Jake Dilla, MPH (he/him) — PacificSource

Mandy Kubisch (she/her) — Multnomah County Behavioral Health Division

Kris Bifulco, MPH — (she/they) — Association of Oregon Community Mental Health Programs

Ian Michael (he/him) — Lines for Life

Alex Considine, M.S.W. (they/them) — Lines for Life

Thomas Crombie (he/him) — Freelance Community Health Educator

Amber Bowman (she/her) — Astoria School District; Clatsop Behavioral Healthcare; Resilient Clatsop County

La'Verne Adams — Cascadia Behavioral Healthcare

David Burnell — (he/him) LifeWorks Northwest

Definitions

Below are important terms and definitions that will be throughout the document. For more terms and identities, please visit: <https://www.hrc.org/resources/glossary-of-terms>

Cisgender — individuals whose assigned sex at birth is the same as their gender identity.

Gender identity — One's sense of being masculine, feminine, both, neither, or fluid. One's gender identity can be the same or different from their sex assigned at birth. Everyone has a sexual orientation and gender identity (SOGI). It's an inclusive term that applies to everyone, whether they identify as lesbian, gay, bisexual, transgender, queer, two-spirit, heterosexual or cisgender.

LGBTQQIAAP2S — Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Ally, Pansexual, 2 Spirit

LGBTQIA2S+ — an abbreviated umbrella term used to describe the community as a whole.

Sexual Orientation — Contains three different and fluid dimensions including **sexual identity**, **sexual behavior**, and **sexual attraction** or fantasy.

- **Sexual behavior** — whether an individual has sex partners who are of the same sex, the opposite sex, both, or neither.
- **Sexual identity** — how an individual thinks of oneself in terms of to whom one is romantically or sexually attracted
- **Sexual attraction** — an individual's sexual interest in others.

Two-Spirit — Traditionally, Native American Two-Spirit people were male, female, and sometimes intersex individuals who combined activities of both men and women with traits unique to their status as Two-Spirit people. Many indigenous people who are lesbian, gay, bisexual, transgender, or gender non-conforming identify as Two-Spirit. However, the term Two-Spirit does not simply mean someone who is Native American/Alaska Native and is queer. For more complete learning and information on Two-Spirit, please visit the [Indian Health Service](#).

Overview

The Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Questioning, Intersex, Asexual, Ally, Pansexual, 2 Spirit (LGBTQQIAAP2S, *hereafter referred to as LGBTQIA2S+*) is an expansive group with a variety of terms to identify themselves and their communities. However, being a part of a sexual minority group increases vulnerability to social stigma and health inequities. The LGBTQIA2S+ community consists of many social identities, sexual orientations, and expressions of gender. LGBTQIA2S+ people can have multiple identities (i.e., race, ethnicity, family, geographic, socioeconomic, age, etc.) and vary widely in the importance they attach to their own sexual orientation, gender identity, and the sense of community they share with other LGBTQIA2S+ people. Many people in the LGBTQIA2S+ community view their sexual orientation or gender identity as extremely or very important to their overall identity, however, others say it carries relatively little weight. LGBTQIA2S+ individuals also differ in how much they have in common with other subgroups within the LGBTQIA2S+ population/community; how much they participate in activities such as pride events and rallies; and how big a role they believe that venues such as LGBTQIA2S+ neighborhoods and bars should play in the future as the community gains more acceptance by the larger society.

There are many factors that contribute to a person's health. Due to perceived, direct, and self-stigma, many people in the LGBTQIA2S+ community struggle in silence and face poorer health outcomes as a result including rates of violence, STIs HIV/AIDS, substance use or tobacco use, depression, anxiety, and suicide-related behavior. Lesbian, gay, and bisexual adults are twice as likely to experience mental health conditions compared to heterosexual adults. LGBT individuals may find it difficult to disclose their sexual identity to clinicians due to fear of different treatment. Additionally, not every clinician or doctor is trained in addressing the concerns of the LGBTQIA2S+ community.

Suicide is a top public health concern and those who identify as LGBTQIA2S+ are at increased risk for suicidal behavior and death by suicide. In the United States, there is no systematic way of collecting information about sexual orientation and gender identity (SOGI) at the time of death, so the suicide rates for LGBTQIA2S+ people are unknown. There is also a lack of representation and diversity in research on LGBTQIA2S+ people, specially BIPOC individuals. Previous

research has predominantly engaged with youth and cis-, white, gay and lesbian people, so findings are skewed and not representative of the community as a whole.

The majority of LGBTQIA2S+ adults and youth who experience discrimination, bullying, or family rejection do not end up suicidal. Those who identify as LBG are six times more likely at risk for suicide attempts compared to those who identify as heterosexual. Sexual minorities are at increased risk for suicidal behavior and mental health problems due to chronic LGBTQ-specific stressors, like discrimination and harassment, rather than inherently developing poor mental health outcomes. Those who identify as transgender are nearly four times as likely to experience a mental health condition and 40% of transgender adults have attempted suicide in their lifetime.

The loss of any person to suicide cannot typically be explained by individual factors alone. Suicide reflects a complex interaction of factors that place stresses on LGBTQIA2S+ people at the societal level, community level, familial and relational level, and individual level. Beyond the complex interaction of multiple and dynamic risk factors, certain suicide risk factors have been found to meaningfully impact the LGBTQIA2S+ Community. Understanding the complex interaction of multiple and dynamic risk factors, power dynamics, and social identities have on the interpersonal, community, and societal experiences of the LGBTQIA2S+ community influence certain suicide risk factors that have been found to meaningfully impact the LGBTQIA2S+ community.

Key Risk and Protective Factors

There are certain factors that lead someone more or less likely to consider or attempt suicide. **Risk factors** increase the chance of behaviors that contribute to a suicide thought or attempt. **Protective factors** are those that reduce the likelihood of suicidal thoughts and thinking. This can vary based on the population. The following risk and protective factors are unique for the LGBTQIA2S+ population(s):

- Risk Factors
- History of mental illness and/or substance use.
- Stress from prejudice, discrimination, and violence, historical and generational trauma — particularly in BIPOC communities.
- Social isolation and ostracized from family and peers.
- Chronic physical health concerns and inequity in health care services, including HIV/AIDS diagnosis and lack of culturally responsive and appropriate behavioral and physical health care providers.
- Poverty and experiencing homelessness.
- Coming out — There have been positive shifts in acceptance, however, this can impact social experiences and relationships and mental health for those not in supportive environments.
- Internalized anti-LGBTQIA2S+ attitudes and beliefs.
- Laws and policies that encourage/protect stigma and discrimination.
- Protective Factors
- Connectedness to others
- LGBTQIA2S+ community, tight-knit/more connected due to shared oppression/exclusion
- Family acceptance.
- Sense of safety.
- Connections to friends and others who care about them.
- Effective behavioral health care.

Recommendations

10. Emphasis on Supporting Rural LGBTQIA2S+ populations

- A.) Expand research and data collection on LGBTQIA2S+ people in rural areas, including adding questions about sexual orientation and gender identity to surveys. This will allow for improvements in understanding how many LGBT people live in Oregon and rural areas to better improve outreach efforts and services.
- B.) There are less people, including LGBTQIA2S+, living in rural areas in Oregon. Around 33% of Oregon's population lives in rural areas and 2% in frontier⁹. People living in rural areas may be less familiar with LGBTQIA2S+ people and issues. OHA should implement rural-specific outreach and communication strategies for improving rural communities' understanding of LGBTQIA2S+ people and issues. Materials and communications should represent a diverse range of identities, orientations, races, ethnicity, and expressions of gender.
- C.) OHA builds and strengthens existing relationships with community organizations and behavioral health providers to promote LGBTQIA2S+ wellness and education. For example, promoting communication and connection points for LGBTQIA2S+ suicide prevention like the grantee meetings for the LGBTQIA2S+ mini-grants, where several rurally-located grantees were able to collaborate and support each other's work.
- D.) Invest in infrastructure in rural areas such as high-speed internet and access, improved transportation, and health centers for LGBTQIA2S+ people.
- E.) Allocate funding to improve LGBTQIA2S+ inclusivity with community partners and state-funded agencies.
- F.) Signal commitment to inclusion in rural communities by updating marketing materials with diverse, culturally responsive to the community it's in images of LGBTQIA2S+ patients and by displaying inclusive and culturally responsive (considering the makeup of the community it's in) posters and stickers in visible parts of the office or workplace.

11. Outreach, Training, and Education

- A.) Cultural competence training for providers of care
 1. Encourage and incentivize evidence-based professional development in workplaces regarding LGBTQIA2S+ inclusion. Behavioral Health and Primary Care Physicians LGBTQIA2S+ Training Curricula from Substance Abuse and Mental Health Services Administration (SAMHSA).
 2. Develop a toolkit and training around how to create more inclusive services of LGBTQIA2S+ people and the intersectionality of other identities they hold.
 3. Incentivizing and encouraging LGBTQIA2S+ individuals to become certified or licensed as providers. This would be a strategic partnership with local community colleges and Universities.
 4. It would be interesting to create a system for providers: for example, first year: training all staff up is optional, but encouraged; second year: require certain job profiles to have training, although all staff is encouraged; third year: require all staff at the organization to have been trained with annual in-service thereafter.

- B.) Develop, implement, and promote suicide prevention training specific for the LGBTQIA2S+ population and the intersectionality of LGBTQIA2S+ and other identities. Encouraging all of the “Big Six (Rivers)” programs and their staff to have supplemental training to enhance understanding and competency to create LGBTQIA2S+ suicide prevention training for LGBTQIA2S+ adults.
- C.) Design materials and other deliverables with the LGBTQIA2S+ community present and meaningfully involved. Including different gender identifies and sexual orientations, as well as allies, family members, and suicide lost survivors. Advocate for unique perspectives from those with different intersectionality to create robust and inclusive messaging.

12. Policy:

- A.) OHA is to adopt an equity tool/lens policy similar to the one utilized in the ASIPP and then apply that tool to all OHS policies and contracts. Based on findings, adjust policies to be more inclusive and culturally responsive to communities throughout Oregon.
- B.) Replicate this process for the Oregon Legislature to impact policy making.

13. Data collection

- A.) Encouraging training for Medical Examiners and coroners collects more specific and inclusive data, drawing on learnings and methods from the LGBT Mortality Project. This can inform strategies at the local/county level as well as at the state level.
- B.) Psychological autopsies were conducted in all counties throughout Oregon.
- C.) SOGI data collection: Alongside provider education of LGBTQIA2S+ community and care, encouraging health care providers to safely and securely collect sexual orientation and gender identity information to use to improve health care for those with specific identities. Additionally, encouraging health care providers to safely and securely collect pronoun information and then using the correct pronouns in health care settings. Providing science-based education to providers so that they fully understand the need and importance of this data as well as trauma-informed ways of counseling the patient/collecting this information.
- D.) Research

14. Inclusion Practices

- A.) Encouraging health care systems to have employees’ pronouns printed on their nametags to normalize gender identity in health care. This signals inclusivity and could open up a conversation between the patient and the doctor. (Everyone has a gender identity and it’s not something that you can assume by looking at someone.)
- B.) Signal commitment to inclusion by updating marketing materials with diverse, culturally responsive and appropriate for the community, images of LGBTQIA2S+ patients and by displaying LGBTQIA2S+ inclusive posters and stickers in visible parts of the office or workplace.

15. Increasing access and availability of services

- A.) Create culturally specific programming in communities where LGBTQIA2S+ population numbers warrant it. Either a safety net type organization for the LGBTQIA2S+ community that provides all types of social services and/or culturally specific programs if that makes more sense for the number of LGBTQIA2S+ people in a community. A direct and strategic partnership with LGBTQIA2S+ organizations like HRC (Human Rights Campaign), Our House of Portland, and the Q Center (or a similar model) for consultation, partnership and potentially expansion into rural areas of our community.
- B.) Organizations that contract with OHA must have non-discrimination policies that include LGBTQIA2S+ protections explicitly, with a commitment to training staff and reassuring a friendly, welcoming, and inclusive service.
- C.) Encourage bills similar to California's [Assembly Bill No. 2218 — Transgender Wellness and Equity Fund](#). This bill establishes funds for organizations serving people identifying as transgender, gender nonconforming, or intersex, to create or fund specific housing programs and partnerships with hospitals, health care clinics, and other providers.

16. Postvention training on death by suicide

- A.) Mandate that all Behavioral Health Care providers and staff are trained in CONNECT or similar postvention training. Update the CONNECT training with more specific information about LGBTQIA2S+ suicide death and grieving, with special attention given to the history of death and grief in the community and the resilience of survivors who often end up in informal peer support roles after a loss.

17. Incentive health and wellness & peer support villages

- A.) Incentivize a peer support specialist training program to appeal to more people and drive more people to become peer support specialists from the LGBTQIA2S+ community.
- B.) Create a toolkit on peer support villages that speaks to how to create and maintain them.
- C.) Create a mini-grant program to assist communities with getting peer support villages off the ground and functioning.
- D.) OHA provides funding for LGBTQIA2S+ people to get behavioral health screenings, HIV testing, etc.
- E.) OHA provides funding to conduct and to offer stipends/incentives for LGBTQIA2S+ health education groups that speak to how to increase resiliency, positive health practices, behavioral health, etc.
- F.) Evaluation of these initiatives by utilizing evaluation programs through local colleges and universities.

18. Older LGBTQIA2S+ Adults

- A.) LGBTQIA2S+ community is living longer, especially when considering discrimination, violence, and disproportionate health burdens. The OHA should meaningfully advocate for intergenerational approaches to support mental health across the lifespan. Creation of materials, initiatives, and education around aging in the LGBTQIA2S+ is a critical protective factor as seeing a future for one self is important in reducing suicide.
- B.) Utilize training, literature, and evidence-based practices from CONNECT and AARP to create sustainable efforts for older adult LGBTQIA2S+ individuals.

18–24 Age Group Full Report

Task, Purpose, and Process:

The task that was set before this workgroup was to develop recommendations for addressing suicidality in Oregonians between the ages of 18–24 years old.

We fully recognize the incredible diversity which exists within this age subsection and the unique challenges that accompany the development of recommendations that embodies both the narrower focus upon a specific age group and the broad focus of immense diversity of the larger adult Oregonian population that is represented within the age cross-section. To attempt to retain a constant fidelity to the lens of lived experience and equity in the development of any recommendations, we took a sub-section approach to each workgroup discussion, focusing on one sub-group at a time and identifying specific needs and barriers inherent to those specific groups within the larger young adult population, including populations of focus such as college/university students, LBGTIA2S+, military-connected, young adults with children, system connected, and BIPOC. More importantly, we put great importance upon not simply having the conversations about each group of focus, but instead consistently inviting the voices of lived experience from those within these groups to every table of discussion.

The result, our recommendations below, is, therefore, the product of our wholehearted attempts to give space and light to these voices, in their words, to guide the path towards meeting the mental health needs and barriers of the young adults of Oregon.

Recommendations:

Life Skills/Socioeconomic Risk Reduction

10. Universities and trade schools should offer transitional life skills programming and/or education during students' numerous timepoints, including during late high school, first year, last year, and during the graduate/post-grad period (i.e. budgeting, insurance, home-buying, job-seeking, etc.)
11. Expansion of current peer-based programming or development of a collective statewide system that draws on organizations already doing the work should be pursued in regards to increased availability of centrally located centers of communal resources, such as found in the Oxford House or Independent Living Skills models, for biopsychosocial/developmental/economic skill building and support.
 - a.) Resources/services of focus should include but are not limited to independent living skills development, mental health counseling and medication management, case management, peer support, employment skill building and assistance, parenting skills and support, and parental respite care.

Interprogram/Interagency Collaboration

- 1) Universities and trade schools should support and promote accessible, safe communication regarding incidents, concerns, or issues related to campus climate with campus administration and have an effective response system (JED Foundation)
- 2) Universities should create open and supportive opportunities to engage around national and international issues/events (JED Foundation)

- 3) Behavioral Health, physical health, and disability services on university and trade school campuses should collaborate to create and reinforce consistent, but appropriately targeted messaging about suicide and mental health
- 4) All post-secondary institutions should participate in resource and information sharing (within and between schools) (JED Foundation)

Advocacy

- 1) OHA should actively support the establishment of a Youth Action Board in every county. This is important as it allows for the voices of 14-15yo individuals to be heard as it relates to their experience and needs, as well as the specific needs and available resources of each unique county within the state. Clackamas County Youth Action Board, as supported in development by True Colors, can provide an example for this implementation and act as a framework for the development of each county's Board.
- 2) At least one member of a county Youth Action Board shall be designated as the representative at all state-level systems of care meetings and/or councils. Given the diversity of the needs of counties across the state, the inclusion of more than one representative would be of critical consideration.

Knowing Services Exist

- 1) Post-secondary institutions should help students learn about suicide prevention programs and mental health services by advertising and promoting them through multiple channels (JED).
 - Potential online platforms to be considered might be Twitch, Discord, Tik Tok, or Instagram. The successful interfacing with this population demonstrated by current organizations, such as Youth Era, can provide feedback regarding the channels which are most effective and therefore can be similarly utilized by the higher education systems in achieving this aim of greater awareness of programming.
 - However, non-social media/non-electronic modalities should also be utilized, including billboards, in-school bulletin boards or other postings in communal areas, hotline/campus mental health numbers on student IDs, as part of graduate student orientation, and in cultural centers and athletic complexes.
- 2) Information regarding resources and programming for perinatal, post-partum, and paternal mental health should be mandatory in its provision to expectant and current parents, regardless of age, gender, marital status, or type of health care/prenatal care sought.
- 3) Universal screenings should include mental health items, such as a Columbia Suicide Severity Rating Scale (CSSR-S), and screenings for problematic substance use, for all expectant and new parents.

Accessing Services

- d. OHA and ODHS should collaborate in the establishment and conduction of a peer-based system of services outside of the ILP program for transition-age youth to account for all TAY/18–24yo individuals who are engaged in ODHS services, regardless of qualification for ILP to develop and support skills for emerging adulthood and mental wellness.

- e. A statewide program of low-cost/free culturally sensitive and trauma-informed prenatal and post-partum services targeting YA should be pursued, including services/groups specifically for sexual assault survivors, single parents, pregnancy-after-loss, and fathers. While some community resources exist to specifically address post-partum depression/mental health, such as those connected with hospitals or clinics (ex: Hope for Mothers – Samaritan Health Services), these are limited in accessibility and are general in scope, resulting in underutilization for numerous reasons, including feeling unwelcomed or judged due to parental age/gender/race/marital status as these aspects may be underrepresented or completely absent within the generally homogenous groups.
- f. OHA should develop and implement staff-client ratio requirements for staffing and caseload for ODHS caseworkers to be adjusted based on acuity rather than the total number of clients to provide care and services sensitive to the individual’s needs and lagging skills, as well as to increase opportunities for early intervention in increasing distress.

Diversity/Equity

- 1) Post-secondary institutions should provide a variety of different structures and culturally relevant program types (i.e. mentor networks, discussion groups, workshops, etc.) focused on supporting the mental health and well-being of students (JED Foundation)
- 2) Post-secondary institutions should identify and promote the mental health and well-being of all students, with intentional cultural responsiveness for students of color, as a campus-wide priority (JED Foundation)
- 3) Create dedicated roles to support the well-being and success of BIPOC, LGBTQIA2S+, veterans, military service members, students with seen and/or unseen disabilities, and other student populations who may be disproportionately affected by suicide (JED Foundation)
- 4) Post-secondary institutions should actively recruit, train, and retain a diverse and culturally competent workforce, particularly those who have “frontline” experiences with students, to support active and open help-seeking behaviors (JED)
- 5) Post-secondary institutions should consider partnering specific cultural groups with mental health professionals who identify within those cultural groups to promote help-seeking behaviors. Professional organizations and their specific sub-groups, such as those of the National Association of Social Workers, American Association of Marriage and Family Therapists, American Psychological Association, and American Counseling Association, should also be utilized as resources for accessing professional resources and sources of employment recruitment.
- 6) Actively pursue professional pipeline to increase diversity and cultural competency of field — this may include educational or living stipends for serving rural populations, educational assistance, loan repayment, and/or scholarships for military/military-connected individuals, BIPOC, and LGBTQIA2S+communities to pursue careers in mental health.

Training

- 1) Statewide free or low-cost Gatekeeper training online modules should be made available to and be required by universities or trade schools for all students and their faculty/staff/administrators (see example in California of contracting with LivingWorks to provide Start for all K-12 students)

- 2) Develop robust programming/resources for peer-focused training and services, particularly targeting community college/trade school programs/campuses utilizing the structure already present on many 4-year campuses.
- 3) Universities and trade schools should consider contracting with training agencies to provide education on suicide prevention, intervention, and postvention to support the creation of a network of safety for students
- 4) Develop and implement robust programming for training available for peer-focused and delivered services, including training in Trauma Informed Care, Adulthood, Tokenism (Tri-Force), and Mental Health First Aid.
- 5) All physicians and other medical professionals, including OB/GYNs, CNMs, and nurses, should have suicide prevention as a mandatory portion of required continuing education in suicide prevention. Also, this mandate should be considered for the required training of employees of public and private family planning and reproductive health agencies, Employment and other state social service programs, and mentoring-focused services.

Postvention

Post-secondary institutions should develop a suicide postvention plan to adequately respond if a student attempts or dies by suicide (see CONNECT training format and Action Alliance 10 Steps to Handling Aftermath of a Suicide). A uniformed response across all state universities, and ultimately all post-secondary institutions within the state, should be considered with individual institutions adding to/adjusting to the needs of each specific campus/institution – reflect Adi’s Act (SB52, 2019 Session) in construction/framework

Research/Data

- 1) Post-secondary institutions should regularly and systematically conduct surveys and focus groups with students to understand their needs and challenges regarding mental health, emotional well-being, and campus climate, including a specific focus on students of color (JED). These survey initiatives should be supported and potentially funded by the state to improve adherence and implementation across all campuses.
- 2) Post-secondary institutions should identify and utilize culturally relevant and promising programs and practices, and collect data on effectiveness (JED)
- 3) The currently ongoing statewide assessment for homelessness should be utilized as a resource for data that bears influence upon risk within the young adult/student populations.
- 4) Establish a unified method for data collection and analysis of mental health incidence and prevalence and suicide, whether on or off academic campus, which is mandated and guided by OHA.

Areas for further study/consideration:

How do we stop young adults, particularly those transitioning out of system/state care, from getting lost?

Funding? “Who’s going to pay for programs/services/etc.?”

How can stigma and distrust of the system/mental health care/”adults” be addressed and reduced to improve the accessibility of services and help-seeking behaviors?

How do we catch everyone/account for everyone in this age group? (young adults living with parents, those not connected to a system)

Resources Consulted:

JED Foundation

The Oregon Alliance to Prevent Suicide (OAPS)

Youth Action Board – specifically Clackamas County Youth Action Board and member Mackenzie Wige

Youth Era

Additionally, the incredible resources and insights provided by the members of this workgroup.

Construction Industry full report

Acknowledgments:

This document is the result of a collaboration with representatives from the construction industry, health and wellness industry, and state agencies, and is part of an all-inclusive effort to address the suicide rates in the construction and general industries here in our great state of Oregon. As seen within this document and with the larger ASIPP group, addressing suicide prevention and mental well-being can not be effectively done alone and needs to include input from everyone. This document also represents the hard work of people who gave up their free time and who had the support of their employers to work on this while they did their day jobs. Ideally, this document can be seen as a living document and can continue to grow. Each category can be expanded upon, used internally as a plan to address suicide prevention, and most of all, it can be used to save lives. This would not have come together without the tireless efforts of the following people who not only did the hard work but whose passion and compassion was seen directly in their perspective, contributions, and feedback. It is absolutely wonderful to see people come together and work on something that can have a critical impact on not only the construction industry but all industries. We would also like to thank Deb Darmata who has done an exemplary job of leading, coordinating, communicating, and extracting the fine work of all of the ASIPP groups. On behalf of the ASIPP Construction Industry Work Group, we thank the Oregon Health Authority for giving us and the construction industry a voice; and for including us in this impactful work.

The following people helped bring this together and will forever be united through this work:

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We would also like to give special thanks to Cal Beyer and Crystal Larson for their review, comments, and feedback. Their expertise saves countless lives. We very much appreciate the time and resources they provided to help make this document a robust and effective resource. Thank you both.

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Perspective

As we shall see, the construction industry has a high rate of suicide both nationally and locally here in Oregon. Rates, data, and statistics are people's lives that are gone. Loved ones that are not coming home anymore. Phone calls to people that we cannot make any more. Coworkers, friends, and family that we will not get to see smile anymore. The Construction Industry is made up of many different people which is representative of our larger populations in a variety of communities and industries. Suicide is more than "an issue" that needs to be spotlighted. It is a suffering that roots itself in depression, substance misuse, and barriers. People who are suffering need to be heard; and the barriers to them getting help need to be removed. What we are going to see in this document are some causal factors that have been termed "Risk Factors" and some proposed corrective actions known as recommendations.

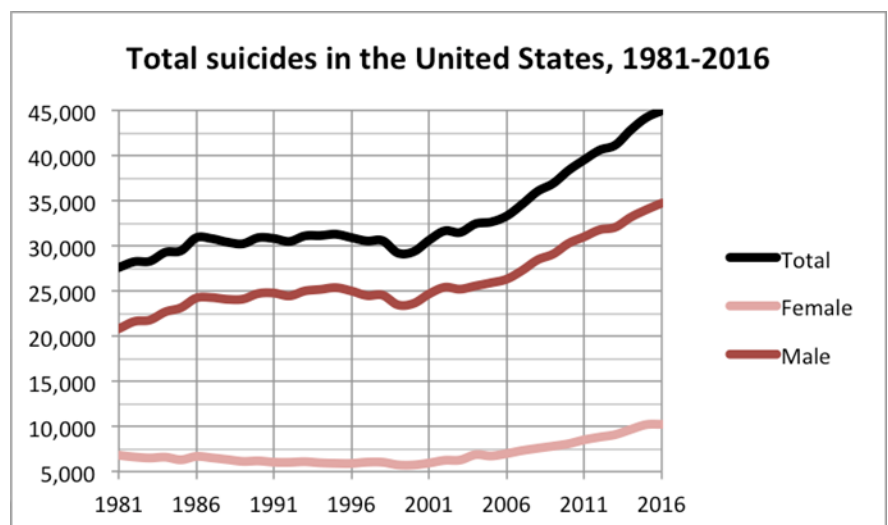
These risk factors are not all-inclusive, but are intended to make us ask the question, "What are the barriers and constraints to getting help for someone who is suffering and having suicidal ideations?" The recommendations in this document need to be thought of theoretically and applied to other risk factors and barriers that are not contained in this document. Apply the theme of the recommendations to other societal and institutional factors that keep people from being forthcoming and getting through a crisis moment. We may not know all the reasons, but we have a better understanding today than we did in the past. Suicide is a complex, multi-faceted issue. There are multiple factors for suicide risk and multiple strategies to address it. If we start to address the issues that have been identified here, we may see the numbers start to decline. "The numbers" are people's lives. We have the opportunity to save lives by removing barriers, providing resources, and illustrating care. This is an opportunity to show the rest of the population effective life-saving strategies which can be applied to other sectors and can reshape our culture to reaffirm the value of an all-inclusive community in saving precious lives.

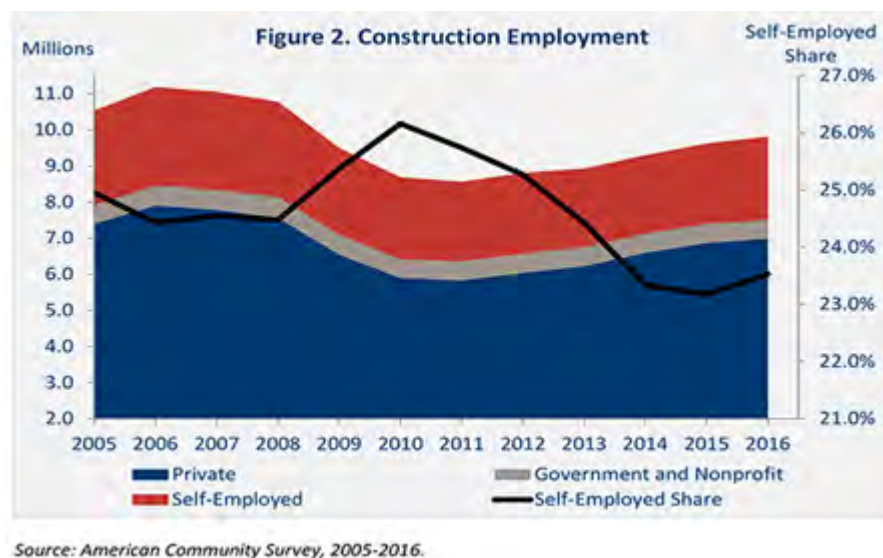
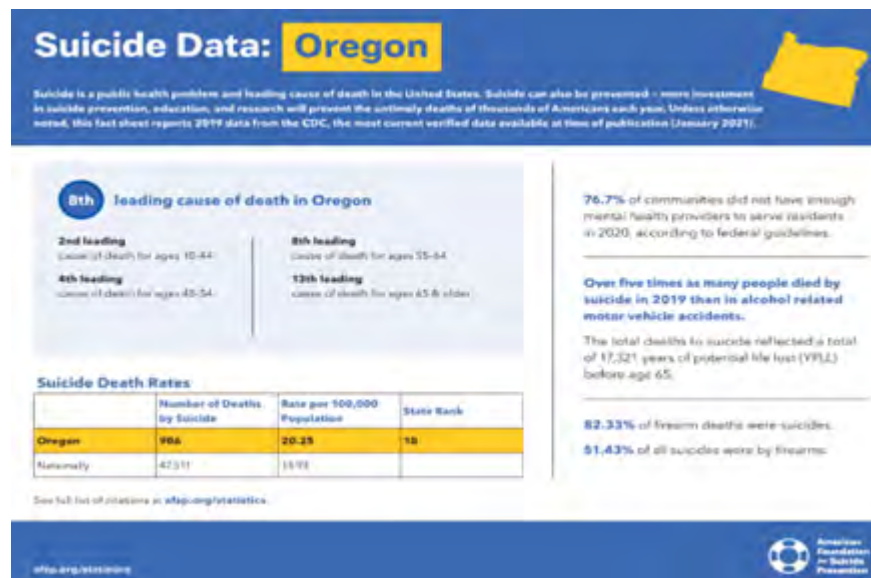
Background

The Data and Cause for Alarm

According to the 2016 Morbidity and Mortality Report, the Construction Industry has a disproportionate rate of suicide per 100,000 workers when compared to most other industries. This is seen when we look at the 2016 Morbidity and Mortality Report of 2016. The report reflects 32 states' results and reveals that the Construction and Extraction group has a suicide rate of 49.4 per 100,000. "The American Foundation for Suicide Prevention reported that in 2016, suicide was the 10th leading cause of death in the U.S., imposing a cost of \$69 billion to the U.S. annually. Other statistics reported

are: The annual age-adjusted suicide rate is 13.42 per 100,000 individuals." https://en.wikipedia.org/wiki/Suicide_in_the_United_States#/media/File:Total_suicides_in_the_United_States_1981_2016.png





<https://www.nahb.org/>.

“The 2016 American Community Survey ACS shows that 9.8 million workers were employed by the construction industry in 2016.”

If there were 9.8 million workers in construction in 2016 with a suicide rate of 49.4 per 100,000 workers, then approximately 4,841 people that worked in the Construction Industry died by suicide. “The fatal injury rate per 100,000 full-time equivalent (FTE) workers in the construction industry remained at 10.1 in 2016 (Dec 20, 2017)”, according to the 2016 Census of Fatal Occupational Injuries (CFOI) from the Bureau of Labor Statistics (BLS). In comparison, there were 1,034 work-related deaths in 2016.

<https://www.constructconnect.com/blog/construction-worker-deaths-6-2016#:~:text=The%20construction%20industry%20represented%2019.9,remained%20at%2010.1%20in%202016.>

Data series	2016	2017	2018	2019
Fatalities				
Number of fatalities	1,034	1,013	1,038	1,102

Blank cells indicate no data reported or data that do not meet publication criteria.
https://www.bls.gov/iag/tgs/iag23.htm#fatalities_injuries_and_illnesses

The following table shows the data from the 2016 Morbidity and Mortality report per trade.

Table 2. Detailed occupational groups meeting reporting criteria with male and female suicide rates* higher† than the population rate (all occupations) and associated major occupational groups and rates — National Violent Death Reporting System, 32 states,§ 2016¶

Detailed occupational group-Construction	Rate (95% CI)†	Rate (95% CI)
Structural iron and steel workers	79.0 (43.5–134.0)†	49.4 (47.2–51.6)†
Brickmasons, blockmasons, stonemasons, and reinforcing iron and rebar workers	67.6 (45.7–97.0)†	49.4 (47.2–51.6)†
Roofers	65.2 (46.1–90.0)†	49.4 (47.2–51.6)†
Construction laborers	62.0 (56.7–67.3)†	49.4 (47.2–51.6)†
Carpet, floor, and tile installers and finishers	55.2 (35.3–83.1)†	49.4 (47.2–51.6)†
Carpenters	54.7 (49.0–60.4)†	49.4 (47.2–51.6)†
Construction equipment operators except paving, surfacing, and tamping equipment operators	52.8 (42.2–63.4)†	49.4 (47.2–51.6)†
Construction managers	45.7 (38.4–53.1)†	17.5 (16.4–18.6)
Electricians	44.0 (37.7–50.2)†	49.4 (47.2–51.6)†
First-line supervisors of construction trades and extraction workers	44.0 (37.4–50.5)†	49.4 (47.2–51.6)†
Painters and paperhangers	36.6 (29.4–43.9)†	49.4 (47.2–51.6)†
Pipelayers, plumbers, pipefitters, and steamfitters	35.4 (28.7–42.1)†	49.4 (47.2–51.6)†

<https://www.cdc.gov/mmwr/volumes/69/wr/mm6903a1.htm>

In Oregon, **suicide deaths and rates among suicide victims aged 16 to 64 years by occupational group, Oregon 2013-2017**, the most current rate for Construction and Extraction Occupations are **86.1** per 100,000 workers is almost double that of the national 2016 rate per 100,000 workers. (Source: ORVDRS) There were **294 loses in the Construction Industry Population to suicide in those same years**. If we look at the number of construction workplace fatalities in the industry for those years, there were 26. <https://www.oregon.gov/dcbs/reports/Documents/comp-fatal/annual-rpt-17.pdf>

Statistics and data-driven information may have some variables that need to be considered.

- The 2016 CDC Morbidity and Mortality report only represent 32 states.
- Some accidents can be unreported suicides.
- Some accidental overdoses can be unreported suicides.
- People who are unemployed from the Construction Industry, may not be represented in the data.

With those considerations and other factors that may affect the numbers and reporting, we can make the following assumptions:

- There were many more attempts reported, recorded, and not represented. For example: in 2019 there were 47,511 Americans died by suicide and 1.38 million attempts. <https://afsp.org/suicide-statistics/>
- We can assume that the data does reflect a serious problem within the construction community; that they are suffering and focused action needs to be taken to respond.

Naturally, we ask the question why. What is it about the Construction Industry that drives these numbers up so high? Why are we losing close to 5,000 to suicide?

It also begs the question, why are we not addressing death by suicide with the same regard as occupational fatalities if they have a 5:1 ratio?

Is it because suicide is a personal health issue and can't be governed?

Can't it?

We would suggest that the unmeasurable and undocumented causes for most injuries and fatalities stem from mental wellness and personal issues. Distraction, anxiety, depression, lack of motivation, substance abuse from stress or pain management can very well be an underlying current that feeds mishaps and incidents. So maybe we can't address and counsel the individual from a clinical standpoint, but we can provide an environment that doesn't sustain dysfunctional habits or relationships. Being assertive with resources and overcommunicating the solidarity of a community is absolutely manageable.

There have been several factors identified that can contribute to the rate but there is not one single thing that can be addressed to reverse this trend. We will discuss the following reasons why, after researching and discussing, we think there is such a high rate.

Risk Factors

When trying to formulate a response to the increase in suicide rate in our industry, we mention risk factors quite frequently. The Construction Industry has some unique risk factors and as mentioned above, we can look at the demographics of the Construction Industry as a standalone risk factor. Risk factors, for the most part, are assumptions or things that contribute to one's risk of suicide. All of these risk factors could be contributing factors for why someone in our industry may start to have suicidal ideations. For clarification purposes, there is no scientific backing and if there it exists, it is not provided in this document. However, throughout the Construction Industry suicide prevention circles, these themes and factors have been generally accepted as truth, industry standards, and reasonable factors to address if a suicide risk assessment was conducted and mitigation actions were to be performed.

Not all of the recommendations can effectively address the risk factors in the Construction Industry. By the nature of the industry, construction is a physically intense, schedule-driven, a high-risk profession that is male-dominated and has little forgiveness for missing a day on the job. The recommendations found within this document have considered the following risk factors and have communicated the ones that we felt were practical, actionable, and applicable to our industry. These have not been listed by priority.

1. Risk Factor #1: Priority Populations

Construction demographics are comprised mostly of populations that fit into the priority population groups. These are groups that have risk factors that can contribute to an increased rate of suicide within that specific population. It is possible that priority populations overlap which can add to the number of risk factors of an individual and it is possible that a person could represent several different priority populations. There are many more priority populations such as the LGBTQIA2S+ and BIPOC communities who experience exclusionary and discriminatory Social Determinants of Health (SDoH), former athletes, people with addictions, including substance misuse disorders, adverse childhood experiences (ACES), and many others.

For the purpose of our recommendations, we have discussed and agreed that the priority populations each have resources for their specific populations. Furthermore, our recommendations aim to be inclusive of all the priority populations and they shall be represented, known as, and synonymous with the Construction Industry throughout this document. We have provided some background data and clarification for some of the major groups within the priority population community.

1. Men

“In 2019, just under 90 percent of the 11.4 million people employed in the U.S. construction industry were male.” <https://www.statista.com/statistics/434758/employment-within-us-construction-by-gender/>

In 2019,

- ✦ “The rate of suicide is highest in **middle-aged white men**.
- ✦ **men died by suicide 3.63x more often than women**.
- ✦ White males accounted for **69.38% of suicide deaths.**” <https://afsp.org/suicide-statistics/>

2. LGBTQIA2S+

LGBT or GLBT is an initialism that stands for lesbian, gay, bisexual, and transgender. The initialism, as well as some of its common variants, functions as an umbrella term for sexuality and gender identity.[2]

It may refer to anyone who is non-heterosexual or non-cisgender, instead of exclusively to people who are lesbian, gay, bisexual, or transgender.[3] To recognize this inclusion, a popular variant, LGBTQ, adds the letter Q for those who identify as queer or are questioning their sexual identity.[4] Those who add intersex people to LGBT groups or organizing may use the extended initialism LGBTI.[5][6] These two initialisms are sometimes combined to form the terms LGBTIQ [7] or LGBT+ to encompass spectrums of sexuality and gender.[8] <https://en.wikipedia.org/wiki/LGBT>

National Survey of youth: <https://www.thetrevorproject.org/survey-2020/>

“Representing the experiences of over 40,000 LGBTQIA2S+ youth ages 13-24 across the United States, it is the largest survey of LGBTQIA2S+ youth mental health ever conducted.

- ✦ Among some of the key findings of the report from LGBTQIA2S+ youth in the survey: 40% of LGBTQIA2S+ respondents seriously considered attempting suicide in the past twelve months, with more than half of transgender and nonbinary youth having seriously considered suicide.”

From the Suicide Prevention Resource Center website <https://www.sprc.org/>:

Like other minority groups, people who are lesbian, gay, bisexual, and/or transgender (LGBT) may experience prejudice and discrimination. Research indicates that mental health problems, misuse of alcohol and other drugs, and suicidal thoughts and behaviors are more common in this group than in the general population.¹

Risk and Protective Factors

Suicide prevention efforts seek to reduce risk factors for suicide and strengthen the factors that help strengthen individuals and protect them from suicide. Here are a few examples:

- **Risk factors**

- ✦ Depression and other mental health problems
- ✦ Alcohol or drug use
- ✦ Stress from prejudice and discrimination (family rejection, harassment, bullying, violence)
- ✦ Feelings of social isolation

- **Protective factors**

- ✦ Family acceptance
- ✦ Connections to friends and others who care about them
- ✦ Sense of safety

- a.) 1. [Haas](#), A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D’Augelli, A. R., Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*, 58(1), 10–51.

3. Veterans

For the purposes of this document, the research that was provided only refers to Veterans as defined below. In an understanding of military personnel, people with military experience should also be considered while exploring the data below and the population discussed within this document.

“**38 U.S.C. § 101(2)** provides: The term “veteran” means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable”.

<https://www.va.gov/OSDBU/docs/Determining-Veteran-Status.pdf>

“Today, approximately 666,400 veterans work in the construction and extraction occupation.”

<https://blog.plangrid.com/2018/11/veterans-in-construction-supporting-our-heroes-in-hardhats-infographic/#:~:text=Veterans%2C%20as%20well%20as%20active,the%20construction%20and%20-extraction%20occupation.>

“In 2019, the VA released its National Veteran Suicide Prevention Annual Report, which stated that the suicide rate for veterans was 1.5 times the rate of non-veteran adults. The report established that there were 6000 or more veteran suicides per year from 2008 to 2017. The report also stated that veterans consist of 13.5% of all deaths by suicide in US adults but only makeup 7.9% of the US adult population.[16]”

https://en.wikipedia.org/wiki/United_States_military_veteran_suicide

4. LGBTQIA2S+ Veterans

- 1) Lesbian, gay, and bisexual Veterans are more likely to report suicidal ideation and to screen positive for posttraumatic stress disorder, depression, and alcohol problems than heterosexual Veterans.

(Veteran Suicide Prevention Annual Report, 2020)

- 2) Sexual/Gender minority (SGM) Veterans likely have the same risk factors for suicide as non-SGM veterans (e.g., post-traumatic stress disorder), but they also contend with a historical institutional stigma that may influence mortality by suicide, a framework known as minority stress.

Minority stress posits that SGM populations experience poorer health than heterosexual populations because of distress associated with societal and interpersonal discrimination, prejudice, and violence.

(Evaluation of Suicide Mortality Among Sexual Minority US Veterans From 2000 to 2017)

- 3) Recognizing and Mitigating Suicide Risk Among Transgender Veterans (VA/DoD Suicide Prevention conference presentation, 5/19/21)

- Risk factors identified below came out of a 2015 survey given to Veterans:
- Serious psychological distress
- Poor general health
- Problematic substance use
- Housing instability
- Arrest history
- Trauma history
- Hx of discrimination

Minority stress — gender-related discrimination or mistreatment in education, employment, housing, health care, public accommodations, and law enforcement encounters.

5. BIPOC and Tribal communities

BIPOC stands for a group of people that identify their combined community of Black, Indigenous, and People of Color. As seen below, American Indians/Alaska Natives have the highest growth rate of suicides when compared to the other populations including White.

Summary of risk factors for each group:

1) American Indian and Alaska Native Populations

- Alcohol and drug use – higher rates of alcohol intoxication at the time of death than any other racial or ethnic group; also high rates of current illicit drug use compared to other racial/ethnic groups.
- Other risk factors: historical trauma (forced relocation, removal of children to boarding schools,

prohibition of practice of native language and cultural traditions), alienation from a family of origin or culture, acculturation (Alaska natives – more adaptation to mainstream culture = more stress, more use of drugs/alcohol), discrimination, community violence, low use of MH services, contagion)

2) Asian, Native Hawaiian, or Pacific Islander Populations:

- High levels of family conflict, acculturation (esp among native Hawaiian youth), discrimination, lower use of MH services, less likely to receive an MH diagnosis due to experiencing problems through physical symptoms, and poor academic achievement.

3) Black populations: marital status (being divorced or widowed), family conflict (more so for Caribbean Black adults), acculturation, hopelessness – racism – discrimination (youth), Black youth less likely to use MH services.

4) Hispanic populations

- Alcohol (2nd highest rate of intoxication during an attempt), less likely to use MH services (and also tend to rely on informal supports like family), alienation, acculturative stress and family conflict (caused by disparate levels of acculturation between parents and children), hopelessness and fatalism (highest among all racial/ethnic groups), discrimination.

[Risk and Protective Factors in Racial/Ethnic Populations in the U.S. | Suicide Prevention Resource Center \(sprc.org\)](https://www.sprc.org/risk-and-protective-factors-in-racial-ethnic-populations-in-the-u.s.)

Veteran Suicide Rate by Race/Ethnicity, 2005–2018

Per the national VA Suicide Prevention Data Report, among the Veteran population overall, from 2005–2018, the distribution of Veterans by group changed, with proportional increases among Veterans identified as Black or African American (from 10.2% in 2005 to 12.3% in 2018), American Indian and Alaska Natives (from 0.7% in 2005 to 0.8% in 2018), and Asian, Hawaiian, and Pacific Islander (from 1.4% in 2005 to 2.0% in 2018). There were decreases among Veterans identified as White (from 84.8% in 2005 to 81.2% in 2018).

From 2015 to 2018, suicide rates were highest among White Veterans and lowest among Black or African American Veterans.

Among Veteran VHA users, suicide rates were highest among individuals with race categorized as White or as either American Indian, Alaska Native, Asian, or Pacific Islander.

In 2018, Black, Hispanic, and White male Veterans in VHA care had similar ratios of age-adjusted suicide rates relative to those of United States adult men in the same demographic group.

The ratio of suicide rates among VHA-engaged Hispanic male Veterans to rates among all Hispanic male U.S. adults was lower in 2018 than in 2017. (source: National VA Suicide Prevention Data Report)

2. Risk Factor #2: Too Tough and Silent

The Construction industry is a male-dominated field where toughness is a gauge of success and a barometer of attitude and cultural base. The bigger the building, the more concrete we pour, the more steel we erect, the miles of copper and pipe we lay, the more hours we put in for the week, and so on. This all leads to an industry where we are all trying to outdo one another and where there is little room for perceived weakness. This perception is an obstacle to reaching out for help when necessary. We can feel isolated even though we are surrounded by other people. This risk factor also encompasses stigma because it is the culture that breeds the stigma, but it is also the culture that can defeat the stigma based on reaffirmation through peers. Leadership and culture training can help drive production through healthy conversations and positive affirmation. Shifting the culture of the Construction Industry to one of acceptance, tolerance, and caring while maintaining a rugged exterior. There is no question that we have to be tough to do this job but we also need to be tough enough to get help when we need it and interact with one another, so we are respectful and professional.

3. Risk Factor #3: Action and Reaction

The Construction Industry is an unobstructed high-performance industry driven by a tight schedule and an even tighter budget. Doing more with less and faster than the last time is a common theme in construction. Crew size, material costs, laydown and fabrication space, are all things that need to be balanced and managed. The resultant stress that is passed throughout the supervision and ultimately is shared with the field who actually put the work in place can be cumbersome and lead to high power emotionally charged conversations, especially when things don't go as planned. When we are successful and things are made efficient, the gear shifts and the schedule is tightened and the pressure is applied. Managing the performance anxiety, including skills gaps, while navigating the realm of interpersonal skills and dealing with the intensity from people who may have limited coping and emotional regulation skills can lead to combative interactions when emotions go unchecked combative personalities can lead to unchecked emotions with little or no educated coping mechanisms. This can lead to misdirected harmful stress relief such as substance abuse or overeating. Personal relationships may suffer if detachment from work is not functional. All of the other negative effects of unchecked stress management such as anger, depression, weight gain, and heart health problems can result from a population where the only relief from one high-stress project is either unemployment or jumping into another project that is "already 2 weeks behind and overbudget", figuratively speaking.

4. Risk Factor #4: Layoffs and Working Ourselves Out of a Job

The projects which we work on are, for the most part, scope-driven and finite contract work. The lights will come on, the doors will open, people will move in, and we will go on to the next one, hopefully. This is where we are all concentrating on being the fastest, safest, most effective person we can be so we are not replaced by someone else, or by someone looking for work and who has a better relationship with the person who is in a hiring position. While we are performing, we are hoping that the next job is there when this one ends and for that matter, it could be an entire project if you are a General Contractor. A specialty contractor may only have one scope of work, so their duration may be shorter. That is just the way the industry is built however, there are ways to help individuals prepare for downtime and adjust their lives where this does not have to be a source of stress and anxiety. This also causes confusion when it comes to managing health care and access to benefits. A lot of the workforce fills out numerous job intake forms and could have multiple health care providers. This hinders the management of vital employee assistance programs, behavioral health care, and proactive health initiatives when they are constantly changing.

Financial stress is a risk factor that can lead to a strain on one's mental health and can be a driving force for distraction and inattention. According to helpguide.org, "Financial stress can lead to Insomnia, Weight gain (or loss), Depression, Anxiety, Relationship difficulties, Social withdrawal, Physical ailments, and Unhealthy coping methods, such as drinking too much, abusing prescription or illegal drugs, gambling, or overeating. Money worries can even lead to self-harm or thoughts of suicide." <https://www.helpguide.org/articles/stress/coping-with-financial-stress.htm>

5. Risk Factor #5: Pain Management

Construction is physically intense work in the field; however, the support staff in the office may have to combat a full-time position that is behind a computer. Physical labor builds a level of fitness but can also lead to pain and soreness at the end of the day. We also work in an industry that has injuries that result from many factors such as tool use, equipment use, walking the job, or just years of service. When discussing pain management, we need to be aware that not all pain is managed at the doctor's office. It can be assumed that some people choose to self-medicate with illicit drugs, alcohol, or over-the-counter medication. When more serious injuries occur, in addition to the day-to-day aches and pain, the clinics and doctors are quick to prescribe opioid-based pain relief. This over-prescription has been attributed to the opioid epidemic that now includes our industry. This highly addictive method of pain management has now added to the cycle of risk factors that contribute to dying by suicide. People can become addicted and ruin their lives supporting their habit and getting caught in an unbearable cycle of drug use which can lead to physical and mental health deterioration. It is important to remember that this is considered a lethal means under the poison category.

6. Risk Factor #6: Isolation and Separation

The construction day is long and starts early. Many of us wake up and get to work while the rest of the community is still sleeping. We also get home late after long commutes and a 10-hour shift. Some shifts also include working nights, and weekends, or may fluctuate multiple times over the course of the project. Fluctuating shifts lead to sleep rhythm disruptions and may need a transitional period that just doesn't happen. Project locations also fluctuate which, besides uncertainty, may also lead a worker beyond a reasonable commuting distance and may call for the worker to stay in a location near the project. This is cumbersome for many reasons. Distance from one's residence can create anxiety about the safety and security of both the house and the loved ones that reside there. We saw this during the recent wildfires. Also, a lot of what we do at home contributes to protective factors such as participation in hobbies, interaction with family members and pets, and maintaining a healthy lifestyle. When workers travel great distances for their jobs, it denies them access to these protective factors, puts a strain on their relationships, and opens the door to forming unhealthy habits like drinking alcohol and eating fast food. It may even lead to depression which is a significant contributing factor to suicide.

7 Risk Factor #7: Access to Lethal Means

Lethal Means are methods that people use when planning a suicide. In the Construction Industry, we need to consider that we are a high-risk industry and there are many exposures to lethal means and temptations that a person in crisis may have access to. Granted they are mitigated and safe for workers to be around but that only pertains to a reasonable person that has had some type of hazard recognition training. There are conditions in the field that, if the safety mechanisms are defeated or the person is intent on getting around them, may provide them with a mean to end their life. Tools and equipment can also be used if intentional self-harm is one's goal. There is little we can do currently except deny access to areas, equipment and tools when not in use and encourage people to reach out for help if they are in crisis through postings and meetings. Education and outreach can be the two most effective things that we can present to encourage people to get help, store their firearms and medications properly, and let them know about effective resources.

There are many other risk factors that can be attributed as a source of pain or stress for an individual. There are also risk factors that people are exposed to in their personal lives in addition to the possibility of being part of a priority population. There are limits to how involved we can become with a person outside of a professional relationship. What we can do, is consider these risk factors and implement resources and initiatives that can help them address issues in both their professional and personal lives. We can start by being a construction community that not only builds things, but that builds each other.

Recommendations

We have grouped the recommendations into nine main categories. Each of the categories has further points that can be broken out and expanded upon. As to what was mentioned earlier, these recommendations are to consider the Construction Industry as a whole and include the priority populations.

1. Training, education and outreach:

Education and Outreach have been effective in creating awareness and providing the knowledge necessary to reduce the amount of safety-related injuries to what it is today. We have identified several areas where training and outreach can be used to reduce the number of suicides that the Construction Industry is experiencing. Funding and cost reduction strategies can be offset with grants for the initial rollout. Training ought to be developed, selected, evaluated and delivered by at least one person with relevant lived experience for the population/audience/industry/subject matter who really understands and can relate personally to the subject matter.

2. Integration into OSHA outreach

We recommend that ASIPP asks Oregon OSHA to recognize those who have died by suicide and the alarming rate of our industry by incorporating Suicide as the first category as a newly established Fatal 5. This can also be done with the passing of legislation at the state level. This will compliment Falls, Struck-by Objects, Electrocutation, and Caught-In or -Between. We can include this topic as a Health & Safety issue and use the existing framework that OSHA uses for addressing the existing Fatal Four. It will bring attention to and recognize this as an epidemic. Oregon OSHA can launch an outreach program for Suicide Prevention which includes media, marketing, resources, and safe messaging. As an industry, we recognize the training structure outreach provided by the OSHA 10 and OSHA 30 courses. By using these existing courses, we will be able to reach the greatest amount of people in our industry. Whether mandated by corporate policy, contract, or required training, these widely used and respected Outreach courses can also include Suicide Prevention and mental well-being as a focused topic in the OSHA 10 & OSHA 30 modules. Washington State has similar legislation found in House Bill 2411 and Senate Bill 6570. <https://intheforefront.org/programs/policy-advocacy/>

3. Evidence-based training and core training

First Aid/CPR training is also another training course that is synonymous with construction and is often backed by contracts as a requirement and or is offered as part of a training path. We recommend that evidence-based training such as Question Persuade Refer (QPR) and Mental Health First Aid (MHFA) be offered to the Construction Industry as required training programs. Funding through grants can help alleviate the financial burden for employers to send their employees to be trained. Training ought to be developed, selected, evaluated and delivered by at least one person with relevant lived experience for the population/audience/industry/subject matter who really understands. This can increase credibility, competency, and buy-in from the audience, and reduce stigma at the same time. increasing hope that people can grow through recovery.

4. Outreach Initiatives for clinics, physicians and organizations

Chronic pain can be a risk factor for addiction, depression, and eventually suicide. In order to curb the over-prescription of opioid pain relief, we recommend an extensive program that offers patients, physicians, and the Construction Industry knowledge of the habit-forming epidemic and alternatives to opioids. We have seen lawmakers take action against pseudoephedrine and help curb the production of methamphetamine. Laws can be made to require an educational prerequisite to be met prior to someone using opioid-based medication. A follow-up from an addiction services member with the patient can be conducted when the prescription runs out. If the patient needs addiction counseling or rehab as a result of the prescription, costs can be offset by the prescribing doctor or a fund set up by all of the prescribing doctors have to contribute to when they prescribe the opioid. The literature will need to be created that can provide information about this topic at safety meetings throughout the industry.

5. Access to lethal means, on- and off-site

Counseling on Access to Lethal Means CALM training is available for use by companies and organizations to educate their employees about the management of firearms and poisoning. Resources including handouts are available for free at the following website. <https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means>

Organizations can have firearm safety presentations and bring in law enforcement and clinicians to have talked about safe handling, storage, and what to do if they are experiencing a crisis. Having people with relevant lived experience increases credibility, knowledge base, competency, and buy-in from the audience. Promotion of gun locks, using safes, and takeback programs to get rid of excess medication, can all be developed and communicated. We can develop an outreach program geared towards gun shop owners, provide safety meeting topics for the Construction Industry, and develop home safety plan templates that will help our employees have a plan for storage and moments of crisis.

We also need to consider the unique opportunities and hazards that the workplace presents. Performing a pre- project risk assessment is typical in construction. With the addition of identifying Lethal Means access and management at home, there can be steps taken that could reduce the access to Lethal Means on the job site. The site can present hazards that we are constantly mitigating so that we can provide a work environment that is free from recognized hazards. However, if someone is intent on defeating the safety measures, they can have access to tools or site conditions that could be deadly. We build tall buildings with leading edges or shafts, use powerful gas-powered tools, and have access to equipment that can present many dangers. Looking at the risk assessment through the “Person in Crisis” lens can help identify and mitigate hazards by taking additional security steps. Some things that can help are netting systems, security guards for off-hours, as well as locking up areas, equipment, and fuel. Also, posting suicide prevention resources such as crisis lines at key points in the project can also help provide resources to a person in crisis. Our recommendation is to require risk assessments that add a “person in crisis” element to them, to have a plan and provide provisions for people that may enter a job site with suicidal intent, and to encourage employers to provide resources and wellness checks for employees. Confidentiality will be maintained, and it is recognized that thoughts of suicide can episodically and should never become a lifelong barrier to an individual’s career.

6. Priority Populations, Inclusion, Equity, Positive Culture, and Safe from Hate

When discussing construction culture and the “Too Tough” attitudes that are in the industry, we need to focus on training the workforce in empathy and inclusion. To do this we can promote programs that encourage a positive culture and keep people safe from hate. Training and outreach should be incorporated into our culture so that “toughness” can include a level of professionalism and empathy so that communication and connectivity can be maintained in a positive manner. We feel that people need to understand that what they say can have a devastating effect on someone and can be the catalyst and trigger of that person that affects them personally. People have diverse upbringings, may have made life choices that they are passionate about, or have experienced trauma. Individuals build resiliency, but coming to work and being subject to harassment, bullying, unwanted comments, hate, or other negative-focused discussions is unacceptable. At the same time, removing people from the job does little to change the culture whereas training can help make people aware that their behavior can be tailored to that of acceptance of a diverse population and be sensitive to people’s personal choices. The Construction Industry needs to learn about unconscious bias, micro-aggressions and how this can impact relationships with coworkers, plus; the importance of positive coaching/mentoring, conflict resolution, and bystander intervention. Individuals within the Construction Industry need to develop a general understanding of the impact of bullying, hazing, and discrimination can have on a person. It is also important to get the necessary tools to know how to react in these situations.

Including priority populations into the data and focused resources will help deliver better solutions. The specific risk factors for each priority population need to be identified, and communicated, and only then can the protective factors effectively address the entire industry as a whole. Some of the solutions to the risk factors of one group may be the answer to what another group may be experiencing. Specific messaging can be used to address a priority population but the protective factor to address that population should include resources that apply to the entire industry.

The recommendation is to provide a framework for the Construction Industry that includes training modules, policy templates, and safety meeting topics that can help align our industry with cultural competence and a basic understanding of respect for diversity, inclusion, and ultimately a positive job site culture.

7. Personal Conversations and Suicide Safety Planning

The Construction Industry does a great job of planning for events that may affect production or safety. There is typically an emergency action plan or a crisis management plan that companies use to rehearse evacuations, fires, or other incidents. We ask the ASIPP to include a planning template for the Construction Industry to use that will include information on prevention, intervention and postvention. This document can easily be added to an existing plan and should discuss what happens in the event that someone has made a suicidal comment, is forthcoming with their thoughts of suicide, is observed in an attempt, or if the site has been made aware of an industry loss to suicide. The plan will need to identify people that have evidence-based training and can have a conversation with someone in crisis, an escalation path to outside agencies if there is an immediate threat to life or health, a reintegration plan for someone who is recovering, and postvention resources so that there is a specific method for delivering talks with safe messaging. Along with these emergency plans, which are reactive, the ASIPP should provide an overall suicide Construction Industry Suicide Prevention plan that can be easily integrated into an existing Health and Safety Plan. Outlining what to do in an emergency is key but like any good safety program, outlining and prescribing preventative measures that are proactive is also a necessity. This program can be a few pages of key

training, response guides, risk assessments, and proactive well-being planning. Plans will need to include both main company offices and satellite job site/project offices as well. Plans can include mental health provisions that need to be broken down by company, county, personnel, and benefit provider, and should be accessible to each employee. There are many resource centers including company-specific benefits that are difficult to manage when there are multiple companies represented on a project site. Having each location's, company's, or labor affiliation's mental health resources easily accessible can provide better management during a crisis, or even just provide awareness and details about resources to the crew.

8. Resources

There are many resources for the general public, priority populations, and the Construction Industry. We have provided a few of them in a database and felt that these organizations, articles, and publications represent a sampling of what other resources would have to offer. Articles from local team members and organizations are included. (See Appendix 1). Gathering these resources for ease of access should be included in the ASIPP. The following are suggestions for resources that can be communicated to organizations to help build a tailored accessible database or action list.

- Compilation of mental health resources per county regarding hotlines, employee benefits, and response units.
- Organizations roll up and resource database.
- Provide resources aligned with the Construction Suicide Prevention Partnership.
- Creating a safe space on site for counseling or peer support i.e., lunchroom, breakroom.
- Addiction resources such as gambling, drug, alcohol, and other vices.
- Resources for depression, anxiety, domestic violence, spousal, child, and elder abuse.

9. Policy

We recognize that policy has a great influence on the success of programs and helps advocate for the workforce. One of the biggest obstacles that the Construction Industry faces is the lack of paid time off. There are programs set up for workers to contribute to a leave time fund so if they do need to take time off they will be able to pay their bills. Employee or Member Assistance Programs provide financial advice that can help the industry manage its finances with regard to the ebb and flow of contract work. Most of the workforce does not know that they have this benefit, or it may not exist for them. This is of particular concern when workers suffer from addiction and need to take time to rehabilitate and recover or they are having a mental health crisis and fear for their employment status.

- We recommend that provisions be provided to include addiction services and treatment, mental health counseling and time to deal with depression or anxiety be included in the Oregon Family Medical Leave Act. Verbiage needs to be clear and included on the required OSHA postings that are required to be posted in a conspicuous location on every job site per employer.
- Unemployment during the time of treatment, rest, and recovery, including provisions for housing and a period for providing heightened care and observation should be made available to Construction Industry employees.
- Company policies need to align with treatment rather than termination if someone is suffering and addiction is revealed through a positive drug test. Construction is a high-risk industry, and we recognize that employees need to be sober on the job. However, the response to someone who is struggling with addiction need not be

that of a punitive and disciplinary nature. The response to someone that is struggling should be of support and providing resources alongside compassion so the workforce can get help and work safely on the job. There are programs that require re-admittance to a company after 2 negative drug tests and a rehab course completion. We need to build these people back to being productive without a chemical dependency.

The goal should be to identify the barriers to someone who wants to raise their hand and get help but refrains from doing so because of fear of retribution. Paid time off or some sort of compensation can be granted to individuals who get help from physicians, clinics, companies, and other organizations contributing to a fund that will help sustain workers while they reach out to break cycles that possibly go back generations or are a result of an addiction from a prescription. This also applies to people who are neglecting to get mental health support for the same reasons; fear of job loss, or income that is sustaining them. A paid week for someone to deal with a mental health condition should not be too much to ask for and may just save their life.

10. Benefit utilization and EAP

- Underutilized Health Benefits specifically EAP/MEP, proactive wellness initiatives, and support for accessing these benefits such as time away from work.
- Health Insurance program for non-union workers.
- Tracking to see how many employees decline health care from an employer. Identifying the reasons why and removing barriers.
- For Union, how complex for those with multi-union or various Locals? Accessing and tracking benefits can be difficult. They may not know how to access their health care.
- Transition from EAP to a counselor for longer-term care.
- EAP in Boston (Modern Assistance). Build networks for beds for Detox; last chance agreements.
- Sober crews. So many individuals trying to get their feet back on the ground need the support of sober crews. One thing is to get employment, but then join a culture of “too tough” and substance misuse that may make it difficult to maintain sobriety or recovery.

We recommend increasing the research and data behind the effects of fatigue, sleep deprivation, and chronic pain. We especially need more research around behavioral health in construction. There are a lot of assumptions but if it doesn't get measured, it doesn't get fixed. We need to clearly identify the compounding effects of the risk factors so that they can be addressed.

11. Services

Communication of resources and compiling a database can help manage and prevent a crisis moment. However, if we look to be innovative, identify barriers, and look to moving the culture forward, we need to look at providing and exploring services that may not appear to be feasible or mainstream, but may be necessary to further reduce the amount of people dying by suicide in our industry and elsewhere.

- ✦ We believe that the 988 suicide response number may be coming online next year. Our question is, who will be responding? Consider including suicide prevention advocates from the construction industry during these discussions.

Will it be law enforcement, emergency medical team, fire departments, or a combination thereof?

Is there a service such as a mobile unit that can respond to someone in crisis and provide a unique service that is a highly skilled mental health crisis response team?

We know of two mobile crisis units that can respond to these types of crises. One of which is “Project Respond”. <https://cascadiabhc.org/services/crisis-intervention/> Are these resources well-known, widely available and ready to respond to a crisis within the construction industry?

There is a protocol for dispatching these units, but the reach of the organization is limited.

- ✦ Because the Construction Industry is made up of diverse priority populations, we feel that a person who is from the industry, with relevant lived experience and equity perspective, or a call center who is trained and can understand the unique conditions and risk factors that the Construction Industry has, would be best suited to respond to a crisis call. To provide focused expertise, we recommend that an indicated prompt, that is specific to the Construction Industry, that can be selected by the caller when they call 988 for help.
- ✦ Oregon OSHA has a Voluntary Participation Program where companies can participate to show an elevated level of safety for their employees. Our recommendation is for suicide prevention and mental well-being efforts to be included as a criterion for the VPP grading system if not a stand-alone system.
- ✦ The industry works extremely hard and sometimes doesn’t have time to eat healthily or participate in healthful activities due to the amount of hours worked or the location of the job site. We recommend that barriers to healthy living be removed and provisions be made available on and off the job site. Factors that reinforce positive behaviors such as discounted gym memberships, healthy food options, health screening and vaccinations, counseling services, yoga classes, and other stress-mitigating opportunities.
- ✦ In construction, incidents and injuries happen which sometimes generate, “Lessons Learned”. The point of these Lessons Learned is to anonymously share information such as a problem statement, causal factors, and a root cause analysis. Moreover, the corrective action(s) is intended to prevent recurrence and learn something. These are not widely shared between companies but should be. Our recommendation is for better information sharing about suicides, with safe messaging and alerts. With respect for privacy, these shared stories can be recorded and dispersed as part of an agenda topic for a much-needed Construction Safety & Wellness Advisory Committee for suicide prevention and mental well-being.
- ✦ To also create a safe space for the workforce to reach out to for support, we recommend the formation of a specific peer support group. Training and a communication strategy should be established that provides ease of access for construction workers such as Active Listening training and a phone application. An outline for an on-site resource can also provide peer support conveniently.

12. Peer support in the construction industry

Peer support is one of the most effective and accepted tools when removing barriers and opening the lines of communication within the Construction Industry. It is here where the stigma, suffering in silence, and fear of sharing can begin to melt away. Building a support network of peers can help foster an environment where people can identify, relate, and show empathy when providing resources or even just listening to one another. This is the base for where resources and information sharing occur. Workers are more likely to talk to one another and link up with people who may have similar backgrounds and risk factors. The following are some examples of the benefits of a Peer Support program.

- Peer Support Programs foster culture change by building internal capacity for unions and job sites to recognize warning signs and respond to crisis when it arises.
 - “Culture eats strategy for breakfast.”
- Peer Support can maximize existing industry protective factors.
 - Culture of Safety – Zero incident goals
 - Brotherhood/Sisterhood – we are in this together.
 - Internal and External Resources – health plans, EAPs, county and community mental health
- Peer Support can mitigate industry risk factors.
 - Fostering an even stronger sense of comradery and connection can encourage help-seeking behavior.
 - Encourages building a culture of caring and empathy – “We can relate to your experience.”
 - Learning to recognize warning signs and how to respond is another tool in the construction toolbox.
- History of Peer Support
 - Peer Support has long been recognized as important evidenced-based practice in suicide prevention and navigating challenges with mental health & substance abuse.

13. Addressing Substance use and Addiction in the Construction Industry

The Construction Industry is a challenging industry, both physically and mentally. The unfortunate truth is that many in the industry use substances to cope with the pain associated with stress, anxiety and demands of the job. The relationship between substance use and suicide is well-established. Providing a comprehensive suicide prevention/intervention plan must include mitigation efforts concerning substance use disorders and addiction.

Recommendations:

- Know the problem.
 - ✦ Utilize updated, accurate data from reliable sources.
- Remove barriers to accessing services.
 - ✦ Offer on-site engagement with peers or service providers if needed.
 - ✦ Lower stigma associated with substance use disorders through regular education and outreach.
 - ✦ Establish proactive education and outreach efforts.
 - i. New employee orientation
 - ii. Toolbox talks
 - iii. EAP involvement
 - iv. Local providers
 - v. Distribute swag featuring access info: magnets/wallet cards, stickers, etc.
 - vi. Embrace AA and NA meetings
- Demonstrate unquestioned support from ownership on down.
 - ✦ De-stigmatize substance use disorders and encourage those in need to seek help.
 - ✦ Consider a less punitive and more help-oriented approach if someone does come forward, and the circumstances allow (no one is hurt, and no damage is done).
 - ✦ Deliver consistent messaging from leadership encouraging staff to access services.
 - ✦ Offer regular toolbox talks that include information on substance use disorders, gambling disorders, signs of a problem, and available resources.
 - ✦ Develop policy based on accurate and reliable information/data and ensure that all staff is aware of them.
 - ✦ Create and support peer-led advisory committees for substance use and mental health mitigation activities and policy development. Include staff with lived experience.
 - ✦ Regularly update and review resources, both company-provided and local.

14. The cost of suicide

There may be resistance for companies to invest in well-being, health care resources, suicide prevention programs and initiatives. One key factor that may motivate action from a business model stand point is the cost impact associated with suicide. We are drawn more towards the humanity of the issue but there are some that are driven by investing in things that are for the betterment of their business. We feel that the workforce and the employees are the best investment, however, to appeal to the business and productivity side of things, we felt it was necessary to include the following excerpt and resource regarding the cost of suicide.

“The national cost of suicides and suicide attempts in the United States in 2013 was \$58.4 billion based on

reported numbers alone. Lost productivity (termed indirect costs) represents most (97.1%) of this cost. A3.4 Adjustment for under-reporting increased the total cost to \$93.5 billion or \$298 per capita, 2.1-2.8 times that of previous studies”

<https://pubmed.ncbi.nlm.nih.gov/26511788/>

<https://www.sprc.org/about-suicide/costs>

According to the Center for Workplace Mental Health “Statistics on Suicide’s Impact on the Workplace: Lost earnings from suicide cost workplaces \$1.3 billion per year. For each suicide that is prevented, an average of \$1,182,559 is saved, including \$3,875 in medical expenses and \$1,178,684 in lost productivity”

<https://workplacementalhealth.org/Mental-Health-Topics/Suicide-Prevention/How-to-Effectively-Invest-In-Suicide-Prevention>

The below link provides a deeper dive into investing in a suicide prevention program. Credit to the Center for Workplace Mental Health. <https://workplacementalhealth.org/Mental-Health-Topics/Suicide-Prevention/How-to-Effectively-Invest-In-Suicide-Prevention>

15. Existing suicide prevention framework

Sometimes organizations do not know where to start. Many want to do something but do not know how to take the first step. There are existing organizations that have developed key topics and framework that can help launch and sustain a suicide prevention program. Here are examples of two resources that can help provide a turn-key agenda. The recommendation for the ASIPP is to be able to provide resources such as these to help guide organizations to readily available resources.

■ **Workplace Suicide Prevention National Guidelines:**

- ✦ Provides a Pledge to show commitment from upper management and to gain buy-in from all levels of the organization.
- ✦ Provides 8 Guiding Principles for organizations to follow.
- ✦ Provides 9 Recommended Practices to help facilitate suicide prevention action in the workplace.
- ✦ Promotes the National Guidelines for Workplace suicide prevention which is a collaborative partnership with the American Association of Suicidology, the American Foundation for Suicide Prevention, and the United Suicide Survivors International.
- ✦ <https://workplacesuicideprevention.com/>

■ **Construction industry alliance for suicide prevention:**

- ✦ Provides resources specific to the Construction Industry.
- ✦ Provides a Pledge to show commitment from upper management and to gain buy-in from all levels of the organization.
- ✦ Provides a Needs Analysis and integration checklist to evaluate an organization’s suicide preparedness.
- ✦ Provides an implementation plan to help facilitate a suicide prevention culture and guide a company to reach its goals while providing resources.
- ✦ <https://preventconstructionsuicide.com/>

- **SafeBuild Alliance**

SafeBuild Alliance has concentrated resources that provide access to articles, organizations, and toolbox talks, and has provided downloadable resources such as Hard Hat stickers, magnets, and wallet cards. These resources can be used at site orientation to help start the initial conversation which helps combat stigma. The resources also now live in the field. If someone is in crisis, the crisis line is right on the hard hat. <http://safebuildalliance.com/resources/mental-health-suicide-prevention>

- **Construction Suicide Prevention Partnership a service of Lines for Life**

Cal Beyer was instrumental in coordinating a shared app that started the initial conversations about forming a local suicide prevention group in Portland. Stakeholders were identified and a group that was forming in Washington was launched. During a Suicide Prevention Summit, hosted by the Construction Financial Management Association in November 2019, the stakeholders gathered and met during lunch. It was discussed and the Oregon Construction Industry Suicide Prevention Task Force was formed. At the first meeting in December, the idea was shared to create a plan that could be given to anyone who asked how to initiate a suicide prevention culture within their organization. It was the Task Force's goal to be the one-stop shop for suicide prevention resources for the Construction Industry. Lines for Life took the lead and the industry responded. They now have a Strategic Plan, Action Guide, Tool box Talks, and logos that will be shared in the upcoming year. <http://linesforlife.org/construction>

- **UA Local 290 Plumbers, Steamfitters, and HVAC/R:**

UA290 Apprentice Resource Community (ARC) has a Union based peer-to-peer support and resource navigation initiative that helps provide resources for Mental Health, Addiction, Suicide Prevention, Union Health Plans and Resources as well as Community Resources. Their mission is to build the internal capacity of the UA Local 290 community to respond to members experiencing addiction, mental health and suicide crisis in a compassionate, supportive way, to help union brothers and sisters navigate and access the professional resources they need and to construct a culture of caring to prevent a crisis from happening in the first place.

UA290 ARC Peer Support Leaders are certified QPR Suicide Prevention instructors, trained in Mental Health First Aid, trained to identify mental health crises, trained in HIPPA and FERPA privacy law, familiar with navigating union health plan resources and familiar with navigating community-based resources.

They have trained over 800 members and staff in QPR gatekeeper training over the course of the past six years. Currently, 290 has 10 active ARC Peer Support Leaders who are certified QPR instructors. To date, they have conducted 2 QPR training at Local 290 (two more coming next month) and 1 QPR training at Local 48. They have engaged in over a dozen crisis interventions with union members in the past 9 months.

- **Pacific Northwest Carpenters Institute: Positive Jobsite Culture Training**

The PJC training was developed by PNCI and their partners, as a tool for apprentices, journey-level workers, foremen and superintendents. They learn about unconscious bias and how this can impact relationships with coworkers, plus; the importance of positive coaching/mentoring, conflict resolution, and bystander intervention. They also highlight the impact bullying, hazing and discrimination can have on a person and get the necessary tools to know how to react in these situations. From 2018-2021, they held 150 PJC classes with 4,952-course completions.

The Positive Jobsite Culture has been recently updated and now includes a testimonial from a member as well as a section on suicide prevention and available resource specific to the Carpenters Union. They have also launched a QPR training initiative to compliment the PJC. They have trained 941 of their members as well as companies that use union carpenters.

■ **Get Trained to Help**

The tri-county collaborative created an online “gateway” where those who live and work in the Metro tri-county (Clackamas, Multnomah & Washington Counties) region can go to learn about, and register for, free mental health first aid and suicide prevention/intervention training. People who live and/or work in the tri-counties can access www.gettrainedtohelp.com to register for the following training:

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1. Question Persuade Refer — QPR — online and in person
2. Applied Suicide Intervention Skills Training — ASIST — in person
3. SafeTALK — in person
4. Adult Mental Health First Aid — (AMHFA) — online and in person
5. Mental Health First Aid for Older Adults (MHFAOA) — in person
6. Mental Health First Aid for Veterans, Military Service Members and Families (MHFAVF) — in person
7. Youth Mental Health First Aid — (YMHFA) — online and in person
8. Counseling on Access to Lethal Means — CALM — online and in person
9. CONNECT — online and in person

Since 2015, over 16,000 participants who live and work in the Metro tri-Counties have built their knowledge and skills by participating in over 680 classes. People from all walks of life – teachers, counselors, veterans, first responders, family members, clergy, health care, housing, youth services, faith community members, students, social service professionals, mental health peers and more – have gained valuable skills and access to important resources.

■ **Innovating Programs General Contractors**

Within the last few years, there have been General Contractors in the Pacific Northwest that have developed and launched suicide prevention programs within their companies. By doing this, they have had critical conversations with the workforce and have begun to destigmatize the conversations around mental health and suicide prevention. Most of all they have led the pack and have begun to shift the culture towards the integration of both physical and mental health as part of their safety program.

- **Howard S. Wright a Balfour Beatty company: Need to Talk? Talk to Me!**
- **Skanska: Suicide Free Environment (SFE)**

- **Hoffman Construction: Tough Enough To Talk**

16. Postvention

We recommend that the ASIPP includes resources for postvention so that companies can have a solid plan for responding to suicides, loss of coworkers, loss of coworkers friends or families especially if the person died by suicide. Having a postvention plan integrated into an organization's crisis management plan, safety plan, or suicide prevention program will provide a resource that can be used for safe messaging when dealing with a loss and can also provide clear steps for activation of the suicide loss response team. The American Foundation for Suicide Prevention has collaborated with many different Veterinarian organizations and has published, "After a Suicide: A Guide for Veterinarian Workplaces". This document is a great example of providing resources and templates in the wake of a tragedy.

<https://www.avma.org/sites/default/files/2020-09/After-a-Suicide-A-Guide-for-Veterinary-Workplaces.pdf>

17. Proactive Well-being

We recommend that the ASIPP include a section specifically focused on proactive physical and mental well-being section. This section should be written to outline activities and habits and provide resources that bolster mental well-being. We simply cannot have a conversation about suicide prevention without including the conversation about physical health and healthy habits. Programs to combat construction risk factors can also be explored by a committee. Programs can be developed that can help continue protective factors like family connectedness, hobbies, and interaction with pets. Helpful habits and peer support groups can help combat the isolation experienced after a long arduous day, week, or even month.

The way that we manage and respond to stress is learned. Topics such as emotional intelligence and self-awareness should be integrated into training programs so that employees can easily identify their activation points, understand how to cope with them, and work on drafting a Resiliency Plan. Anger and depression are two factors that can contribute to suicides. Creating resources for the workforce can bring awareness to these two driving forces which can lead to suicide if they go unchecked. However, it is not only being emotionally intelligent and self-aware enough to understand when we are having an adverse reaction to something stressful or negative. As mentioned, it is having the coping skills that allow us to remain in control and to be sustainably resilient. This can only be done by processing information and reacting to it with a well-rehearsed plan of action that is rooted and maintained by physical and mental well-being. Having the support and foundation for this is essential for its utilization.

When discussing suicide prevention efforts with an employer, it is beneficial to highlight training and initiatives as wellness opportunities. Providing information about how a death by suicide or an attempt at suicide can have an enormous impact on not just the individual, but the workplace as a whole. Suicide prevention efforts across the workplace ideally allow employees to communicate when they are in crisis before something more severe occurs. Here are a few things that can be highlighted in those discussions about wellness and suicide prevention:

- **Fiscal Incentive:** We know that wellness within the workplace can lead to less burnout, turnover, and time out of work. Similar to the impact retention efforts can have on maintaining quality employees, when we create a culture of wellness and are able to prevent crises, workers can continue their work.
- **Workplace Culture:** Workplace culture is another factor in dictating quality work, timely and effective work,

and retained workforce. When the workplace culture is one where people feel supported, able to prioritize their mental health as needed, and know they have people to go to if something is not right, it makes a difference to overall morale and work effort. Developing a culture that prioritizes mutual support, willingness to check-in and asks how someone is doing, or noticing when something is off, creates a community of safety.

Some existing programs and resources for wellness can be found in the following programs.

- **The American Heart Association, Hard Hats with Heart.**

Their focus is to provide well-being resources to the Construction Industry. Heart Disease is the number one killer in America. AHA's approach has outlined heart-healthy activities and behaviors that promote physical heart health which concurrently also promotes mental well-being. They take it a step further by discussing mental health resources as well as financial and other resources that can help the overall health of the worker. Hydration, nutrition, sleep, and exercise; as well as resources for First Aid/CPR are all available under the construction hard hat.

<https://www.heart.org/en/affiliates/oregon/oregon-and-southwest-washington/oregon-hard-hats-with-heart>

- **NIOSH, Total Worker Health:**

Housed locally by the Oregon Healthy Workforce Center via OHSU. <https://www.ohsu.edu/oregon-healthy-workforce-center>

“The Total Worker Health (TWH) approach prioritizes a hazard-free work environment for all workers. It also brings together all aspects of work in integrated interventions that collectively address worker safety, health, and well-being.” <https://www.cdc.gov/niosh/twh/totalhealth.html>

18. Technology and social media

As an industry, we need to be able to provide resources and ease of access to those resources in a multifaceted communication plan. This plan needs to consider and include the several different avenues from which people get their information; none more prevalent than social media. It is our recommendation that the ASIPP includes a communication strategy that extends the outreach to social media that specifically speaks to or includes the construction industry. Having an effective campaign can reach the industry workforce and staff while they are responding or browsing their networks via social media.

It is our recommendation that the ASIPP secures funding to launch Apps specific to or including the construction industry that can help increase emotional intelligence, physical fitness, and suicide prevention. There are many apps that can do this now, but an Oregon-based resource can be woven into this document and will build more trust and use if our industry has a local resource. Funding to make these resources available at no cost can also increase their use and help drive down the number of suicides.

Some examples of applications are:

- **Total Brain:** The Total Brain app is a powerful neuroscience-based mental health and brain performance app that allows users to self-monitor all 12 brain capacities and risks. With digital neuroscience, brain capacities and risks can be measured, improved, and managed — just like physical health. <https://www.totalbrain.com/>

- **Ask a Friend App** which is made available through the Jason Foundation. Grass roots approach to utilizing a network of affiliate offices across the nation. www.jasonfoundation.com
- Other applications include Joyable, SAMHSA Suicide Safe, Safety Plan, Better Stop Suicide, and MY3.

There is an app that is available in the UK but not here in the US. <https://www.constructionindustryhelpline.com/our-app.html>

Conclusion

There are many factors that we have discussed and solutions that we have offered. We ask that the focus of our efforts is centered around a cultural shift and resource availability.

We ask that the ASIPP reinforce the following:

- Quality of communication, information sharing (whether it be data or story-driven).
- Identifying and removing obstacles for people who need to reach out for help.
- Promoting and participating in healthful activities.
- Providing resources and support for one another proactively and in a time of need.
- Creating, maintaining, and reinforcing a culture of acceptance, inclusion and of care and concern that redefines what it means to be tough and work in the construction industry.

Through policy and programs, the Construction Industry can begin to require that Suicide Prevention and Mental Well-being be integrated into existing safety programs, outreach, training, and culture. For our final recommendation, we would like to see the ASIPP formalize workforce development initiatives. There are many that tie to DEI and are effective in illustrating a framework and excellent example. We can begin to formalize a culture of care and formalize workforce development.

Engrained in these efforts, Diversity Equity and Inclusion shall be the underlying current that gives the energy for this culture to grow. Finally, having multi-lingual and multi-cultural resources will have a unifying impact.

“When we think about the high rate of suicide in the Construction Industry, particularly here in Oregon, we need to consider the enormity of the number of families whom the Construction Industry touches. The improvements we can make will not only have a cultural life-saving effect to our immediate industry but can begin to shape and grow our society.” Steve Frost

Veterans full report

Guiding principles

- Upon implementation, all recommendations must consider the need for training on military cultural awareness for military-connected families, communities, and the health care provider network
- All recommendations must recognize different identities and key populations within the veteran and military community
- To recognize and prioritize continuity of care, implementation efforts should include process improvement methodologies
- Recommendations are intended to support and address the needs of all veterans and military service members
- These recommendations were developed and are being submitted as a part of a larger plan, but are intended to respond to an immediate need, requiring urgent implementation efforts

Recommendations			
	Where It Started...	What It Became...	Foundation Upon Which To Expand...
1.	Emphasize military cultural responsiveness in the health care provider network	<p>a. Oregon Health Authority (OHA) should encourage all health care providers to complete standardized suicide prevention training inclusive of a military cultural lens. This training should be part of their training and/or ongoing learning. This training should be a requirement for any health care provider receiving referrals from the Veterans Health Administration (VHA) or Department of Defense (DoD).</p> <p>b. OHA should promote screening efforts for early identification of suicide risk, and connection to services based on the risk identified.</p> <p>c. OHA should consider leveraging existing resources and training available through the VHA and engage County and Tribal Veteran Service Officers (CVSOs, TVSOs) when planning for different training opportunities.</p>	<p>During the 2019-2021 biennium, OHA contracted with Lines for Life to deliver a series of suicide prevention/military culture training to health care providers. The training was opened to other military-connected service providers.</p> <p>Beginning in 2016, OHA became a supporting partner in the promotion of the Star Behavioral Health Provider Trainings. These training were, in part, used to meet requirements associated with the CCBHC demonstration program. OHA continues to be a supporting partner in this training.</p>

Recommendations			
	Where It Started...	What It Became...	Foundation Upon Which To Expand...
2.	Recognize different identities within the veteran community	<p>a. OHA should coordinate or partner with organizations who are offering military cultural training to create culturally specific training and resource lists focusing on key populations within the military community such as Black, Indigenous, People of Color (BIPOC), women, Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQIA2S+), and Tribal veterans and military service members. An example of this is OHA continuing to partner with Lines for Life to provide more cultural training inclusive of content specific to key populations presenting in the military community</p> <p>b. OHA should coordinate with external partners to create, support, or fund a social media campaign promoting visual awareness and inclusivity of key populations within the military community, such as BIPOC, women, LGBTQIA2S+, and Tribal veterans and military service members.</p> <p>c. OHA should consider process improvement methodologies when engaging in new work or partnerships designed to support key populations with the military community</p> <p>d. OHA should promote inclusion and representation of key populations in advisory groups and decision-making bodies (borrow the consumer language of “nothing about us without us)</p>	<p>During the 2019-2021 biennium, OHA contracted with Lines for Life to deliver a series of suicide prevention/ military culture training to health care providers. The contract required the development of specific content focusing on LGBTQIA2S+, women, and tribal veterans</p> <p>In 2020, OHA coordinated with ODVA to contribute content to, and promote, the Veterans’ Resource Navigator.</p> <p>Between 2018 – 2019, OHA launched a Veteran Behavioral Health listserv and a Veteran and Military Behavioral Health website.</p> <p>Beginning in 2021, OHA set aside funding to support the behavioral health needs of tribal veterans.</p>

Recommendations			
	Where It Started...	What It Became...	Foundation Upon Which To Expand...
3.	Offer military families education	<p>a. To support veterans and their families, OHA should coordinate with ODVA's family representative and the ODVA-funded Campus Veteran Coordinators to collaborate on training, offering educational opportunities, and the development of resource materials</p> <p>b. OHA should partner with non-profit and community-based organizations, such as NAMI to provide education to families and promote resource sharing.</p> <p>c. OHA should partner with a university or other appropriate educational institution to bring in a support program such as the Veteran Spouse Network.</p> <p>d. OHA should provide peer-delivered services focusing on the unmet needs of military families and military spouses</p> <p>e. OHA should make suicide prevention gatekeeper training widely accessible to military families</p>	<p>In the 2021-2023 biennium, OHA will contract with NAMI Multnomah to support a variety of military-specific programing, inclusive, but not limited to the support of a NAMI Family/ Caregiver Support Group and Mental Health Awareness Presentations (via NAMI Multnomah's Evening with the Experts model)</p> <p>Beginning in 2019, OHA contracted with AOCMHP to financially support veteran and military-specific MHFA training in Oregon</p>
4.	Offer service-connected community members and organizations education	<p>a. OHA should partner with organizations such as the American Foundation for Suicide Prevention (AFSP) Oregon Chapter to offer educational opportunities, such as safe gun storage, to community organizations statewide, with a particular emphasis on rural and frontier communities</p> <p>b. OHA should coordinate with ODVA's Aging Veterans Services to provide educational materials to Oregon's aging veterans to promote information, resources, and learning opportunities regarding potential eligibility for services.</p>	<p>OHA was a fiscal sponsor of the 2019 Veterans + Military Suicide Prevention Conference, hosted by Lines for Life</p> <p>OHA is a fiscal sponsor of the veterans and military track of the 2021 Oregon Suicide Prevention Conference</p>

Recommendations			
	Where It Started...	What It Became...	Foundation Upon Which To Expand...
4.	Offer service-connected community members and organizations education	<p>c. OHA should offer VSOs training in specific behavioral health topics such as Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), compassion fatigue, etc.</p> <p>d. To support “turning off” the stay-strong mentality, OHA should provide community education aimed at supporting veterans who are retiring or transitioning into non-active duty roles.</p>	
5.	Address Sector/System Intersectionality	<p>a. After conducting a resource inventory, OHA should support efforts at increased collaboration between federal Veterans Affairs offices and civilian organizations.</p> <p>b. OHA should partner with other sectors (county, city, state, federal) to gather information to inform a centralized resource list with resources and specialized points of contact</p> <p>c. OHA should focus on breaking down silos by leveraging existing resources such as 211 or being at the table to contribute to the development of new systems, such as 988.</p> <p>d. OHA should engage with federal Veterans Affairs Ombudpersons and US personnel to bring awareness and attention to the ASIPP and other state-level efforts impacting the behavioral health of veterans in Oregon.</p>	<p>In 2019, OHA released the Oregon Veterans Behavioral Health Services Improvement Study (based on data and community engagement efforts between 2017-2019) and hosted 17 statewide community forums in an effort to seek cross-sector input into veterans’ behavioral health in Oregon</p> <p>Beginning in 2020, OHA awarded funds to support the efforts of community-based organizations and rural/frontier providers in serving veteran and military populations</p> <p>Beginning in 2019, OHA contracted with AOCMHP to financially support veteran and military-specific MHFA training in Oregon</p>

Recommendations			
	Where It Started...	What It Became...	Foundation Upon Which To Expand...
6.	<p>Address gaps in the behavioral health workforce and support behavioral health workforce development.</p> <p>Note: This recommendation is specific to behavioral health (substance use and mental health) health care providers</p>	<p>a. OHA should promote the use of national consultation programs such as the Suicide Risk Management Consultation Program and the National Center for PTSD Consultation Program.</p> <p>b. OHA should create and coordinate a scholarship program to assist with field placements for behavioral health professionals in rural and frontier areas that experiences workforce shortages</p> <p>c. OHA should explore options to coordinate with OHSU or other educational institutions to incentive or allow for debt forgiveness of health care providers serving the veteran community.</p> <p>d. OHA should explore opportunities to address non-financial incentives impacting clinician retention and professional workforce shortages. Examples may include addressing workplace culture, caseload counts, educational opportunities, or other benefits.</p> <p>e. OHA should recognize the unique role private practices have in serving the veteran and military community while understanding their limited ability and resources to become fully certified outpatient clinics</p>	<p>Beginning in 2020 OHA contracted Still Serving Counseling & Services, LLC to support training and workforce development opportunities of veteran and military-connected staff.</p>

Recommendations			
	Where It Started...	What It Became...	Foundation Upon Which To Expand...
7.	Address the needs of all military to reduce suicide (regardless of discharge, service length, etc.)	<p>a. OHA should help veterans and military service members who fall into service gaps when requirements of discharge status, length or service, or service type/deployment criteria are put in place.</p> <p>b. OHA should explore establishing different levels of care or tiers of services in response to gaps or delays the veteran and military community may experience when accessing person-centered behavioral health care.</p> <p>c. OHA should develop messaging to address the misconception that the federal government takes care of all the behavioral health needs of the National Guard</p>	
8.	Address vet/mil employment issues as a protective factor to reduce suicide (through regional considerations and Oregon employment offices)	<p>a. OHA should partner with organizations to identify and address opportunities and challenges associated with post-military service veteran employment (ex: veteran meet-ups, stand-downs, employer recruiting events)</p> <p>b. OHA should coordinate with the State of Oregon Employment Department and the Oregon Supported Employment Center for Excellence to discuss supporting veteran-specific job development and placement strategies.</p>	

Recommendations			
	Where It Started...	What It Became...	Foundation Upon Which To Expand...
9.	Focus on short-term implementation efforts and impact	<p>a. OHA should conduct immediate outreach and engagement with nonprofit and community-based organizations such as Transition Projects (TPI) in Portland to maximize and leverage existing community supports currently focusing on the veteran and military population.</p> <p>b. OHA should create a rapid response team to address the immediate behavioral health needs of high-risk veteran and military populations who may be un/under-insured and do not have service-connected eligibility determined.</p>	
10.	Peer Supports	<p>a. OHA should partner with organizations that offer Peer Delivered Services (PDS)</p> <p>b. OHA should emphasize Peer Delivered Services and recognize the unique ability of veteran peers to serve veterans and military service members within and outside the traditional VA health care system.</p> <p>c. OHA should provide peer support for military-connected families and spouses.</p> <p>d. OHA should explore opportunities to expand peer support models (both training and delivery of PDS) across sectors to develop an established veteran peer support community outside the four walls.</p>	<p>Between 2019-2021, OHA piloted a Veteran Behavioral Health Peer Support Specialist (VBHPSS) program at three CMHPs in Oregon. The model leveraged the unique experiences of Traditional Health Workers who identified as consumers of behavioral health services and had lived experience in the military.</p> <p>In the 2021-2023 biennium, OHA plans to expand on the VBHPSS pilot through a competitive application and funding process.</p> <p>Beginning in 2020 OHA contracted with several organizations, including Dual Diagnosis Anonymous, NAMI Multnomah, and Community Counseling Solutions, to support peer-delivered programming specific to the veteran and military population.</p>

Means Matter workgroup recommendations

Adult Suicide Intervention and Prevention Plan

Workgroup Summary

The Means Matter workgroup was tasked with developing recommendations specific to lethal means safety for Oregon's first five-year Adult Suicide Intervention and Prevention Plan (ASIPP). Between February and May of 2021, workgroup members met weekly for a total of 12 weeks. For eight consecutive weeks within that period, meetings focused on different topics of consideration that intersect with lethal means and often included subject matter experts as guests to share additional information. The recommendations included in this report (see "Recommendations by Topic") are generally organized by these topics. Additional recommendations that did not specifically fit in the context of lethal means safety, but were seen as important by group members, are included in the "Additional Notes" section.

The workgroup included a core group of about 8 members each week, and additional members that joined less frequently (see "Workgroup Attendance"). The following group members attended at least half of the 12 meetings:

- Elissa Adair, Lines for Life
- Eric Akin, Hood River County Veteran Services
- Kris Bifulco, Association of Oregon Community Mental Health Programs
- Zev Braun, State of Safety
- Deb Darmata, Oregon Health Authority
- Stevie Dyal, Crook County Health Department
- James Eriksen, Multnomah County Sheriff's Office
- Derek LeBlanc, Kids S.A.F.E. Foundation

Each member participated in the workgroup on a volunteer basis and came from various fields (e.g., veterans health care, law enforcement, construction industries, county government, firearms training). Workgroup meetings officially began on 2/10/2021 and concluded on 5/5/2021, though a more permanent version of the workgroup may continue in combination with members of the other six workgroups of the ASIPP.

Additionally, meeting notes from each of the eight topic-based meetings are available upon request from Zev Braun, chair of the Means Matter workgroup, by emailing zev@stateofsafety.org.

Recommendations by Topic

Occupations

Date: March 3rd Guest speakers:

- Steven Frost, Howard Wright Construction
- Nathan Smith, Neal Creek Forest Products

1. Incorporate mental health promotion and suicide prevention resources and information into regularly scheduled safety meetings for industries that employ high-risk populations.
 - a.) “Toolbox talk” example:
<https://www.cpwr.com/wp-content/uploads/publications/TT-Opioids.pdf>
 - b.) Could include a “Taking safety home” message, applied to lethal means safety but also fire danger, emergency preparedness, and chemical identification/safety.
 - c.) Develop wallet-sized cards with emergency contact information and helplines to be placed in an employee’s helmet, shoe, or wallet.
 - d.) Ensure that materials are printed in both English and Spanish and that pictures feature racial and gender diversity in the workforce.
2. Promote both safe firearm storage and prescription drug/opioid safety when discussing lethal means safety, as workplace injuries that require prescription drugs can be easily misused.
 - a.) Promote alternatives to opioid painkillers when possible (e.g., Heal Safely).
3. Promote lethal means safety practices on and off job sites, including distribution of materials for lethal means safety planning.
 - a.) Temporary offsite storage of firearms
 1. Requires clarification of ORS 166.435 (Firearm transfer and temporary provision law)
 2. Explore basing this action on ORS 30.800 (Good Samaritan law).
 - b.) Safe storage of firearms, drugs, and household toxic substances
 - c.) Nets around high places to catch falls
 - d.) Security cameras, fences, and hatches on crane ladders to detect and deter unauthorized use of equipment
 - e.) Workplace suicide prevention plan example: <https://www.constructionexec.com/article/ten-tips-for-creating-a-workplace-suicide-prevention-plan>
4. Promote and consider funding wellness programs for high-risk occupational groups that offer classes and/or counseling support for mental health, financial health, nutrition, cultural affiliations, environmental factors, and fitness.
 - a.) Consider incentives to encourage employee participation in wellness programming (e.g., paid hours for participation, and salary bonuses for specific accomplishments).
 - b.) Potentially invite family members of employees to participate or be aware of these services and activities.
 - c.) Program example: SAMHSA’s 8 Dimensions of Wellness <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4958.pdf>

5. Provide all employees who are issued a firearm by their employer, with a safe storage device and training on proper use.
 - a.) For a workplace example, contact James Eriksen at the Multnomah County Sheriff's Office, at james.eriksen@mcsso.us.
6. Identify employees at high risk of suicide for one-on-one confidential follow-up with trained staff or an outside expert (e.g., chaplain, peer support person).
 - a.) Vulnerable times for an employee:
 1. In the aftermath of death on the job or trauma in the line of work (e.g., law enforcement, EMS, fire departments, emergency dispatchers, hospital emergency department staff, towing company drivers)
 2. In the aftermath of a personal injury or loss of a loved one
 3. At times of employee termination, discipline, reduction or transition of responsibility, retirement, or during an exit interviewing process
 - b.) Provide training or funding for crisis intervention programs (e.g., Critical Incident Stress Management (CISM), Trauma Intervention Program (TIP)), to be deployed during employee follow-up.
 1. Especially for low-resource communities without existing infrastructure
 - c.) Conduct follow-ups after first clearing the process with a workplace legal review or general counsel, in case a disclaimer, workplace policy, or liability waiver is necessary.
7. Consider adding a question or checkbox to incident reporting forms (for applicable occupations) about current suicide risk or suicide ideation/attempt history.

Firearms Training

Date: March 10th Guest speakers: none

1. Develop a module that complements existing firearm safety and CHL curriculum that focuses on suicide prevention and includes safe storage concepts.
 - a.) Four options for the module:
 1. Invite a mental health professional with suicide prevention and lethal means training to teach the live module. Potentially provide the professional with a template slide deck presentation.
 2. Encourage the instructor to teach the live module. Potentially provide instructors with a template slide deck presentation.
 3. Instructor to play video in class on suicide awareness and lethal means safety, produced by Oregon stakeholders or borrowed from outside organizations.
 1. Utah Bureau of Crime Investigation: <https://secure.utah.gov/concealed-firearms/renew/preventionVideo.html>

4. Encourage instructors to provide digital and printed materials (produced by OHA, other Oregon stakeholders, or borrowed from outside organizations) to students to passively pick up.
 - b.) Ensure that module includes both English and Spanish languages, and that pictures feature the racial and gender diversity of the gun-owning community.
 - c.) Have persons with lived experience of suicide or suicide attempts review the module before finalization, to consider language usage, user-friendliness, suicide prevention resource information, age appropriateness, equity, confidentiality measures, and other considerations.
 - d.) Potentially include content that discusses and corrects myths surrounding suicide and firearm ownership, and pertinent laws (e.g., ORS 30.800, ORS 166.435).
2. Incentivize firearm safety instructors to include the training module on mental health and suicide prevention awareness in their classes, with a focus on ways to keep oneself or a family member/friend safe if they develop a high risk for suicide.
3. Recommend that Oregon establish standardized training requirements (e.g., through OSP and/or DPSST) for Concealed Handgun License competency courses or other firearm-related courses.
 - a.) Washington state example (for semiautomatic rifles): <https://www.atg.wa.gov/initiative-1639#10%20safety%20training>
 - b.) Oregon Department of Fish & Wildlife example: <https://myodfw.com/articles/hunter-education-classes-and-field-days-schedule>
4. Encourage gun shops and shooting ranges to communicate with new firearm owners (especially those who purchased during state COVID restrictions) on firearm safety training opportunities through ODFW, local law enforcement, or private trainers.

Veterans

Date: March 17th Guest speakers:

- Ian Michael, Lines for Life
 - Monireh Moghadam, Portland VA Healthcare System
1. Provide printed posters and brochures on suicide awareness and lethal means safety directly to firearm retailers, shooting ranges, gun shows, and other firearm-related businesses.
 - a.) Focus on normalizing and destigmatizing conversations on mental health, especially for people who don't trust health care providers speaking about firearm safety.
 - b.) Correct misinformation among veterans is largely based around having their firearms confiscated if they speak out about mental health challenges.
 1. Provide understandable and concise information on Oregon laws related to firearm transfer and restriction, to explain how to preserve ownership rights and store firearms safely while following the laws.
 - a.) Transfer law: [ORS 166.435](#)

- b.) ERPO law: [ORS 166.527](#)
- c.) Prohibited Persons law: [ORS 166.250](#) and [ORS 166.255](#)

- c.) Ensure that materials are printed in both English and Spanish and that pictures feature the racial and gender diversity of gun-owning and veteran communities.
2. Provide veteran’s specific digital and print resources and information to firearm safety instructors.
 3. Implement HB 2315 (2021) to ensure that behavioral health providers are trained in lethal means safety (e.g., CALM training included in continuing education opportunities) as part of their suicide prevention, intervention, and treatment education.
 4. Recommend that future legislation expand the requirements of HB 2315 (2021) to include physical health providers, and to explicitly require education that includes lethal means safety.

Older Adults

Date: March 24th Guest speakers:

- Nirmala Dhar, Oregon Health Authority
1. Improve identification of suicide risk and lethal means access for older adults in primary health care settings.
 - a.) Provide guidance and/or training to primary health care facilities on how to have those conversations.
 1. Incorporate information from <http://oregonfirearmsafety.org/>.
 2. Oregon Pediatric Society provides webinars with CEU credit (<https://oregonpediatricsociety.org/education/>) and may provide more intensive training for participating clinics around the state.
 2. Develop guidelines and requirements for assisted living facilities and older adult communities that allow gun ownership to have safe storage facilities in place.

Health Providers

No Date

Guest speakers (from other topics):

- Michael Sodini, Walk the Talk America
 - Nirmala Dhar, Oregon Health Authority
1. Direct Oregon mental health clinicians to complete a cultural competency course and Counseling on Access to Lethal Means (CALM) training.
 - a.) Clinicians that complete the course or already are familiar with gun culture can have their names added to a publicly-viewable list of Second Amendment (2A)-friendly clinicians (analogous to the Oregon Behavioral Health Provider Directory).

b.) Course offerings include:

1. Walk the Talk America (funded largely by firearms manufacturers): <https://walkthetalkamerica.org/classes-introductory-course/>
 2. Lines for Life Military Cultural Awareness Suicide Prevention Training: <https://intheforefront.org/news/events/firearms-safety-training-2/>
 3. University of Washington Forefront Suicide Prevention Training: <https://web.cvent.com/event/3455533b-63f2-4ce4-9f76-ae8b27ffc624/summary>
2. Provide funding and/or CEUs for behavioral health providers to attend firearms training courses in order to:
- a.) increase their cultural competency,
 - b.) facilitate professional connections to establish referral pathways to behavioral health services,
 - c.) and promote suicide awareness training for range staff and instructors.
3. Educate health professionals on the function of, and process for, seeking an Extreme Risk Protective Order (ERPO).

Local Businesses

Date: March 31st Guest speakers:

- Michael Sodini, Walk the Talk America
1. Prepare outreach materials for firearms community distribution.
 - a.) Walk the Talk America already has developed culturally appropriate materials and is happy to collaborate on efforts in Oregon.
 - b.) Add specific local/county-level information on mental health resources (including a list of 2A-friendly clinicians) for materials distributed in different areas of Oregon.
 - c.) Ensure that materials are printed in both English and Spanish languages and that pictures feature the racial and gender diversity of the gun-owning community.
 2. Distribute outreach materials to gun shops using 2A-friendly people as messengers.
 - a.) Develop a precise script, with the fundamental message that “if we police our own, we won’t face as much pressure for firearms regulation” and “I am here to support and protect you as I hope you would protect me if I am experiencing a mental health crisis.”
 - b.) Include questions on offering temporary offsite firearm storage in the script, if applicable.
 - c.) Seek advice from the Gun Shop Project at the Colorado Department of Public Health and Environment (Contact: Matthew Wetenkamp, matthew.wetenkamp@state.co.us).
 3. Consider developing a temporary offsite firearm storage process for Oregon gun owners to offload their firearms to trusted recipients when they or someone in their household is undergoing mental health challenges (See following topic: “Offsite Firearm Storage”).
 - a.) Add this information, and contact information for local firearm dealers that wish to provide this service, to outreach materials.

4. Encourage Oregon firearms accessory manufacturers to include outreach materials (e.g., brochure, card) with their products.
 - a.) Major accessory manufacturers include: Leupold Optics, Crimson Trace
 - b.) WTTA may be able to facilitate these conversations
 - c.) Ensure that materials are printed in both English and Spanish languages and that pictures feature the racial and gender diversity of the gun-owning community.

Temporary Offsite Storage

Date: April 7th

Guest speakers: none

1. OHA to formally request that the Oregon Department of Justice clarify ORS 166.435 to describe the process and requirements that gun owners must abide by to transfer firearms to licensed firearm dealers, family members, friends, and other entities.
 - a.) For example, how are “imminent” and “only as long as is necessary” defined and by whom in Sec. 1(a)(F) of ORS 166.435?
 - b.) How would a licensed firearm dealer (excluded in Sec. 1(b) and Sec. 1(c)) receive and return a firearm to a firearm owner lawfully?
2. Ensure that temporary firearm transfers are done with confidentiality so that transferors will not be marked as mentally ill or suicidal.
3. Develop a list of gun-related businesses, local law enforcement agencies, national guard facilities, and other entities who are willing to hold onto guns temporarily, and develop a database or visual map of these participating businesses for the public to view.
 - a.) Seek insight from outside organizations like:
 1. Hold My Guns: <https://www.holdmyguns.org/>
 2. Colorado Firearm Safety Coalition: <https://coloradofirearmsafetycoalition.org/gun-storage-map/>
 3. Marylanders Against Gun Violence: <https://mdpgv.org/safestoragemap/>
4. Create a grant fund for gun shops to purchase large gun safes for storage of customer firearms, to pay for attorney fees incurred in review of the shop’s consignment return process agreement (and potential contracts with Hold My Guns), and to purchase general liability insurance.
 - a.) Explore creating agreements for firearm safe manufacturers, distributors, and/or vendors to provide discounts or giveaways to participating gun shops.

Race/Ethnicity and LGBTQIA2S+

Date: April 14th Guest speakers:

- Canada Parker Taylor, Multnomah County Health Department
 - Sharyn Hinchcliffe, Pink Pistols—Seattle
1. Develop Sexual Orientation and Gender Identity data tracking process for suicide deaths and suicide attempts to better understand lethal means data specific to this group.
 2. Conduct outreach on lethal means safety and suicide awareness at pride events and culturally-specific community events across the state.
 - a.) Known events:
 1. Good In The Hood (Portland): <https://www.goodnthehood.org/>
 2. Cinco de Mayo Fiesta (Portland): <https://cincodemayoportland.com/>
 3. Portland Veterans Day Parade: <https://www.veteransdaypdx.org/>
 4. Pride Northwest (Portland): <https://www.pridenw.org/portlandpride>
 5. Eugene Pride: <https://www.eugenepride.org/>
 6. Southern Oregon Pride: <https://www.sopride.org/>
 - b.) Distribute firearm and medication locking devices along with materials, if available.
 3. Engage with organizations that represent specific high-risk identity groups (e.g., BIPOC, Native Americans, LGBTQIA2S+) to increase promotion of suicide awareness and lethal means safety concepts at gun shows and related events, such as:
 - a.) Pink Pistols
 - b.) National African American Gun Association
 - c.) National Black Veterans Association
 - d.) Latino Community Association (Bend)
 - e.) Parents, Families, and Friends of Lesbian and Gay chapters

Substance Addiction

Date: April 21st Guest speakers:

- Lynn Vigil, Crook County Health Department
 - William Nunemann, Lines for Life
 - Allyn Cripe, Lines for Life
 - Angie Arledge, Lines for Life
1. Facilitate coordination between the Oregon Poison Center and county health departments to enhance substance addiction prevention and postvention work as it relates to intentional overdose response work and connecting to services.
 2. Develop or provide grant funding for a coordinated response to nonfatal, intentional overdose cases, to reduce future risk of overdose and/or suicide.
 - a.) At-home crisis response could resemble Project Hope in Clackamas County.
 - b.) Provision of safety planning guidance with a focus on lethal means upon discharge from hospitals or in-patient mental health facilities
 3. Ensure that Oregon's [Drug Takeback Program](#) provides and promotes safe medication disposal sites proximal to workplaces with higher risk for overdose and/or suicide (e.g., construction sites, manufacturing, and logistics warehouses).
 - a.) Establish access to these disposal sites outside of regular business hours to increase accessibility for workers with irregular hours.
 - b.) Coordinate placement of disposal locations with [DEA Controlled Substance Public Disposal Locations](#).
 4. Combine firearm safe storage and medication-safe storage (including prescription drug takeback program information) in suicide prevention outreach efforts and training (e.g., MHFA, ASIST, CALM, QPR).
 5. Encourage the inclusion of basic naloxone administration skills in CPR training to increase community bystander first-aid capacity and awareness.
 - a.) Inclusion example: https://elearning.heart.org/course_enrolment?course=437&code=MjIzOTg1Mjc=&rand=
 6. Give technical assistance to counties for securing grants (e.g., SAMHSA) to fund addiction services and overdose response, and encourage their collaboration with county suicide prevention efforts.

Additional notes

General Older Adult Recommendations

3. Provide additional support to local health systems for a timely response in supporting individuals who have been identified at risk for suicide by primary care professionals.
 - a. Expand the amount of Medicare-certified behavioral health providers. The solution may involve expanding telehealth access to certified behavioral health providers in rural areas of Oregon.
4. Teach older adults how to use modern forms of technology and software to help them stay connected to friends/family.
 - a. Explore funding options for providing older adults with this technology.

General Equity/ LGBTQIA2S+ Recommendations

4. Ensure that behavioral health services and other outreach services (e.g., street outreach for houseless people) are culturally appropriate for BIPOC, Native American, and LGBTQIA2S+ people — (aligns with HB2949 relating to diversifying the behavioral health workforce through incentive and pipeline programs and HB2086 relating to culturally specific behavioral health services for BIPOC and Native Americans).
 - a. Use medical examiner data, law enforcement data, and other sources to develop more targeted changes to the care and service system and address equity.

General Construction Recommendations

7. Explore funding options for the development of a program to augment worker incomes in trades or employers with very limited sick leave or strict drug policies, such that workers feel less fear of potentially being terminated from work for seeking addiction treatment.
 - a. Especially construction, extraction, hospitality, food/drive service, and logistics industries.

Survivor/postvention recommendations

1. Include site-specific physical protections and communications for locations that become suicide hot spots.
2. Ensure counties have the resources necessary to respond and monitor locations, and if not make resources available.
3. Support safety planning and lethal means counseling after a suicide attempt.

Oregon Older Adult Suicide Intervention and Prevention Plan recommendations

Submitted: June 30, 2021, by the Older Adult Suicide Intervention and Prevention Plan Committee

1. Goal 1. Increase points of care

Integrate and coordinate older adult suicide prevention activities across multiple sectors, settings and points of care and connection including: community/senior centers, libraries, social groups/clubs, social media, health care settings, natural systems of support, faith communities, community-based care settings, auxiliary services, barbershops/salons, mail/meal delivery, transportation, gatekeepers, financial systems, local older adult-serving businesses, peer settings, affinity groups, culturally specific organizations, etc.

2. Goal 2. Increase awareness and education

Provide training to community and clinical service providers on the prevention of suicide and related behaviors. Implement evidence-based, evidence-informed and practice-based education and awareness efforts designed for older adult mental health promotion such as Older Adult Question, Persuade, Refer (OAQPR), Military-Connected QPR, QPR for Faith Communities, Older Adult Mental Health First Aid (OAMHFA). Develop culturally specific efforts and resources with older adult BIPOC, LGBTQIA2S+ communities and other marginalized communities.

3. Goal 3. Increase protective factors.

Increase knowledge of factors that offer protection from suicidal behaviors in older adults and that promote wellness and recovery such as social connection, social determinants of health, limited access to means, promotion of mental health and physical health (whole health) services and support. Increase culturally appropriate protective factors in older BIPOC, LGBTQIA2S+ and other marginalized communities. Promote activities that support the sense of community-wide belonging and inclusion. Reduce marginalization, discrimination, and exclusion.

4. Goal 4. Increase community-based prevention programs

Implement programs that promote wellness and prevent suicide and related behaviors such as Wellness Initiative for Senior Education (WISE), Aging Mastery Program (AMP), Program to Encourage Active, Rewarding Lives (PEARLS), Buried in Treasures (BIT), Oregon Senior Peer Outreach (OSPO), peer-to-peer programs, Senior Loneliness Line and other effective tools and programs. Develop culturally-specific programs with older BIPOC, LGBTQIA2S+ and other marginalized communities.

5. Goal 5. Improve clinical strategies

Promote suicide prevention and mental health services as a core component of health care services and delivery. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

6. Goal 6. Promote means safety

Promote efforts to address means safety among older adults through educational efforts such as Counseling on Access to Lethal Means (CALM), conversations with care providers and other social or medical support persons, firearm safety/locks programs, outreach to Veterans/military-connected communities and families, care partners, rural/isolated older adults, and other groups with a propensity towards gun ownership.

7. Goal 7. Improve postvention planning and response

Increase postvention education, preparation and support for older adult congregate settings such as senior living communities, senior/community centers, congregate meal/activity sites, villages (virtual peer communities), care communities, faith communities, culturally specific organizations, etc.

8. Goal 8: Improve suicide prevention equity

Promote research around the causes and impacts of disparities in suicide rates among older adult groups such as LGBTQIA2S+, BIPOC, white men, income level, gender, etc. Implement new strategies based on research outcomes.

- SAMHSA Resources for Older Adults
With Items for Older Adults on Suicide Prevention and Postvention
<https://www.samhsa.gov/resources-serving-older-adults>
- Engage, Educate, Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging
<https://www.samhsa.gov/behavioral-health-disparities-in-aging>
- Oregon Older Adult Behavioral Health Initiative
<https://oregonbhi.org/>
- Commit To Connect
<https://acl.gov/CommitToConnect/activities>
- American Society on Aging
<https://www.asaging.org/>
- Oregon Gerontological Association
<https://www.oregongero.org/>
- National Center for Elder Abuse
<https://ncea.acl.gov/Resources/Publications.aspx>
- AARP (see dropdown menu for helpful links)
<https://www.aarp.org/>
- Long-Term Supports Scorecard (AARP)
<https://www.longtermscorecard.org/>

BIPOC AI/AN ASIPP recommendations

Recommendations for BIPOC Suicide/Behavioral Health Planning

OVERVIEW & PURPOSE

Racism is a public health crisis. In Oregon, accessing safe, effective, and culturally informed behavioral health/health care often comes with increased burdens and barriers for BIPOC individuals seeking non-emergency and emergency care. The social determinants of health and intersectionality compound and multiply many of the struggles BIPOC communities encounter in receiving quality care, reducing suicide deaths, and deaths by “slow suicide” which can be more common in communities of color. Integrated, community-based health approaches and initiatives could greatly improve the quality of life and lifespan of BIPOC community members.

Areas Of Focus

1. Increasing BIPOC behavioral health providers and retaining them.
2. Decreasing barriers for BIPOC communities accessing higher education in identified fields
3. Improving outcomes for BIPOC individuals who do engage in behavioral health services.
4. Decreasing barriers to culturally responsive health care.
5. Use an anti-racist, integrated public health framework to address systemic inequality.

Strategies

Education

1. Loan forgiveness programs to compliment federal programs. <https://bhw.hrsa.gov/funding/apply-loan-repayment/faculty-lrp>
2. In-state scholarship opportunities for BIPOC students seeking a health-related degree, generated in conjunction with public universities and community college grant opportunities.
3. Internship opportunities for high school students to encourage them to join behavioral health-related fields.
4. Provide free CEU training for all providers to understand and apply culturally adaptive assessment tools.

Community

5. Building active relationships through outreach with BIPOC organizations of all types to fully become embedded in the community. Invite the community to partner in creating initiatives.
6. Provide comprehensive postvention services to all BIPOC families experiencing suicide loss, working with county suicide specialists to create a sustainable postvention and outreach plan.

Integrated Health

7. Connect behavioral health initiatives to the Healthier Together Plan. All the equity initiatives noted in the Healthier Together plan are also part of greater suicide prevention work.
8. <https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/2020-2024/Healthier-Together-Oregon-full-plan.pdf>

Recommendations for Preventing Suicide Among Boys and Men in Oregon

Prepared by the ASIPP Boys and Men Sub-Committee

Introduction

Roughly 75% of people who die by suicide in Oregon and the US are male. Between 2000 and 2019, 10,260 males died by suicide in the state of Oregon (OHA-Vital Statistics, 2021). In 2019 alone, 684 males died by suicide, compared to 224 females — the greatest number of deaths for either population in state history. In contrast to females, who's risk profile plateaus in mid-life, male suicide risk increases exponentially across the lifespan, making older adult males the population with the greatest suicide risk (Hedegaard et al., 2021). Oftentimes, men who die by suicide, die on their first attempt, leading to a case-fatality rate nearly 5 times that of women (Conner et al., 2019). The primary method of suicide for males is firearms and the rate of firearm suicide has been steadily increasing for over a decade (Curtin, Martinez 2019).

Mortality data such as those above are often cited in suicide prevention literature to emphasize the crisis of male suicide, however, the complex reasons for these disparities are rarely discussed or addressed in most suicide prevention programming and policy in the US. The following information and recommendations below represent a portfolio of programs, practices and policies that will engage men at risk of suicide and reduce the risk factors unique to men, leading to a reduction in the male suicide rate and the rate of suicide and traumatic sequelae in other populations. The Boys and Men Sub-Committee strongly urges the Oregon Health Authority to deliberately and explicitly address the crisis of suicide among men in the Oregon Adult Suicide Intervention and Prevention Plan.

Population of Interest

Boys and Men in Oregon are the primary population addressed in this set of recommendations. Commonly, epidemiologic data about suicide are recorded and reported in binary sex terminology (male and female) and rarely reflect the range of gender identities. In fact, the surveillance systems relevant to the vast majority of suicide mortality, attempt and ideation research in Oregon do not systematically record gender identity, relying solely on sex assigned at birth. The Boys and Men Sub-Committee, while forced to cite these data, acknowledges that this binary classification is inadequate and fails to recognize the identities of transgender and non-binary people. Furthermore, we recognize that binary gender classifications and related cultural expectations actually contribute to increased suicide behavior. With these thoughts in mind, when we refer to “men” in this document, we are referring to people who identify as male or as a man regardless of the sex assigned at birth.

Men's Health and Health Behavior

Men in the US consume and abuse more drugs and alcohol, die of cancer more often, experience earlier onset of cardiovascular disease, suffer more often from untreated depression and die from accidents and homicides more often than women (Courtenay, 2000). These disparities among others, result in a life expectancy for men that is a full 5 years less than that of women (Murphy et al., 2020). And as mentioned above, men die by suicide significantly more often than women as well. In plain language — men die earlier, more often and more violently than women.

Often times suicide is described as an outcome of mental health problems. While this is true, it is also an act of self-directed violence, an act of violence that is influenced by similar risk factors as interpersonal acts of violence (Wilkins et al., 2018). Beyond the various health disparities mentioned above, men are significantly more likely than women to

perpetrate acts of interpersonal crime including homicide, physical assault, sexual assault and intimate partner violence (Oregon Uniform Crime Report).

Men, Masculinity and Population Health

The behavioral, medical and suicide-specific health disparities cited above beg the question: Why? The reasons for these disparities are complex and if addressed have the potential to impact not only men’s suicide risk and health but the health of other men, women, children and families. Common risk factors and explanations for these disparities include the greater likelihood of substance abuse among men, men’s greater likelihood to have access to and use highly lethal means, adherence to the rigid norms of Western masculinity that influence men’s help-seeking behavior, their lower engagement in behavioral health and medical services and cultural expectations of achievement, status and/or dominance stemming from patriarchal attitudes and beliefs.

Of particular interest to the Boys and Men Sub-committee is the topic of masculinity, particularly maladaptive masculine attitudes and behaviors. We believe these attitudes and behaviors are the root cause of many of the risk factors for men’s suicide, violence and other health disparities. Masculinity refers to a set of attributes, qualities, behaviors and roles generally viewed by society as characteristic of men. Masculinity is a social construct with no meaningful biological or natural basis. We do not advocate for the term “masculinity” to be understood as a normative statement of what it means to be a man that applies to all men. We do not endorse that masculinity is a singularly understood construct that can or should be reified or described as having an essential definition.

We do believe that masculinity can and should be flexible to incorporate a wide variety of traits and behaviors and encourage the use of the term “masculinities” to identify the plurality of masculine identities available to men. We are highly aware that society tries to impose restrictive gender norms on all boys and men, sometimes referred to as the “Man Box,” not allowing for the expression of masculinities. The Boys and Men Sub-Committee believes that when the suicide prevention community addresses the roots of men’s suicide risk in maladaptive masculine behaviors, that we will improve the health of our communities across multiple outcomes for multiple populations.

Recommendations

1. Strategically Engage Men During Major Life Transitions

Reason: When men encounter major life transitions, such as retirement, unemployment, separation and divorce, or exit the criminal justice system, their suicide risk and mental health vulnerability increases (Brenner & Barnes, 2012). Thus, it is essential to reach men prior to and during these transitions to provide support and resources about suicide risk and prevention (Yousaf, Grunfeld, & Hunter, 2016). Professionals who may be particularly well-suited to encounter and reach men during these transitions include clergy, social service and case workers, counselors and therapists, physicians, district attorneys and lawyers, retirement planners, bartenders, barbers, bankers and financial planners, and probation and parole and correctional officers.

Action Steps:

- a.) These above professionals should receive state-sponsored training in suicide risk for men during major life transitions that can be provided by local, state or contracted Big River Suicide Prevention Training Staff or other certified mental health providers. Consultants with whom OHA can partner to develop this type of programming include mental health professionals, social workers, trade organizations and unions and state and county governments.

- b.) Professionals in these settings should display and distribute suicide prevention resources for men and be able to help build awareness about men’s higher risk for suicide with all men they encounter. These OHA-sponsored resources can be developed in partnership with many of the groups mentioned above in collaboration with contracted marketing and design firms.

2. Provide behavioral health care services in non-therapeutic settings

Reason: Men’s reluctance to seek help is a significant factor in men’s high suicide rate. Despite the many stressors that men face, many men are reluctant to participate in traditional psychotherapy. Their reasons include shame about needing help, perceived loss of control in the therapy process, fear of being judged or being misunderstood, cost, and not knowing how to navigate connecting with a counselor. This dilemma has led some authors to recommend creating therapeutic opportunities in nontraditional settings as a way to address men’s barriers to help-seeking. (Davies, Shen-Miller & Isacco, 2010). Telehealth has been shown to be popular among some men for its ability to provide services without experiencing the shame of going into an office.

Psychoeducational and support groups that focus on depression management, life coping strategies and suicide prevention can offer men information without “outing” them as needing help. Programs like AA and other 12-step programs can be helpful in providing support and information on addictions, a frequent factor in many suicides. Podcasts that can be accessed from one’s home can be helpful in coping with stress, anxiety, and depression. Crisis lines and related services are important services in preventing suicide in this way as well.

Two specific examples of providing therapeutic/support services in non-traditional settings related to violence and suicide prevention include: Elevate Him — a Portland-based organization dedicated to eliminating suicide by men through awareness, support groups, professional attire and community connections, and the Eugene-based McKenzie River Men’s Center committed to helping men lead healthier lives and reduce violence through community education and awareness, support groups and training health professionals on how to engage men in services.

Action Steps:

- a.) Promote and provide funding for programs that provide therapeutic opportunities for men in non-therapy settings. Examples include:
 - 1. Psychoeducational Support Groups
 - 2. 12 Step Programs
 - 3. Elevate Him
 - 4. Men’s Shed
- b.) Advocate for the continuation and expansion of behavioral telehealth services
- c.) Educate service providers on the value of therapeutic services in non-therapeutic settings

3. **Evolve masculine norms that are expansive, inclusive and lead to the health and safety of boys, men and communities.**

Reason: Many American men are taught to hide their vulnerability, take risks, and be independent, unemotional, competitive, and aggressive. These rigid masculine standards have led many men to feel that they don't belong and don't measure up to being a man. Current norms discourage men from taking care of themselves and seeking help, lower their self-esteem and contribute to depression and high rates of male suicide. Additionally, these norms do not acknowledge differences in men's power and privilege due to their race, ethnicity, cultural background, sexual orientation, gender identity, or economic class. This makes it easier to ignore the effects of racism, classism, and homophobia on men and boys of color, and gay, bisexual, queer, or transgendered men. Racism and homophobia negatively impact mental health and can contribute to suicide.

Many authors now use the term masculinities to acknowledge that there are multiple healthy ways to live one's life as a man. It is crucial that we create a society in which all men feel welcome and guided by gender norms that promote the health and safety of our families, communities, and boys and men. To have healthier boys and men we must replace unhealthy norms with healthy ones. Changing gender norms requires a sustained effort by our entire community. One strategy is to engage and educate the community about masculinities and suicide prevention through community dialogues. These events bring mental health professionals, educators, concerned community members and diverse members of the general public together to talk about promoting healthy masculinities and reducing suicide.

Community dialogues are an effective way to help community members identify and promote masculine norms that contribute to the health and safety of men and the reduction of male suicide. To do this it is important that we reach out to diverse places, systems, organizations and people such as recovery meetings, religious institutions, public-facing nonprofits, middle and secondary schools and colleges. The community events described can engage diverse groups of people in the process of altering the male socialization process so that we can create healthier and happier boys and men and reduce male suicide.

Action Steps:

Provide support and incentives for organizations to provide community dialogues that

- a.) promote the recognition, acceptance, and expansion of the diverse, healthy ways that men live their lives
- b.) discuss the impact of race, culture, sexual orientation and gender identity on one's identity as a man
- c.) recognize how male socialization and role expectations can lead to sexual and other forms of interpersonal violence
- d.) Identify masculine norms that promote the health and safety of all people
- e.) educate parents and mentors of boys and men about strategies to raise healthy boys and men.

4. **Provide opportunities for civic engagement in which men can support their communities and find meaning and purpose**

Reason: Studies have shown individuals experience improved quality of life when they consistently engage in civic activities (Pew Charitable Trust, 2021). Civic engagement can take many forms, from individual volunteerism to organizational involvement to electoral participation. It can include efforts to directly address an issue, work with others in a community to solve a problem or interact with the institutions of representative democracy. Civic engagement encompasses a range of specific activities such as working in a soup kitchen, serving on a neighborhood association, writing a letter to an elected official or voting. Social isolation is a significant risk factor for suicide and opportunities for civic engagement provide men a place to meet others, create relationships and even potentially find a sense of purpose and meaning.

Action Steps:

- a.) OHA should create diverse partnerships with nonprofits, and culturally specific community-facing agencies that have volunteer programs for men in various settings examples include: Big Brothers and Big Sisters and other mentoring organizations, Court Appointed Special Advocates, restorative justice programs, urban and land restoration initiatives, sports coaching associations, Kiwanis, Lion's Club, Rotary Club,
- b.) OHA should provide men with the material, education, and means to create their own programs for civic engagement in their communities.
- c.) OHA should provide funds for agencies to expand their volunteer programs for new services and update already existing services that are specific to men, and boys.
- d.) OHA and/or 211 should create a central location for information on civic engagement opportunities to allow inter-agency communication and improve citizen

5. **Implement a sustained male-specific public awareness campaign that demonstrates an alternative, healthy set of masculine norms**

Reason: Health promotion campaigns are effective ways to raise community awareness of health issues, recruit people to get involved in advocacy and change health behavior. Universal mental health promotion and suicide prevention campaigns often do not meet the needs of men, especially in relation to language, content or cultural acknowledgment. Men's health needs and barriers are unique and should be addressed to effectively educate the public and reach men. Examples of male-specific health campaigns related to men, masculinity and/or suicide include: Man Therapy, RUOK and Movember

Action Steps:

- a.) OHA should develop a media and communication plan to empower men to get involved in their own mental health and support the mental health of other people. This campaign should be sensitive to the psychosocial traits of men of all ages and craft messages appropriate to their needs. Specific themes to highlight include the value of social connection,
- b.) Campaign materials should be distributed online, in print, radio and television

6. Improve the diagnosis and treatment of depression in men in health care settings

Reason: Many men present symptoms of depression that are not considered diagnostic of Major Depressive Disorder or Persistent Depressive Disorder (dysthymia) in the DSM-V or ICD-10. Men tend to experience and express depression with greater levels of irritability, anger, aggression and stress compared to women. Additionally, men who are diagnosed with depression in primary care settings tend to identify somatic rather than emotional symptoms of depression which are not addressed by most universal depression screening tools (Suh & Gallo, 1997). The inaccuracy of depression screening leads to an underdiagnosis of depression in men in both behavioral and primary health care settings and potentially greater suicides (Wilhelm & Parker, 1994)

Action Steps:

- a.) Promote the option of using male-specific depression scales when working with men in any primary or behavioral health care setting to ensure the accurate diagnosis of depression in men: Examples may include
 - ✦ The Gotland Male Depression Scale
 - ✦ The Diamond Male Depression Scale
 - ✦ The Masculine Depression Scale
- b.) Promote the American Psychological Association Guidelines for Psychological Practice with Boys and Men with mental health professionals working with men regardless of licensure type
- c.) OHA should develop training for clinicians working with men to educate service providers on how to create services congruent with the culture of men and masculinities. Primary care providers should particularly be trained in recognizing the externalizing signs of depression in men

7. Advocate for and Support Mental Health and Wellness for Boys throughout the School System

Reason: Today's boys are tomorrow's men. In consideration that suicide risk begins to elevate for boys during middle adolescence (Miron et al., 2019), it is essential to reach boys early with comprehensive suicide prevention education that normalizes help-seeking and emotional vulnerability. Boys of certain cultural backgrounds, such as Black, indigenous, and Caucasian, are at elevated risk and prevention efforts should be culturally-informed and targeted when feasible (Lindsey et al., 2019). Many boys' mental health is also influenced by rigid conformity to masculine norms, such as aggression and emotional restriction, and resistance to help-seeking, which can contribute to elevated suicide risk and diminished well-being (Courtenay, 2003).

Action Steps:

- a.) Starting at the beginning of elementary school and continuing through high school, provide all boys with annual developmentally-appropriate healthy masculinities training in schools to support all boys feeling that they have more options beyond the Guy Code while emphasizing the importance of emotional expression, vulnerability and help-seeking sources of strength (for intervention examples, Exner-Cortens et al., 2020; NCPFCE., n.d.). Of course, all kids need access to healthy gender education, and this can be paired with sexual health curricula in the public school system. OHA can partner with clinicians and prevention-researchers to develop a comprehensive healthy masculinities curriculum for boys from elementary through high school, along with training individuals in the school system to help implement the curriculum such as teachers, counselors, and coaches. Healthy masculinities and gender interventions can also be delivered in concert with or as part of Social Emotional Learning (SEL) curricula.

- b.) Teachers, administrators, coaches and physical education instructors, and other staff are uniquely positioned to encounter boys who may be experiencing psychological difficulties or environmental stressors that can contribute to mental health issues and consequently suicide risk. Thus, with support from OHA, the Board of Education and Suicide Prevention Coordinators should provide these important front-line individuals with training in identifying suicide risk signs in boys during adolescence, as well as ways to effectively intervene, relationally connect, and express concern and caring when encountering a boy visibly struggling (internally or externally) and who may be at greater risk (Johnson & Parsons, 2012).

8. Advocate for the development of billing codes that support follow-up care and outreach during times of life transition or crisis.

Reason: “Outreach” activities are those that involve a trained person proactively attempting to contact another person for the purposes of behavioral health engagement or treatment. Outreach activities are regularly recommended as essential in suicide prevention and intervention since many people presumed to be at risk of suicide, do not seek treatment or support, especially immediately before their suicide behavior. Also, the period of days and weeks after discharge from the hospital after a suicide attempt are some of the most dangerous for the person to die by suicide. And this is especially important for men because they don’t often pursue support or follow-up with clinical care and therefore more outreach must occur.

Outreach activities usually include telephone, face-to-face, or written attempts to reach a person possibly at risk of suicide or behavioral health issues. It may require several failed attempts to reach the person and considerable drive time to do face-to-face outreach in the community. Unfortunately, Medicaid and private insurance billing codes only cover services in the presence (face-to-face or telephonic) of the person. It does not pay for failed attempts to reach the person or drive time.

Action Steps:

- a.) The Oregon Health Authority should immediately use its current expertise to draft Medicaid billing codes that would provide payment for Outreach Services and then request that the Centers for Medicare and Medicaid Services approve these codes for Oregon.
- b.) The State of Oregon’s regulatory processes should require those private insurance companies operating in the state to pay for Outreach Services.

9. Improve state-level leadership and direction in men’s health

Reason: Universal health promotion information is generally ill-suited to the needs of men. In fact, men with adherence to Western masculine norms often have lower health literacy than men without (Milner et al., 2019). Health literacy is a core component of health access and serves as a vital bridge to well-being.

Action Steps:

- a.) OHA develop a men’s health advocate position, to increase providers’ awareness and knowledge of the impact of male socialization on men’s health and safety and the safety of the entire community.
- b.) This position should have the opportunity to review state literature with men’s needs in mind and develop materials that address the cultural realities of men’s health behavior.

Appendix: Masculine Norms and Suicide

During the writing of our recommendations, the Sub-committee developed the following list of maladaptive and alternative masculine norms. We developed this list in an effort to come to a common understanding of the issues related to men, masculinity and suicide. We share these lists with the reader to expand on the concepts we feel are most important to the prevention of suicide among men.

Maladaptive Norms

Risk-taking — Physical violence and substance misuse are rites of passage and are acceptable ways of expressing oneself and coping in the absence of direct emotional expression. Risk-taking influences the acceptability of interpersonal violence and predisposes men's capability for suicide

Toughness — Men should have a stoic attitude towards their own mental, emotional, and physical pain. A hyper-focus on toughness influences men's self-perception should they survive a suicide attempt and therefore their attraction to highly lethal means so as not to appear like a coward

Economic role — Men are naturally providers and protectors. This is so central to masculine identity that should a man fail in performing these roles, he has failed entirely. The pain of this loss of stability and status is unacceptable and intolerably painful.

Independence — Men do not need help and should not ask for it from anyone. Vulnerability is a liability.

Feelings — Men should not have or discuss a wide range of emotions, particularly men should not behave in ways that demonstrate various emotional states such as sadness or loneliness. However, anger is an acceptable emotion to feel and express in the absence of others.

Relationships — Men should use power to dominate others in family and social relationships and should be in control. When men cannot be in control, they have failed romantically, as a parent or as an employee.

Alternative Norms

Interdependence — It's ok to need and ask for help from a friend or a professional health care provider – It is a sign of strength, not weakness. Developing friendships at any stage of life, particularly later in life, is healthy. Companionship allows us to help ourselves and others.

Family & Economic Role — The roles of men in families can be numerous and flexible. They have not failed if they are not the sole provider in the long or short term. Men can nurture their children and share intimacy with their family members.

Health & Help Seeking — Mental and physical health problems are normal parts of having bodies. Men who participate in behavioral health treatment are caring for themselves and value their health.

Feelings — It is important to develop an emotional vocabulary and healthy to express a wide range of emotions around others. We all experience emotions and it is OK to communicate about these experiences with others.

Meaning & Purpose — Men have value and a greater purpose than being a worker or providers for their families. Men can lead rich lives of spiritual, social connection and civic importance.

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ASSIP — Rural Workgroup Full Report

1. **Objective: Reduce the number of suicides completed by the use of firearms.**

Reason: Firearms owners are at increased risk of dying by suicide, they should have a voice in identifying solutions that will mitigate risk

Plan Recommendations:

- Ask firearms dealers, shooting ranges and instructors what they think will be most helpful to reduce suicide deaths and be something that the gun community themselves would use. The goal would be to identify types of skills, information and resources they might use to educate customers about firearm lethal means and suicide.

2. **Objective: Increase the likelihood that people will seek help prior to, or while they are thinking about suicide.**

Reason: Promoting the concept through inclusive strategic messaging that it is OK to ask for help. Making sure that educational outreach is tailored to subcultures within rural communities (population density, access to treatment, race/ethnic groups, religious groups, sporting, occupational, age groups, etc.) and addresses their cultural norms around mental health and suicide.

Plan Recommendations:

- Use or develop help-seeking campaigns specific to rural communities that...
 - ✦ Reduce stigma
 - ✦ Promote mental health and substance use resources and the relationship between the two

3. Objective: Identify and utilize “hubs” in rural communities for targeted outreach with mental health promotion and suicide prevention resources and information

Reason: Rural communities face many barriers to accessing mental health resources and information

Plan Recommendations:

- Identify and fund supports and protective factors already existing in rural communities and promote those resources.
- Promote programs that enhance connectedness across communities such as Sources of Strength, *ASK the Question*, *Mind your Mind (launched by central Oregon)*
- Promote information and resources in rural areas at:
 - a.) Post offices
Messaging campaigns, information, and resources *ASK the Question*
 - b.) Churches
Suicide Prevention Competencies for Faith-Based Leaders
 - c.) Law enforcement agencies (as integrated community members who know everybody and can be supportive community caregivers)
 - d.) Schools
 - e.) Advertise and provide gatekeeper training, especially in rural areas for parents and other community members

4. Objective: Improve the usefulness and applicability of suicide-related data in rural areas.

Reason: Because of confidentiality reasons due to their small populations, many counties in Oregon do not know their own suicide rates in comparison to others, even over the long term. This creates a rural/urban cultural divide and dilutes suicide prevention efforts.

Plan Recommendations:

- Use alternate data such as hospitalizations, death rates (suicide and overdose) and service access/ utilization for smaller communities along with rates per 100, 000.
- Aggregate rural counties to reach the 100, 000 threshold to represent rural suicide rates to rural community members

5. Objective: Determine opportunities to further support not only the recruitment of behavioral health providers to rural communities but also incentives to stay long-term.

Reason: Rural communities have difficulty filling behavioral health positions and often clinicians leave the area after meeting licensing requirements

Plan Recommendations:

- Standardize behavioral health clinician training requirements to support clients with suicidal ideation
- Standardize screening and treatment of suicidal ideation

- Improve infrastructure that will attract and retain professionals including increased salary, high-speed internet, housing, and community programming

6. **Objective: Provide infrastructure that promotes mental health, community connectedness, treatment access and quality of life**

Reason: There is an increased stigma about mental health in our rural communities, more effort is needed to improve mental health literacy and increase protective factors

Plan Recommendations:

- Develop infrastructure such as broadband, housing, parks, increased social services, etc.
- Ensure quality social-emotional learning programs are available in rural schools
- Provide educational opportunities for parents and community members
- Have OHA develop Medicaid billing/encounter codes that promote behavioral health outreach activities and propose for approval from CMS.

7. **Objective: Address geographic inequity by allocating state funding to regions where there are the highest suicide rates and statistical risks (age, physical isolation, lack of mental health services, opioid usage, firearm access, and rurality).**

Reasons: In Oregon, funding for suicide prevention programs has largely gone to the population centers of the state, even for services or programming that eventually is intended for rural areas. This can miss valuable cultural and accessibility nuance in local delivery. Processes that work in the big city may not work in rural communities. It is time to move the dial on the disproportionate rates of suicide behavior in rural areas by putting the money where the problem is.

Plan Recommendations:

- OHA ensures that all funding for suicide prevention programming is distributed to organizations working in the state in proportion to the aggregate risk as determined by age, physical isolation, lack of mental health services, opioid usage, firearm access, and rurality.

Mental Health Systems workgroup recommendations

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Introduction Mental Health Systems

The Mental Health Systems Workgroup was initially organized to address the needs of adults experiencing severe and persistent mental illness but has since expanded to address the needs of all adult consumers of mental health services across Oregon. The workgroup met six times to discuss strengths and gaps related to suicide prevention within the state mental health system.

The following questions provided background for workgroup discussions:

1. What does the ASIPP look like for adult mental health consumers in Oregon?
2. What are current barriers to addressing suicide prevention and intervention with adult mental health consumers?
3. How can the ASIPP be specifically accessible and responsive to adult mental health consumers for meaningful outcomes?
4. What does current data tell us about the “state of the union” of existing initiatives and programs in the effectiveness, accessibility, and palatability?
5. What are the potential action steps that can be recommended to move toward provision of the ASIPP for adult mental health consumers?
6. How can equity remain at the forefront of any recommendations for the ASIPP?
7. What additional considerations should be held in mind regarding diversity, representation, and voice within adult mental health consumers to shape adequate and appropriate recommendations?

The four strategic directions as identified by the National Action Alliance for Suicide Prevention were utilized as a means to organize our concepts. These four strategies include:

1. Healthy and Empowered Individuals, Families, and Communities
2. Clinical and Community Preventive Services
3. Treatment and Support Services
4. Surveillance, Research, and Evaluation

The group then identified strengths and gaps in Oregon’s mental health systems in alignment with these strategies. From there, common themes emerged that prompted goals, reasoning, and our recommendations. The identified themes were used in the creation of the following goals:

1. Establish OHA Advisory Committee(s) for ongoing advising to OHA regarding adult suicide prevention
2. Implement and Expand Culturally-Responsive and Linguistically-Appropriate Services
3. Expand Peer-Delivered/Informed Services
4. Integrate and Coordinate Mental Health Activities Across Systems
5. Improve and Expand Workforce Development and Training
6. Identify Social Determinants of Health Among Mental Health Consumers to Improve Outcomes
7. Emphasize Use of Media and Communication to Promote Hope, Healing, and Wellness

The goals, reasons, and recommendations of the workgroup are listed on the following pages. It should be noted that the workgroup recommends that culturally responsive and linguistically appropriate services, as well as peer-delivered/informed services, be integrated into all recommendations.

Workgroup Recommendations

8. **Goal: Establish OHA Advisory Committee(s)** for ongoing advising to OHA regarding adult suicide prevention, or join with an existing committee to align goals and expand the focus of suicide prevention across the life span. Options to consider include forming a group made up of representatives from the ASIPP and those with lived experience, and/or collaborating with the Oregon Alliance to Prevent Suicide or other related advisory committees.
9. **Goal: Implement and Expand Culturally-Responsive and Linguistically-Appropriate Services**

Reason: Traditional mental health services are primarily focused toward white, English-speaking, able-bodied consumers. Services that support those of other cultures, languages, and abilities help providers better respect and consider a client’s cultural background — from diagnosis, to implementation of treatment, to long-term health outcomes. Respect and consideration of these needs lay a foundation of trust, and this allows organizations to better align their mental health services and infrastructure with best-practice care for these communities and populations.

Recommendations:

- More culturally responsive approaches to suicide prevention, intervention, and postvention need to be integrated into day-to-day care
- Mental Health services should strive to develop a more diverse workforce to reflect and support communities, including Mental Health professionals and peer-delivered services
- Cultural activities should be emphasized (when clinically appropriate) and adequately funded/reimbursed as an integral part of treatment (i.e. sweat lodges with Native American population, Eastern medicine, etc.)

10. Goal: Expand Peer-Delivered/Informed Services

Reason: The Centers for Medicare and Medicaid Services (CMS) recognize peer-delivered services as a successful tool in the treatment of mental health disorders. Authentic engagement in peer-delivered services alongside mental health treatment helps create better outcomes, reduces the cost of care, expands the workforce, and gives credibility to outreach efforts. Peer-delivered recovery supports offer help, hope, and wellness to those experiencing mental health disorders.

Recommendations:

- System barriers should be addressed in order to achieve broadly distributed, well-funded peer services that adhere to a fidelity model and include effective peer supervision
- Peer services should reflect the community they are serving, and should not be siloed to specialized populations/organizations
- Caring contacts and other informal, often peer-delivered services should be reimbursable through Medicaid and private insurance.

11. Goal: Integrate and Coordinate Mental Health Activities Across Systems

Reason: Mental health system partners, especially those who work with individuals experiencing Intellectual/Developmental Disabilities and Substance Use Disorders, should work collaboratively to cross-train staff and reduce barriers to accessing culturally responsive, trauma-informed, and peer-supported services. Effective and efficient integrated care should exist throughout the continuum of services. Services should include but are not limited to: outreach activities, communication with the individual and family, and connecting with natural supports. Incentives — including the elimination of legislative salary caps and payment for outreach activities — should be considered. Braiding funds across systems would allow access to services that would best fit an individual's needs, regardless of geographic location, insurance, or other barriers.

Recommendations:

- Medical and behavioral health agencies should proactively collaborate to address barriers to access and minimize duplication of services, and policies should be implemented to guide this collaboration and coordination
- Coordination, education, and support should exist between Mental Health and criminal justice systems
- Systems that are “siloed” (i.e. I/DD, older adult MH, SUD) may have funding/licensure/structural/training limitations that inhibit widespread access to Mental Health services (i.e. MH services are difficult to provide in I/DD residential settings due to non-transferable licensure/funding)
- OHA should develop Medicaid billing codes that pay for outreach activities and propose these codes to the federal government.
- Mental Health consumers should have specific, invested access to housing supports, including considerations for houseless populations
- Policies should delineate and clarify “next steps” following utilization of crisis services (i.e. connection to housing, outpatient services, etc.) in a way that is supportive of the individual and their dignity
- “Diagnostic overshadowing” presents negative connotations and assumptions about suicidal behavior

based on diagnosis (i.e. suicidal ideation can be seen as a need-seeking behavior among SUD/IDD individuals instead of a mental health crisis) and should be avoided to provide equitable, coordinated care

- Standardized testing for anxiety/depression/suicide (i.e. PHQ-9, GAD, etc.) need to be adapted for different abilities, communication styles, and cognitive differences, as they currently may present barriers to accessing adequate care

12. Goal: Improve and Expand Workforce Development & Training

Reason: Oregon is facing a crisis in workforce development, especially for culturally-responsive, trauma-informed, and suicide-safe-care-trained providers. Some of the barriers include low salaries, housing costs, retention and staff turnover issues, and lack of community infrastructure and support for Black, Indigenous and People of Color. Robust training with adequate funding/incentive to support workforce development is needed for all types of behavioral health service providers, including peers, non-clinical care providers, and community members. Training must also address suicidality effectively without bias, stigma, or assumptions that could be harmful.

Recommendations:

- Suicide awareness training is well-received in communities, so it should be marketed and pushed broadly across communities. Additional considerations should be made to target training for occupations/agencies that have direct contact with vulnerable populations (i.e. food stamp offices, libraries, hotels, etc.).
- Non-MH providers and community members who have contact with individuals experiencing suicidal thoughts need more training around crisis intervention and safety planning to improve confidence and preparedness in conversations
- More understanding and training are needed in health care systems (and particularly in emergency services) regarding the intersection of MH with co-existing concerns/diagnoses, including I/DD diagnosis, substance use, pain management, trauma, and interpersonal violence. This will support matching the level of care for an individual to their level of need.
- Providers need to understand that suicidal ideation can improve, but also can still be a serious issue for those who experience thoughts chronically
- Providers would benefit from more awareness about parasuicidal and passive suicidal behaviors (i.e. restricting eating), as well as excessive risk-taking behaviors (i.e. stepping into traffic)
- Many mental health providers (including CADCs, QMHAs, and peer support professionals) do not feel qualified or willing to work with actively suicidal individuals, so more understanding and training in direct intervention and safety planning is extremely important. All licensures/accreditations should have targeted, best-practice training specific to suicide care, and should be in alignment with the requirements of HB 2315.
- ASIPP Advisory Committee should be involved in the implementation of HB 2315 to ensure that required training meet suicide risk assessment, treatment, and management best practices
- Insurance, waitlists, and other barriers exist for individuals attempting to access treatment modalities indicated for treating suicidal thoughts and behaviors (i.e. DBT, CBT, etc.)
- Data around suicide attempts/non-fatal suicide outcomes needs further understanding for application in practice
- Organizations should actively reduce concerns around liability in suicide care through education and awareness for staff

13. Goal: Identify Social Determinants of Health Among Mental Health Consumers to Improve Outcomes

Reason: Research indicates that better health outcomes result from access to safe housing, food, jobs, and transportation. Poverty strongly predicts poor health, as an individual cannot adequately address their mental health concerns without access to basic needs. Poverty is also strongly related to inequitable services and practices within the mental health realm, such as high cost to access care, limitations on services provided through OHP/Medicaid, lack of access to services in rural communities, and lack of care coordination for individuals attempting to access services.

Recommendations:

- Increase access to services that impact social determinants of health. Examples include added flexible funding, implementation of harm reduction models, such as Housing First, better nutrition, and increased awareness of resources, such as Non-emergency Medical Transportation.
- Barriers to accessing mental health services, particularly along the lines of social determinants of health (i.e. poverty, homelessness, etc.) should be eliminated.
- Resources for bilingual/bicultural consumers (translators, documents in spoken language, etc) need to be improved
- “Psychological autopsy” policies for use in suicide postvention are needed to assess root causes of suicide, update our violent death data, and inform prevention efforts
- ASIPP Advisory Committee should inform practices of Healthier Together Oregon

14. Goal: Emphasize Use of Media and Communication to Promote Hope, Healing, and Wellness

Reason: Media plays a huge role in our society and culture and impacts many facets of public perception and general knowledge. To prevent suicide and promote mental wellness, we need to be able to talk about it openly — without fear or shame. How we talk about suicide and mental health matters, as conversations and messaging must be conveyed in ways that support safety, means reduction, wellness, and recovery. Media and communications, on both macro and micro scales, have an obligation to our communities to provide consistent, caring, and normalized messaging about suicide and mental health.

Recommendations:

- Media should promote viewing suicide as both a public health issue for overall community health, as well as a behavioral health issue for people experiencing suicidality as a behavioral health challenge
- Agencies should fund/support campaigns that aim to reduce the stigma around suicide and access the right help at the right time
- Agencies and organizations should work with media outlets to promote gatekeeper training in communities to recognize signs of suicide, provide connection to appropriate service, and debunk common lay-assumptions around suicide
- Organizations need comprehensive postvention policies, including some form of sentinel event review to assess for systems barriers, trauma-informed supports for staff, and safe-messaging guidelines
 - ✦ <https://suicidology.org/reporting-recommendations>
- Requirements for postvention planning and communication should be expanded to the entire lifespan (similar to the guidelines and requirements in SB 561 for postvention response to youth suicide) to reduce the risk of suicide contagion and improve best practice responses to suicides
- All media and communications should consider accessibility needs, including language, alternate forms of distribution, and access to technology. In rural communities, communications should be tailored to the resources available in the area (i.e. flyers in a grocery store, resources at a meal site, etc.).

Appendix 3

ASIPP focus group final report

Input for the Adult Suicide Intervention and Prevention Plan with funding support from the Oregon Health Authority

Submitted by Lines for Life

www.LinesforLife.org

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This work was produced with support and accompaniment from many including the community members who participated and/or recruited participants as well as those who volunteered to moderate and advise who are listed below.

Michelle Bangen	Heather Osetereich
Jenn Fraga	Georgette Taluy
Leslie Golden	Donna Marie Drucker
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Jonathan Hankins	

Hosts: Daniell Zeigler, Denise Acker

Source: (Steve Breen / San Diego Union-Tribune)

Background

A focus group is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a non-restrictive, non-threatening environment. It is conducted with approximately 7 to 10 people by a skilled interviewer. The discussion is comfortable and often rewarding for participants as they share their ideas and perceptions. Group members influence each other by responding to ideas and comments in the discussion (adapted from Krueger 1994). Focus groups do not test hypotheses, rather they generate topics and perspectives to consider and explore further.

The Oregon Health Authority contracted with Lines for Life in the summer of 2021 to conduct virtual focus groups with seven priority populations in order to expand the number of individuals providing input to the Adult Suicide Intervention and Prevention Plan (ASIPP) and increase the representation of marginalized communities at higher statistical risk. The focus groups provided an opportunity for under-represented voices to convene as an affinity group to provide examples of their life experience that might illustrate and inform recommendations. Each focus group was a one-time 90+ minute session. The groups also considered and processed the implications of these personal experiences and shared takeaways. The hope is that these discussions will surface and include perspectives that might otherwise be overlooked. They create a formal, structured space for those who have used suicide-related programs and services to think out loud and out of the box about what might best prevent and stop suicide for each GROUP as a GROUP while distinguishing and recognizing who you are as an individual really matters too.

These focus groups are in addition to a parallel stakeholder process of volunteer workgroups that have met regularly (from approximately February to July 2021) to discuss, deliberate and propose policy recommendations on how best to address suicide statewide.

This report summarizes findings across all 8 focus groups (representing 7 populations), with recognition of and attention to the fact that there was significant within and between group diversity. Participants also submitted their individual recommendations and comments stated exactly as they wished without any intervening analysis or interpretation. Those “suggestion box” style inputs were reported to OHA in a separate document and are not included here.

The seven groups selected as a priority were identified with stakeholder input via a survey conducted by OHA.

Table 1: Focus Groups Conducted

Focus group	Date(s) held	Attendance
Attempt Survivors	4/21/2021	9
Chronic Illness Disability	6/28/2021	9
Houselessness	7/1/2021	7
LGBTQIA2S+	4/16/2021	7
Older Adults	4/9/21 and 7/6/21	9
Rural	4/26/2021	13
Veterans	4/23/2021	8
3 Participants Attended Two Groups	Total:	62

Methods

The priority was to create as safe and inclusive space as possible for those who have been directly impacted by suicide to share personal stories of life experiences, experiences often associated with social stigmas such as houselessness, involuntary commitment, suicide attempts, disability, etc. Stories were intense but not graphic – participants were asked to be thoughtful and share a level of detail appropriate for this one-time, short, virtual time together. Groups were staffed by one or two volunteer moderators who were matched to the demographic of the group (houselessness was the exception) and as possible to have visibly racially diverse moderators and hosts (the rural, veteran and LGBTQIA2S+ groups did not have a staff person of color; though all had moderators from the identity group). The rural and LGBTQIA2S+ groups did not have any participants attending who self-identified as a person of color so moderators did in fact match the ethnicities represented in those two groups.

Moderator training and the interview guide were reviewed by two independent qualitative researchers who provided feedback. These researchers attended and supported the training in addition to the Lines for Life trainer/researcher. Moderators received an electronic or mailed orientation packet that included the interview guide. The discussion of how qualitative research differed from a clinical interview (including a comparison to support groups) and the mock focus group were the aspects of training most appreciated by volunteer moderators as preparation. The interview guide is provided in the Appendix.

Table 2: Moderator Training Agenda

Time	Topic	Speaker/Trainer
2:30–2:40	Welcome and Introductions	Deb Darmata
2:40–2:50	Designing Qualitative Research	Elissa Adair
2:50–3:10	Asking Questions in Qualitative Research	Elissa Adair
	Vs. Clinical Interview	
	Guide Introduction	Heather Oseterreich
	Probe Introduction	
3:10–3:25	Question Guide Exercise and Review	Group
3:25–3:35	BREAK with your co-moderator	
3:35–4:10	Demonstration of a Large Focus Group	Group (Elissa)
4:10–4:55	BREAK Small Practice Focus Group	Breakout Rooms

Each group had a notetaker (the primary researcher, analyst and author of this report, Dr. Elissa Adair, Program Evaluator, Lines for Life who attended all groups) and a co-host (either Daniell Zeigler or Denise Acker, Lines for Life program staff who supported safety and technical issues). The OHA Adult Suicide Prevention Coordinator, Debra Darmata, attended nearly all groups and when present provided an orientation to the ASIPP development process and a thank you. The notetaker joined at the end of each group and asked for clarification/explanation if needed.

The guide had three main sections: a round-robin rating of how the state was doing in regard to suicide intervention and prevention; broad consideration of the strengths and needs of the particular demographic group as a group; and the opportunity to share and process some personal stories, especially in terms of what they demonstrated did and did not work well to address the issue of suicide.

A safety protocol was introduced at the beginning of each group with instructions as to how to access individual support via the National Suicide Prevention Lifeline or access a staff person directly via chat. Chat was also used to check-in with individuals during the group. The group was asked for permission to record and all agreed with the understanding that comments were to be kept confidential including by other group members. (NOTE: Every effort has been made to stay as close to participants' own words as possible while maintaining confidentiality. De-identified information appears in CAPS. Editing for clarity is indicated with []). Ground rules also included a request that participants stay on camera and let us know when they left the group. Nearly all groups lasted longer than the scheduled 90 minutes. While the moderator typically completed on-time, staff stayed until the participant(s) excused themselves. This “soft” closure was to make sure that there were no abrupt endings and to allow participants to end engagement at the time they personally were ready to close.

Notes were taken in excel and verified using Zoom recordings and transcripts. All information was de-identified though speaker initials were kept in the raw data file. If a speaker's perspective referenced another group that they also belonged to, that intersectionality was noted in coding. As an example, veterans were present for every population category. Quotes were coded using a category sort that tagged each comment to main themes. Themes were modified iteratively to better capture topics raised in focus groups. Every effort is made to recognize themes that resonated across groups while not discarding topics that were especially important to any one group and to explain why topics mattered. It was not possible to include all topics that were individual issues – analysis focused on themes that emerged within or across groups (at least 3 participants). The goal was to gather experiences that illustrated universal challenges and not to call out organizations for poor performance even though participants often expressed anger or dismay at the treatment they received from a particular provider. Any population-level solution suggested is mentioned (even if endorsed by fewer than three participants). Individual solutions, such as particular alternative treatments, are not reported.

The 59 individuals who participated (3 participated in two groups) are not representative of all Oregonians. Time and budget limited the total number of groups held and the depth of analysis (one group per population; one coder/analyst; 7 populations). Specific requests were made during the recruitment process and/or by participants for a group in Spanish and BIPOC group(s). An intersectional group that emerged organically in the discussion were those who had experience with the criminal justice system (including a few individuals who opted into the criminal justice system to get help with addiction). These three populations might make sense to prioritize if focus groups are conducted again in the future.

Recruitment and participation

OHA (phone calls, personal e-mails and mass e-mails), the Oregon Alliance for Suicide Prevention (newsletter e-mails) and Lines for Life (newsletter, staff and veteran outreach) circulated invitations to their networks. Participants registered at a link specific to the priority group and were asked to report their age and county of residence. Before the group occurred, registrations were reviewed and up to 26 participants were invited to attend. Attendance averaged about 50% of registrants with up to two reminders. In the few groups that were over-registered, an effort was made to select those contributing to geographic diversity. If a registrant was recognized as a member of an existing ASIPP workgroup, they were not selected as they had an existing route to provide input. If a participant expressed interest in joining a workgroup, they were given information about how to join (at least one did). The concurrent timing and similar names for the focus groups and workgroups were not ideal – participants and members were confused about which was which and these findings were not available to input into workgroup discussions.

No effort was made to screen or selectively include based on identity criteria – all recruitment materials made it clear that the groups were asking for the lived experience of this population. It was up to the individual to decide whether they fit a group and if they fit more than one which to attend. There was one group in which a person shared at the end with the group that they did not identify as a group member. In other groups, participants who typically felt they were not a “fit” either excused themselves at the start or asked the moderator privately if their experience was sufficiently appropriate to remain.

A post-survey included an open comment box in addition to collecting individual recommendations for OHA and contact information for gift card distribution. Comments were overwhelmingly positive and included: *the facilitators did an outstanding job, thank you for the opportunity, great discussion. The very few recommendations for improvement included: having a group that focuses on BIPOC as there are other experiences that I have to share that I didn't quite feel comfortable sharing in this group; more time for sharing personal stories; one member, in particular, seemed to get the most attention.*

Table 3: Age Groups of Participants

Age Group	Attendance
25-29	5
30-39	13
40-49	11
50-64	17
65 and over	11
Unknown	2
Total:	59

Table 4: Counties of Residence Represented

County	Attendance
Multnomah, Washington	21
Clackamas, Columbia, Yamhill	10
Benton, Lane, Lincoln, Linn	10
Marion	6
Deschutes, Jefferson	5
Coos, Curry, Jackson	3
Malheur	2
Hood River	1
Unknown Rural	1
Total:	59

The focus group process was successful because of the participants who chose to attend. Participants were earnest, and passionate about the topic, worked together and showed up for each other, often by sharing resources they recommended in the chat. Participants had very diverse life experiences to share – a wide range of stories were captured. Their participation increased the representation of traditionally un- and under-represented

perspectives. Their recommendations were driven by life experience. One participant summarized this sentiment in a written comment:

Being a gender queer, non-binary/trans person with several different mental health disorders (and some physical disabilities), not only is it rare to find other people who experience the same combination of “otherness”, it’s practically unimaginable that we’d be gathered into a group to be asked questions that specifically involved us, let alone that our input would actually be taken seriously. Basically, it’s nice to feel like a contributing member of the community, whose identity and unique experience are being acknowledged, embraced and specifically valued. Being seen and given a seat at the table, as highly marginalized, “fringe” members of society, is paramount to addressing the unique issues we face.

Virtual format

An effort was made to supplement in-person the virtual format for two groups: the one related to houselessness and the second group of older adults. It was felt that both groups might experience technical barriers to virtual participation. A Zoom Room at a shelter was not found. A Zoom Room at a senior center was made available but utilized by only one participant. Since Zoom was required for participation, it is likely that the most vulnerable and isolated members of these groups were not able to attend.

A total of 17 counties were represented by the 59 participants. It is likely that the virtual format allowed for wider geographic representation than in-person would.

Process improvement recommendations

The focus groups described here provide some preliminary insights from those with lived experiences related to suicide. Participants had very different levels of knowledge about suicide, its epidemiology, and the Oregon Health Authority’s programs which impacted their participation. For example, I mean I’m certainly willing to help and to serve in any way that I can. But I feel very ignorant about what we’re talking about (Attempt Survivor). Other public opinion-gathering methods may therefore deliver more actionable insights.

It is recommended that OHA

- Budget for a stakeholder involvement virtual hub and plan for ongoing input gathering through ASIPP implementation.
- Compile a list of organizations and individuals willing to serve as paid community hosts for and consumer advisors to ASIPP community-based work. Organizations could be tapped to identify appropriate consumers, host Zoom Rooms and further increase the diversity of involved stakeholders.
- Consider employing civic engagement methodologies such as deliberative polling or co-design rather than focus groups because these approaches level-set baseline knowledge by providing the same background information to everyone. This allows for group deliberation about an issue before eliciting recommendations or proposing solutions.
- Communicate data quarterly on target audiences reached with what types of intervention programs and/or educational communication campaigns with an eye to reporting year-over-year growth. Participants across groups wanted prominent, visible communications describing concrete actions that were being taken to address suicide in their group. Such information would ground focus groups in data and thus provide an invaluable springboard for future discussion.

Key findings: Groups

Findings are organized first by population and second by theme.

Attempt Survivor Group

The attempt survivors effectively delved into the logistical details of what happens before, during and after a suicidal crisis by providing descriptions of experiences and communications with 911, mobile crisis teams, emergency rooms, providers, family and friends, etc. Participants in this group thought about the pros and cons of seeking support, about the consequences of acknowledging suicidal thoughts or attempts (such as “involuntary commitment” or a “mandatory hold”) and understood what level of acuity they needed to report to get the care they sought. The diversity of experiences that precipitated a suicide attempt were very diverse and multi-factorial, relating to employment, housing, addiction, prescription changes, hospitalization for a physical health reason, childhood sexual trauma, relationship issues and multi-generational mental health conditions.

The routes to recovery described were similarly diverse and included encounters with caring strangers, a friend’s proactive intervention as well as calling for help for themselves. Their discussion included stated ambivalence about the effectiveness of mandatory holds: “. . .whether or not they should exist, I’m, I’m not so sure. Because that was a really panicky experience for me” (Attempt Survivor).

Attempt survivors were also represented in many of the other identity groups (for example, veterans, houselessness, older adults). What attempt survivors had in common across the board and where they found the connection was in their identity as survivors, a recognition that they were at risk for a future incident, and ongoing experiences with mental health care and treatment (including medication). There was acknowledgment and agreement early in this group that a suicide attempt was itself traumatizing, and that the system needed to change so it would be less so. The changes recommended were raised in multiple groups and are described in detail below: namely, the need to receive appropriate care quickly, immediate and available peer support (including in the hospital), and respite care that felt safe (hospitals often did not). Finally, attempt survivors are uniquely motivated and effective champions for suicide prevention, as one participant summarized at this group’s end: And it’s almost empowering in a way that we’re still here and that we’re that not only still here, but using that to kind of help other people so that they don’t end up in a place that we once were. [This] is extremely powerful and that really is the best resource for a lot of people like us is being able to have that person to talk to you (Attempt Survivor).

Chronic Conditions Group

Participants with ongoing mental health concerns did not all identify as having a “disability” though some did, and some managed chronic physical conditions as well. This group broadly considered the societal drivers and barriers (housing, employment, transportation) and reverberating impacts of mental health on families and communities. Discussion and comments were most like the older adult groups (which also had participants who identified as having a chronic condition) even though young and younger adults were also represented. Medication management came up as a challenge (this concern was repeated by those with chronic conditions in Rural, Attempt and Older Adult groups).

Participants spoke as recipients and as providers (peer wellness/support specialists). This group prioritized peer respite care and alternatives to hospitalization and incarceration. A number of personal experiences with emergency and residential care shared below highlighted how receiving care can itself be traumatizing. The one positive experience reported recognized this as exceptional: I finally did get help, um you know it was pretty easy for me, based upon the

fact... that I'm white and then I'm male right, and then I was a veteran so it was like the doors were already unlocked and open right and I didn't know that I needed to walk through, right I didn't know how sick I really was because denial is such a part of addiction. And I didn't know that I was suffering from PTSD and so yeah it's quite an eye-opener, I think education, obviously, is key, but there are so many barriers for so many people (Chronic Conditions). Again, the barriers reiterated and discussed in this group felt overwhelming.

Experience of Houselessness Group

This group reported the lowest overall ratings of the status quo (ones and twos). None of the participants were currently unhoused. Stories illustrated downward spirals and accruing negative experiences as well as increasing barriers to help-seeking. It was recognized that intersectionality (identification with multiple, marginalized groups) further exacerbated the societal stigma and oppression experienced by this group. This group felt that substance users and those with addictions needed sobering centers and shelters to admit them that were on par with those available to those who did not use. Participants described themselves as particularly vulnerable with a history of childhood trauma and used words like “coerced” or “strong-armed” to describe approaches to help that were in fact not helpful at all.

One participant explained the barriers faced: “You can't overcome them.” Another continued and described houselessness as follows:

*I try to explain to regular people and they're just, you know, most of them just don't get it. It is a full-time job when you're homeless to survive to get food to have shelter to get close, to get a shower to maybe get laundry, to have access to mail to hold on to your sh** like your license, or God forbid your prescriptions.*

And so I just, I just want to make that part of the barrier, clear up front that it's, it's on, you know, everything is on top of that survivability thing, and whether you're outside, or in a shelter. You're still feeling it. No matter what, you know if you're in a 50-bed shelter. You sleep, you know there's people I know that slept with their shoes on because they didn't want their shoes to get stolen (Houseless). It is exactly these challenging circumstances described by the houselessness group that it is hoped adult suicide prevention efforts might address before they occur.

LGBTQIA2S+

Ratings from this group were also low, mostly twos and threes. The primary reason for these low ratings was societal acceptance, negative stereotypes and lack of funding for targeted programs. This group focused on youth and school-based experiences more than other groups, and like the older adult group saw the benefit of intergenerational connections.

Group cohesion did not form as seamlessly as for other groups. The diversity within this community was emphasized by participants. Due to a technical issue, the moderator was not on camera. In an effort to improve what seemed inadequate group dynamics, the note-taker, whose affiliation was as the mother and ally of an LGBTQIA2S+ daughter, left the group recognizing that this as an appropriate response to the importance participants placed on an LGBTQIA2S+ identity she did not share. Shortly after, a participant stated they did not identify as LGBTQIA2S+ and left as well. Those remaining processed the participant's departure as an example of the complexity of LGBTQIA2S+ identity and how even spaces defined for LGBTQIA2S+ and described as safe might not be. Participants who had not spoken did contribute more after this participant left.

Being misgendered, not being called by their chosen name, receiving insensitive physical or mental health assessments, having their identity pathologized, and not having family support to access services were all raised as commonplace and evident barriers to help-seeking. These were some concrete examples of what the group identified as “systemic marginalization” and what it meant to be: uniquely antagonized in our society – there is not a lot of structural support for the kind of mental strain that puts on the [LGBTQIA2S+] community. Later this same participant talked about the heaviness of being an LGBTQIA2S+ person in our culture (LGBTQIA2S+). When pressed to identify solutions, the group was initially at a loss: eventually, services by and for the community, including schools and clinics designed for LGBTQIA2S+ emerged as worthwhile approaches. While peers were important to this group, it was within the context of full LGBTQIA2S+ community support and the informal connections of “mutual aid” and not as a formal peer program.

Older Adults

There were two older adult groups due to low attendance. Nearly all served in paid or volunteer roles as peer supports, had relevant professional experience, or served on committees as advocates for aging-related issues. These roles were valued, referenced in introductions or comments, and informed a conversation that centered on the important contributions older adults make to improving society and how best to tap their wisdom formally via mentoring (a term they preferred to peer support specialists or counselor) and employment. The second group felt that some mental health terms and ways of talking might prove off-putting to older adults, and not all conversations effectively translated from generation to generation. They indicated that some facilitation or training might be needed to support the intergenerational communication needed to build strong community connections and promote mental health for everyone of all ages.

The older adult groups had little visible diversity and participants noted this lack of ethnic diversity and male participation. Interestingly, older adult men were well-represented among focus groups of other identities, this identity group was not the one they chose to attend. The older adult group was one of the few groups to volunteer faith leaders and faith communities as sources of support.

Rural

The rural group was the largest with 13 participants and included a number who spoke as veterans about difficulties accessing VA services. The group proceeded at a measured, thoughtful pace with considered turn-taking. It was striking how effectively this group integrated providers and consumers, in part because of how many participants identified as both. While participants identified differences in the type of services and visibility of suicide prevention, this group coalesced around their rural identity – including the sense of close-knit community, both in the group itself and in the locations they represented.

Ratings were generally in the mid-range, with most stating a 4 or 5, though a few felt a 7 or 8 was warranted. The primary reason for lower ratings was a lack of funding and resources. Transportation, distance and isolation were recognized barriers: the main thing is just like physical distance and there’s just... you get so isolated like trying to do outreach is almost impossible because, like where do you do outreach at? Because people don’t gather a lot of times. And so, just like if I needed help like who could come and help me. Like I live 20 minutes outside of Rural like who could come and help me absolutely no one like no one could come and help me if I actually needed like a physical person here to come and help me. This group felt that stigma associated with help-seeking remained: They’re still some people, you know be like oh you’re fine just get over that sort of thing, as opposed to really asking questions and trying to get to the

root of the problem just kind of you know dust yourself off and keep going is something still in rural counties something I've noticed still being a thing, unfortunately. Lack of privacy was a related barrier in small communities. When everyone knows each other, help-seeking is much more visible (for example, others seeing where your recognizable car was parked or running into your counselor in the supermarket). Finally, the rural group was the only one to discuss postvention as an especially important component.

Veterans

The veterans' group had a strong sense of community and articulated a shared culture involving: the recognition that those opting into military service often had histories of trauma, that discharge to civilian life was both a loss and intense life transition, shared curiosity about other cultures, and how important it was that veterans trust the resources before using them. Ratings were somewhat higher than other groups — there was only one 4, and one 5; most ratings were a 6 or 7. Yet, some veterans did not see themselves as part of/eligible for the veteran community because of the particularities of their medical service: I just wanted to stop on what you just said, one of the biggest things that we're having problems with is that there are some veterans that don't consider them[selves] veterans. Because ... they're being asked, are you a veteran. Well, no, no, but if you ask them, have you served? Then they will say yes, and the reason is because they don't feel that, since they... served in peacetime they're not a veteran.

Veterans almost joked about how many niche groups existed to provide the support they sought, the challenge was finding them: I feel like that's one of the challenges that we do face is there are a large number of veteran organization and groups, some of them are public some of them are private some other volunteer, I think that's going to be one of the bigger challenges to try to tease out.

This group was one that did feel the investment in provider training was worthwhile, however, they also focused on the value of veteran-to-veteran outreach, and a few found that military leaders/supervisors open to discussing mental health were especially impactful.

Select Findings by Group

Table 5: Themes Raised Ever and Often in Each Group

Theme	Attempt Survivors	Chronic Conditions	Houselessness	LGBTQIA2S+	Older Adults	Rural	Vets
Issues and factors							
Access/Navigation	X	X	x	X	X	X	X
Visible Communications	x		x	X	x	X	X
Addictions/Substance Use	x	x	X		x	x	x
Chronic Conditions	x	x		X	X	x	x
Crisis Response	X	x			x	x	
Faith/Spirituality			x	X	x	x	
Life or Care Transitions	x	X	X	X	x	X	X
Loneliness/Isolation	x	x	x	X	X	x	x
Prejudice/Stereotypes	x	x	X	X	x	x	
Sense of Purpose/QOL	x			X	x	x	X

Theme	Attempt Survivors	Chronic Conditions	Houselessness	LGBTQIA2S+	Older Adults	Rural	Vets
Solutions							
Provider Education					x		x
Peers/Peer Respite	x	x	x	x	x	x	x
Mobile Crisis	x	x	x		x	x	
Parks/Walking/Housing	x	x			x	x	x
Service Dog		x	x				x
Intergenerational				x	x	x	
BARRIERS							
Communication	x	x			x	x	x
Technology			x		x	x	x
Transportation	x	x	x		x	x	x

x- ever mentioned; X- mentioned more often

A select number of issues and factors anticipated or arising were monitored across all groups. These topics are referenced in greater detail in relation to the themes below. Table 5 summarizes these topics. Barriers such as transportation, wifi, mobile phones and charging stations are mentioned in passing below but were seen as necessary and the first step to help-seeking.

Key findings: Themes

How Participants Rated OHA Efforts

The focus groups asked directly for participants to rate OHA efforts. “Thinking about its laws and policies, its public services and its paid employees – how well does the state of Oregon support suicide prevention and intervention among GROUP?” These ratings were intended as a conversation-starter round robin and served to clarify participant expectations. Generally, participants felt more could be done more quickly and that youth suicide prevention efforts were most visible. A few felt there was surface acknowledgment without real funded action. When asked, participants explained why they chose the ratings they did:

I give it [a] two because there’s no follow-through (Attempt Survivor). Another participant in the same group continued: There’s not a lot of follow-up. I work... in the mental health and addiction field, and we need more peer mentors, peer support specialist, recovery mentors, crisis workers. You can have all these resources, but if you’re not following up with them like what was the point. There’s pros and cons, Oregon has some of the best resource out there, OHP covers them. But yeah ... I was gonna say a 5 (Attempt Survivor). Later in this same group, successful follow-up was highlighted in chat: My peer support person is amazing and if feels like I get weekly follow-up from her. She really cares. That’s key— knowing someone cares.

[I rated it a 10]. After living in SOUTHERN CITY, where I had a suicide attempt and very, very horrific experience with the system there. And then Oregon has just been a paradise in comparison I get to see a therapist every week which. Never in my life, ... have I been able to see a therapist every week that’s just huge and last year I was suicidal I was having constant ideation and I talked to my doctor about how many pills I’d have to take in order to you know, relieve my pain and she immediately called 911 and I was sent to, sent to the emergency room then transferred to a mental hospital LOCATION.

And at first, I was really mad at my doctor, but she explained the law to me and I realized, it was her responsibility accountability oh yeah and there has been a lot and my doctor sees me as frequently as I want to see her. And we finally found a good combination of meds, medications so yeah I've been, I've been impressed (Attempt Survivor). Another participant in the same group did not call 911 but instead called a mobile crisis response team and gave Oregon a high rating because there was an option that had mental health providers and not police responders.

I would probably give Oregon a seven because I think that there's always more work that we can be doing...I also see we have a much more robust suicide prevention program which I do not see in other states that isn't to say I haven't seen older adults who have really struggles, I have had a few interactions with some older adults ... who didn't know where to go or what to do and that could be county-specific, but if we were comparing on a national scale I would give it a 7 ... specifically toward older adults. I just, I feel as if Oregon has a decent program — whether we're doing a good job of reaching our older adults, that that I think is probably where we're struggling the most (Older Adult 1).

I had rated a one because there's there's nothing that I have seen the Oregon Health Authority doing that it has to do with Suicide Prevention now if you go into Google and put in OHA Suicide Prevention, you will get the website, but you got to do that, and so I have seen no publicity out there on either a news forecast or advertising or anything that has do with Suicide Prevention from Oregon Health Authority and especially none having to do with that with older adults (Older Adult 1).

For me, that giving a three was being really generous honestly I've had lots of experiences with trying to find mental health providers and the wait is always incredibly long and also having chronic illness it's like there's trying to get in with a therapist is difficult, trying to find the right medications is difficult. It's all just they send you in circles and you don't really get the answers that you're needing and it's a really frustrating process and, by the time that you actually like when you're in the moment needing the help that you need right in that moment you're either going to be sent to like an Inpatient program or you're going to have to wait for several months just to be seen for absolutely anything (Chronic Conditions).

I did score 6. My main complaint, would be the turnover (primarily among local mental health district counselors) and that you're not able to maintain a relationship with those that you're trying to establish help from and me anytime we have actually gotten like a 45-minute wait time to have somebody respond, where I have just dialed 911 and been quite successful with the local police or the Sheriff coming, so our relationships, there are great because those, although there is turn over there, they are at least stable and show up (Rural).

Items to consider:

- Participants make direct comparisons between Oregon and other states.
- Service visibility, access and navigation were repeatedly described as needing improvement.
- In contrast, the Oregon Health Plan benefits were repeatedly described positively. The availability of peer support through the Oregon Health Plan was one important benefit.

Service Visibility, Access, Navigation and Care Coordination

All groups spoke to the challenge of finding appropriate, available help at the time it was needed. The issues were described as not knowing about services, not having enough services, not having services that match acuity, not having help to find services that were tailored specifically to them and not having services work together. Solutions when offered included specialty services such as: school counselors that specialize in LGBT youth and self-harm victims and just like someone that'll be there to listen to try and help you become the best that you can be given the circumstances (LGBTQIA2S+). When such specialized services were provided, the challenge became finding the right ones among all that

were available and then having the insurance and the appropriate level of acuity to quality and receive services (Veteran). Below are a number of examples:

I think that we're lacking resources for in between situations like that, like I wasn't quite bad enough to go to the hospital, but it wasn't really safe at home either by myself. And I'm lucky that I have family that could come and help care for me, but not everybody has that that's experiencing mental health crisis. And being turned away from hospitals and things like that to receive care just perpetuates I think the crisis that they're experiencing (Chronic Conditions).

I was lucky enough to have OHP at the time, so that I wouldn't have to pay for it, but anything I tried before that I wasn't able to get the help that I needed I had to literally tell someone that I was going to hurt myself that I was done. In order to get the help that I needed And that was the first time and that I'd ever told anybody and I had attempted three times before throughout middle school and high school and It was just I felt that I wasn't going to be listened to, that I was just going to be turned away after all of these other experiences that I had had, and I mean, I think I was like 24 at the time and It wasn't that I was just everything was just too much you know. Working two jobs and still not having enough money to help pay rent and keep my [relative] fed and making sure she could eat and there were nights I wasn't like there's not enough resources, and when you make a certain amount. Like I was making \$100 too much to be able to get food stamps so that also has a toll on your mental health like it's you can still be struggling and not qualify for certain programs, and that takes a toll on literally every aspect of your life and mental health (Chronic Conditions).

A related issue that caused significant stress was care transitions (for example to a new therapist, to a new health insurance, to a hospital or provider in a different county or state). It was felt that transitions should include a warm-handoff where everyone met together and transfer of information because as one participant explained: *I don't want to have to retell you every single freaking thing I've said in the last however many months (Chronic Conditions). The period after a "psych hold" was seen as a particularly critical transition: This conversation has me thinking a lot about the importance of like a continuity of care. I am currently kind of the safe person for one of my friends who had a similar experience with their psych hold about a month ago. And then she really refuses to enter back into care because there was a change with medication, there was a change of treatment, there was a negative experience again feeling like you know a prisoner in herself and that just continues this cycle of trauma and I just. I don't know if there's a good solution around psych holds, but there's certainly have to be better systems, so there can be communication with primary health care providers with you know their Community support specialist there just seems to be this real disconnect as a lay person helping someone in crisis navigate these systems there's just these huge disconnect so folks aren't getting continuity of care, especially when they come in and out of psych holds (Rural). The person in the group who had shared an experience of a psych hold agreed: Navigation, that was one of the biggest things for me...who to talk to achieve things... how do I work through the system...so yeah, navigator PLEASE that's, that's the hardest part (Rural).*

Clearly, infrastructure matters. For example, in rural communities, not having affordable or quality internet impeded care receipt, especially during COVID. Lack of housing creates barriers to care that are often insurmountable. As one participant explained: *I know when I was houseless a lot of the services required you to call somewhere, or to go somewhere physically, and if you didn't have access to a working cell phone at that moment, or didn't have access to transportation to get somewhere to find a group, that was really difficult. I know also accessing kind of non-urgent but more like long-term care like counseling or therapy can be really challenging if you don't have insurance or even if you have insurance if you're trying to initially set up finding someone that that you can kind of connect to for more long term weekly or bi-weekly kind of counseling. It's also been my experience that those kinds of services tend to be kind of geared towards the masses and not often specific to specific identities, so it was really hard for me to find an LGBTQIA2S+ therapist, especially one of color that*

I felt could meet my needs. And I still haven't found to this day that was both Latinx or Latino and understood LGBTQIA2S+ identities. So I think those are some of the challenges that I've experienced (Houseless).

Service animals were frequently mentioned for how helpful they were and also because of the barriers encountered go have their animals with them (in residential treatment or when finding housing): *So I think for me that that first step was getting a dog and risking it where I almost got kicked out of my apartment because I thought that I could have dogs there and then scrambling trying to go to the VA and get this emotional support letter and ... truly, knowing that people like me who get these emotional support animals like actually need them, and knowing that people have kind of, given that a bad name [is frustrating]. (Veteran).*

The rural participant quoted previously who described navigation as the “biggest thing” had experienced houselessness. They faced compounding challenges which felt like an inescapable cycle: Since then it's like wow I really ruined things for myself and so carrying that kind of guilt and you know this, this kind of the suicidal thoughts that carry over. With not being able to do what I did for a living I'm disabled and on housing now waiting on social security stuff so there's all these things that I need to be involved in in order to try to move forward, but like ..you know, access to those types of things where I've gotten in this conundrum of like well there's reasons for these things that I'm upset and depressed and anxiety and. So I have this you know real-world solutions for these real-world problems like getting this apartment was huge I was living in my car for over [could not hear] ... But it's it comes down to those real-world solutions for real-world problems, but then maybe you get stuck in this well, if I got that then I'd be happy well if I got that that I'd be happy and it's, it's just pretty wild, but I think, as far as to be able to contact people and talk yeah that's that's good. But some of the way that the suicidal thoughts are addressed at the hospital I had trouble with it, then, if you talk correctly to the psychologist than they say he's okay. And then they turn you loose and it's like okay great now I'm out of that jail, but not a lot got solved there; that's kind of my struggle. So I sit and adopt positions that I can be comfortable with and. I keep on doing all that paperwork and you know... (Rural). This story is another example of what those living in poverty and/or with disability encountered – that growth and recovery remained just out of reach.

Items to consider:

- Finding the services that fit your individual and unique needs is especially challenging.
- It is especially distressing if the services do not match the level of care needed.
- Care transitions can be as or more challenging than the initial search for care.
- If basic needs are not addressed, barriers to finding services become insurmountable.
- If past service experiences were negative, it creates barriers to future help-seeking.

Public Awareness and Communications Campaigns

There was one positive example from the rural group of a community that successfully elevated the issue of suicide through extensive outreach, social marketing, prevention training and high visibility of the National Suicide Prevention Lifeline. Most participants felt information and openness about mental health were lacking: [we] need to change the mindset that accepting help is a weakness (Veteran).

Visibility of Services

Not knowing who to call was a recurring theme (Rural, Veteran). Many felt there was insufficient communication with the public about available services and service types. The information available was often incomplete or inconsistent:

Something that I personally run into in my, you know, research into finding resources and things like that has been really challenging and it seems like agencies are kind of inconsistent in their resource sharing or knowledge even maybe, so I think being able to have those consistently given out to individuals would be more helpful for finding services that may work (Chronic Conditions). Participants often exchanged information about available services during the focus group or in chat. A few praised initiatives that raised the visibility of help available include the use of signs with phone numbers where suicides occur and other prominent locations.

Visibility of Identity Groups

Older adults, LGBTQIA2S+, and Houselessness – these three groups specifically stated that the lack of visibility of their community members in wider media negatively impacted their mental health, making them feel overlooked and ignored. It sort of felt like just the general public at large didn't see me and that if they did see me, they immediately wanted to look away (Houselessness). One school staff person called out an in-school visibility campaign that included photos of LGBTQIA2S+, names and their societal contributions as especially impactful in combating stereotypes and fostering acceptance.

Finally, direct person-to-person conversational outreach to vulnerable communities with printed materials about available services was considered essential to overcoming the many barriers to help-seeking. One vet explained: You can give pamphlets all day long but that is only going to reach a small part if any. A veteran-operated, rapport-building focus will do it faster than anything.

Items to consider:

- It is not just that information is lacking, it is also incorrect or conflicting.
- The web and telephone are used to find specific resources, often unsuccessfully.
- Prominent signage and advertising must visibly include those groups impacted.
- Direct conversation demonstrates interpersonal caring and normalizes help-seeking.

Proactive Services: Support that Comes to You and Follows-Up Over Time

A number of services (available, discontinued or proposed) were seen as effective because they proactively outreach to the person wherever they may be and include: mobile crisis, home-based care, loaner or free mobiles/IPads/computers, driving assistance, PEARLS program (<https://ccno.org/pearls/>), a discontinued gatekeeper program, drop-in centers and street outreach. These services were referenced as impactful and life-saving. They were important because they connect the ones that are obviously falling through the cracks (Veteran).

One person entered a shelter because of a flier for a homeless shelter they were given. *I wanted to feel safe. I wanted to be safe. The only thing I was looking for. I wasn't looking, I wasn't planning on getting clean I wasn't planning on changing my life I just, I just wanted to be safe feel safe for a little while, just for a little while. Um, so it through the turn of events and the programs that were offered in that shelter. I was able to get clean and sober and, you know, change my life, but absolutely the worst days of my entire life, where those last days before, as it turned out before I got clean* (Houseless). Another pointed out that when houseless, having a safe place to sleep, or someone there, while you slept, was critically important. A veteran prioritized the need for providing phones and charging stations so the houseless had the means to access services.

Mobile crisis support, generally and named specifically [CAHOOTS](#), was consistently seen as essential. *My experience has been different in different counties I had, I used to live in incorporated NAME County and the mental health crisis line, if you were in crisis they would send a counselor, along with the police. And, and the police will pretty much stay silent. And, but the counselor was absolutely wonderful and empathic, compassionate, warm, gentle soft spoken very supportive [happened about 7 years ago] (Older Adult 2).*

Follow-up outreach was also important, and especially prioritized by attempt survivors: *Just to [see] how you're doing, what can I do for you, help of navigation for resources, set up a crisis management [plan]. Also, there's a thing, where you can add it to my chart so if there was a crisis and you had to be committed and it's set to your terms. That should be really important. (Attempt Survivor). However, not everyone felt follow-up provided was appropriate. Another mention of the safety plan explained how important it was that it be more than a plan to call a crisis line (Rural/VETERAN). One participant found follow-up unwelcome: And the heaviness that is attached when you do report, so those that continue to call and check on you it's kind of like burdensome. And that you know these people and they want to know more, it feels really heavy so maybe if there was a place to drop in more often that's what I'm finding that my teens would rather have available. And I do feel like we have a QPR training moving in our area, but the funding is not necessarily there and I think that's all I wanted to add. Thank you (Rural).*

Items to consider:

- The most vulnerable need help to come to them or help to be where they already are.
- Mobile crisis response staffed by mental health providers was considered essential
- Follow-up that is readily available, better documented, and on the person's own terms is helpful.

Providers

Nearly all groups touched on their interactions with providers and described experiences as more bad than good. Experiences were with many different types of providers involved from routine primary care to 911 emergency services and police to involuntary hospitalization. These experiences summarized yield insights about provider attributes that worked well and less well in establishing rapport

Table 6: Select Words/Sentiments used to Describe Provider and Provider Interactions

More Positive Descriptors of Providers	More Negative Descriptors of Providers
nice, great someone who really cares	bitchy
Level with you	Authority figure Saying you understand when you clearly do not
Able to see the warning signs; red flags	Off-the-wall treatment recommendations Misjudging the mental health acuity
Knowledgeable, well-trained, attentive	Lack of understanding of what brings people to suicide or to ask for help
Helpful, humane	Unhelpful, terse Not being taken seriously, being made fun of
Trauma-informed, understand collaborative problem-solving	Being made to feel like added work/a burden
Authentic, Honest, Culturally Competent, Positive, Sympathetic (used to describe a peer provider)	Burdensome Heavy

The stories were heart-wrenching and moderators and participants were often visibly moved by the stories shared and chat contained expressions of support from one participant to another. After one participant described a compounding journey toward a suicidal crisis precipitated by a surgery that included cursory interactions with health and behavioral health providers at multiple time points, the moderator summarized: it was an experience of “not necessarily being heard and understood not necessarily having someone asking enough of the right questions to really be able to assess and meet you where you are right?” There was strong group agreement that this is indeed what occurs (Attempt Survivors).

In the first two years that I moved to Oregon, I had experienced a crisis and I went to the emergency room. And I told them what was going on and how I was feeling and they told me to just go home and just find somewhere else to be that I wasn't bad enough to be given any treatment or hospitalized or even any medication to help me just come down off of the crisis mindset that I was in. And they had me leave the hospital with no support nowhere to go no meds and it was only because I happen to have the privilege of a friend who had enough room to have me for a weekend that I survived that experience. The lack of community care and people in the hospital really understanding what brings people to ask for help and providing that help with compassion and empathy was shocking (Chronic Conditions).

In that same group, another participant's story received verbal and written confirmation from other group members as an accurate, relatable description of what they also experienced. *I hear you know people talking about you know, trying to get help. And throughout my many, many years of being suicidal off and on I have tried to get help. And I just wanted to just kind of clarify, I guess, for me, what that help in the traditional healthcare system looked like so. I had a crisis, I went into what I thought would be the closest place to get help, help for that crisis and what I ended up with were a bunch of bitchy nurses and doctors who were very upset that I was there wasting their time as someone who would be you know so brazen as to want to give away their precious life, you know when there were people there with real problems, who wanted to live. And you sit and you sit and you sit for hours and hours with nothing happening, just spinning in your thoughts until eventually, someone comes in with some sort of medication generally they don't even tell you what this is and say here you go this will help you. You know, relax or or you know... then they leave again and you sit and you sit and you just sit and you wait and then eventually. If it's bad enough it's been determined by the few questions that they do ask if it's been determined that it's bad enough, eventually, a TV will be brought in so that you can be interviewed via Tele health by someone who gives no sh*** asking basically the questions that they have to ask to decide whether or not to put a hold on you. When they decide to put a hold on you, the atmosphere changes drastically. So, once they decided to put a hold on you, then you're going wherever ... they've decided to determine that they have a bed open to send you and you get transported, you know, police-style to wherever the place is and it's usually just some kind of crumbling understaffed you know clinical holding tank. Where again nobody tries to talk to you, and then they put you through this admissions process that's completely invasive. With people, you don't know and you're just sent off to some, to a room to lay there and wait for some sort of services and what's happened to me, every time I sit in these places for two or three days and I realize there's nothing here that's going to fucking help me there's nobody here that wants to help I need to pretend that I'm okay so I can at least get my freedom back and go kill myself, like, I want to or move on with my life, again, as I think I may be able to for the next little while that's what services have always looked like to me. And that does nothing to help anybody who's suicidal other than just push pause and give time for you to change your own mind. And it's disgusting it's worthless, and so I don't even try anymore, when I have these issues, I realized that I'm up against either I'm going to kill myself or my support system will help me reel that in and do what I need to do to get back on track, but that's the system to help. [It] is no help at all (Chronic Conditions).*

One loss survivor summed up stories such as these by saying: *something that really needs to be changed is treating mental illness, like a crime (Rural)*. There was resounding group support for this sentiment.

Again, provider transitions arose as a source of stress. *I mean anytime I'm on like Facebook and see people asking for recommendations for you know providers that are going to understand them, [this LGBTQIA2S+ specialty clinic] it's really heavily recommended just because you know it's, it's a place people can go and you know, hopefully, are going to be like seen and heard as a whole person, and you know you don't have to play like provider roulette where you don't know the level of competency from the provider you're going to be getting. Which yeah I mean I've had I've unfortunately had every time I find a good provider, it seems like they moved out of state. Like every time I find a provider that I'm just like oh my God you, you understand me like you're queer and trans competent and you actually know about how to manage you know my medical needs, you know I'll see him for like a month [until] like oh yeah I'm moving like okay back to the drawing board (LGBTQIA2S+).*

Participants who worked closely with providers shared their vantage point: *I see a lot of secondary traumatic stress, I see a lot of burnout and it leads people to behave in ways towards others and I'm talking about staff, lead staff, in all types of situations all types of first responders, to treat the residents here poorly at times. And I've seen it in other situations at other agencies and other places where people are you know in crisis situations regularly, and I think that you know the proper training, I think schedule flexibility [another participant added in chat – more part-time positions]. I think that you know generous time off for folks who work in these type of situations would really go a long way towards helping folks be able to come back and bring their most empathic self when they come to work so that they can actually build relationships and rapport with people as they should be, in order to help you know with healing. I think that would really be helpful (Chronic Conditions).*

Items to consider:

- Provider transitions were a significant source of stress; staff turnover was an identified problem.
- There are recognized power differentials and dynamics that are described as damaging.
- Addressing those inequities, and making care more humane, would require a system overhaul.

Family and Friends

It is striking that family and friends arose with diverse sentiments and descriptions within and across groups. They were identified as a protective factor, particularly spouses for older men (Older Adult 1). They were also associated with a stigmatizing attitude in that some felt that many older adults believed professional mental health services were for those who did not have family or friends to support them (Older Adult 1). Multiple groups raised the added challenges that arose when family or friends are not supportive of an individual or their problems (LGBTQIA2S+, Older Adult 2, ADD). When family and friends contributed in positive ways it was primarily by being someone to talk with, someone who could relate: *I've had a few incidents, with some of my friends and I think just paying attention to the red flags like I had a buddy that was just giving away all his stuff, and I mean that was a huge red flag like catching them before they you know just talking to somebody and being there for support like I heard it around here. You know having that Somebody with related experience [that] doesn't feel like they're an authority figure like THAT can save somebody's life, and I mean that, like my friend, like just talking to somebody that that can pull them off the edge when they are wanting to jump off (Attempt Survivors).* Suicide prevention training was mentioned, particularly Mental Health First Aid, as helpful for motivating intervening before the crisis occurs.

A BIPOC veteran who described their experience with fellow service members in crisis, when asked talked about why cultural differences mattered: *A common thread that feels safe is that that small intimate relationship more than something brought in, I think it's on the small intimate scale where people can feel comfortable really just saying how*

they feel and you know others not being afraid yeah because you know so much is hidden yeah um yeah, so it's still on a small intimate scale (Attempt Survivors).

When actually [a person] shouldn't have to say, those [words I am thinking of suicide] we should be watching and watching the symptoms and the signs and we should be more aware of what [person] is going through right. We should be more attuned. To the symptoms, just like we should be when someone's having a heart attack or a stroke, and we should be more present to what [person] is going through and I, just it's society, and it goes back to your first question and it's about [how] society needs to change (Chronic Conditions).

Two individuals in different groups (Older Adults, Chronic Conditions) mentioned that their right to choose suicide for a mental health condition was important to them. One reason given to choose death was insufficient familial support for those impacted by a loved one's mental illness.

I really feel like the death with dignity laws should include allowing people who have dealt with suicidal ideation for years and have never been able to get help and have never been able to get the the services that they need that that we should have the option to have a death with dignity and have the plan. With support so that it's not leaving a traumatic experience behind for other people like you know. What happens afterwards, you know I've also had friends and family take their lives, so I know what happens afterwards and it doesn't need to be that way for survivors and it doesn't need to be that way for the people that have to struggle with this. What is often a terminal illness and looked at in a way that it's not the same as cancer or the host of other terminal illnesses that put people through so much pain and suffering before they're finally able to let go of their bodies like yeah this isn't fair. You have access to wrap-around care for family care so that I can go and get help and know that my daughter is going to be taken care of and if you're not gonna let me bring my dog that he is going to be taken care of that my husband is going to be taken care of like how are they taking care of the people around me who are affected by my illness that is not even considered in those plans so that's just another missing piece that needs to be part of the discussion when we talk about solutions yeah. Thank you so much, I really do appreciate that and your willingness to talk through all that I appreciate it so much thank you (Chronic Illness).

Items to consider:

- The families of those with mental health concerns require support and services.
- The care, connection and attention of family and friends are often, but not always, supportive.
- It was felt that the community working together best supported mental health care.
- The weight of being a “burden” to others exacerbates living with a mental health concern.

Peer Support Services

Peer support services were consistently identified in all groups as most important for suicide prevention including crisis support, hospital visits, recovery, relapse prevention, and navigation/advocacy. Peer support benefited those receiving and those delivering services.

And honestly, to speak very candidly I think peer support is what saved my life because then I started peer-supporting other people. And it just like teaching that kind of person, person-centered outreach. I just sort of started peer-supporting myself too I guess (Houselessness).

To be effective, peer support is needed to function on equal footing and in coordination with providers. A few participants shared stories that demonstrated provider disrespect for peers. It was clear that the use of and access to peers varies greatly by location. However, generally, participants saw peers becoming better integrated into the behavioral health

workforce. One participant employed as a peer explained his vantage point when asked to rate OHA overall:

When I started here in NAME I think I was one of three peers and they had so little idea what to do with me, my first assignment was organizing the storage room. Now it is quite the opposite. So I've seen things like that it's really nice, we have a new 24-hour crisis Center. We have policies in place where, if we do have any of our folks end up at the emergency room for mental health crisis we are notified within a couple hours and our policy is to have at least one member of their mental health team, make contact with them within 24 hours or next business day in case it happens over the weekend. I've seen a lot of things coming into place a lot more suicide training. We have plenty of training already, but there have been in the last probably three or four years there's been a huge uptick in the number of those available trainings and opportunities for years, and some of our clients even to speak to our entire program so all the whole behavioral health program. So I think my, I've been seeing a heading the right direction, I definitely wish there was a lot more, to put a six (rating) is it. I would be on the fence some good some bad, but I see trending more towards good. (Chronic Conditions).

The following quotes illustrate how peer support works in practice and why it has a great impact.

There's just a normalization that happens there around peers like around here like [in this focus group]. Nobody is in this room is saying Oh, my goodness, I can't believe you attempted, you know there's no feeling of how like giant and horrendous it is, obviously loss of life is a big deal. But if you've lived it, you know that it's a few bad steps away and it's not something that should be like yeah horrifying to people (Attempt Survivor).

She got her bachelor's degree when she was 50 and I think her master's degree [at] 57. She has multiple health issues right now, including ambulatory problems. And boy, she is really on top of things. And, you know, she's working in a paid job she's not, she's not a volunteer, She's being paid and is really valuable. And for now, when we hired her [as a peer support specialist] I thought, boy, if anyone has seen her as a client seen her as a provider. I can't imagine anyone would be able to have more physical things to complain about and they see this. This peer provider. It's like, it puts everything in perspective it's like she's out there doing it. And she had she's tremendously supportive of other people, and she really. She's just you know, she's just so impressive (Older Adult 2).

From chat: *As peers we can also see the warning signs in such a different way. Rather than a trained clinical checklist of the warning signs, we can predict behaviors as attempt survivors as others cannot that easily (Attempt Survivors).*

A friend got involved ... and then ... basically forced me to go to a hospital... And that, I mean to this day that's still what saved me right, like that that peer interaction having Community having a person that was invested in my life and I think that yeah for me like peer services would have been huge ... Even if I had had care in that case, if they didn't bring a peer to me who understood, what I was going through who didn't see themselves above me then I yeah and wouldn't [the only peer support they had was the peer who got them to the hospital, to begin with) — that support would have been useful (Attempt Survivors).

Peer support was consistently and repeatedly raised as the one most important step to prevent and address suicide.

Items to consider:

- Peer support is appropriate throughout the continuum of care from diagnosis, hospitalization, follow-up, maintenance and through to becoming a peer counselor oneself.
- Peer specialists and counselors need ongoing support and follow-up themselves.
- Peers bring perspectives providers lack. Providers do not always recognize their value.

Sense of Purpose/Quality of Life/Self-Actualization

Participants recognized that suicide is impacted by both community and individual factors. *[If] people don't feel their life is at least sometimes worthwhile or pleasant, then they're more likely to be looking at leaving the earth (Older Adult 2).* Factors that contribute to the quality of life included meaningful paid work, built environment including accessible outdoor paths and parks, and other community gathering spaces that facilitate conversation and housing (Older Adults, Rural, LGBTQIA2S+).

If we can build programs and build, you know, housing and facilities that make it easier for people to get together and. And if we, if we start changing the stereotypes of what older adults can and cannot do. Then things, things I think will get better, and also with you know You know if people start feeling more at home discussing various kinds of impediments, substance use, addiction, similar to yours (referring to a personal story shared in this group). There, there are a lot of ways that people with lived experience can connect with other people that are just, we're just in the beginning of [that] right now (Older Adult 2).

Systemic marginalization was identified as an ongoing stressor (best articulated in the LGBTQIA2S+ group) that leads to epidemic levels of suicide. Participants knew that addressing such oppression was both challenging and essential. Micro-aggressions and marginalization (for example, lack of acceptance or visibility) decreased quality of life and self-actualization. Conversion therapy and therapists with a faith-based orientation that denied queer identities were seen as especially damaging.

Psycho-educational solutions that broadly address and build protective factors were also referenced as important. Better understanding how the brain and body function helped those experiencing suicidal thoughts manage those feelings: *There was also this part of my brain that compulsively thought about suicide. And that sometimes that wasn't true I didn't actually want to die, but I was it was such a part of my experience, I remember, just like super random but like I would have these moments, where I had a great day, I was great I was like oh, I gotta go wash my hands (referring to an obsessive compulsion). . . . I should die today, you know, like just that. Like where did that come from? And just somebody having that piece of information to tell me like question your thoughts question actually if you really want this Is this true Is this true for you today? and what do you do to combat that? (Attempt Survivor). This psycho-education might help address those coming from a place of feeling they are not good enough, not worthy enough (Veteran) not strong enough (a different veteran who shared a story of military sexual trauma). The articulated goal is to help develop a shared understanding that vulnerability is now a strength, that we can all come together (Veteran). It might also help address denial (which came up only a few times): I don't have any problems... it's everyone else. The way I am is normal (Veteran).*

The stories shared by veterans in the veterans' group include some action steps taken by veterans to achieve self-actualization: *I went back home to STATE and. . . . It was a really rough time because there was no, no support I lost the brotherhood from the BRANCH or I didn't have friends, because they all moved off did their own things, and so I was just in a dark hole and that's why. I mean, like, I guess, I feel like it's all in that person's head because I decided to take my route, you know the pursuit of happiness, to get out of that Funk, like, I thought, if I stayed in STATE I wouldn't make it past a certain age, so that's why I decided to come to Oregon. And you know pursuit of happiness for myself (Veteran).* Contact with the criminal justice system, one participant indicated they turned themselves in, also proved a turning point. Others talked about going to school This group demonstrated in chat and on video their admiration for each other and their humility in the face of what they had managed to survive: *I say that to say that you know. Even dark times. You live dark times there's likely a little light in the jungle. I mean. And I saw the light and I said, you know what I need to go through this I need to go through life.: I got a job at ORGANIZATION after working with ORGANIZATION services. I enrolled in NAMI*

last week, two weeks ago. I got accepted last week that's their big that's that's the I got accepted for veterans support peer support specialist training... and I'll get my certificate and: I just want to say, I just want to say, congratulations to everybody this group, [you've all] come a long way. No stop now. And you know man. I mean I've only I've only been clean for like three and a half years close to a little more three years but I'm looking forward to doing it longer than that. I'm looking forward to to living my life in, you know better, and enjoy the rest of my life and I got a granddaughter being just came in the world... (Veteran)

Opportunities for Self-Improvement and Post-Traumatic Growth

Very occasionally participants referred to how their own outlooks had advanced since a crisis and what helped them achieve those advances. These included finding empowerment through peer support or advocacy roles as well as coming to recognize the ongoing nature of their mental health concerns.

[The moderator was] saying that even peer support specialists need help, sometimes, well that's the beauty of peer support that we have lived experience and people can identify with us or relate to us, and we can share our painful experiences and, and how we got through them how we can, how we healed and came through the other side. And our peers and our peers can support us. Mm-hmm. And, and so that they can have that feeling of being of help in society (Older Adult 2).

And when I brought those things up, I was looked at, I wasn't really responded to. And I believe that that was just indicative of what happens in our society with older adults. You know, people will be polite and listen to us momentarily. And then they kind of go on about their business and say well you know it's an old person and what do they know. So I'm here. And I want it said I want. I want older adults to have a voice [or seat at the table affirms moderator, really, the table]. And I want more discussion from those, including myself, who have had suicide attempts about that process. Not what some agency can do for me or what, but how can I help myself, what, what do I need to build to build me (Older Adult 1).

The houselessness group talked about the importance of “[radical acceptance](#)” in their recovery, summarizing it succinctly as: *Accept the fact that there are things that are just beyond your sphere of influence if you will, and that it's not personal it just, I don't really like to saying — it is what it is, but that sort of covers it (Houselessness).*

Self-acceptance was also described as part of growth and recovery. *I think that actually in my last attempt um I had spent probably a couple years at this point convincing myself whether or not I knew that it was never going to happen again and that I was never going to get into that state again because of whatever fairytale I was living in but, now I'm very aware of that and, being aware that it might happen again makes me more equipped to stop to prevent it, and also, I think, somebody else doing that you know... Because it's a huge fall, the huge fall to think I'm never going to be here again, and then it hitting you, and that makes you want to give up [on life] a whole lot more... (Attempt Survivor).*

These comments existed in parallel to a recognition that societal barriers also impede growth and recovery, for example: *the means testing [to receive benefits such as SNAP – Supplemental Nutrition Assistance Program] requires people with disabilities to stay super poor... you could still be poor and not qualify, so I don't think that requiring people with disabilities to stay poor actually allows any of us to get better or get ahead (Chronic Conditions).* This participant continued in chat: *I just wanted to add that at-will employment and the housing situation ... [favors] landlords and developers and disadvantages people with disabilities.* Another recommendation posted in chat in this group was for state authorities to assure that landlords who evicted tenants without cause pay a lump-sum to help with re-location (it was stated that this was thought to be legally required). Societal supports and circumstances, and not just individual actions and attitudes, lead to growth and recovery.

Items to consider:

- Physiological, neurological, and historical understanding (psycho-education) helped.
- A goal stated by participants is to live a better, happy, more fulfilling life.
- There was a nuanced sense of the importance of and limits to self-determination.
- Systemic marginalization, oppression and inequity – all impede recovery and growth.
- Serving in peer support and advocacy roles to address such impediments helped.

Final Content Notes

Although moderators and participants did touch on the COVID pandemic and its implications for mental health, the discussion was limited. Increased access to virtual services, however, was seen positively.

Insurance coverage was often identified as a barrier to receiving preventative physical and mental health care and continuity of services.

Conclusions

Suicide is multi-layered and multi-factorial impacting individuals, families, and communities. The significant societal transformation toward a more equitable system in which everyone is valued, contributes, and has economic, housing and food security will lead to community connectedness and individual sense of purpose that prevents suicide. The health care system's current focus on responding to an acute crisis does not support recovery and growth as people are struggling with multi-generational, chronic, and recurring mental health concerns. Participants called for a system overhaul not just specific policy changes. Importantly, they were looking for evident, reported change and progress as they felt there was more talk than action.

Key Takeaways

Key takeaways were reiterated across multiple groups. To clarify, provider education, for example, is not listed, because one group (LGBTQIA2S+) discussed how even educated providers did not deliver acceptable care.

Everyone must be attune to warning signs

The ability to identify warning signs was seen as a broad community responsibility. There was dismay at how often warning signs (in themselves and others) were disregarded, under-estimated or missed. It was not okay to simply identify warning signs – it was important that there was a plan for follow-up and that whoever helped to identify a warning sign continued to check in and follow-up over time. Smaller, grassroots, community organizations were seen as important and potential hosts for training such as Mental Health First Aid and ASIST.

Implement changes that create intergenerational community connections

LGBTQIA2S+, Older Adults, Rural – these groups thought prevention, not just programs but also urban, park and housing design would have the most impact and the greatest reach when young people (through school programming such as mentoring or community events) worked collaboratively with adult and older adult community members. Achieving the productive intergenerational dialogue envisioned may require training, facilitation and practice.

Raise awareness; improve visibility of services and resources; include those who use them

Participants commented that they felt invisible and not heard – both as a member of their identity group and as a person with a mental health concern – it was important to see oneself represented, included and publicly visible in communications and improvement efforts. Another phrase a veteran used was “being put on a back burner.” When stigma and stereotypes did arise as public perceptions important to combat, participants prioritized a need for prominent communications that were accessible, understandable, educational, and consistent (same message from all sources) for those seeking mental health assistance either for themselves or a friend/family member. It was felt this information would be best communicated person-to-person by a peer who could help navigate and problem-solve and really see them as individuals. Finally, many participants benefited from a psycho-educational understanding of their own mental health condition and felt this understanding was one way to develop the “radical acceptance” they felt recovery required.

Expand the current behavioral health workforce with peer support specialists

Peer support services were consistently identified in all groups as most important for suicide prevention including crisis support, hospital visits, recovery, relapse prevention (including having a peer support specialist you are working with listed in your safety plan to call in a future crisis), and navigation/advocacy. Peers were also seen as providing ongoing group support to each other and helpful roles for those in recovery and/or managing chronic mental health concerns (it works “two-ways”). It is recommended that the number of peer support specialists be increased and that their services be easy to access at any point and free/covered by insurance and that these roles be defined to be protective of these workers themselves (flexible schedules, for example). OHA should report on the number of active peers and their caseloads by geographic region to monitor for increased availability of their services.

The LGBTQIA2S+ and Veterans groups espoused more informal, typically self-funded models of community-driven mutual aid as compared to formal peer specialists. Older adults preferred the term “mentor.” Peer support likely takes distinctly different forms to serve different communities.

Reward providers who stay in their roles, especially those working in rural areas

While nearly all groups mentioned provider burnout, turnover and subsequent care transitions as a problem, the rural group suggested that providers be rewarded for staying in place and that these rewards should include both direct incentives (competitive salaries and flexible schedules) as well as indirect community-wide enhancements (more livable cities, better schools, improved green spaces) that made living in a location desirable. Such enhancements would have mental health benefits for all.

Expand community mobile crisis response teams and drop-in centers staffed by peers and mental health providers as alternatives to 911 and emergency rooms

All groups discussed poor experiences receiving treatment in emergency rooms and hospitals. Most groups also shared at least one experience related to the use of mobile crisis teams staffed by mental health providers that did or did not also include police as first responders. These mobile crisis response teams, an example is CAHOOTS in Eugene, were seen as more effective and less traumatizing alternatives to calling 911. While the rural group had examples of supportive involvement of police officers during a mental health crisis, other groups (Attempt Survivors, Chronic Conditions, Older Adults) expressed reluctance to involve police or negative experiences when police were involved.

Address mandatory hospitalization

Less restrictive alternatives to mandatory hospitalization (including peer respite care) should be more readily available. There were doubts raised as to the effectiveness of in-patient “mandatory holds” and a request by one participant to revisit policies to be followed for those in mental health crisis to determine if those policies were in fact helpful. The discussion focused on how even the thought of a mandatory hold was a barrier to seeking care. Nearly all who experienced a mandatory hold felt that the commitment experience itself exacerbated rather than addressed the crisis. A utilization review that looks at re-admission and suicide rates subsequent to a mandatory hold and a forensic review of whether and when a mandatory hold might have prevented a completed suicide are both recommended. The [OHA website](#) should be updated to include links to [NAMI](#) and provide alternatives that might negate the need for in-patient, civil commitment.

Address houselessness before it occurs

Increase the number and types of affordable housing available. Design affordable housing to foster community connection. Make safe, secure temporary housing available when needed for the short-term (even a few days can be restorative). Provide benefits that reduce the mental health consequences of housing transitions. Safe, secure housing was described as four walls and a locked door (but even just a door would suffice). Suicide prevention requires that people have and retain a place to live; a goal of suicide prevention is to reduce the number of individuals currently or ever unsheltered in Oregon. Such efforts must be inclusive and supportive of those with substance use disorder. Once houselessness does occur, proactive services that come to you and follow-up are required as barriers to self-help seeking for those who are houseless are numerous and overwhelming.

Expand follow-up care, post-crisis and beyond

Follow-up should occur after any mental health concern is raised with a provider, including caring contacts after hospitalization. Follow-up was identified as an important, effective strategy to check on people before a crisis happens and after a crisis occurs. Follow-up facilitates treatment engagement and supports long-term recovery: creating a healing connection and a mindset that sees care as continuous and not episodic or acute. Insurance coverage may need to change in order to support this broader, preventative continuum of care. It is recommended that (1) peer specialists provide follow-up as possible/appropriate; (2) that follow-up be readily available upon request (not required) of a person, family member or provider and not limited to post-discharge; and (3) follow-up includes a safety plan that identifies and documents a service acceptable to the person to use in future if needed. These care preferences might be compiled to better align offerings to demand.

Recommendations

These additional recommendations derive from participant comments but were not stated group takeaways.

Compile and report patient satisfaction measures

OHA should monitor and report patient satisfaction with mental health and crisis response services and work to achieve consistent and continuous empathic and effective mental health care. Participants described care encounters (with health and behavioral providers, both out-patient and in-patient) that exacerbated their vulnerable state. Participants wanted care that was individualized because providers communicated openly, asked questions, and assessed thoroughly. Participants wanted care that was appropriate to their acuity, provided treatment options that suited them, and that was accepting, calming, and normalizing. Combined, all these factors created the sense of safety and security needed to rest, recover, and heal.

Create a 24/7 telehealth crisis response team designed for and by LGBTQIA2S+

The LGBTQIA2S+ group talked about the need for clinics and schools designed for LGBTQIA2S+. The stories this group shared were mostly about receiving culturally demeaning emergency services. Rural residents faced further challenges. It is therefore recommended that the solutions identified as worthwhile approaches to clinics and schools be applied to create a telehealth crisis response team designed for and by LGBTQIA2S+.

Appendix 4

ASIPP Development: Methodology

The ASIPP: Methods for developing the plan

The ASIPP was developed over a period of approximately two years with much of the work centered on gathering community and partner input with a series of feedback loops. Over 130 Oregonians helped to create this plan. Input and feedback were gathered from across Oregon through the following:

- A large and engaged group of 130 partners representing 68 organizations met monthly
 - In terms of race and ethnicity, the group included proportionally more people of color than Oregon's population, though still 82 percent white. Other demographics were much more diverse, such as sexual orientation, gender identity and formal education. For more detail on group demographics, see [Appendix I](#).
- Several small workgroups that were predominately made up of members from the large partner group.
 - 70 percent of large partner group members participated in one or more small workgroups
 - Approximately 10 percent of the small workgroup participants did not attend the large group meetings
- Focus groups which included persons who identify as LGBTQIA2S+, persons with chronic illnesses or disabilities, attempt survivors, persons residing in rural communities, persons experiencing housing insecurities, older adults and veterans
- Two surveys which included county suicide prevention coordinators and members of suicide prevention coalitions and councils throughout the state, and
- A Tribal consultation.
 - In an ongoing effort to consult with the nine federally-recognized Tribes of Oregon and confer with the Urban Indian Health Program on issues that may affect Tribes and the health of their members, a letter detailing the ASIPP development was sent out.

Large partner group – This group met monthly with the purpose of reviewing the work of the small workgroups and providing feedback. The large partner group was integral to moving the recommendations made by the small workgroups onward into the plan. This process was accomplished through discussions and voting. The large group met a total of 14 times with an average attendance of 33 participants per meeting.

Small workgroups – 10 smaller workgroups were developed based on specific risk factors, populations that have disparate rates of suicide or populations that have been historically excluded. These included:

- LGBTQIA2S+
- Ages 18–24
- Construction industry workers
- Veterans and military-connected personnel
- Older adults
- Disabilities and chronic illness
- Black, Indigenous and people of color (BIPOC) and American Indian/Alaska Native (AI/AN)
- Men, and
- Rural and remote areas

Each small workgroup met over a period of several months and was charged with creating a list of recommendations specific to that population to be considered for the ASIPP. The recommendations were based on:

- A literature review
- Discussion, and
- Each member and group's own expertise which often included lived experience.

The small workgroup membership was self-selected based on interest except for the BIPOC and AI/AN group, which included only those who identify as BIPOC or AI/AN. All other groups were open. For example, members did not have to identify as LGBTQIA2S+ or be an older adult to participate in those respective workgroups. It is recognized that all people have intersectional identities and may fit into several of these groups. All small workgroups were encouraged to collaborate with other small workgroups with intersectional identities in mind.

There were three other focused workgroups that were important to ASIPP development:

- Means matter
- Mental health systems
- Lived experience, and
- Equity

The mental health systems small workgroup participants were a combination of behavioral health care workers (psychologists, counselors, therapists, social workers, etc.) and consumers of behavioral health care care. The group was tasked with making recommendations for the ASIPP regarding improving mental health care systems and practices in Oregon.

Appendix 5

Lived Experience

ASIPP Lived Experience Values / Framework

Types of Lived Experience with Suicide

1. Lived Self Experience
 - a.) Including first time-, episodic- and/or chronic- thoughts, urges, actions.
 - b.) This includes people with lived experience regardless of whether or not someone has received treatment or a formal diagnosis.
2. Lived Supporter Experience
 - a.) Formal / informal support for someone with lived self-experience or lived loss.
 - b.) These supports could be trained professionals, trained gatekeepers, unpaid helpers, or voluntary empathic care.
3. Lived Loss Survivor Experience
 - a.) Someone who has a personal loss of someone they know to suicide.
 - b.) Someone who has lost someone to suicide in a professional capacity.
 - c.) Someone who has been exposed to a suicide loss in any capacity, such as the loss of a loved celebrity or public figure.

For all of these identities, we acknowledge the entire spectrum of experiences and know that not everyone will fit into the above categories.

Values

1. Nothing about us without us.
2. Self-determination. We have autonomy and choice around our treatment. For example, I am able to decide who I choose to see and am receiving the treatment I selected.
3. We are respected as the expert in our life; we're believed when we share our story. For example, no gaslighting. No condescension.
4. Right to confidentiality. Our information is only shared with who we choose, how we choose and when we choose to share.
5. We have the right to access and preserve our charts and notes. We want to be able to review and annotate our chart to ensure accuracy.
6. We have the right receive support and treatment without judgement. People are seen as individuals and not their diagnosis. I may have schizophrenia but I'm not "a schizophrenic". I'm many things and although I may be impacted by my diagnosis, I'm not my diagnosis.
7. Our identities are respected, and services are individually and culturally responsive.
8. Services should be accessible and equitable to all. For example, materials should be offered in different formats and languages, and in plain language. When technical terms must be used, a glossary should be included. We need physical access to services for those with physical, cognitive, and other disabilities.
9. Providers and programs are trauma informed, trauma free, and trauma responsive. Safe spaces should be created for people to share their experiences and truth.
10. The harm-reduction approach should be widely implemented among providers. We should not be excluded from treatment or services due to any substance use concerns. We should not be excluded from services for "not getting better" on "your timeline".

Appendix 6

Equity tool for Oregon's Adult suicide intervention and prevention plan (ASIPP)

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

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

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

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

Standards and expectations valued by dominant cultures contribute to high rates of suicide in both social identity groups that are harmed and not helped, as well as those that have easy open access to help and prevention as a result of their social identities. While high-risk populations may be identified as the groups with the largest represented demographic in suicide (i.e. veterans, White-males, LGBTQI+, construction workers), those numbers do not automatically situate suicide in discussions of equity. Naming the largest group populations is not the same as identifying groups that have been impacted by harm and blocked access to help as a result of their race, sex, class, age, ability, language and sexuality. Most importantly, in an equity lens we must look at high-risk populations with a lens toward their social identities and systems that have impacted their risk for suicide rather than solely a lens of individualism.

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

Core concepts

- The reasons people die by suicide are complex and rooted in the context of dominant culture.
- Suicide prevention is about changing our beliefs, values, practices, and policies from an individual lens on suicide to a culturally contextualized lens.
- Disparities strongly and systematically exist for individuals and groups with certain social identities and/or group characteristics.
- Social identities are gender, race, ethnicity, social class, wealth, educational attainment, religion, sexual orientation, ability, age, language, housing status, immigration status, veteran status, geographical location, and specific professions i.e., military/service members, police officers/first responders, etc.
- While high-risk populations may be identified as the groups with the largest represented demographic in suicide, it is not the same as identifying groups that have been impacted by forms of oppression, including racism, sexism, classism, ageism, ableism, homo- and transphobia, and linguicism.
- Most importantly, in an equity lens, we must consider high-risk populations in the context of their social identities and systems that have impacted their risk for suicide, rather than individual characteristics alone.

Equity Principles And Reflection Questions

Principle 1

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

Questions to be answered by small groups

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

Examples

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

Principle 2

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

Questions to be answered by small groups

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

Examples

- Changing requirements by funders that only provide “evidence-based” or known programming to include community-based, localized approaches
- Not assuming that a behavioral health intervention is always the best way to prevent suicide
- Black communities may practice “other-mothering” which is the idea that all kids within the community are raised by all the adults
- Familism of Mexican-American families that the family is more important than the individual
- LGBTQI+ creating families not defined by blood alone
- “Leave No Man Behind” or “No Veteran Stands Alone” mentality from the military so they work to support each other
- Community affinity groups (Black Lives Matter, Gay Men’s Chorus, Movimiento Estudiantil Chicano de Aztlán, churches, Alcoholics Anonymous, American Association of University Women, Veterans of Foreign War)
- “Street Smarts” among the homeless about how to navigate agencies and create a community with people who will watch out for them
- Asian Americans live in multigenerational households in which elders teach and support younger generations
- “The Talk” of older generations speaking frankly with young people about racism and how to protect themselves from police violence

Principle 3

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

Questions to be answered by small groups

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

Examples

- A service intended for a particular social identity also meets the needs of an individual's other salient identities
- A person of faith finding support in a community that also supports their LGBTQIA2S+ identity
- A veteran can find a person who understands military service even if they live in a rural community
- An older Spanish-speaking adult receives services in Spanish that incorporate the familial context of their multi-generational home
- An undocumented person experiencing housing insecurity is able to access services in a way that protects their anonymity
- Prevention and intervention designed for a broad category of men may not take into account the harm and lack of access for a Mexican-American male who only speaks Spanish (race, gender, and language).

Principle 4

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

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

Questions to be answered by small groups

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

Examples

- Including questions about culture at all levels of assessment and in the interpretation of assessments to avoid mislabeling, misdiagnosing, and/or mistreating (Individual Level)
- A White mental health provider exploring the impact of racism or the social support network of a Black client rather than focusing solely on strategies like gratitude and mindfulness that are common or well-accepted by White/Western culture, and that situate all the power within the individual (Individual Level)
- Developing a suicide safety plan that considers the family structure, which may include a person's reliance on aunts, uncles, siblings, or grandparents, rather than only considering the nuclear family as the primary support (Interpersonal Level)
- Agencies taking a proactive approach to addressing unconscious bias to better engage individuals in culturally responsive and culturally specific treatment options (Institutional Level)
- Strategies that address community conditions like neighborhood poverty, high density of alcohol outlets, and lack of transportation (Institutional Level)
- Strategies that address institutional barriers like excessive bureaucracy, restrictive screening, geographical location, resource gatekeeping (Institutional Level)
- Adapting evidence-based education and prevention programs, treatment modalities, etc. for communities whose members were likely left out of research that created the evidence base in the first place (Institutional and Societal Levels)
- Addressing perspectives that reinforce the individualistic nature of mental health and suicide stigma in US culture (Societal Level)
- Developing a treatment plan for an individual with a disability by including them in the decision-making rather than making decisions solely based on the disability diagnosis and/or by talking to the caregiver rather than the individual seeking treatment (Societal Level)
- Develop strategies that consider institutional traumas. For example, when helping a person who identifies as LGBTQIA2S+, it would be most appropriate to provide a list of church's that are open and affirming when providing resources (Institutional Level).

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Appendix 7

ASIPP Themes and Initiatives from partner workgroups

Theme 1: Peer-Delivered Services

Initiative 1.1 OHA should support veteran and veteran family peer-delivered services

Initiative 1.2 OHA should implement peer-delivered services for youth transitioning out of foster programs

Initiative 1.3 OHA should support the workforce by providing peer programs, especially to industries with high suicide rates or companies that have had suicide clusters

Initiative 1.4 OHA should ensure that certified peers and traditional health workers receive specific education around suicide prevention, intervention and postvention

Initiative 1.5 OHA should support implementation of Peer Delivered services for LGBTQIA2S+ adults who are experiencing suicidal thoughts or behaviors with a target population of those experiencing housing insecurities or financial distress.

Theme 2: Cultural Agility

Initiative 2.1 OHA should implement rural-specific outreach and communication strategies for creating safety for LGBTQIA2S+ communities in rural and remote areas.

Initiative 2.2 OHA and LGBTQIA2S+ partners should develop a toolkit/training on how to create services that are more inclusive

Initiative 2.3 OHA should support the mental health of older LGBTQIA2S+ adults

Initiative 2.4 Ensure that all behavioral health services and outreach services are culturally and linguistically appropriate for BIPOC, Native American and LGBTQIA2S+ people

Initiative 2.5 Strategically engage men during major life transitions such as retirement, unemployment, separation, death of a spouse, moving from military to civilian, transitioning from foster care, divorce, or exit from criminal justice systems.

Initiative 2.6 Implement a sustained male-specific public awareness campaign that demonstrates an alternative, healthy set of masculine norms

Initiative 2.7 OHA should develop a 24/7 TELEHEALTH CRISIS RESPONSE TEAM designed for and by LGBTQIA2S+

Theme 3: Workforce Shortages

Initiative 3.1 Support debt forgiveness programs for health care providers serving in the veteran community.

Initiative 3.2 Attract and retain behavioral health care providers in rural areas by offering scholarship field placements, living stipends, loan repayment, and educational opportunities.

Initiative 3.3 Actively support diverse behavioral workforce professionals by offering internships or mentorships for disenfranchised populations

Theme 4: Workforce Competence

Initiative 4.1 All physicians and other medical professionals should be required to complete continuing education in suicide prevention

Initiative 4.2 Improve identification of suicide risk and lethal means assessments targeting older adults, IDD patients, men, and post-partum patients in primary health care settings

Initiative 4.3 Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors

Initiative 4.4 OHA should encourage hospitals, and physicians, to complete a suicide risk assessment following any serious diagnosis

Initiative 4.5 After a suicidal crisis, follow-up should be provided.

Initiative 4.6 Level of care needs to be commensurate with the level of need. Educate health care providers on how to match the level of care with the level of need.

Initiative 4.7 Increase safety planning training among health care professionals

Theme 5: Postvention and Post-Mortem Data Collection

Initiative 5.1 OHA to provide statewide training for Medical Examiners to collect more specific and inclusive data

Initiative 5.2 Increase the number of psychological autopsies performed

Initiative 5.3 Increase culturally responsive postvention services across Oregon with a focus on BIPOC, AI/AN, LGBTQIA2S+, veterans, and older adults populations

Theme 6: Gatekeeper Training

Initiative 6.1 OHA should fund and promote suicide prevention gatekeeper training for employment sectors with disparate rates of suicide.

Initiative 6.2 OHA should fund and promote suicide prevention training as a part of all CIT training statewide.

Initiative 6.3 OHA should increase gatekeeper training and outreach for Black youth ages 18–24 or those who work with black youth ages 18–24.

Initiative 6.4 Increase gatekeeper training for family and friends of Older Adults and Veterans

Initiative 6.5 Increase the number of suicide prevention trainers, especially in rural areas

Initiative 6.6 Promote and provide CALM training to gatekeepers and health care professionals.

Theme 7: Outreach

Initiative 7.1 Incorporate mental health promotion and suicide prevention resources and information into regularly scheduled safety meetings for industries that employ high-risk populations

Initiative 7.2 Increase outreach and communication regarding services and ensure that the information is correct

Initiative 7.3 Increase proactive forms of outreach which may include mobile crisis, home-based care, street outreach, drop-in centers, PEARLS programs, etc.

Initiative 7.4 Increase support and education for families who support family members who experience mental health concerns and suicidal thoughts and behaviors.

Theme 8: System and Policy

Initiative 8.1 OHA should develop policies, procedures, and requirements (including appropriate billing codes) that promote Medicaid reimbursement of outreach, caring contacts, follow-up services, non-traditional therapies, therapy in non-traditional places, and peer-delivered services

Initiative 8.2 System-wide use of an anti-racist integrated public health framework to address systemic inequality by decreasing barriers to culturally responsive health care and using culturally adaptive assessment tools.

Initiative 8.3 Health care professionals including but not limited to emergency departments should have policies that promote smooth transitions of care.

Initiative 8.4 Health care organizations employing Traditional Health Workers (including Peer Support Specialists) should have clear polices that include peer supervision and support for Traditional Health Workers (including Peer Support Specialists) to prevent and mitigate vicarious/secondary trauma, compassion fatigue and burnout.

Initiative 8.5 Increase infrastructure including adopting specific models to provide the least restrictive options during a suicidal crisis.

Initiative 8.6 Increase coordination and collaboration between OHA's suicide prevention plan and activities and counties' plan and activities. OHA should serve as a clearinghouse for suicide prevention and provide timely information to counties throughout the state.

Initiative 8.7 OHA should Increase collaboration and coordination among other types of prevention activities such as AOD, Tobacco, Gambling, Violence, etc.

Initiative 8.8 Encourage and fund behavioral health care services in a setting that is “non-traditional”

Initiative 8.9 Encourage and fund culturally rooted treatments such as sweat lodges with Native American populations and Eastern medicine.

Initiative 8.10 OHA should provide better supports to the statewide suicide prevention councils, and coalitions.

Theme 9: Means Reduction

Initiative 9.1 Develop guidelines and requirements for assisted living facilities and older adult communities that allow gun ownership to have safe storage facilities in place

Initiative 9.2 OHA should formally request that the Oregon Department of Justice clarify ORS 166.435 to describe the process and requirements for the transfer of gun ownership and provide educational distribution regarding this law

Initiative 9.3 Develop and distribute a list of entities that are willing and able to temporarily hold guns for safe storage

Initiative 9.4 Promote safe storage of firearms, drugs, and household toxic substances to include the general population but targeting older adults

Initiative 9.5 Partner with Gun Safety instructors to develop and distribute a suicide prevention module that complements existing firearm safety and CHL curriculum

Theme 10: Responsible Media

Initiative 10.1 OHA will develop media and communication campaigns that promote hope, healing, and wellness and portray suicide as both a public health and behavioral health issue.

Initiative 10.2 Any media campaign should portray the diversity and there should be media campaigns about mental health, stigma and suicide that target disenfranchised populations

Initiative 10.3 Create media campaigns that combat ageism and actively confront the stigma associated with aging

Theme 11: Connection

Initiative 11.1 Build active relationships through outreach with BIPOC organizations of all types to become fully embedded in the community

Initiative 11.2 Increase points of care by Integrating and coordinating older adult suicide prevention activities across multiple sectors, settings and points of care and connection

Initiative 11.3 Increase opportunities, programming, etc., to reduce social isolation with a target of high-risk populations such as older adults.

Theme 12: Data

Initiative 12.1 Partner with pertinent organizations to collect data to better understand the impact of illness/ disabilities on mental health, including suicide

Initiative 12.2 Partner with pertinent organizations to collect data to better understand the impact of racism on mental health, including suicide

Initiative 12.3 OHA should monitor and report patient satisfaction with mental health and crisis response services and work to achieve consistent and continuous empathic and effective mental health care.

Appendix 8

Data Limitations

Limitations of Data Used for Suicide Surveillance

OHA has identified suicide prevention as one of its top priority issues. Suicide is a complex behavior and is associated with many factors, including:

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

To monitor and track suicide as well as some risk and protective factors that lead to or prevent suicide, Oregon uses various existing administrative data sets, surveys, and active surveillance efforts.

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

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

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

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

Generation of missing data would require more resources, position authority and planning and would involve many steps, including:

- Linkage of several large administrative data sets
- In-person case interviews
- Requirements for law enforcement agencies and health care providers to release individual information
- Personnel for data entry and database management, and
- Requirements for hospitals to report some more types of data, such as ED data, and specific reporting criteria.

Specific considerations for administrative data sets:

Administrative data sets typically capture population data yet tracking public health trends is not their primary function. For example, administrative data sets do not capture all instances of hospital inpatient visits for suicide attempts. The data do not have information on factors that may have led persons to suicide, such as untreated depression or life stressors. Depending on the administrative dataset used there is varying support for tracking suicide trends.

Oregon uses administrative data sets to track outcomes such as deaths, medical outcomes, and emergency department visits. These data sources include:

- Death certificates collected by the Center for Health Statistics (CHS) at the Oregon Public Health Division (PHD), and
- Hospitalization discharge data (HDD) and emergency departments (ED for 2018 forward) from the Oregon Association of Hospitals and Health Systems (OAHS).
- Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) data for emergency departments and urgent care centers across Oregon.

Specific considerations for survey data:

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

- Behavioral Risk Factor Surveillance System (BRFSS)
- National Survey on Drug Use and Health
- American Community Survey
- Oregon LGBTQIA2S+ Older Adult Survey
- American Community Survey
- National Survey on Drug and Health
- National Survey of Substance Abuse Treatment Services

These surveys are both state and nationally administered. Some of these surveys periodically include questions about suicidality or mental health issues. However, questions often depend on funding from individual programs

(for example, BRFSS) to continue data collection for specific questions year-to-year. As of late, the response rate to these telephone surveys (for example, BRFSS) has been low (for example, <50%, which has implications on the generalizability of the data).

Specific considerations for active public health tracking efforts

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

- They do not distinguish suicide attempts from other forms of self-harm.
- Data derived from emergency department and urgent care center visits are still being received and updated and minor fluctuation is anticipated.
- Not all people in Oregon have access to an emergency department or urgent care center.
- People with suicidal ideations may forgo medical assistance.

Specific considerations for death certificate data

Death certificate data are collected by the Center for Health Statistics (CHS) at the Oregon Public Health Division (PHD). The data have been traditionally used for public health surveillance. The data provide detailed demographics, the general mechanism of injury, health outcomes and geographical information. However, the data do not tell the story behind deaths, such as why the people die by suicide and do not have information on factors that may have led persons to suicide, such as untreated depression or life stressors.

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

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

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

However, the lack of standardized questionnaires and investigations on deaths in Oregon creates challenges for consistent data collection and reporting. Therefore, ORVDRS data does not include consistent information from all agencies on certain data elements (for example, LGBTQIA2S+ status among people who died by suicide). Reliance upon data collected from limited witnesses and contacts of a person who died by suicide can result in incomplete information collected about the incident. Therefore, ORVDRS data may underestimate some given circumstances or risk factors.

Appendix 9

Circumstances

Circumstances surrounding suicide incidents, by age group 18–24 and sex, Oregon, 2016–2020

Circumstances	Aged 18–24		
	All sexes	Males	Females
Diagnosed mental disorder, % of total suicides	33.2	29.0	53.4
Alcohol problem, % of total suicides	10.7	11.3	8.2
Non-alcohol substance use problem, % of total suicides	17.8	17.2	20.5
Current depressed mood, % of total suicides	26.2	25.4	30.1
Current treatment for mental health/substance use problem, % of total suicides	17.5	14.9	30.1
Recently disclosed intent to die by suicide, % of total suicides	18.9	18.3	21.9
History of suicide attempt, % of total suicides	20.1	16.3	38.4
Left a suicide note, % of total suicides	30.6	28.7	39.7
History of expressed suicidal thought or plan, % of total suicides	31.5	29.3	42.5
Intimate partner problem, % of total suicides	22.9	21.1	31.5
Family stressor(s), % of total suicides	7.2	6.5	11.0
Recent criminal / non-criminal legal problem, % of total suicides	5.6	6.8	0.0
Financial/job problem, % of total suicides	5.8	6.2	4.1
Physical health problem, % of total suicides	1.4	1.4	1.4
Death of a family member or friend within past five years, % of total suicides	3.7	4.5	0.0
Suicide of a family member or friend within past five years, % of total suicides	1.2	1.1	1.4
School problem, % of total suicides	2.1	2.3	1.4
Experienced a crisis within two weeks, % of total suicides	14.5	13.8	17.8
Crisis related to a problem with an intimate partner, % of total suicides	8.2	7.3	12.3
Crisis related to physical health problems, % of total suicides	0.0	0.0	0.0
Crisis related to recent criminal / civil legal problem, % of total suicides	1.4	1.7	0.0
Crisis related to family stressor(s), % of total suicides	1.6	1.7	1.4
Crisis related to financial / job problem, % of total suicides	0.2	0.3	0.0
Crisis related to eviction, % of total suicides	0.7	0.6	1.4
Suspected alcohol use prior to the incident	20.6	21.1	17.8

Circumstances surrounding suicide incidents, by age group 25-54 and sex, Oregon, 2015-2019

Circumstances	Aged 25-54		
	All sexes	Males	Females
Diagnosed mental disorder, % of total suicides	37.7	34.2	48.5
Alcohol problem, % of total suicides	20.3	20.3	20.5
Non-alcohol substance use problem, % of total suicides	17.9	18.1	17.5
Current depressed mood, % of total suicides	27.2	26.9	28.3
Current treatment for mental health/substance use problem, % of total suicides	22.0	19.5	29.6
Recently disclosed intent to die by suicide, % of total suicides	22.8	23.0	22.0
History of suicide attempt, % of total suicides	19.4	16.7	27.3
Left a suicide note, % of total suicides	26.3	24.8	30.8
History of expressed suicidal thought or plan, % of total suicides	32.1	31.2	34.3
Intimate partner problem, % of total suicides	28.9	29.7	26.1
Family stressor(s), % of total suicides	5.4	4.9	7.0
Recent criminal / non-criminal legal problem, % of total suicides	11.8	12.9	8.2
Financial/job problem, % of total suicides	12.7	13.1	11.1
Physical health problem, % of total suicides	6.9	6.3	8.8
Death of a family member or friend within past five years, % of total suicides	3.6	3.6	3.7
Suicide of a family member or friend within past five years, % of total suicides	1.1	1.0	1.6
School problem, % of total suicides	0.1	0.1	0.4
Experienced a crisis within two weeks, % of total suicides	20.4	21.2	17.7
Crisis related to a problem with an intimate partner, % of total suicides	10.8	11.2	9.7
Crisis related to physical health problems, % of total suicides	0.4	0.5	0.4
Crisis related to recent criminal / civil legal problem, % of total suicides	4.7	5.5	2.1
Crisis related to family stressor(s), % of total suicides	0.8	0.5	1.6
Crisis related to financial / job problem, % of total suicides	1.8	1.9	1.6
Crisis related to eviction, % of total suicides	1.5	1.6	1.0
Suspected alcohol use prior to the incident	27.5	28.1	25.9

Circumstances surrounding suicide incidents, by age group 55 and up and sex, Oregon, 2016–2020

Circumstances	Aged >= 55		
	All sexes	Males	Females
Diagnosed mental disorder, % of total suicides	31.5	27.3	45.3
Alcohol problem, % of total suicides	14.3	15.4	10.7
Non-alcohol substance use problem, % of total suicides	5.1	5.5	3.9
Current depressed mood, % of total suicides	30.2	30.0	30.7
Current treatment for mental health/substance use problem, % of total suicides	20.3	17.5	29.4
Recently disclosed intent to die by suicide, % of total suicides	21.1	21.4	20.1
History of suicide attempt, % of total suicides	11.1	8.7	18.8
Left a suicide note, % of total suicides	31.3	29.3	38.0
History of expressed suicidal thought or plan, % of total suicides	30.2	29.3	33.3
Intimate partner problem, % of total suicides	10.5	11.7	6.5
Family stressor(s), % of total suicides	3.8	3.2	5.7
Recent criminal / non-criminal legal problem, % of total suicides	4.5	5.4	1.8
Financial/job problem, % of total suicides	7.5	8.0	6.0
Physical health problem, % of total suicides	33.5	36.2	24.7
Death of a family member or friend within past five years, % of total suicides	5.9	6.2	4.7
Suicide of a family member or friend within past five years, % of total suicides	1.1	1.0	1.3
School problem, % of total suicides	0.0	0.0	0.0
Experienced a crisis within two weeks, % of total suicides	15.3	17.1	9.4
Crisis related to a problem with an intimate partner, % of total suicides	3.3	3.8	1.6
Crisis related to physical health problems, % of total suicides	4.6	5.3	2.3
Crisis related to recent criminal / civil legal problem, % of total suicides	2.1	2.8	0.0
Crisis related to family stressor(s), % of total suicides	0.6	0.7	0.3
Crisis related to financial / job problem, % of total suicides	1.0	1.0	0.8
Crisis related to eviction, % of total suicides	1.9	2.0	1.6
Suspected alcohol use prior to the incident	17.3	17.1	18.0

Appendix 10

Suicidal Thoughts and Behaviors

Suicide deaths tell only part of the picture. Suicide typically begins with unbearable psychological pain, often precipitated by loss, or losses with little hope of recovering from those losses which can lead to thoughts about ending one's life (Ducasse et., al 2017). This is not true for everyone who experiences great loss. There are those who never think about suicide and the similarities and differences between those who do and those who do not think about suicide are complicated and multifaceted. The risk of suicide is positively associated with psychological pain, independent of depression (Verrocchio et., al 2016). During 2017-2019, among adults 18 and older in Oregon, when asked about "serious thoughts of suicide within the past year" 5.9% endorsed this item, which is higher than the national average of 4.5%. [Link to Source](#). The overwhelming majority of people who think about suicide never go on to make an attempt or die by suicide. CDC reports that for every person who dies by suicide, 278 seriously consider suicide, but do not die which is less than 1%. This is part of the reason that suicide is statistically impossible to predict. Although the majority of people who die by suicide think about it prior, the majority of people who experience suicidal ideation never die by suicide.

SAMSHA published an article in 2014 examining the progression from ideations to plan and from plan to attempt in adults. Results showed that of the 3.9% that experienced suicidal thoughts (within the past year), 1.1% went on to make a plan and of those 0.5% made an attempt. It is generally estimated that 1 in 25 suicide attempts end in death. This is an estimate because many attempts do not result in emergency services. "Stated another way, nearly one-third of adults who had serious thoughts of suicide made suicide plans, and about 1 in 9 adults who had serious thoughts of suicide made a suicide attempt. In other words, more than two-thirds of adults in 2014 who had serious thoughts of suicide did not make suicide plans, and 8 out of 9 adults who had serious thoughts of suicide did not attempt suicide."

According to AFSP, it is estimated that 1.38 million Americans attempted suicide in 2019 which is a rate of 420 per 100,000. Females are much more likely to think about suicide and make a suicide attempt (3X more likely) than men despite men being more likely (4 X more likely) to die of suicide. Although the majority of those who make a suicide attempt do not end up dying by suicide, and most never repeat an attempt, 5.4% of previous attempters die by suicide (Bosttwick et. al, 2016), which is why having made a suicide attempt in one's lifetime is a risk factor for suicide.

In addition to putting one at greater risk for suicide death, making a suicide attempt can create immediate and even long-term difficulties such as job loss, financial burden, emotional turmoil for loved ones and even permanent disability. Suicide prevention must be about more than preventing suicide death, but also preventing attempts. suicide prevention should include helping others who are thinking about suicide to live lives that are experienced as worth living. [Bryan](#), (2022) a clinician and suicide prevention researcher, has suggested the following strategies that could prevent suicide by improving the well-being and quality of life:

1. Enhance financial security.
2. Preserve the health and attractiveness of our natural environments making it easier for those to enjoy and appreciate nature's beauty.
3. Expand access to health care.
4. Improve affordability of health care.
5. Design neighborhoods and communities that facilitate social connections.
6. Support and encourage the expression of gratitude and appreciation within social groups.

Oregon does have limited data points that shed some light on ideation and attempts, however, It's important to remember that ideation and attempts are likely under-reported.

Appendix 11

Risk and Protective Factors

- Suicide risk factors **are characteristics of a person or their environment** that increase the likelihood that they will die by suicide (i.e., suicide risk). For example, prior suicide attempt(s), misuse and abuse of alcohol or other drugs, mental health concerns, and access to lethal means.
- Protective factors are personal or environmental characteristics that help protect people from suicide, i.e., access to effective behavioral health care, life skills, connection to family, friends and so on.
- Risk, protective, precipitating, and warning signs **can be different** for different age groups or other **demographics** such as sexual orientation, veteran status, race, and ethnicity.
- An environmental characteristic can serve as a protective factor for the general population but a risk factor for others. For example, in general, strong religious beliefs are a protective factor, however, this is often not the case for the LGBTQIA2S+ population where they may receive strong judgment from others within that congregation or experience self-loathing as a result of their strong religious beliefs. A similar but slightly different example is a military culture where camaraderie can be both a protective factor and a risk factor depending on the situation. For example, although the sense of camaraderie is typically a protective factor, that same sense of allegiance can become a risk factor in certain circumstances such as reporting military sexual assault or bullying.
- Risk and protective factors are not created equal and do not necessarily “cancel” each other out.
- Evidenced-based protective factors are derived from public health population-based studies and have relevance to upstream primary prevention and strategic planning but lack evidence to support their role as mitigating or buffering suicide risk for **individuals** in **immediate** risk for suicide. There are not “evidenced-based” risk factors for every high-priority population chosen, thus some are based on logical reasoning. For example, this is true for the construction industry where despite lacking evidenced-based risk factors specific to the construction industry, there are evidence-based risk factors for personal or environmental characteristics that have a high preponderance in the construction industry such as being male, unemployment, financial instability, lack of consistent mental health resources, access to lethal means, etc.
- Reasons for living and reasons for dying do not cancel each other out and can change in a moment for **individuals**.
- There is no single rating scale or algorithm that can accurately predict suicide because suicide is a convergence of many factors, both current and predisposing.
- Risk assessments, although highly encouraged (the best that we have right now) are helpful but flawed. For some people, their risk of suicide can move from little or no risk to extreme risk in a very short space of time (a few hours or less). In addition, risk assessments produce a lot of false positives with 96% of those who report having thoughts of suicide and 99.6% of those who are not having thoughts of suicide, not dying of suicide, or even making an attempt within the year of reporting no thoughts of suicide or thoughts of suicide. For every 3,000 persons reporting no thoughts of suicide, 12 will attempt within the next year. For every 3,000 persons reporting thoughts of suicide, 120 will attempt within the next year but 2,880 will not. Although more than half of those who attempt or die by suicide report having suicidal ideation within the past year, very few that have suicidal ideation will attempt or die by suicide (Bryan, 2022). Despite this **ALL thoughts of suicide should be taken seriously**; however, we must get better at asking the right questions, and being open to the possibility that suicide risk may be different than what we have thus far understood. The field of suicidology is a young one.
- New research regarding suicide risk is centered on “machine learning” and understanding more about “change patterns” in individuals.

Appendix 12

Rates By County

Suicide deaths and age-adjusted rates by county, Oregon, 2016–2020

County	Rate per 100,000 population	County	Rate per 100,000 population
Baker	35.9	Lincoln	35.7
Benton	14.3	Linn	21.0
Clackamas	15.9	Malheur	15.5
Clatsop	21.2	Marion	16.6
Columbia	22.9	Morrow	18.6 [†]
Coos	25.6	Multnomah	16.5
Crook	26.6	Polk	12.9
Curry	30.5	Sherman	*
Deschutes	19.3	Tillamook	19.4
Douglas	28.7	Umatilla	20.6
Gilliam	*	Union	15.3
Grant	38.1	Wallowa	19.6 [†]
Harney	43.1	Wasco	21.9
Hood River	12.5	Washington	13.1
Jackson	26.7	Wheeler	*
Jefferson	24.7	Yamhill	18.5
Josephine	29.1		
Klamath	33.3	Remote counties	23.7
Lake	11.3 [†]	Rural counties	25.0
Lane	22.8	Urban counties	17.3

[†] Rates based on fewer than 12 events for the entire period are considered unreliable.

* Rates based on a count < 5 are not reported.

Appendix 13

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Appendix 14

Crosswalk with Other Published Documents

[OHA Youth Suicide Intervention and Prevention Plan 2021-2025](#)

[National Strategy for Suicide Prevention](#): This was developed by the U.S. Surgeon General and the Action Alliance as a guide for U.S. suicide prevention efforts. It includes 13 goals and 60 objectives for suicide prevention which have informed state and local plans, including the Oregon ASIPP.

[CDC Technical Package](#): A report from the Centers of Disease Control summarizing evidence-based state- and community-level strategies with the greatest potential to prevent suicide.

[SPRC State Infrastructure Tool](#): A website that offers a summary of the critical infrastructure elements states need to have in place for effective and sustained suicide prevention efforts, as well as tools for implementation and advocacy.

[San Diego County Plan](#): The suicide prevention plan for San Diego County

Tribal Behavioral Health Strategic Plan 2019-2024: This plan was written by The Oregon Native American Behavioral Health Collaborative, which works to improve behavioral health for tribal communities in Oregon. Representatives from the nine federally recognized tribes in Oregon, the Native American Rehabilitation Association of the Northwest, OHA, ODHS Office of Tribal Affairs, and the Northwest Portland Area Indian Health Board form the Oregon Native American Behavioral Health Collaborative. Available [here](#).

[Healthier Together Oregon](#): This initiative serves as the basis for collective action on key health issues in Oregon by identifying population-wide priorities and strategies for improving the health of people in Oregon.

[Oregon Veterans' Behavioral Health Services Improvement Study: Needs Assessment & Recommendation](#):

[VA/DOD Clinical Practice Guidelines for Assessment & Management of Patients At Risk For Suicide](#)

[National Strategy for Preventing Veteran Suicide 2018-2028](#)

[Behavioral Health Barometer, Oregon, Volume 6](#)

Barometer_Volume6.pdf) which are indicators through the 2019 National Survey on Drug and Health and the National Survey of Substance Abuse Treatment Services

[Adult Behavioral Risk Survey \(BRFSS\)](#)

[2018 CCO Metrics DEEPER DIVE](#)

[Governor's Behavioral Health Advisory Council Recommendations \(2020\)](#)

[OHA 2015-2018 Behavioral Health Strategic Plan](#)

[OCHA Oregon Commission on Hispanic Affairs: Crisis de Nuestro Bienestar: A Report on Latino Mental Health \(2020\)](#)

[Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness \(2016\)](#)

[Oregon LGBTQIA2S+ Older Adult Survey: 2021](#)

[Input from Oregon Gun Owners on Firearm Safety and Suicide Prevention: 2020](#)

[Evaluation of the Behavioral Health Initiative for Older Adults and People with Physical Disabilities: 2019-2021](#)

[Oregon Areas of Unmet Health Care Report](#)

[Fact Sheet: New Strategy Outlines Five Priorities for Reducing Military and Veteran Suicide](#)

Appendix 15

Terms Defined

Please note: These are not necessarily defined terms in Oregon Administrative Rules or Oregon Revised Statutes. The purpose of this list of definitions is to have a common understanding among those implementing the ASIPP.

ASIPP: Adult Suicide Intervention and Prevention Plan was developed between 2020 and 2022 by collecting and integrating partner feedback via workgroups, surveys and focus groups. Over 130 Oregonians were involved in developing this plan. This is the first adult plan in Oregon, published in 2023 and will be revised every five years.

Centering Values or Lenses: A list of terms located in the center of the Suicide Prevention Framework. These terms represent themes that all suicide prevention work, planning, and decision-making should consider, elevate, integrate, and prioritize.

Collaboration: To work together towards a common goal. The OHA Suicide Prevention team believes that the most impactful suicide prevention activities happen locally where strong relationships can thrive. It is also true that all Oregonian communities or populations have access to the same resources, and therefore statewide resources are critical. Collaboration was included as a Centering Value in the suicide prevention framework to elevate the need for initiatives that are locally grounded and accessible to all.

Collective Impact: The Collective Impact approach is designed to “bring people together, in a structured way, to achieve social change” and is one of the foundations of the ASIPP 2023–2027. The Collective Impact Forum describes the five elements of the approach as:

- Common Agenda – coming together to collectively define the problem and create a shared vision to solve it.
- Shared Measurement – agreeing to track progress in the same way, which allows for continuous improvement.
- Mutually Reinforcing Activities – coordinating collective efforts to maximize the end result.
- Continuous Communication – building trust and relationships among all participants.
- Strong Backbone — having a team dedicated to orchestrating the work of the group.

The OHA Suicide Prevention team believes that by working together with shared goals, measurements and resources, we can make a larger impact in suicide prevention – and therefore collective impact was chosen as a Centering Value in the suicide prevention framework.

Core Values: Traits or qualities that are not just worthwhile, they represent an individual’s or an organization’s highest priorities, deeply held beliefs, and core, fundamental driving forces.

Cross-Sector approach within Strategic Pathways: A cross-sector approach occurs when Initiatives are identified by more than one sector within a single Strategic Pathway. This is most likely to happen when an adult is multi-system involved or in spaces where sectors already naturally overlap. It is likely that certain occupations, primary health care, behavioral health care, adult-serving organizations such as senior centers, LGBTQIA2S+ centers, veteran centers, etc., would all have relevant initiatives within a Strategic Pathway. The specific Strategic Initiative to achieve that Strategic Pathway might be different depending on which sector was working on it.

Cultural Competence: Cultural competence, also known as intercultural competence, is a range of cognitive, affective, and behavioral skills that lead to effective and appropriate communication with people of other cultures.

Disparate Rates of Suicide: People of any age, race, ethnicity, or sex can experience suicide risk, but certain groups have substantially higher rates of suicide than the general U.S. population. Health disparities are differences between the health of one population and another in measures of who gets the disease, who have the disease, who dies from the disease and other adverse health conditions among specific population groups. If a health outcome is seen to a greater or lesser extent between populations, there is disparity.

Diversity: The range of human differences, recognizing that everyone and every group is valued. Diversity broadly includes but is not limited to race, ethnicity and gender as well as age, national origin, religion, disability, sexual orientation, socioeconomic status, education, marital status, language and physical appearance. It also includes different ideas, perspectives and values.

Ease and impact: Ease and impact are in reference to a process by which a selected group of people and interested parties categorize and prioritize possible strategic priority initiatives by:

- **Ease:**
 - How much work and how many resources will this take?
 - Do we already have the talent and resources we need or will we have to get them?
- **Impact:**
 - What reach will this have?
 - What level of effectiveness will this have for Oregon?
 - What amount of difference would this make to the big picture of suicide prevention?

Equity: A term acknowledging that all people or all communities are not starting from the same place due to historic and current systems of oppression. Equity provides different levels of support based on an individual's or group's needs to achieve fairness in outcomes. Equity strives for the distribution and redistribution of power and resources to communities and people most harmed by systemic and individual acts of racism and oppression.

Ethnicity: A concept accepted by people in society that arranges people into smaller social groups based on characteristics such as a shared sense of group membership, values, behavioral patterns, language, political and economic interests, history, and where ancestors resided.

Foundation: Refers to the foundation on the Suicide Prevention Framework. Research, Data, Evaluation and Policy are included in the foundation of the suicide prevention framework to represent that the whole framework is supported and grounded in these efforts.

Guiding Principles: Principles or precepts that guide an organization throughout its life in all circumstances, irrespective of changes in its goals, strategies, type of work or management.

Health Inequities: Systematic, avoidable, unjust and unfair differences in health status and mortality rates across population groups. These differences are rooted in social and economic injustice attributed to the social, economic and environmental conditions in which people live, work and play.

Historical Trauma: Intergenerational trauma is experienced by a specific cultural group that has a history of being systematically oppressed. Current lifespan trauma, superimposed upon a traumatic ancestral past creates additional adversity. Historical trauma can have an impact on psychological and physical health.

Institutional Racism: A system in which institutional policies and practices create different, inequitable outcomes for different racial groups.

Integrated health care: A unique approach to health care that's characterized by close collaboration and communication between multiple doctors and health care professionals which includes behavioral health care professionals.

Intersectional Identities or Intersectionality: An analytical framework for understanding how aspects of a person's social and political identities combine to create different modes of discrimination and privilege. **Intersectionality** identifies multiple factors of advantages and disadvantages. It is the methodology of studying and examining how various socially and culturally constructed categories (sex, gender, race, class, disability, etc.) interact on multiple and often simultaneous levels and contribute to systematic inequities. Intersectionality examines and attempts to clarify ways in which a person can simultaneously experience privilege and oppression. It is a way to see the interactive efforts of various forms of discrimination and disempowerment. Intersectionality looks at the way racism interacts with patriarchy, heterosexism, classism, xenophobia and ableism. It views the overlapping vulnerabilities created by these systems to create specific challenges. It means significant numbers of people in our communities aren't being served by social justice efforts because they do not address particular ways they are experiencing discrimination.

Latinx: A term used to describe people who are of or relate to Latin American origin or descent. It is a gender-neutral or nonbinary alternative to Latino or Latina.

Levels of interventions and strategies

Universal or primary level – These interventions have broad, community-wide reach. All people in Oregon will receive or benefit from these interventions. They are similar to tier 1 in the multi-tiered system of support (MTSS) model in education.

Selected or Secondary Level – these interventions are given to specific, targeted sectors or populations to maximize their benefit. They are similar to Tier 2 in an MTSS model in education, these interventions happen in addition to the universal interventions.

Indicated or Tertiary Level – these interventions are given to a very narrow scope of sectors or populations when risk or need for more intervention is indicated. These represent things like treatment for suicide thoughts, care coordination between levels of care, etc. They are similar to Tier 3 in an MTSS model in education, these interventions are given in addition to all other levels of intervention.

LGBTQIA2S+: Lesbian, Gay, Bisexual, Transgender, Queer, Two Spirit, Intersex, Asexual

Lived Experience Voice or Voices of Lived Experience: While generally referring to a person who has direct and relevant experience with a social issue or combination of issues, in suicide prevention this term includes those who have:

- suicide thoughts or behaviors,
- attempted suicide,
- supported a friend, family member or other important person through a suicide crisis, or
- lost a loved one to suicide.

Means / Methods: Means and methods of suicide or suicide attempts are often used interchangeably. In the [National Strategy](#) means is defined as “The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs)”. Methods are described as “Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose)”.

Military-Connected Personnel: Individuals who served in the military in any capacity, as well as family members, chosen family, and caregivers of individuals who served in the military.

Postvention: Interventions for bereaved survivors, community members, caregivers, and health care providers to destigmatize suicide, assist with the recovery process, and serve as a secondary prevention effort to minimize the risk of future suicides due to complicated grief, contagion, or unresolved trauma. Suicide postvention work also includes *psychological autopsies* which is a method involving collecting all available information on the deceased via structured interviews of family members, relatives or friends as well as attending health care personnel.

Protective Factors: Personal or environmental characteristics that help protect people from suicide, i.e., access to effective behavioral health care, life skills, connection to family, friends and so on.

Race: A concept accepted by people in society that groups people based on skin color and other apparent physical differences without any genetic or scientific basis. This social construct was created and used to justify the social and economic oppression of people of color.

Racism: Distinct from racial prejudice, hatred or discrimination, racism involves one group having the power to carry out systematic discrimination through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices.

RASCI Model: RASCI is a model with which to assign the roles and responsibilities to implement the strategic priority initiatives by the level of involvement. The levels include assigning who is:

- Responsible
- Accountable
- Supporting
- Consulted, and
- Informed.

The OHA suicide prevention team has agreed to assign strategic priority initiatives using this model, to the extent possible. Learn more [here](#).

Risk factors: Characteristics of a person or their environment increase the likelihood they will die by suicide (that is, suicide risk). For example, prior suicide attempt or attempts, misuse and abuse of alcohol or other drugs, mental health concerns and access to lethal means.

Sector or Sector-based Approach: A sector is an area *where* suicide prevention can happen, and a sector-based approach means that the Framework will include distinct strategic priority initiatives for certain sectors. Some sectors have multiple subsectors. A **Multiple Sectoral Approach** means that one or more sectors are involved in suicide prevention for a population simultaneously. For example, reducing the rate of suicide for older adults may involve health care, assisted living facilities, senior centers, and the VA. While there are many more sectors that could be included in this work, the highlighted sectors are:

- Education
 - Colleges/Universities/Community Colleges
 - Apprenticeship Programs
- Primary health care
 - Emergency Departments and Urgent Care Centers
 - Hospitals including VAs
 - Primary Care Providers/Clinics
- Behavioral health care
 - Outpatient Services
 - Crisis Response and Stabilization Services
 - In-patient Services
- Adult-Serving Entities
 - Community-Based Organizations
 - Social Service Organizations
- Occupations
 - Construction
 - Forestry
 - Fishing
- Government
 - OHA
 - State Medical Examiners
 - LMHA (Local Mental Health Authorities)
 - Legislators

Social Connectivity: The degree to which one feels close and connected to others. It involves feeling loved, cared for, and valued, and forms the basis of interpersonal relationships.

Strategic pillars: The strategic pillars are the first level of the suicide prevention framework. These match the National Strategy for Suicide Prevention. They also represent the four pillars of the YSIPP 2016–2020. These do not change over time. The strategic pillars in ASIPP 2023–2027 are:

- Healthy and empowered individuals, families and communities (universal level)
- Clinical and community prevention services (selected level)
- Treatment and support services (indicated level)

Research, data, evaluation and policy were placed at the foundation of the suicide prevention framework to represent that the whole framework is supported and grounded in these efforts.

Strategic goals: Each pillar has three to four strategic goals embedded within it. These goals are not likely to change over time. They are based on the National Strategy for Suicide Prevention, the CDC Technical Package for suicide prevention, and Oregon’s suicide prevention landscape. Without the strategic pathways, they are not easily measured – they are “what” needs to happen. The strategic pathways are “how” we will do this work.

Strategic pathways: This is the measurable way we will know we’ve achieved success for the strategic objectives. Each Goal has two to five strategic pathways. For example, under the goal of “means reduction,” one pathway is “All Oregonians experiencing behavioral health problems will have access to safe storage of lethal means.” Strategic pathways may change over time, or new strategic pathways may be added over time, based on the success of implementation and the effectiveness of the efforts. These pathways were chosen based on the themes that emerged from feedback gathered, the literature reviewed, and best practices scanned. For more about this, reference the [Pathways Crosswalk of Evidence/Experts](#).

Strategic priority initiatives: These are the “project plan” for how Oregon will achieve success within each Strategic Pathway. What steps will we take? These will be SMART (specific, measurable, achievable, realistic, and timely). These should reflect what’s needed next – “meet the moment”. As such, these will change over time – likely they will be edited yearly based on implementation success, new needs and resources, etc. For example, a strategic priority initiative might be “Every local mental health authority will receive information on the availability of low or no-cost medicine lock boxes and gun safes through AOCMHP by Dec. 15, 2021.”

Structural Racism: A system in which public policies, institutional practices, cultural representations and other norms work in various, often reinforcing ways to perpetuate racial group inequities. It is a feature of the society in which we all exist.

Suicide Cluster: A group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community. *Suicide Contagion* is the exposure to suicide or suicidal behaviors within one’s family, one’s peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors. Individuals most at risk of suicide contagion are those geographically, socially, or psychologically close to the deceased.

Themes: These are the common areas of feedback that emerge through partner feedback including large and small workgroups, surveys and focus groups. Themes became recommendations to OHA for Strategic Pathways in the framework.

Trauma-Informed Practices: There is not one common definition for this term. Generally, the term “trauma-informed” refers to someone who recognizes the prevalence of adverse childhood experiences, that many behaviors and symptoms are the results of traumatic experiences, and that treating those who have experienced trauma with kindness and choice can [help](#) avoid re-traumatization. The OHA Suicide Prevention team uses this Standards of Practice document developed by Trauma Informed Oregon found here as a guide.

Upstream or Upstream Prevention: This is a broad term meant to represent interventions or strategies that are put into place at the universal or primary level. The goal of “upstream prevention” is to equip people with coping skills, wellness support, and opportunities to thrive prior to any warning signs of suicide risk.

Youth Suicide Prevention and Intervention Plan (YSIPP): The Oregon legislature mandated the creation of this plan. The first Youth Suicide Intervention and Prevention Plan was written in 2015 for the timeframe of 2016–2020.

The [Youth Suicide Intervention and Prevention Plan 2021-2025](#) was developed between March 2020 and August 2021. The original release date was scheduled for Jan 2021 but, due to COVID-19, was revised to Fall 2021.

Adult Suicide Intervention and Prevention Plan

2023–2027



This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact the Health Systems Division at 503-602-2597, 711 for TTY, or email Debra.Darmata@oha.oregon.gov.

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