Clackamas County Suicide Prevention Stakeholder Assessment Summary

August 2019

UNIVERSITY OF OREGON

Assessment Overview

Background

The purpose of the Clackamas County Suicide Prevention Stakeholder Assessment ("the Assessment") was to identify and gather information from individuals across the county who are engaged with, or could provide insight on, suicide prevention needs, efforts, and resources in Clackamas County.

The Assessment is a component of a larger initiative, guided by the Clackamas County Suicide Prevention Coalition, to strengthen the county's response to suicide risk. This response includes efforts to prevent suicide events (attempts and deaths by suicide), to reduce the impact of suicide events that do occur (including through preventing further suicide events and by providing support to affected individuals and communities), and to enhance citizens' sense of community belonging.

Approach

An Implementation Science-based conceptual model, the *Consolidated Framework for Implementation Research* (CFIR)[1], was utilized in shaping the Assessment approach. The CFIR model specifies several domains that, when assessed, provide a comprehensive view of the system targeted for improvement. These domains include:

- The **Outer Setting**, which describes existing needs and resources, the policy environment, and other relevant structural considerations.
- The **Inner Setting**, or the aspects of the system which facilitate – or are barriers to – implementing the desired improvements. Examples of Inner Setting features include cultural, social, or institutional norms; effective or ineffective communication channels; and readiness for change.
- **Process** characteristics, which include key allies and change agents, existing resources and experience for strategic planning, and capacity for evaluating change efforts.
- Attributes of the **Interventions** selected to facilitate the desired change, including the evidence base for the chosen strategies, the adaptability of approaches, and their implementation complexity and cost.

The aim of the Assessment was primarily to examine the Outer Setting as it related to suicide prevention goals of Clackamas County. In the following section, the key findings of the Assessment are described.

1. Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing Implementation Science. *Implementation Science*, *4*(50). doi:10.1186/1748-5908-4-50

Profile of Respondents

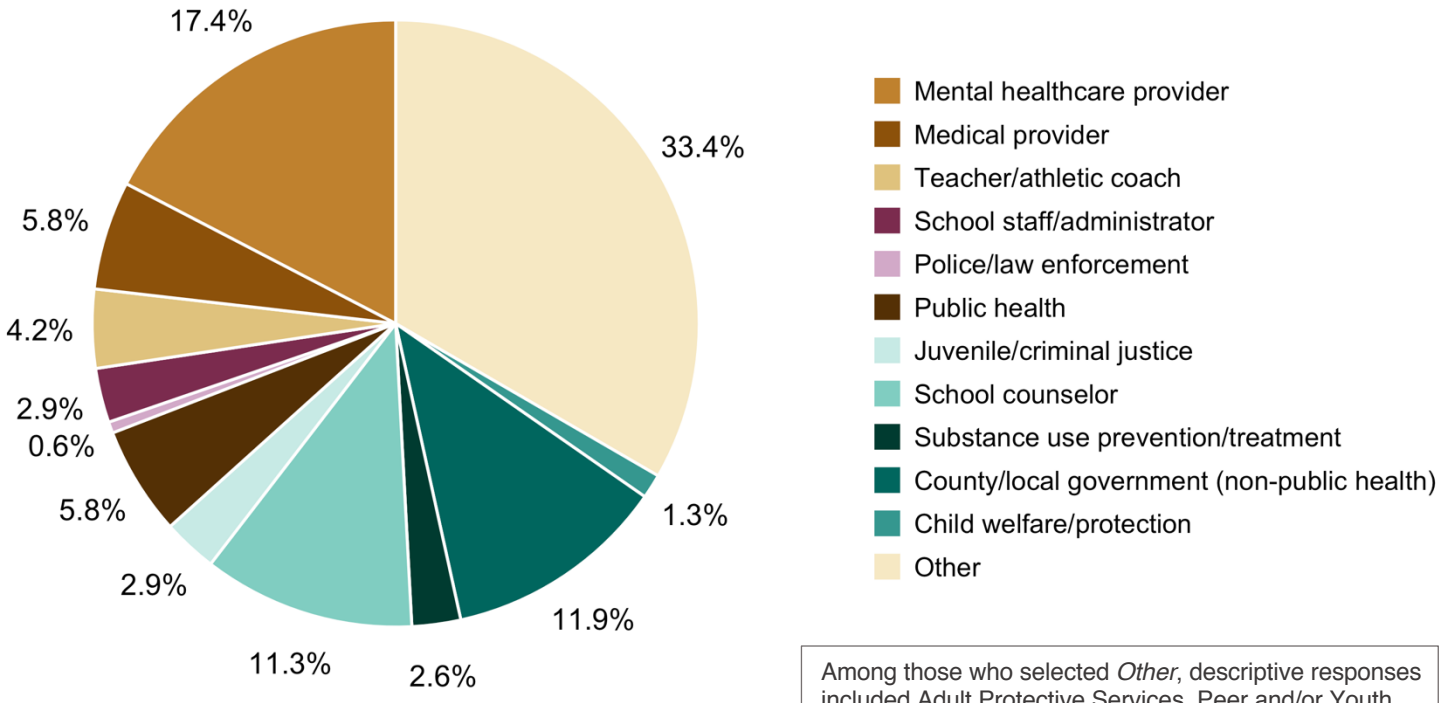
Sample

258 residents of Clackamas County completed the Assessment over an approximately three-month period. The Assessment was primarily disseminated via an online survey platform, and English, Spanish, Vietnamese, and Russian-language versions were made available. Only one non-English questionnaire was completed. Thirteen questionnaires were completed by hand.

Professional Representation

Respondents were asked for their current profession(s); the proportion of each profession is presented in the figure below, and the number of endorsements of each profession is provided in the Appendix. Respondents were permitted to select multiple professions, therefore the proportions provided are based on the total number of reported professions and not the total number of respondents.

Respondent Professions



Among those who selected *Other*, descriptive responses included Adult Protective Services, Peer and/or Youth Support, Suicide Survivor, Youth Community Member, Health Educator, and other non-profit roles such as medical or non-medical (i.e., benefits) case manager and liaison to homeless populations.

Profile of Respondents

School Audience

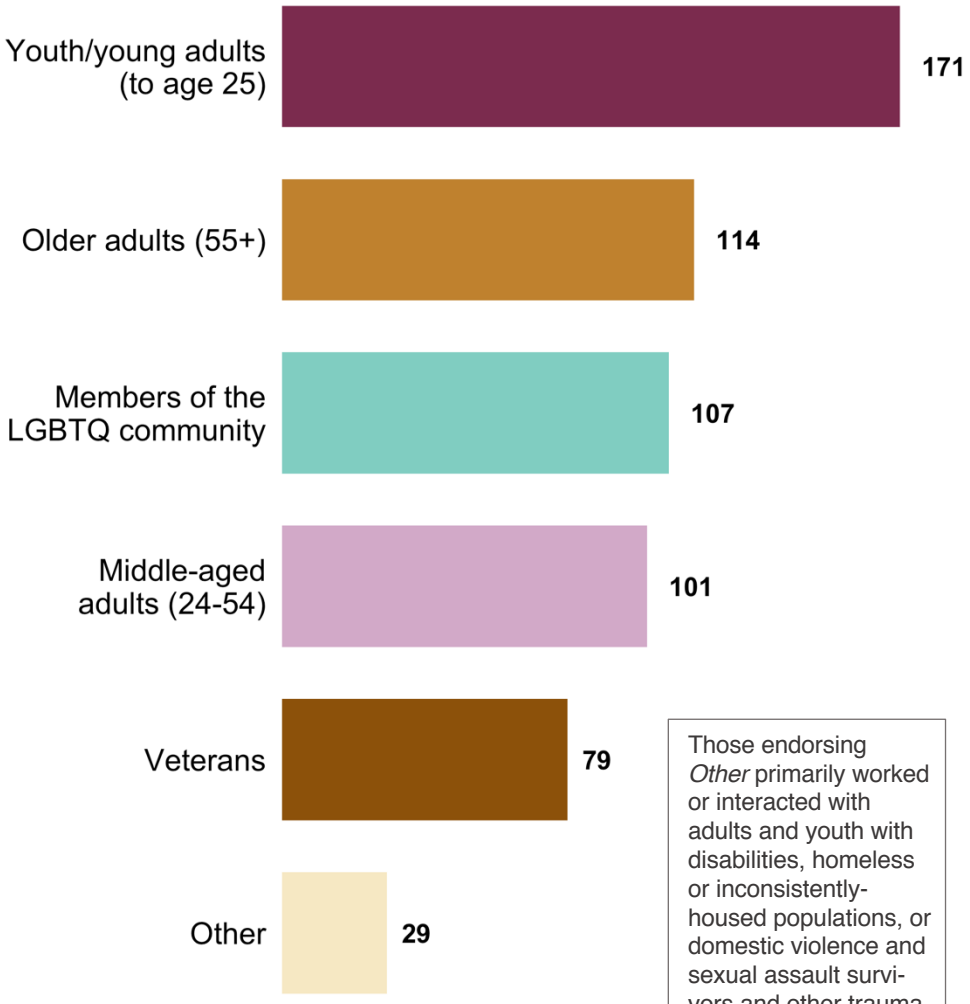
Among respondents who indicated that they worked in a school environment, **20%** worked in an elementary school, **25%** in a middle school, and **55%** in a high school.

Primary Population Demographic

Of respondents who endorsed whether they primarily worked among urban or rural populations, **70%** worked among urban populations and **30%** worked primarily with rural populations.

Populations at Risk

Respondents were asked which of the following populations at risk for suicide they regularly interact with: Youth/young adults (to age 25), middle-aged adults (24-54), older adults (55+), veterans, and/or members of the LGBTQ community. Respondents could endorse multiple populations as well as an *Other* selection, providing a description of additional populations at risk. The number of respondents interacting with each population is shown at right. Youth and young adults aged 25 and under were the primary population of focus.



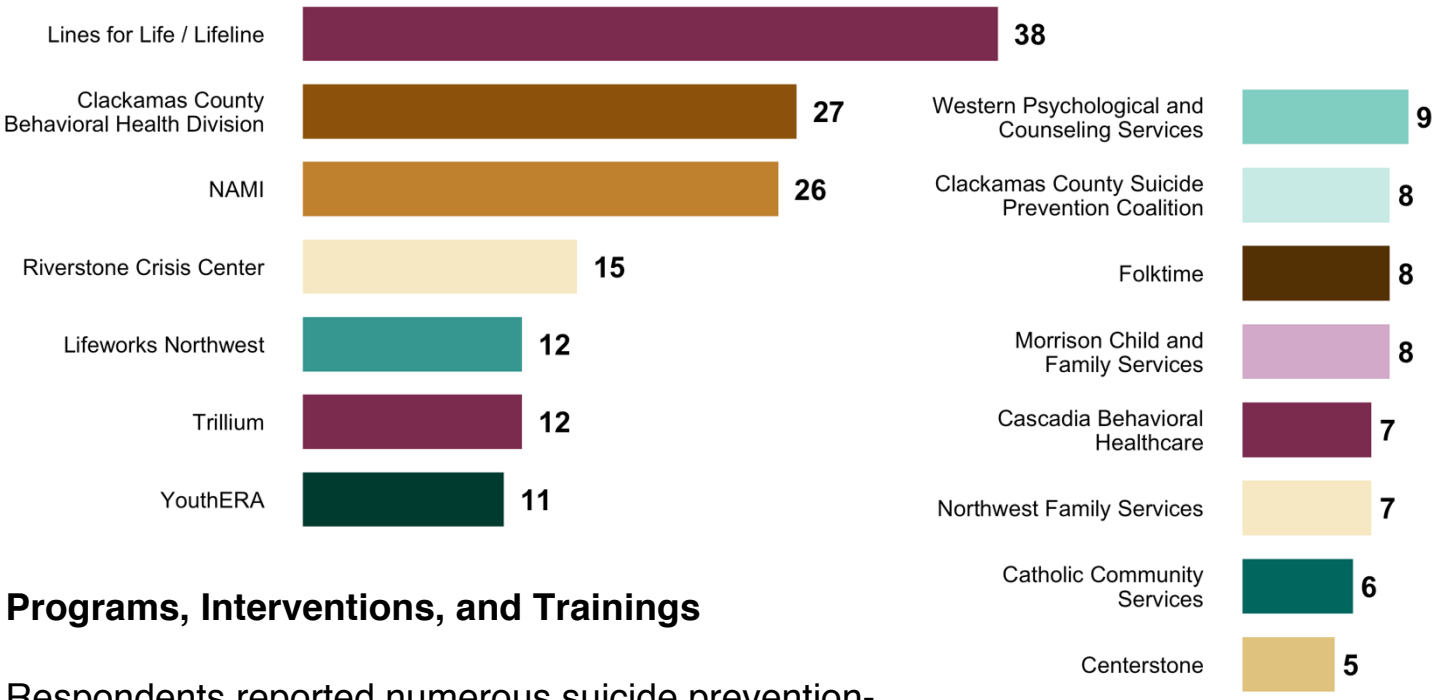
Those endorsing *Other* primarily worked or interacted with adults and youth with disabilities, homeless or inconsistently-housed populations, or domestic violence and sexual assault survivors and other trauma-affected populations.

Resource Awareness

Respondents were asked for their awareness of resources – in the form of community-based organizations, programs or interventions, or training opportunities – that support suicide prevention and mental health promotion in Clackamas County.

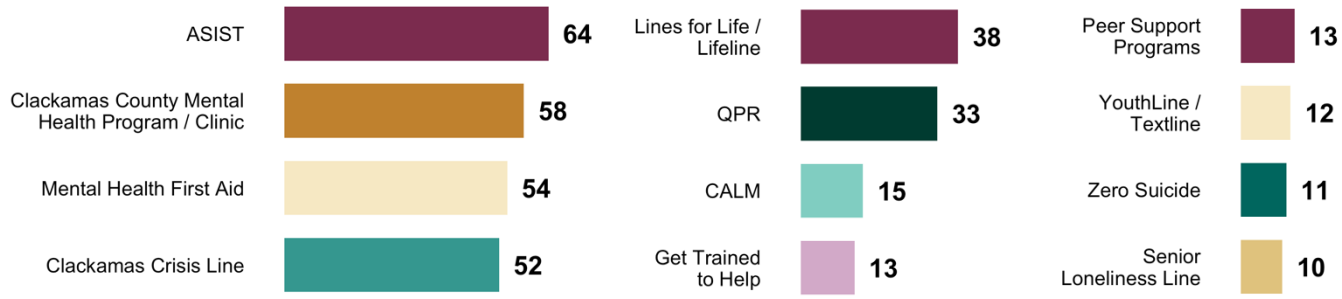
Community-based Organizations (CBOs)

A number of CBOs were reported, and those noted by five or more respondents are shown below. A full list of CBOs is provided in the Appendix.



Programs, Interventions, and Trainings

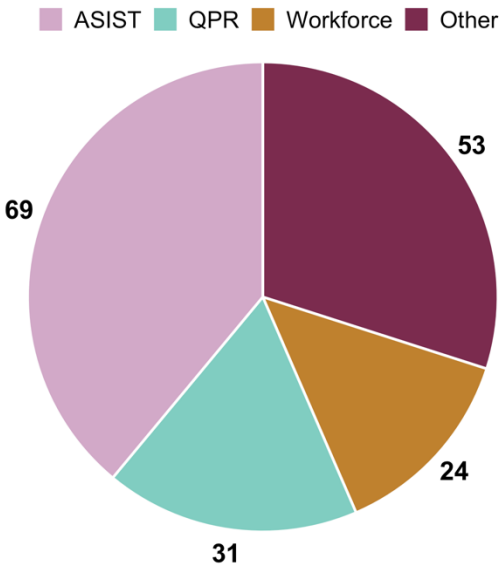
Respondents reported numerous suicide prevention-related programs, interventions, and training opportunities that they were aware of in Clackamas County; those reported 10 or more times are shown below. A full list of responses is included in the Appendix.



Respondent Training

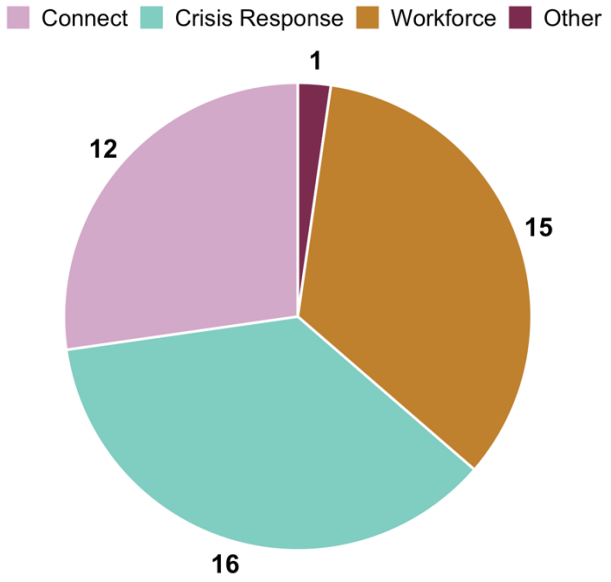
Respondents reported on the suicide and/or mental-health awareness-related trainings they had received. Respondents were asked to separately report suicide prevention and suicide postvention trainings, as well as general mental health awareness/promotion trainings. The number of respondents endorsing each training is shown below.

Suicide Prevention Trainings



For **suicide prevention** trainings, workforce-based trainings included non-specific suicide awareness trainings, or training that took place as part of an academic (e.g., MSW) or clinical (e.g., nursing) training program. Common trainings reported as *Other* included CALM, Sources of Strength, non-specific trainings offered by Clackamas County Behavioral Health Division, and trainings focused on LGBTQ populations.

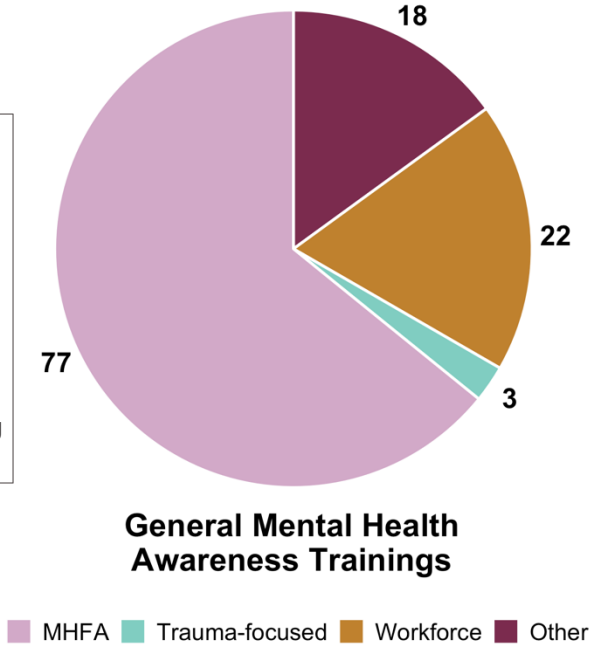
Suicide Postvention Trainings



For **suicide postvention** trainings, the most common crisis response training reported was Flight Team (CMI). Other workforce-based trainings included non-specific trainings offered by employers, held at conferences, or included as part of professional training programs (e.g., master's degree). The Zero Suicide program postvention training was reported as *Other.*

For **general mental health awareness** trainings, non-specific workplace trainings were most commonly reported among workforce-based trainings, followed by peer-support training. Psychological First Aid and the STAR program behavioral health training were reported as *Other.*

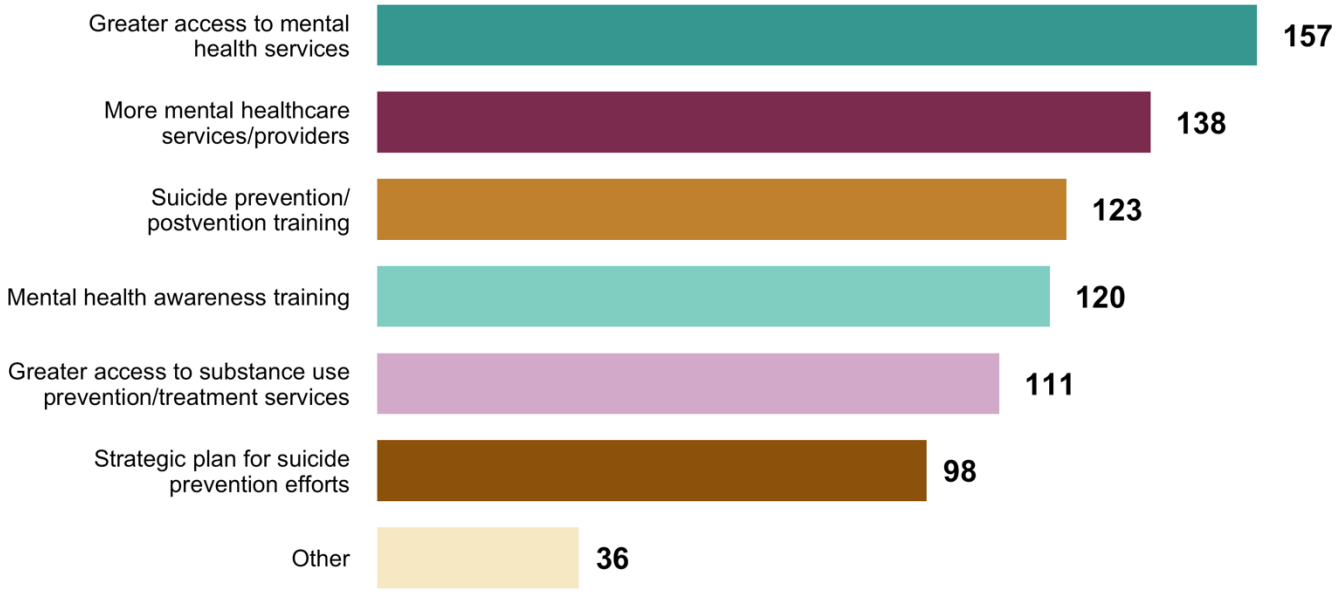
General Mental Health Awareness Trainings



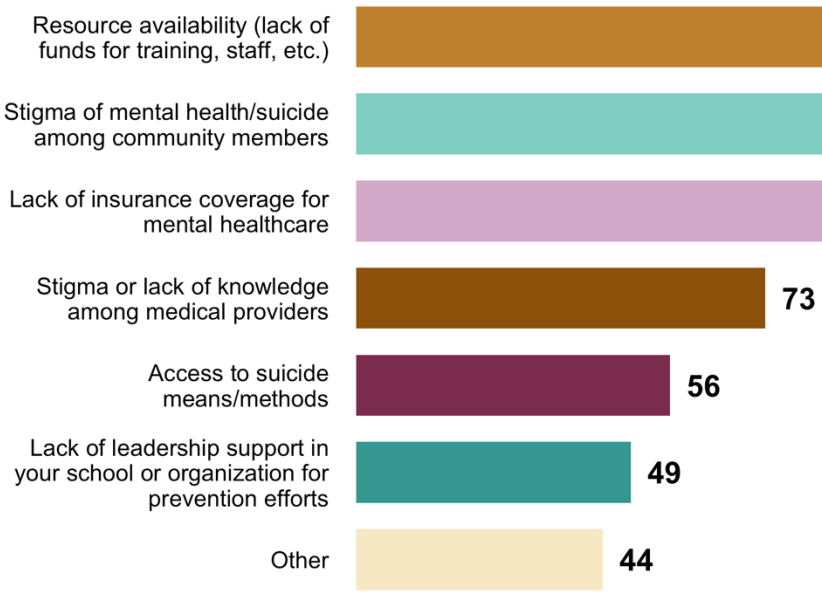
Needs and Barriers

The final component of the Assessment requested that respondents identify, from their perspective, the most important needs and barriers to better addressing and preventing suicide in Clackamas County. The number of endorsements of each of the response options is shown below. An open response field was also provided for respondents to identify other needs or barriers, which are included in full in the Appendix.

Needs



Barriers



Other **needs** included suicide survivor support services, improved housing options, structured school-based programs, coverage of private practitioners by OHP, and culturally-specific services for sexual, gender, and other minorities. Other **barriers** included lack of communication among lawmakers, lack of knowledge of early prevention strategies, isolation and lack of connection for rural communities, stigma among law enforcement and criminal justice officials and systems, and lack of transportation services for patients.

Appendix

CBOs and Other Organizations

American Foundation for Suicide Prevention (3)
ASHA (1)
Burnside Mission Shelter and Outreach (1)
Call to Safety (1)
Canby Suicide Prevention Task Force (1)
Cascadia Behavioral Healthcare (7)
Catholic Community Services (6)
CCSS (2)
Centerstone (5)
Central City Concern (1)
Clackamas Children's Center (2)
Clackamas County Aging and Disability Resource Connection (1)
Clackamas County Behavioral Health Division (27)
Clackamas County Health Centers (2)
Clackamas County Suicide Prevention Coalition (8)
Clackamas County Suicide Prevention Team (4)
Clackamas Resource Center (1)
Clackamas Service Center (1)
Clackamas Women's Services (2)
Crisis Assessment and Treatment Center (1)
Family Stepping Stones (1)
Folktime (8)
GOBHI (1)
Hilltop Behavioral Health (2)
Inn Home for Boys (1)
Inside Out (1)
Kaiser Permanente (2)
Lifeworks Northwest (12)
Lines for Life / Lifeline (38)
Lutheran Family Services (1)
MHAO (3)
Milwaukie Hospital (1)
Morrison Child and Family Services (8)
NAMI (26)
Northwest Family Services (7)
Oregon Alliance to Prevent Suicide (1)
Oregon Family Support Network (2)
Prov WF CAPU (1)
Public Safety (1)
Q Center (1)
Riverstone Crisis Center (15)
Sandy Behavioral Health (2)
SPCCC (1)
Sunshine Wellness Center (1)
The Living Room (4)
Trevor Project (4)
Trillium (12)
Unity (4)
Wade Clinic (Estacada) (1)
Western Psychological and Counseling Services (9)
Willamette Falls Hospital (4)
Witchita Community Center (1)
Wolf Pack Consulting and Therapeutic Services (1)
Youth Move (1)
Youth Villages (3)
YouthERA (11)

Programs, Interventions, and Trainings

211 Resource Line (3)
ASIST (64)
Ask the Question (7)
ASMR (1)
CALM (15)
Canby Suicide Prevention Task Force Trainings (1)
Care Coordination Programs (3)
Clackamas County Mental Health Program / Clinic (58)
Clackamas County Suicide Prevention Trainings (non-specific) (9)
Clackamas Crisis Line (52)
Columbia-Suicide Severity Rating Scale Training / Implementation (8)
Connect (9)
Consultation with Suicide Prevention Coordinator (1)
Drop-in programs (1)
ECPR (1)
Ending the Silence (2)
First responders trainings / programs (3)
Friendship Line (1)
Get Trained to Help (13)
Healthshare (1)
Hearing Voices (1)
Hospital-based Intensive Psychological Units (4)
Joint Commission Behavioral Healthcare Annual Conference (1)

Appendix

Lines for Life / Lifeline (38)
Mental Health First Aid (54)
National Child Traumatic Stress Network Trainings (non-specific) (1)
National Council of Behavioral Healthcare Annual Conference (1)
Northwest Family Services Training (1)
Oregon Warmline (4)
PEARLS (1)
Peer Support Programs (13)
PESI Trainings (non-specific) (1)
Police Non-emergency Line (1)
Project Respond (1)
Psychological First Aid (2)
QPR (33)
Response (5)
Safety Planning (1)
Sandy Hook Promise (1)
School-based counseling (5)
School-based Trainings (non-specific) (4)
See Something, Say Something (1)
Seeking Safety (1)
Senior Loneliness Line (10)
Sources of Strength (6)
Stanley Brown Safety Planning (1)
STAR Programs (1)
Stop Stigma (1)
Student-based Health Center (1)
Threat Assessment Team (1)
Trauma Intervention Project (1)
Veteran's Crisis Line (2)
WIC (1)
Wraparound Services (1)
Youth Mental Health First Aid (3)
YouthLine / Textline (12)
YPSN Trainings (non-specific) (1)
YSPN Listserv (1)
Zero Suicide (11)

Needs

1. More peer services and ways to transport those in the most need in rural areas.
2. Suicide survivor support.
3. More education/intervention for the under-12 demographic.
4. Easier and quicker access to mental health providers.
5. More low-cost housing options; housing as prevention.
6. Structured programs that can be offered in schools that are supported by experts in the suicide prevention community.
7. Decreasing mental health stigma.
8. Training in mental health awareness for those who work with public on a daily basis.
9. Trauma-informed school practices.
10. Mental health inpatient services.
11. Stigma busting activities that allow people who want help to be comfortable asking for it.
12. Greater "depth on the bench" so that when a community is hit by two or more events, there are enough trained people who can respond.
13. OHP needs to allow private practitioners to be on the "panel" of providers, not just large companies.
14. Greater access to community building for at-risk populations.
15. More individual therapists for OHP clients: many report systems trauma (long wait times, being turned away, frequent provider changes) from seeking crisis services at county or community behavioral health clinics.
16. OHP to allow private practitioners to see clients instead of insisting the client go to a general practice business.
17. Transgender and LGBTQ safe spaces.
18. I think just getting more people talking about it and helping everyone be more comfortable with asking difficult questions. I do love the ASIST training and fully appreciate that it serves every population and isn't just focused on the MH profession.
19. Training on who to call and how to coordinate care if someone tells you they are contemplating suicide. What number do you call and what are best practices?
20. Greater Access to peer support, less restrictions around eligibility to provide services.
21. We need a better system for people to access services right when they need them.

Appendix

22. More Adult/Youth/Family peer support.
23. ERs and health care professionals addressing substance use issues and risk for suicide in ERs.
24. More mental health crisis services available 24/7.
25. More service options once a person or family member calls a crisis line.
26. Mobile peers within programs.
27. Culturally specific trainings on suicide: suicide in trans(+) communities, addressing suicide cross-culturally, harm-reduction.
28. Training on supporting friends and family who are suicidal (not only for service providers to talk to people in their personal lives, but workshops/conversations with youth on how they're already support their friends, what's working for them or what they're needing, and strategies they can use to keep themselves and their friends safe.
29. More family support and early intervention.
30. More mobile MH/crisis services.
31. Law revisions and amendments to address stigma through protocols/policy.
32. More peer support services.
33. Education on how to talk about suicide between groups/ages to reduce stigma.

Barriers

1. Lack of support in schools, and staff knowledge of what to do when a student discloses ideation to them.
2. Lack of accessible data on under-12 demographic.
3. Even with insurance it can take weeks or months to get in to see someone.
4. Lack of funding for RAP housing.
5. Poor access to affordable housing.
6. Poor crisis services, lack of crisis mobile response.
7. Lack of support to develop and implement a school-wide suicide intervention and prevention programming in our school. It would be ideal to have experts come in to help us with organizing the programming and to provide training for faculty, students, and parents.
8. Lack of private insurance coverage for ICTS level of care, CCS (e.g., immediate level D services).
9. Severe lack of intervention availability from inpatient admission down to outpatient therapy.
10. Lack of communication with schools when students are seeking medical treatment.
11. Lack of knowledge of medication prescribed and its effects.
12. Fragmentation in community and lack of social connection.
13. Lack of school counselors and school social workers to provide prevention.
14. Lack of mental health providers in Clackamas County (wait lists).
15. Lack of transportation and access for overwhelmed families and support by a mental health provider to make sure they follow through. It would be good that if a child has an evaluation for example at CCMHC that they make sure treatment happens and if it doesn't get DHS or school counselors involved to make sure there is follow through.
16. While the school district talks about the importance of mental health support, their actions don't always reflect that. At the elementary level we are severely lacking coverage and resources for supporting those in a mental health crisis.
17. Lack of detox facilities because people are being turned away.
18. Not enough money spent in Clackamas County. CCOs say, "We're doing great stigma reduction work – In Multnomah County." There are tremendous resources – in Oregon City. How do our entire county's residents become a priority for the resources of time, money and personnel location?
19. Limited coverage under insurance, especially for HealthShare, and insurance companies only cover certain practitioners.
20. Lack of accessible longer term inpatient mental health and substance abuse programs for people who have not had success with shorter term programs.
21. Basic Medicare does not seem to cover mental health services.

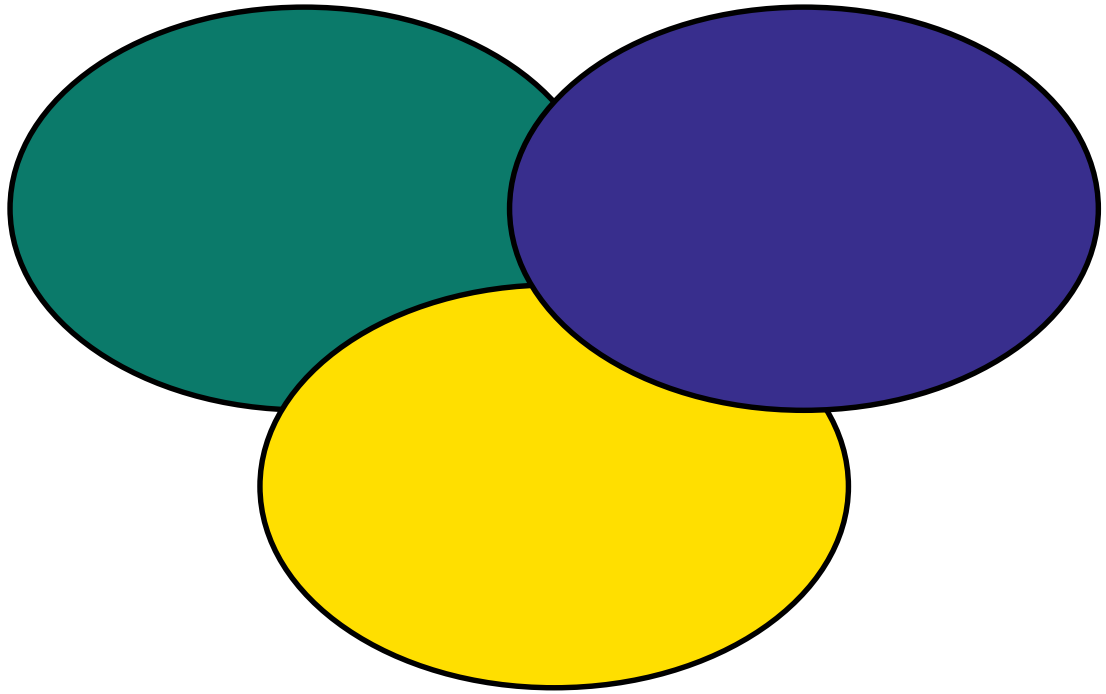
Appendix

22. Healthcare providers need more education on addressing the LGBTQ+ community and need more trauma-informed care training to avoid re-traumatization.
23. OHP insisting the client go to a general practice business, instead of allowing private practitioners to see clients.
24. Lack of services for clients who do not have access to transportation/don't drive.
25. Lack of individual therapists available to low income, uninsured or OHP clients. Crisis walk in clinics and community BHC services can make it worse if client feels "like a number" and has to wait too long to be seen when in crisis or is turned away too many times for lack of ability to pay or for wrong insurance.
26. Lack of resource availability geographically: rural areas are underserved.
27. Transportation to mental healthcare services.
28. Fear: people are still too afraid to talk about mental health/suicide.
29. Lack of knowledge in community, especially about how to respond when someone says they are contemplating suicide.
30. Lack of County and state leadership for prevention efforts, lack of accountability and responsibility on the county, state and federal government.
31. Lack of trained providers.
32. Isolation and lack of connection for rural communities (including transportation).
33. Lack of knowledge around early prevention strategies.
34. Too many guns.
35. Lack of communication amongst lawmakers.
36. Lack of interpersonal communication/connection.
37. Use of law enforcement as an intervention for someone who is experiencing suicidal ideations (not an appropriate intervention).

1


Suicide Prevention
Coalition
Clackamas Country
Hold • On • To • Hope

2



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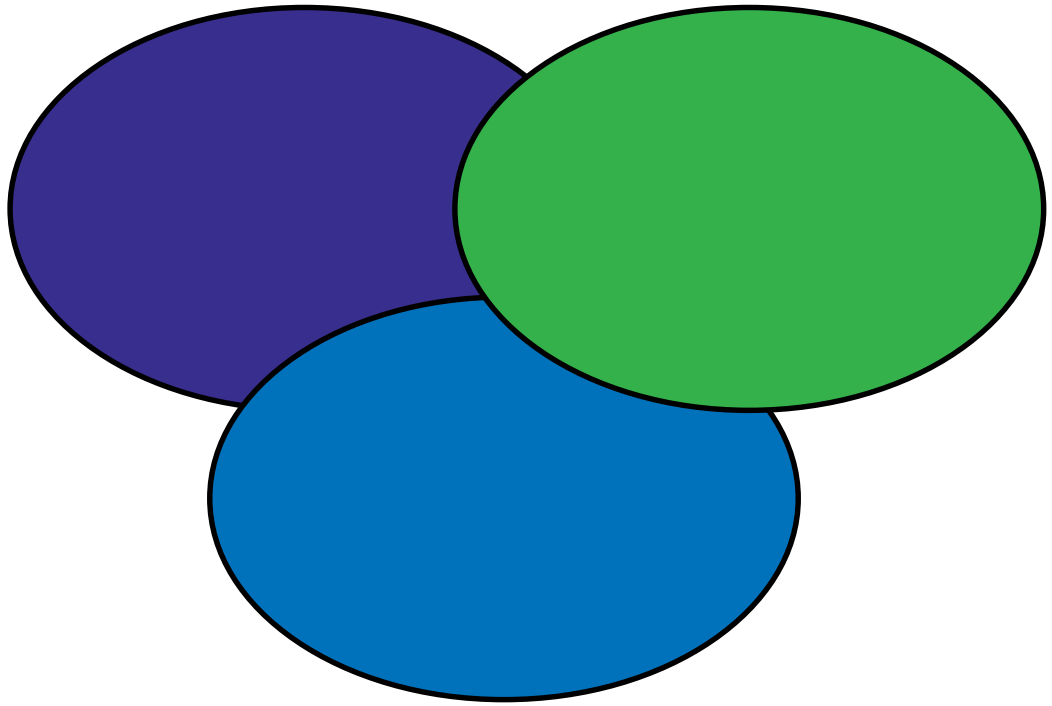

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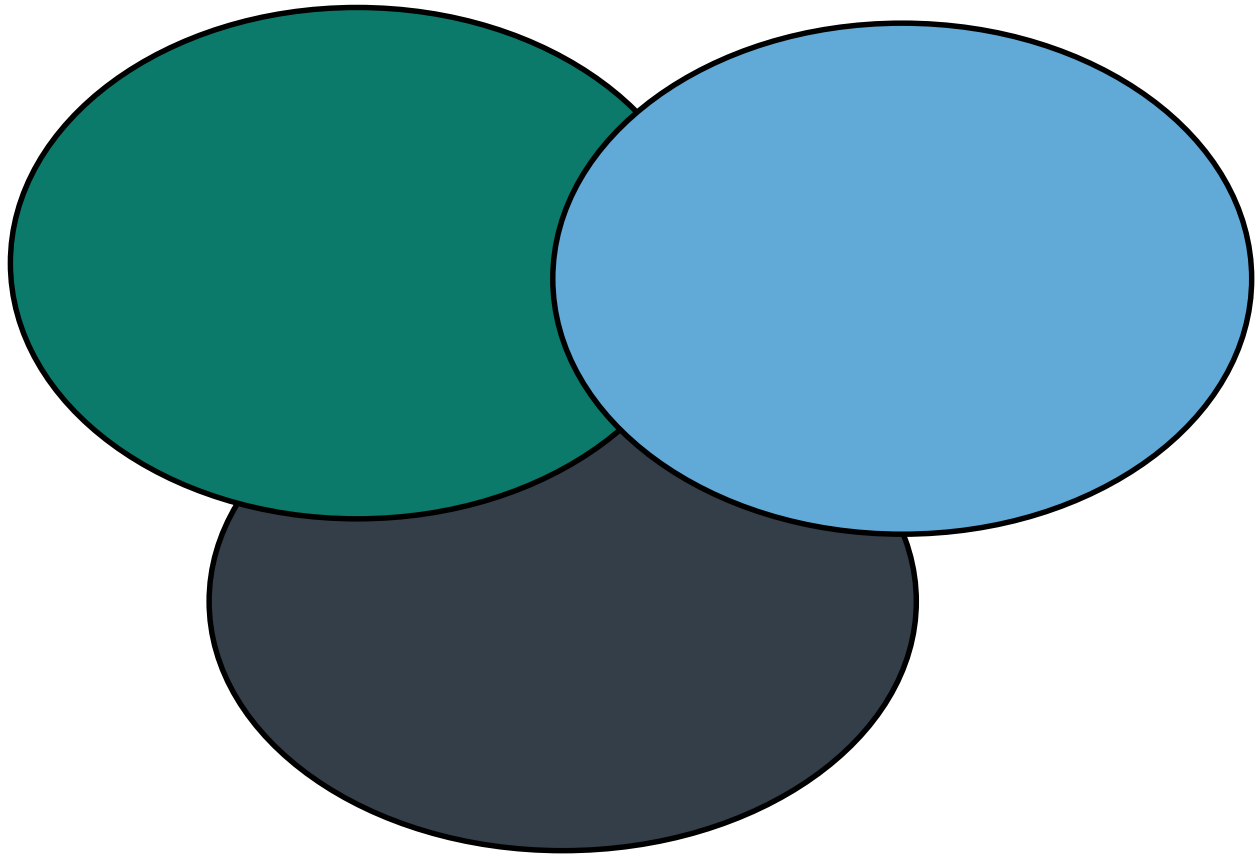

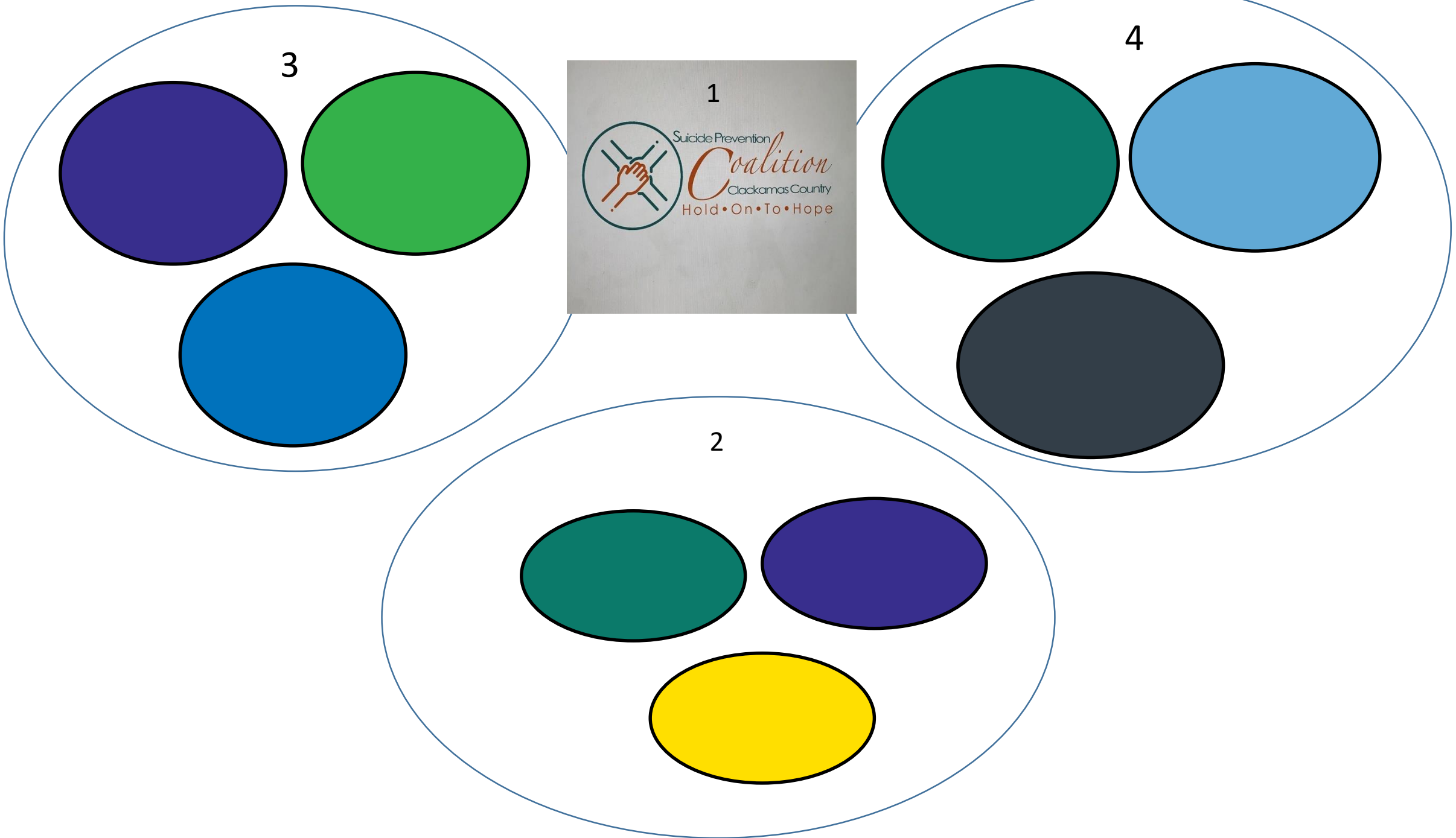
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1
Suicide Prevention
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Hold • On • To • Hope
4
2


Suicide Prevention
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Taglines: Whether

Considerations: Why is it relevant to logo design?

- Spark a connection,
- Clarify what you do,
- Summarize your value and/or
- Define your philosophy
- Especially useful when you are new

Considerations: When adding a tagline to your logo

- Design the logo and tagline as standalones and in various formats
- If not distinct, you are better off without one
- Too much detail can muddy the design

If yes, proposed process:

- Generate ideas from the steering committee
- Host a session with folks with lived experience and loss survivors from the coalition and possibly others to generate/review tagline options
- Present tagline options to full coalition for decision