Clackamas County

Suicide Prevention Strategic Plan 2023

Suicide Prevention Coalition
of Clackamas County

Connection. Support. Community.

Table of Contents

A message from the Suicide Prevention Coalition of Clackamas County 1

Executive Summary 2

How to Use this Plan........ 4

Equity Statement........ 4

Background 5

Understanding the Local Impacts........ 6

Means of Death by Suicide........ 7

Priority Areas, Strategic Directions and Suggested Action Items 9

Youth and Young Adults Priority Area 9

Means Safety Priority Area 10

Health Care Priority Area 11

Community Priority Area 12

Next Steps 13

Evaluation and Collective Impact........ 13

Call to Action 13

Acknowledgments 14

Sources........ 17

Appendix: Community Engagement Results........ 18

Suicide Prevention Coalition of Clackamas County Stakeholder Needs Assessment Survey (2019) . 18

Resource Mapping Survey........ 21

Resource Mapping Interviews........ 23

Ease/Impact Analysis........ 25

A message from the Suicide Prevention Coalition of Clackamas County

The Suicide Prevention Coalition of Clackamas County (SPCC) is pleased to present the Clackamas County Suicide Prevention Strategic Plan 2023 (SPSP) and invite you to work with us towards the collective mission of reducing suicide and its devastating impact in Clackamas County. This mission, and the strategy outlined within the SPSP, are aligned with the County's Community Health Improvement Plan, and our Performance Clackamas strategic plan.

The SPCC launched in October 2018 to bring a community voice to complement and inform the County's suicide prevention efforts. In addition to the Coalition, our organization has embraced the Zero Suicide initiative systems approach which has included required mental health awareness and suicide prevention training for staff, policies, and procedures to support and sustain the work and universal suicide risk screening at our behavioral health, primary care and urgent mental health walk in clinics. Because research supports that gatekeeper trainings improve people's knowledge, skills, and confidence in helping individuals who experience suicidal ideation and enhances positive beliefs about the efficacy of suicide prevention, the County, since 2015, has offered no cost suicide prevention trainings to our community and trained thousands.

In 2018, the County developed a postvention protocol to support suicide loss survivors. In 2019, Folk Time Peer Organization organized the first ever support group in Clackamas for people who have attempted or live with thoughts of suicide. In 2021, the County launched the Suicide Fatality Review Committee to evaluate the circumstances that may have contributed to a death from suicide and to identify areas in our community systems where opportunities for system improvements exist.

The SPSP extends the work of the SPCC and our organization with strategies designed to expand the collective impact of suicide prevention efforts and engage the community in a comprehensive approach to reduce suicides in the County.

The SPSP was developed over time with input from more than 200 members of our community, including representatives of groups at higher risk of suicide and people with lived experience of suicide loss, attempt survivors or people living with thoughts of suicide. The SPSP is a dynamic document. It will be developed further and reviewed and revised on a regular basis to meet the changing needs and circumstances of Clackamas County. We urge you to join us as we work together to continue to prevent suicide and pursue a vision of protected, safe, and resilient Clackamas County communities.

Executive Summary

In many ways, Oregon is leading the nation in suicide prevention efforts. Statewide, our strength is evident in ***18 regional suicide prevention coalitions across the state***, a dedicated and effective ***Alliance to Prevent Suicide***, a team of Oregon Heath Authority suicide prevention coordinators, legislation (***SB 52/Adi's Act***) that requires school districts across the state to adopt a policy that requires a comprehensive district plan on student suicide prevention for students in grades K – 12, ***school suicide prevention and wellness programming*** that supports schools in doing this work, and state legislation that mandates that behavioral health workers become ***better trained in suicide prevention, intervention and postvention through continuing education***.

COVID-19 brought unique needs to the work of suicide prevention and our state adjusted quickly. State contractors and advocates put in many hours to create as much protection as possible for Oregonians. As a result of the work put in, the number of suicides in 2020 did not increase from 2019, in fact it decreased from 908 in 2019 to 835 in 2020. This continued effort at the state level has paved the way for Clackamas County to develop its own local plan.

The vision for the Clackamas County's Suicide Prevention Strategic Plan is to provide a blueprint on a comprehensive and collective approach to preventing suicide and its devastating consequences. The important work to prevent suicide across the lifespan remains a top priority for Clackamas County.

Suicide remains a persistent, pervasive, and yet largely preventable cause of death. Every death by suicide carries a substantial and long-lasting ripple effect into our community.

Activities used to create this plan included community engagement, targeted outreach to members of groups that are at increased risk for suicide, and alignment with the below strategic models and planning frameworks:

- The San Diego County 2018 Suicide Prevention Action Plan Update
- The Youth Suicide Intervention and Plan 2021-2025
- Adult Suicide Intervention and Prevention Plan 2021-2025
- The National Strategy for Suicide Prevention
- The Centers for Disease Control Strategies and Approaches to Prevent Suicide
- Blueprint for a Healthy Clackamas County (CHIP) 2020-2023

Clackamas County's suicide prevention efforts are evident in leadership support and ongoing commitment to this work as well as a community that is motivated and eager to have conversations about suicide and implementation of programming. In the last six years, we have gone from what was initially a vision to an array of programing options for suicide prevention, intervention and postvention. This includes providing universal screening for suicide risk at all County operated mental health, primary care and urgent walk-in clinics, the development of a Suicide Prevention Coalition of Clackamas County Suicide Prevention Coalition and Suicide Fatality Review, the creation of a suicide attempt survivor support group for both adults and youth, formal partnerships with our firearm community and the creation of a postvention response team to better support our community after a death from suicide.

But our work is far from done. The elevated rates of suicide and the stigma around mental health and suicide continues to prevent individuals from receiving support or offering support to those that struggle. The risk of suicide for our communities of color are rising at a rate that is disproportionate to their population growth in the county. Creating a planful approach and one that looks at social identities and systems that affect suicide risk rather than solely through a lens of individualism will allow us to

leverage resources for a larger impact and to be intentional about reducing suicides.

We organized the plan around four key priority areas – **Youth and Young Adults, Means Safety, Health Care and Community**. Strategic directions and possible action steps were developed for each area using the following process:

- We solicited input and feedback through individual interviews and community surveys
- Key themes were identified by our partners at the University of Oregon Suicide Prevention Lab
- Using the key themes, the SPCC identified draft strategic directions and possible action steps
- Using an ease/impact process, the Steering Committee of the Coalition, with leadership and guidance from the University of Oregon Suicide Prevention Lab, determined which strategic directions would advance immediately and which would be reviewed again when the plan is next under evaluation.

The Clackamas County Suicide Prevention Coordinator and the University of Oregon Suicide Prevention Lab staff finalized the plan.

How to Use this Plan

Clackamas County's Strategic Plan aligns with the ***National Strategy for Suicide Prevention***, ***CDC Preventing Suicide: A Technical Package of Policy, Programs and Practices***, Oregon's ***Youth Suicide Intervention and Prevention Plan***, Oregon's Adult Suicide Intervention and Prevention Plan, ***Blueprint for a Healthy Clackamas County (CHIP)*** and ***Performance Clackamas***. Alignment with these national, state, and local plans helps to connect and leverage the work, allowing for an even greater impact.

Stakeholders are encouraged to use this plan to support the development of organizational plans and programs that prevent suicide.

Equity Statement

The reasons people die by suicide are complex and rooted in a cultural context, and 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 affect their access to help and support. Policies, practices and programming 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. Most importantly, in an equity lens we must look at high-risk populations with a lens toward their social identities and systems that have affected their risk for suicide rather than solely a lens of individualism.

With the knowledge that equity is a cornerstone to effective suicide prevention, the Equity Assessment Tool developed by the Adult Suicide Intervention and Prevention Plan Equity Workgroup will be used by the Suicide Prevention Coalition of Clackamas County to ensure that recommendations for Suicide Prevention Strategic Plan decision making and implementation include equity at the forefront.[A]

[A] *Equity Tool for Oregon's Adult Suicide Intervention and Prevention Plan (ASIPP), 2022*

Background

Shortly after creating the position of Suicide Prevention Coordinator in 2016, Clackamas County Health, Housing and Human services adopted the Zero Suicide initiative which meant Intentional efforts in our organization to change culture and improve services for suicide safer care.

In early 2018, Clackamas County experienced a cluster of youth suicides where four young people died in a 5-day period. Not only did these deaths capture the attention of the broader community, but it was also more than clear that it would take many voices and organizations working together to prevent additional lives from being lost. The Suicide Prevention Coalition of Clackamas County would be born in October 2018 as a part of this vital strategy.

The Suicide Prevention Coalition of Clackamas County is comprised of representation from various sectors of our community, including the following

- Law Enforcement
- Veterans and Veteran Serving Organizations
- Schools
- Health Care including Behavioral Health, Physical Health, Substance Use Disorder Providers
- Prevention Specialists
- Firearm Community Members
- Juvenile Justice Agencies
- Department of Human Services Adults and People with Disabilities
- Adult and Youth Peer Support Agencies
- Suicide Loss Survivors, Suicide Attempt Survivors, and others with lived experience
- Faith Based Organizations
- Community Based Organizations

Between July and November 2018, the Coalition conducted 19 listening sessions. The 260 participants representing 70 organizations shared valuable perspectives about protective and risk factors. In every meeting, people shared stories of loss or surviving attempts or people living with thoughts of suicide. Themes and insights were generated from the listening sessions to better understand local priorities, and participants shared what was important:

- Everyone needs at least one connection
- Everyone needs to know warning signs
- More coordinated services in every corner of our county is needed

In October 2018, Coalition members shared reasons for coming and discussed how to move forward. Between the local voices listening sessions and from community members at this and future meetings, the Coalition decided on the following priorities for action:

- Encourage outreach and communication for suicide prevention
- Improve equitable access and coordination for treatment, services & supports
- Increase awareness of risk factors and warning signs

Understanding the Local Impacts

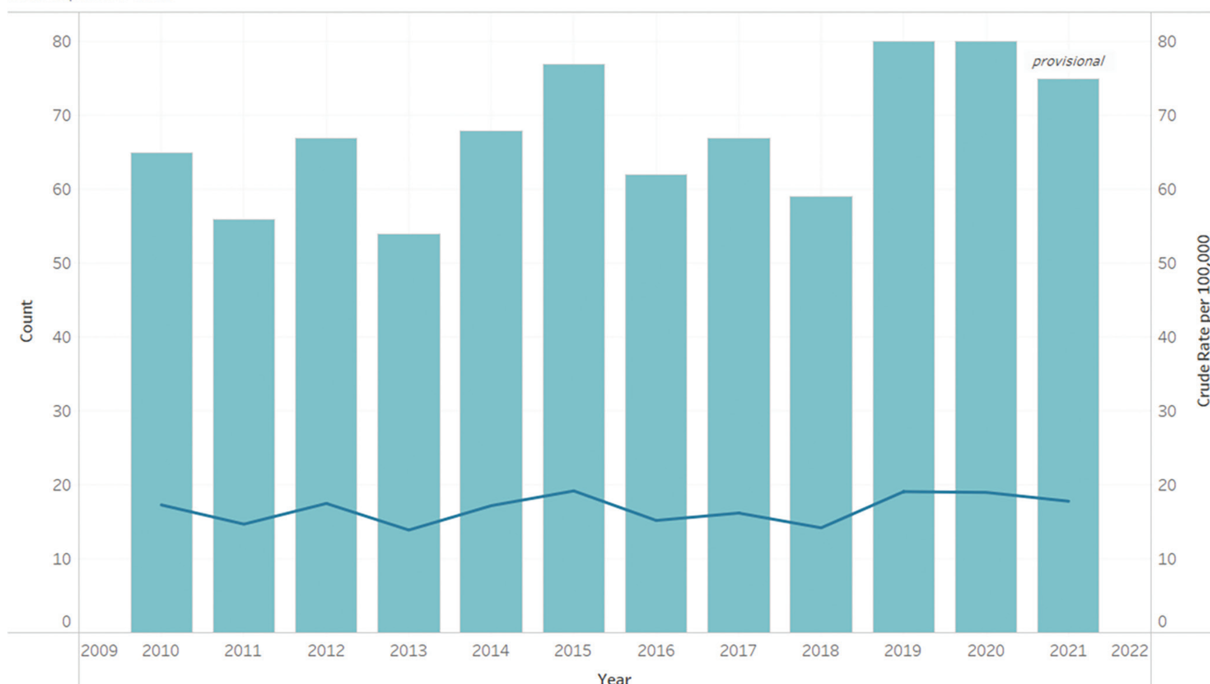
Epidemiological overview of suicide in Clackamas County

While 2021 data are preliminary and subject to change, data from the Clackamas County Medical Examiner's Office and the National Center for Health Statistics suggest that there were fewer deaths by suicide in 2021 than in 2019 and 2020.[1,3] There are projected to be even fewer deaths in 2022.[3] However, the annual rate of deaths by suicide in Clackamas County has varied year to year, trending slightly upward, since 2010 (see Figure 1).

The majority of deaths by suicide in Clackamas County are among males, with only 22% being female.[1] Expanded gender identity categories are unavailable for these data. National level data show that transgender and non-binary individuals are at higher risk of death by suicide than cis gender individuals.[4] Prevention efforts must bear that in mind despite local data being insufficient to reflect local risk.

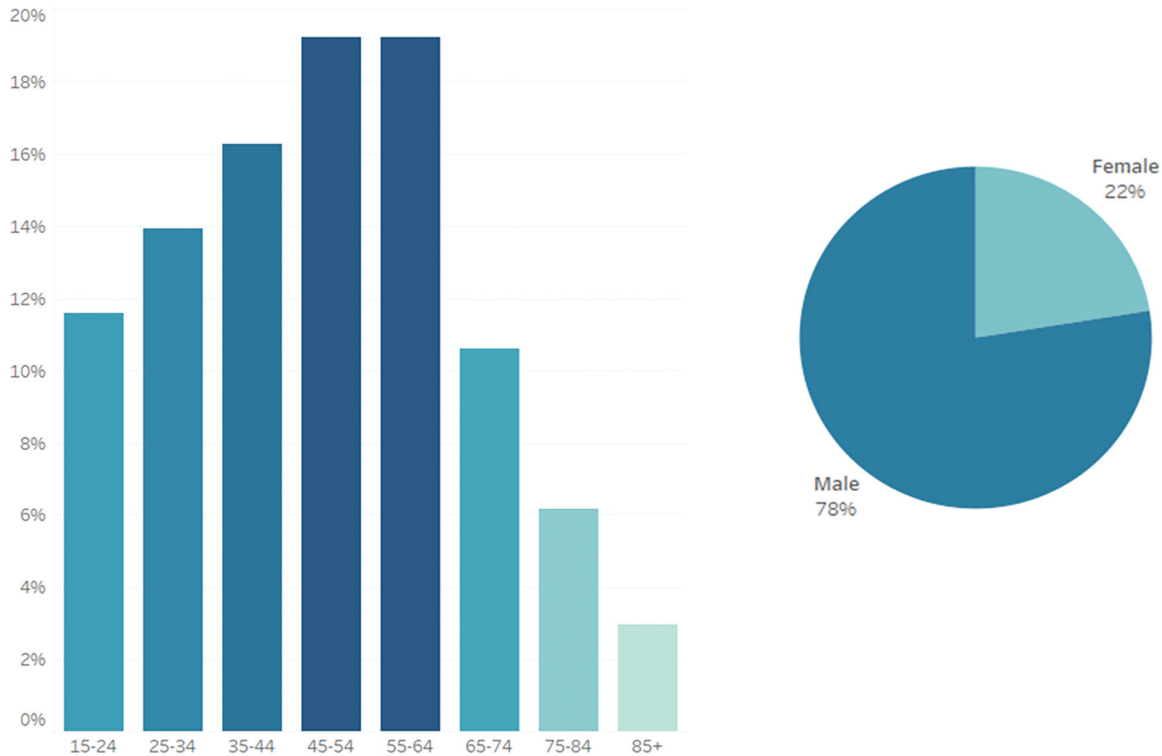
Population growth in our county has kept relative pace with deaths by suicide, creating an annual rate that masks the full impact suicide has had on our community. For example, 2015 had the highest suicide rate at 19.[2] per 100,000, but 2019 and 2020 had the highest counts of suicide with 80 each year.[1]

Figure 1



The age ranges that experience the most deaths by suicide are 45–64-year-olds. While younger people make up a higher percentage of those who die by suicide than people over age 85, those 85+ have a much higher rate and have had a striking percent increase in the last few years.[1,3] We know through narrative data that the life events leading up to a person's death by suicide are different across the lifespan so interventions and prevention efforts must be different.[3]

Figure 2



Most deaths by suicide in Clackamas County are among White residents[1] (95%); however, the distribution of race and ethnicity of decedents shifts from year to year. From 2010 to 2020, 4% of deaths by suicide have been among Latinx individuals but, in 2019 alone, almost 7% of those who died by suicide were Hispanic or Latinx[2].

While the number of deaths by suicide among American Indian and Alaska Native residents is too low to be publicly reported by the National Center for Health Statistics, Clackamas County Vital Statistics reports having no deaths by suicide among American Indian and Alaska Native individuals from 2015 to 2019, but that population accounted for 2.5% of deaths by suicide in 2020[1,2].

These data show that, despite White residents being the majority of deaths from suicide, communities of color are at increasing risk. Their risk is rising at a rate that is disproportionate to their population growth in the county and the rate of suicide among communities of color is quite variable from year to year (expanded race and ethnicity categories unavailable for these data).

Means of Death by Suicide

Since 2010, 53% of all deaths by suicide in Clackamas County were completed using a firearm (see Figure 3).Additionally, the percent of deaths by firearm has increased substantially each year.[1,3] There has been a 56% increase in firearms as the mechanism in deaths by suicide from 2010 to 2020.[1,3] Deaths by hanging have also increased across these years but not nearly to the same extent as firearms; no other mechanisms have increased.[3]

Figure 3

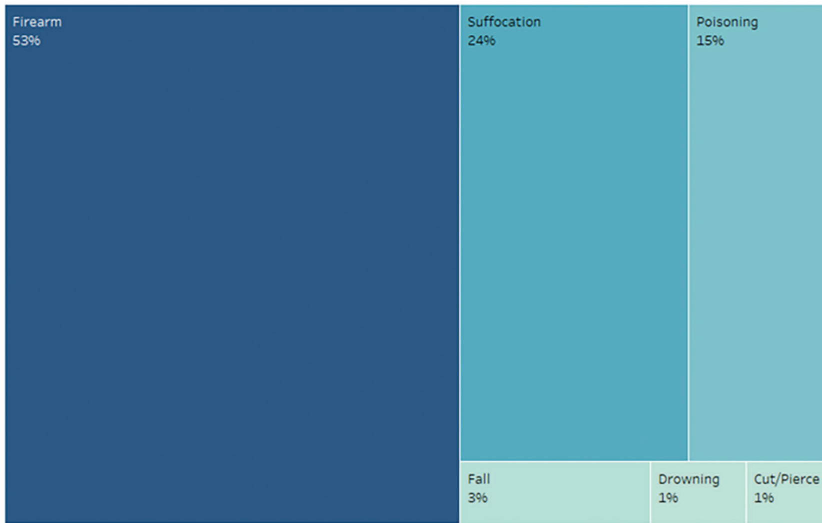
Deaths by Suicide in Clackamas County by Mechanism (2010 - 2021) // by Firearm Annually (2010, 2015, 2020)

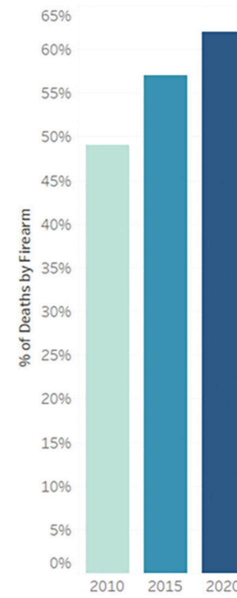
***2021 data are provisional**

Source: CDC Wonder - National Center for Health Statistics, National Vital Statistics System

Created by: Clackamas County Public Health

Date: September 2022





Priority Areas, Strategic Directions and Suggested Action Items

Information collected from key stakeholders was utilized to guide the development of the Clackamas County Suicide Prevention Strategic Plan and the priority areas and strategic directions. The main aim of the information gathered was to learn about past and current suicide prevention activities and future priorities from Clackamas County stakeholders and community members.

Informed by this input, the Strategic Plan has been organized around four key priority areas – Youth and Young Adults, Means Safety, Health Care and Community. *See the Appendix* to review the community engagement results, which informed how the strategic directions and possible action steps were developed for each area.

Youth and Young Adults Priority Area

Youth and young adults and the agencies and individuals who care for and support them will regularly be provided with skills and resources and will understand their role in suicide prevention.

Strategic Directions (listed in priority order)	Examples of Suggested Action Items
1a. Increase awareness of how to identify a peer who may be struggling, how to be of support, and when to involve a trusted adult.	• Create a system within an electronic portal or app that youth and young adults can access for support. • Identify and request technical assistance on increasing student awareness from k – 12 and higher education academic environments who are utilizing *Sources of Strength* or *Jed Foundation* programming or other upstream prevention curriculums. • Increase the availability of trainings for youth and young adults. • Train youth and young adults how to identify signs and symptoms of someone who is struggling • Youth and young adults will provide input about how to identify signs and symptoms of someone who is struggling and where to receive training. • Identify touchpoints and systems, other than schools, where youth and young adults may spend time or receive support. • Collaborate with youth and young adult serving organizations to promote and distribute information on suicide prevention trainings. • A dissemination plan for distribution of this information will occur and will include youth and young adult input.
1b. Increase parent/ caregiver awareness about suicide warning signs and other areas of suicide prevention such as intervention, postvention and how to navigate accessing help.	• Collaborate with school or district leadership to identify effective ways of engaging and educating parents/caregivers. • Have schools, districts and other organizations sponsor or host suicide prevention and mental health awareness trainings for parents/caregivers. • Create a system within an electronic portal or app that parents/caregivers can access for support. • Use schools, districts, higher education environments and other organization's social media platforms, and other forms of communication to provide factual and informative information.

1c. Improve safe transitions from hospital to home and school.	• Better understand HB 3090 (2017), the existing Oregon law that requires hospitals with emergency departments to adopt and implement policies for those who discharge after being seen for a behavioral health crisis. • Explore how hospitals in Clackamas County are meeting this requirement. • Offer to support local hospitals and/or school districts in establishing a process for safe transitions.
1d. Increase awareness on the issue of suicide prevention and improve engagement in, and implementation of, effective suicide prevention activities.	• Meet annually and on an ad hoc basis with district and higher education environment leadership to provide an overview of available suicide prevention related supports. • Messaging about availability of supports will occur two times during the academic year. • Coordinate, offer and collaborate with others to provide mental health awareness/suicide prevention trainings to staff, parents/caregivers and students about how to identify suicide warning signs and how to navigate help in Clackamas County.
1e. Increase utilization of prevention strategies such as universal suicide risk screenings and early prevention curriculum.	• Promote the annual use of early prevention curriculum that promotes resiliency, help seeking behaviors and connection for youth and young adults. • Meet annually and on an ad hoc basis with school district and higher education environment leadership to provide an overview of the effectiveness of universal suicide risk screenings as a prevention strategy.

Means Safety Priority Area

In collaboration with the firearm community, law enforcement agencies, community-based organizations, academic environments, health care providers and suicide prevention training partners, promote means safety as part of a comprehensive approach to suicide prevention.

Strategic Directions (listed in priority order)	Examples of Suggested Action Items
2a. Engage the firearm community in this work and let them lead versus telling them what to do.	• Collaborate with and regularly attend meetings with the Oregon Firearm Safety Coalition. • Generate a list of all Federal Firearms Licensees (FFL's) to understand location and number of firearm retailers located in Clackamas County. • Partner with Clackamas County Sheriff's Office to approach FFL's to, 1) distribute messaging with each sale; 2) display messaging in their business; 3) inquire as to whether or not the FFL would be a temporary storage location for firearms. • Identify temporary storage options for firearms. • Attend the Oregon Alliance to Prevent Suicide lethal means advisory group and partner as appropriate.
2b. Increase awareness about access to secure storage items such as rifle cases, gun cable locks and medication lock boxes and why using them can saves lives.	• Continue to make available no cost secure storage items. • Ask the firearm community about where and who should be distributing secure storage items. • Collaborate with law enforcement agencies, academic environments, behavioral health, physical health, and substance use providers and suicide prevention training partners to announce availability about secure storage items and how to access. • Make secure storage devices and suicide prevention resources available to community members in all Clackamas County Health Equity Zones.

2c. Provide suicide prevention trainings within the firearm community.	• Identify all firearm clubs and ranges in Clackamas County. • Support these clubs and ranges in including suicide prevention as part of their new member orientation. • Increase *Question, Persuade and Refer (QPR)* trainers that identify as firearm owners. • Develop a cohort of QPR trainers that are firearm owners and tailor QPR training to better meet the needs of the firearm community. • Outreach to *Veterans of Foreign Wars*, *American Legion's* and other similar networks to offer suicide prevention trainings to their membership.
2d. Increase firearm cultural competence for behavioral, physical health and substance use providers and those who may not identify as part of the firearm community.	• Create a firearm culture training designed and facilitated by firearm owners for behavioral, physical health and substance use providers and those not part of the firearm community. • Identify target areas in Clackamas County and support the distribution of the *Addressing Firearm, Safety in Your Suicidal Patient Video Resources and the People Who Love Guns Love You flier*. • Promote the Oregon Counseling on Access to Lethal Means (CALM) training. • Normalize firearm ownership through messaging, conversations, bringing firearm owners and non-owners together.

Health Care Priority Area

Promote suicide prevention as a core component of health care services and implement best or promising practices for identifying and supporting individuals at risk for suicide.

Strategic Directions (listed in priority order)	Examples of Suggested Action Items
3a. Increase lived experience and other related community engagement opportunities that increase hope, connection, and resiliency.	• Identify support group curriculum that can be used in Clackamas County to increase hope, connection, and resiliency. • Identify and train community members, community partners and others to facilitate the • identified group curriculum. • Disseminate information to community members about the availability of groups.
3b. Training for, and materials to, healthcare providers will highlight universal suicide risk screening and treatment for suicidality.	• Identify smaller health systems and primary care clinics and offer technical support, training, support for the development of protocols and pathways to increase utilization of universal suicide risk screening. • Develop and distribute a toolkit that supports implementation of universal suicide risk screening and treatment for suicidality in health care settings. • Include education about universal suicide risk screening during mental health awareness or suicide prevention trainings provided to health care providers/agencies. • Leverage and collaborate with existing health care providers/agencies to increase the practice of universal suicide risk screening.
3c. Diversify and increase utilization of mental health and suicide prevention trainings available to health care providers.	• Identify what trainings larger health care systems offer to their workforce that are brief and adapted. • Explore alternate format for these trainings to remove potential barriers to attending. • Request a list of trainings that are brief and adapted from the Oregon Health Authority and what plans they may have for expansion. • Communicate about the availability of these trainings to the health care community.

Community Priority Area

Develop, implement, and support community-based programs and education that promote wellness, safe messaging and prevent suicide within our community.

Strategic Directions (listed in priority order)	Examples of Suggested Action Items
4a. Increase and sustain mental health awareness and suicide prevention training trainer capacity.	• Create a “trainer hub” that includes the names of any individual who has expressed interest in becoming a trainer and utilize this list for recruitment. • Increase diversity in the trainer group through steps such as broadening the type and variety of trainings offered to our community. • Parents/guardians, natural supports and caregivers, adult senior centers, businesses, faith communities and other community members will learn about training availability through targeted messaging.
4b. Increase awareness of suicide prevention related resources and make information accessible to all Clackamas County residents.	• Mental health awareness and suicide prevention trainings that Clackamas County sponsors, contracts for or provides will be made available in the preferred language of community members. • Easy-to-understand print, multimedia materials and signage will be provided in the languages used by our community. • Identify and promote mental health awareness, suicide prevention and other trainings that represent the cultural diversity of our community. • Partner with existing community-based organizations, media partners and others to disseminate this information. • Request that *Clackamas County Public and Governmental Affairs (PGA)* distribute safe messaging and information on suicide prevention resources and trainings to the community. • Request that Clackamas County’s Public and Governmental Affairs develop a communication plan for all communication needs. • Collaborate with media outlets and utilize forums such as town halls to increase awareness.
4c. Develop strong social networks and connections to reduce isolation	• Create events to bring people together. • Create programs such as the utilization of *caring contacts* to reach individuals in the community who experience isolation, loneliness or who otherwise may benefit from increased connection.

Next Steps

Clackamas County and the Suicide Prevention Coalition of Clackamas County appeal to all individuals and organizations to be vigilant, persistent, and actively engaged in preventing suicide. We envision the Suicide Prevention Strategic Plan as a guide to mobilize efforts across multiple sectors.

With the development of the Suicide Prevention Strategic Plan comes a restructuring of the Suicide Prevention Coalition of Clackamas County. In addition to the Steering Committee, the leadership body for the Coalition, and the Suicide Fatality Review Committee, the Coalition will have four standing action teams (committees), each representing one priority area in the Suicide Prevention Strategic Plan. These action teams are: **Youth and Young Adults, Health Care, Community, and Means Safety**.

These action teams will meet monthly to advance the work of the Suicide Prevention Strategic Plan. Quarterly Suicide Prevention Coalition meetings will provide an educational or training opportunity to keep our community abreast on the suicide prevention field as well as a provide a venue where updates about action team work and strategic directions will be shared.

Evaluation and Collective Impact

In 2023, an evaluation and tracking plan will be developed that will include measurable outcomes and target dates for each initiative in all four priority areas. Beginning in 2025, the Clackamas County Suicide Prevention Strategic Plan will be reviewed and modified every two years based on evaluation results and community feedback.

Call to Action

To impact suicide deaths and attempts, no single individual, organization, or sector can be solely responsible. Our intention is that all stakeholders can look at this plan and see where they fit in, and that they will be inspired to act. We invite organizations and individuals throughout Clackamas County to be part of the collective effort to decrease suicide and its devastating consequences by working with the Suicide Prevention Coalition of Clackamas County to:

- ***Join us in future Coalition planning and work***. We cannot do this work without our community and your involvement. Participate in one of the four priority area action teams.
- Participate in conversations and community activities that raise awareness and decrease stigma associated with mental health and suicide.
- Host or ***take a mental health awareness or suicide prevention training*** to better identify and support individuals who may be struggling. Everyone can play a role in suicide prevention.
- Implement universal suicide screenings in health care settings.
- Create environments that prevent unauthorized use of firearms and reduce access to other lethal means such as medications.

For further details and to get involved, go to ***www.clackamas.us/behavioralhealth/suicideprevention.html***. Please contact Galli Murray, Clackamas County Suicide Prevention Coordinator, at ***gallimur@clackamas.us*** to get involved or with questions.

Acknowledgments

Clackamas County would like to thank the University of Oregon Suicide Prevention Lab for their work on the development of the Clackamas County Suicide Prevention Strategic Plan. We also extend our appreciation to the Suicide Prevention Coalition of Clackamas County and Steering Committee, who have stayed involved and active despite the impact of the pandemic and the associated difficulty of engagement.

The Clackamas County Suicide Prevention Strategic Plan would not exist were it not for over 200 people from our community who participated in listening sessions, the 80 people who completed surveys and the 25 key individuals who were interviewed between 2018-2020. We engaged the voices of individuals from communities who are at higher statistical risk for suicide, loss and attempt survivors, individuals who live with thoughts of suicide and suicide prevention advocates and champions.

We appreciate the time of the following people and organizations who participated in the interviews and surveys that informed this plan.

- Aaron Henry, Veteran Service Officer, Clackamas County Social Services Division
- Aging & Disability Resource Center
- Aging & People with Disabilities – DHS
- Ally Linfoot, Peer Services Coordinator, Clackamas County Behavioral Health Division
- American Legion
- American Medical Response
- Amy Jo Cook, Clackamas Fire Community Paramedic, Clackamas County Fire District #1
- Arcadia Retirement
- Canby Adult Center
- Canby Schools
- Carlos Romero, Wrap Around Care Coordinator, Clackamas County Behavioral Health Division
- Cascadia Behavioral Health
- Clackamas County Aging Services Advisory Council
- Clackamas County Children Youth & Families Division
- City Managers, City of Gladstone
- Clackamas County Public Health Division
- Community Health Workers
- Community Living Above
- Court Appointed Special Advocates
- Dave Romprey Warm Line
- Donna-Marie Drucker, President and Co-founder Oregon Firearm Safety Coalition
- Educators
- Elaine Morelock, Community Outreach and Equity TOSA, Oregon City School District
- Elected Officials
- Elise Thompson, Operations Director, Clackamas County Behavioral Health Division
- Folk Time
- Fire Emergency Medical Technicians
- Estacada Food Bank
- Food Bank Customers
- Funeral Home Directors
- Grandparents
- Geoff Moser, Mental Health and Addictions Association of Oregon
- High School & Community College Students
- Housing Authority of Clackamas County
- Housing Authority Residents
- Clackamas County Juvenile Department Staff
- Jane Uchison, Psy.D., Behavioral Health Program Director, Metropolitan Pediatric Clinics
- Jen Hopkinson, Counseling Program Manager, Clackamas Women Services
- Jenna Morrison, Under Sheriff, Clackamas County Sheriff's Office
- Joel Ekdahl, Teacher, Canby School District/GSA Adult Mentor/PFLAG Member

- Kim Whitely, Older Adult Behavioral Health Coordinator, Clackamas County Behavioral Health Division
- Koreen Barreras-Brown, Superintendent, Colton School District
- Larry Moseley, Veteran and Older Adult, Member of Clackamas County Veteran's Advisory Committee
- Margaret Moore, LCSW, Supervisor, Clackamas County Health Centers Division
- Mary Rumbaugh, Director, Clackamas County Behavioral Health Division
- Michael Ralls, Director of Student Services, North Clackamas School District
- Michael Salitore, Director of Student Services, Molalla River School District
- Mike Vermace, Clackamas County Sheriff and Fire Chaplain, Clackamas County Sheriff's Office
- Northwest Primary Care
- Clackamas County Older Adult Advisory Council
- Older Adults
- Oregon City Schools
- Oregon Department of Human Services
- Oregon Legislative Staff
- Oregon Project Independence
- OSU Extension
- Pacific Medical Group
- Parents
- Parrott Creek
- Peers
- People with Lived Experience
- Philip Mason-Joyner, Director, Clackamas County Public Health Division
- Planned Parenthood
- Plaza Los Robles Residents
- Prentice Greary, DPN, MBA, CADC III, CODA
- Providence Health & Services
- Rose Fuller, Executive Director, Northwest Family Services
- School Counselors
- Self Sufficiency Program – DHS
- Senior Companions
- Spencer Rohde, Police Officer & School Resource Officer for Oregon City High School, Oregon City Police Department
- Stephanie Jefferson, Lead Case Manager, Clackamas County Behavioral Health Division
- Students
- Suicide Loss Survivors
- Support Group Leaders
- The Pathfinders Network
- Todos Juntos
- Teresa Kaufman, School Counselor, Oregon City School District
- Tito Mendoza, LCSW, Veteran Service Officer, Clackamas County Social Services Division
- Tonia LeBeau, Care Coordinator Team Lead, Northwest Primary Care Clinics
- Veterans and Families Resources Center
- Veterans of Foreign Wars
- Visjna Brooks, LCSW, Lead Social Worker, Providence Willamette Falls Hospital Emergency Department
- Volunteers
- West Linn Wilsonville Schools
- Youth ERA
- Youth Leadership & Youth Advisory Councils
- Youth Villages

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- Mary Rumbaugh, Director, Clackamas County Behavioral Health Division

University of Oregon Suicide Prevention Lab

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- Kaliq Fulton-Mathis, M.Ed., Research Assistant, Center on Human Development

- Jonathan Rochelle, M.S., Doctoral Candidate, Special Education
- Nicholas J. Parr, Ph.D., MPH, Associate Director, VA Evidence Synthesis Program Coordinating Center

Clackamas County Suicide Prevention Coalition Staff and Steering Committee Members

- Galli Murray, LCSW, Clackamas County Suicide Prevention Coordinator
- Kathy Turner, CPCC, Special Projects Coordinator
- Carlos Benson Martinez, Clackamas County Youth Homelessness Continuum Program Coordinator
- Elisa Gerber, Clackamas County, ODHS Aging and People with Disabilities
- Jenn Fraga, CSWA, Oregon Alliance to Prevent Suicide, Lived Experience
- Joan Hoff, MA, AFSP, Suicide Bereavement Support NW
- Monica Parmley-Frutiger, LCSW

Sources

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Appendix: Community Engagement Results

The following section provides a summary from the community engagement process. Collected information from key stakeholders was utilized to guide the development of the Clackamas County Suicide Prevention Strategic Plan and the priority areas and strategic directions. The main aim of the information gathered was to learn about past and current suicide prevention activities and future priorities from Clackamas County stakeholders and community members. All methods discussed result from the University of Oregon Suicide Prevention Lab (UOSPL) collaboration with the Suicide Prevention Coalition of Clackamas County (SPCC).

Information Gathering Procedures

The UOSPL employed a parallel mixed-methods design by using qualitative and quantitative methods, which included: discussion groups, semi-structured formative interviews, and online surveys. The majority of information collected was quantitative (i.e., surveys), however, qualitative information (e.g., key informant interviews) was equally as critical to the development of this plan. Interviewees gave verbal consent to video and audio recording and transcribing. The following content describes the information that was gathered and all sources of information.

Suicide Prevention Coalition of Clackamas County Stakeholder Needs Assessment Survey (2019)

The purpose of the Clackamas County Suicide Prevention Stakeholder Needs Assessment Survey 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 aim of the survey was primarily to examine the existing needs and resources, the policy environment, and other relevant structural considerations as it related to suicide prevention goals of Clackamas County. In the following section, the key findings of the survey are described.

Sample

258 residents of Clackamas County completed the survey over an approximately three-month period. The survey was primarily disseminated via an online survey platform, and English, Spanish, Vietnamese, and Russian-language versions were made available. Only one non-English survey was completed. Thirteen surveys were completed by hand. Respondents were asked for their current profession(s); the proportion of each profession is outlined below. 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.

- Mental health care provider (17.4%)
- Medical provider (5.8%)
- Teacher/athletic coach (4.2%)
- School staff/administrator (2.9%)
- Police/law enforcement (0.6%)

- Public health (5.8%)
- Juvenile/criminal justice (2.9%)
- School counselor (11.3%)
- Substance use prevention/treatment (2.6%)
- County/local government (non-public health) (11.9%)
- Child welfare/protection (1.3%)
- Other (33.4%)

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. 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. Youth and young adults aged 25 and under were the primary population of focus by respondents.

Awareness of Resources

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 behavioral health promotion in Clackamas County. A number of community-based organizations were identified, however, detailed below were the most commonly reported.

- Lines for Life/Lifeline (38)
- Clackamas County Behavioral Health Division (27)
- NAMI (26)
- Clackamas MHC (formerly Riverstone Crisis Center) (15)
- Lifeworks Northwest (12)
- Trillium (12)
- Youth ERA (11)

Programs, Interventions, and Trainings

Respondents reported numerous suicide prevention-related programs, interventions, and training opportunities that they were aware of in Clackamas County; below were the most commonly reported.

- ASIST (64)
- Clackamas County MHC (58)
- Mental Health First Aid (54)
- Clackamas Crisis and Support Line (52)
- Lines for Life/Lifeline (38)
- QPR (33)

- CALM (15)

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 behavioral health awareness/promotion trainings. The most common suicide prevention training reported was ASIST (69); Other (53) was indicated as the second highest. 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.

For general mental health awareness trainings, the most common response was Mental Health First Aid (77); the second highest response were non-specific workforce trainings (22).

For suicide postvention trainings, the most common was crisis response (16). The second highest reported response was workforce (15), which included non-specific trainings offered by employers, held at conferences, or included as part of a professional training program (e.g., master's degree).

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.

Needs:

- Greater access to mental health services (157)
- More mental health care services/provers (138)
- Suicide prevention/postvention training (123)
- Mental Health awareness training (120)
- Greater access to substance use prevention/treatment services (111)
- Strategic plan for suicide prevention efforts (98)
- Other (36)

Other needs included suicide survivor support services, improved housing options, structured school-based programs, coverage of private practitioners by Oregon Health Plan (OHP), and culturally specific services for sexual, gender, and other minorities.

Barriers:

- Resource availability (lack of funding for training, staff, etc.) (134)
- Stigma of mental health/suicide among community members (124)
- Lack of insurance coverage for mental health care (121)
- Stigma of lack of knowledge among medical providers (73)
- Access to suicide means/methods (56)
- Lack of leadership support in your school or organization for prevention efforts (49)
- Other (44)

Other barriers included lack of communication among law makers, 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.

Resource Mapping Survey

The UOSPL distributed the Resource Mapping Survey in August of 2020 to Clackamas County stakeholders to gather contextual community-level data. Below are the key findings from the survey results organized by sector. A total of 80 respondents completed the survey with representatives from the school, community, clinical, and individual domains. The survey was distributed using community targeted *listservs* associated with the Suicide Prevention Coalition of Clackamas County.

School respondents represented 20% (N = 16) of total survey entries with representation from High Schools (63%), Middle Schools (31%) and Elementary Schools (6%). Findings indicated that QPR and ASIST were the most commonly used gatekeeper trainings in schools. Additional questions were asked around five key themes 1) training adequacy, 2) awareness, 3) stigma, 4) staffing, and 5) school resources/capacity. The responses were measured on agreement and rating scales with specific findings detailed below:

- Enough trained **staff**: 50% somewhat/strongly agree, 38% disagree
- Enough trained **students**: 0% agree, 73% disagree
- Well-attended student groups: 56% agree, 25% disagree
- High **staff** awareness of student groups: 44% agree, 31% disagree
- High **student** awareness of student groups: 50% agree, 25% disagree
- Students experience mental health stigma: 31% agree, 38% disagree
- Adequate staffing for mental health programs: 13% agree, 75% disagree
- Enough resources to support students at risk: 63% yes, 28% no
  - Educational materials for parents and students most wanted resource
- 47% say **ESD** is supportive; 40% would not say
- 35% say **school district office** is supportive; 43% would not say
- 64% say **parent community** is supportive
- 73% say local school building/admin is supportive

Community respondents represented 29% (N = 23) of total survey entries with representation from Urban (50%), Suburban (45%), and Rural (5%) areas. Findings indicated that most respondents (75%) would agree that programs offered by their organization are accessible. However, half of respondents (50%) disagree that enough people are trained in their community. Additional questions were asked around the five key themes of 1) training adequacy, 2) awareness, 3) staffing, 4) accessibility, and 5) community resources/capacity. The responses were measured on agreement and rating scales with specific findings detailed below:

- Enough trained in community: 25% agree, 50% disagree
- Programs offered by org are accessible: 75% agree
- High awareness of programs offered by org: 25% agree, 35% disagree
- Adequate funding and staffing for MH programs: 80% disagree
- Enough resources to support someone at risk: 63% yes, 37% no
  - Additional training, staff, and educational materials for adults most wanted resources

Individual respondents represented 23% (N = 18) of total survey entries with representation from Urban (17%), Suburban (61%), and Rural (22%) areas. Respondents were acknowledged at the individual level to account for varying stakeholder perspectives within the Community/Individual domains. Responses

from the Individual and Community groups were later combined to influence the comprehensive composite Community priority area. Additional questions were asked around the five key themes of 1) training adequacy, 2) awareness, 3) staffing, 4) accessibility, and 5) community resources/capacity. The responses were measured on agreement and rating scales with specific findings detailed below:

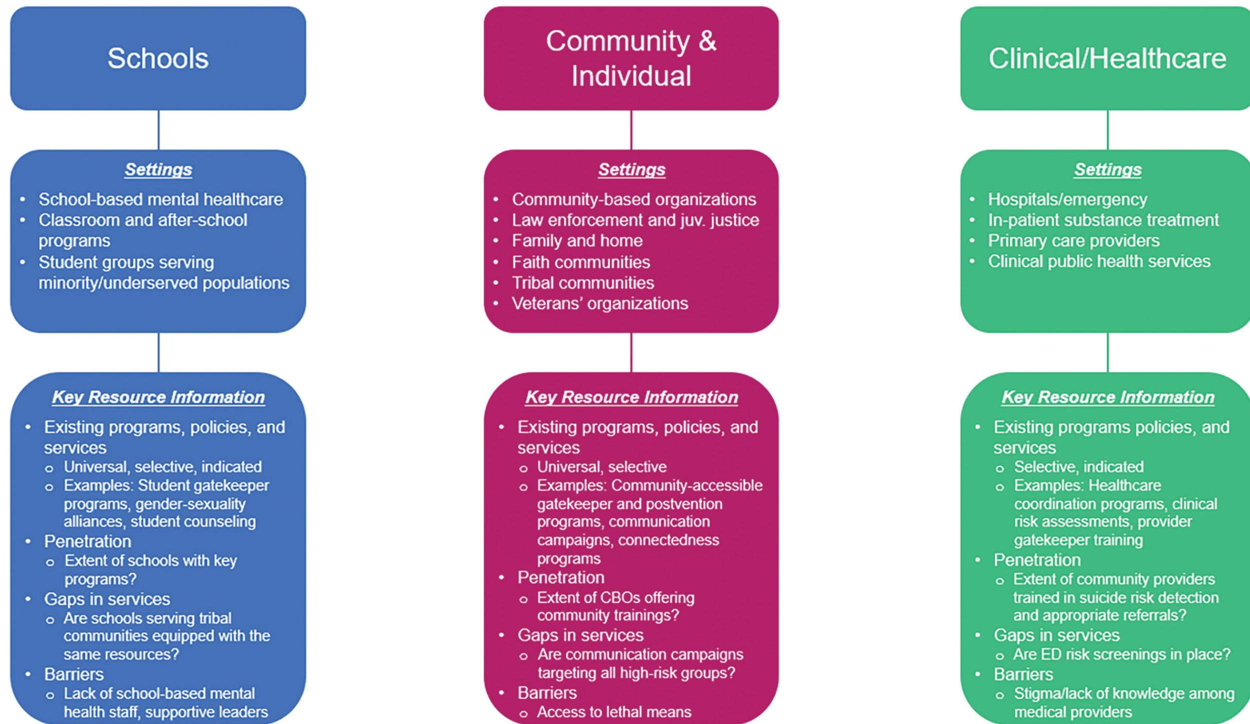
- Enough trained in community: 84% disagree
- Programs offered in community are accessible: 28% agree, 44% disagree
- High awareness of programs offered in community: 18% agree, 71% disagree
- People experience MH stigma: 65% agree, 25% disagree
- Adequate funding and staffing for MH programs: 0% agree, 83% disagree
- Enough resources to support someone at risk: 61% yes, 39% no
  - Additional training, additional programs and staff in community, and educational materials for adults and youth/adolescents most wanted resources

Clinical respondents represented 29% (N = 23) of total survey entries with representation from Urban (35%), Suburban (52%), and Rural (13%) areas. Findings indicated that most respondents were aware of programs offered by their organization and that those programs are accessible. Although, the main barriers to the Clinical group appear in funding and staffing for the programs. Additional questions were asked around the five key themes of 1) training adequacy, 2) awareness, 3) staffing, 4) accessibility, and 5) community resources/capacity. The responses were measured on agreement and rating scales with specific findings detailed below:

- Programs offered by org are accessible: 70% agree, 26% disagree
- High awareness of programs offered by org: 56% agree, 30% disagree
- Adequate funding and staffing for MH programs: 26% agree, 52% disagree
- Enough resources to support someone at risk: 87% yes, 13% no
- Educational materials for patients and families, better coordination between service providers, and additional resources for continuity of care services most wanted resources

The results of the resourcing mapping survey are presented in Figure 4 separated by sector. Each sector includes the settings that were represented by respondents of the survey. Additionally, key resource information that was indicated by respondents outlines 1) the existing programs, policies, and services that exist within the domain; 2) questions of integrated practice and service within the domain; 3) questions of potential gaps and shortcomings; and 4) barriers that challenge implementation of programs, policies, and services within the domain.

Figure 4. *Resource Mapping Survey Results by Sector*



Resource Mapping Interviews

Methodology: To identify available suicide prevention resources, knowledge, barriers, and opportunities, key informant interviews were conducted with school, community, clinical/healthcare sector stakeholders throughout Clackamas County. Interviews were semi-structured in format and were conducted by Suicide Prevention Coalition of Clackamas County leadership. Interviewers utilized an interview guide tailored to each sector. Interview transcripts were then coded to identify key themes and findings, which are summarized below.

Schools Sector	
Resource: Suicide Prevention Trainings and Connectivity Groups	• Most participants indicated trainings are available but too infrequent; insufficient professional development time for teachers, and most of available time needs to be used for teaching-related professional development • Not enough organizational staff or students trained; training individual staff is a risk investment, because if they leave, the knowledge (and sometimes the program) is lost • Trainings are not trauma-informed • Difficult to manage multiple suicide prevention and wellbeing-related initiatives, such as non-integrated prevention, postvention training, and Multi-Tiered Systems of Support. • Students are resistant to connectivity groups when they have overt behavioral health focus

Resource: Behavioral Health Services	• Behavioral health services are available, but access is limited • Limited qualified staff, included multilingual staff to support students and families • More rural areas are in "services deserts" ("Our counselors were referring over 30 students a month for behavioral health services and two would actually go to their intake and one would continue after intake.") • Lack of protocols for subacute students (i.e., not yet suicidal but needing intervention) and liability concerns around non-behavioral health staff providing behavioral health support to students • Parents and families are not aware of state-level policy changes that impact provision of suicide-related prevention and behavioral health services
Major Barrier: Stigma	• Stigma is prevalent for staff and students reporting behavioral health concerns • For students, "stigma originates at home rather than at school" (i.e., from home background and cultural norms around behavioral health concerns)
Opportunities	• Train wider array of staff, e.g., secretaries and others that work one-on-one with students • Provide parent/family-targeted education on statewide suicide-related policies and initiatives • Implement trauma-informed training to educate about student perspectives and variations in experiences and behaviors • Work to integrate suicide prevention and wellbeing initiatives into one continuum of support/care • "Behavioral health coordination needs to be director level because it helps to get in the door with partners and government – people want to talk to school administrators (over 'coordinators'); 'social services' also in title because it is the language of stakeholders outside schools"
Community Sector	
Resource: Suicide Prevention Trainings	• Most participants indicated trainings are available, but not enough organizational staff or community members are trained • Trainings are too infrequent to counter knowledge loss due to staff turnover and skills loss • Trainings do not reach those who need them most (e.g., trainings focus on adults and organizational staff, rather than directly reaching children and families) • Suicide prevention information is overwhelming, difficult to wade through, and "easily forgettable"
Resource: Behavioral Health Services	• Behavioral health services are available but poorly integrated (e.g., not accessible without a case manager), overtaxed (e.g., long wait times), and underfunded • Low income, POC and/or disability status are major access barriers; lack of POC providers • Outreach not well-targeted to disproportionately impacted communities (e.g., minorities, Veterans, LGBTQ) • First responders are supported but need specialized behavioral health support (i.e., appropriate to frequently violent and traumatic experiences and/or delivered by peer in non-stigmatizing way) • Some services require case manager to access, yet case managers can be overburdened and unable to take on new patients
Major Barrier: Stigma	• Stigma and internalized (self) stigma are prevalent, including among first responders (i.e., as "helpers," they should not need to be helped themselves) • Resistance to admitting or acknowledging behavioral health concerns, and fear of losing employment, children, or health care provider if seeking behavioral support • Lack of awareness that "suicide is a community problem that takes a community to solve" • First responders and law enforcement feel least stigmatized when engaged by peers

Opportunities	• Produce billboards, brochures, and other "quick access" educational materials that "mainstream" talking about behavioral health and suicide • Address organizational norms, particularly among first responders • Boil down training to, e.g., "five simple questions to ask your partner or community member" or to efficacy-focused training of how to "ask are you ok" and then have the Clackamas County Crisis Line handy to provide
Clinical/Health Care Sector Domain	
Resource: Suicide Prevention Trainings	• Training varies from formal and required to informal information sharing
Resource: Behavioral Health Services	• Behavioral health services are available but racial/ethnic and language minorities, those with experience of behavioral health concerns, and older adults underrepresented or underserved • Providers of non-behavioral health care often feel unprepared when a patient screens positive for suicidality • When only one type of service is available locally (e.g., group-based support programs), such a one-size-fits-all approach excludes some needing support who may not be comfortable with approach (e.g., due to social anxiety)
Major Barrier: Organization Structures	• Structural barriers (e.g., education requirements) for peers to access salaried staff positions; regulations that require providers of behavioral health interventions to have master's degree in behavioral health field are overly prescriptive and restricting, and preclude others such as peers and nurses from providing services • Some non-behavioral health care settings do not enough time allotted to staff training or professional development to allow for suicide prevention training; consequently, staff do not feel comfortable engaging patients about behavioral health • Those in crisis can access support initially, but ongoing support can be difficult to access
Major Barrier: Stigma	• Prevalent view that behavioral health is not a basic need and that behavioral health concerns are not crises, and as a result individuals avoid using crisis lines • People who have co-occurring substance misuse often labeled as high risk (e.g., as having drug-seeking behavior) and denied services
Opportunities	• Reduce barriers to hiring peers who can better connect with at-risk populations and open pathways for those with advanced degrees in non-behavioral health areas to provide behavioral health services • Provide non-clinical staff (e.g., receptionists) the same level of training as clinical staff, because they regularly encounter at-risk individuals • Pilot or implement low-to-no barrier respite system ("not a hospital, not a locked psychiatric ward, just a place for when 'I'm not comfortable being home alone'") • Broadly implement brief universal screening (e.g., with PHQ-2), potentially along with brief trainings for staff on available behavioral health services in Clackamas County and how to refer/access

Ease/Impact Analysis

From January to March of 2022, the UOSPL facilitated an Ease-Impact analysis to expand upon the findings from the Clackamas County Needs Assessment and Resource Mapping. Ease-impact analyses are an effective evaluation tool that allows users to prioritize action steps and initiatives by charting on a matrix the estimated level of ease (amount of work involved) and impact (total effect it will have) that an individual action will have.

The analysis was conducted with the Coalition's Steering Committee and occurred over three working session meetings. The UOSPL created jam boards of goals in four domain areas: 1) Youth and Young

Adults, 2) Means Safety, 3) Health Care, and 4) Community. These goals were developed with a Diversity, Equity, and Inclusion/Lived Experience lens (DEI & LE). For each domain area, the Coalition's Steering Committee team charted the embedded initiatives by coming to consensus over where in the matrix each item should be ranked.

Upon completion of the ease-impact analysis, the UOSPL facilitated a final stage of ranking each individual initiative within the four domains. The leadership team used the findings from the analysis to submit a final prioritization ranking of the embedded initiatives, which was used for guiding the structuring of this plan by listing top priority initiatives first.