HEALTH SYSTEMS DIVISION

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Testimony Narrative
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SB 833: Relating to suicide

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Good afternoon, Senator Gelser, Vice Chair Olsen, and members of the committee:

My name is Frances Purdy. I am the Family Partnership Specialist with the Health Systems Division of the Oregon Health Authority. The agency is neutral on this bill. I am here to testify on how this initiative would fit into the existing system, as well as workforce challenges and implementation issues.

This bill seeks to have a positive impact on people who have attempted suicide and those who have lost a family member to suicide by facilitating linkages to peer support resources and behavioral health services. The bill does three things:

1. It requires law enforcement to encourage someone who has attempted suicide to authorize the officer to facilitate a referral to a peer support program;
2. It requires law enforcement to encourage family members of someone who has died by suicide to authorize the officer to facilitate referral to a peer support program, and
3. It requires hospitals to adopt and enforce a policy that upon discharge following a suicide attempt, the hospital will encourage the patient to sign an authorization for the hospital to disclose contact information for peer support follow-up.

Overall, this bill is one step toward reducing the high risk of additional suicide attempts by the person or by family members. And it's important to note that peer support services would have to be available in the community in order for the bill to be effective.

Now, I will share some alarming statistics with you.

- In Oregon, suicide is the second leading cause of death for those between the ages of 15 and 34. In 2015, 762 Oregon residents died by suicide.
- Over 2,000 Oregonians are hospitalized for suicidal behaviors each year.
- In 2015, there were 529 suicide-related hospitalizations and 84 suicide deaths among young people aged 10 to 24. These cases would have required peer support to the attempt survivor and/or their family (parents and siblings).
- Also In 2015, 16 percent of 11th graders reported seriously considering suicide in the past 12 months. Despite our efforts to help these young people, the youth suicide rate has been rising in Oregon each year since 2011.
- That same year, 672 people that were 25 or older committed suicide. The most recent data, from 2014, show that 2,187 people aged 25 or older were hospitalized for harming themselves or attempting suicide.

Peer and family support services would have been required for all suicide attempt survivors and family (parents and siblings).

Law enforcement referral after a suicide attempt

Law enforcement may refer people who have attempted suicide to mental health providers; however, that treatment may be delayed anywhere from two weeks to 90 days. There are several things that can delay treatment, including challenges getting post-assessment appointments, lack of insurance or the money to cover co-pays, and stigma. Peer Support Specialist approach services with an immediate call to promote connectedness and decrease isolation. Modeling hope and helping people develop day-to-day skills in self-care have both been shown to reduce the risk of suicide. Regular contact with a Peer Support Specialist also includes a focus on reducing access to lethal means and implementing safety planning.

Law enforcement's referral after a death by suicide

Grief or bereavement is a normal process that is generally not included in the typical array of behavioral health treatment services. Individual bereavement and support groups are generally facilitated by people with similar life experience. The focus is addressing the paradoxes and conflicts with attachments and loss, feeling and showing emotions, and unique approaches to self-care and reducing isolation. It is important not to pathologize grief and getting support from peers really helps.

Post hospitalization referral to Peer Support

In response to HB 2023, the Oregon Hospital Association developed policies and procedures for all hospitals requiring that outpatient appointments be made within seven days of discharge. Without continuing supportive contact, less than 50 percent of those discharged from hospitals get outpatient treatment, and most do not attend more than one session. There are many potential reasons for this—access to appropriate care, insurance coverage and ability to pay, and stigma. Sound familiar?

Peer Support provides care continuity by encouraging hope and helping survivors navigate multiple and complex systems. It also helps them develop their treatment and safety plan with professionals, family and friends. Helping survivors be involved to the fullest extent possible is called "person-centered planning" or "family and youth-driven services" and gives them control over selecting and using services, including choosing their provider. Engagement, expression of hope for the future and choice of services decreases the risk for further suicidal behavior, including completed suicide.

In addition to offering peer support, other evidence-based practices to prevent re-attempts include case management or care coordination, 24-hour contact with a mental health provider, and active follow-up, including phone calls, letters, emails and postcards to decrease isolation and increase connectedness. These interventions include a one-hour discharge session to address suicidal ideation, attempts, risk, protective factors, and referral options. One specific program offers nine additional follow-up contacts, either by telephone or home visits over the next 18 months. This approach has also been shown to decrease hospitalization rates and suicides in adults.

Parent support, problem solving skills, and suicide prevention training have all been shown to be effective with children, youth, and young adults. This is also part of Peer Delivered Services and includes how to increase protective factors with consideration to the young person's developmental needs. For young adults, the focus is on how to engage with social-emotional learning programs of peer support and other interventions used with adults.

Gaps in implementing SB 833.

Currently, Peer Support is a Medicaid billable service but is not typically covered by commercial insurance plans. For Medicaid, Peer Support can only be billed through an approved billing agency, like a community mental health program or health/behavioral health clinic. The peer support services agency would have to be affiliated with such an approved billing agency. Few are.

Additionally, for the peer support service to be billable, the patient must have a diagnosis and a treatment plan. Hospitals that provide the information at discharge could refer to a peer support program affiliated with a billing agency.

A referral from law enforcement would be insufficient to bill Medicaid or most other insurers. Bereavement/grief support also would not be billable to Medicaid and most insurers, in part because normal grief is not a billable Medicaid diagnosis and support groups are excluded from payment by insurers.

The fiscal impact associated with SB 833 provides for payment for peer support services that are currently not available or are not billable to Medicaid and other insurers. Payment is necessary in order to have a workforce that is not based on volunteers, who need ongoing training and supervision and are unlikely to provide continuity of care. Whether dealing with grief or support for suicide prevention, the peer support needs to be reliably present with safe and appropriate services delivered by peer support specialists trained in suicide risk and harm reduction, safety planning and community engagement skills, in addition to peer delivered services competencies. Oregon does have a certification process for peer support that addresses necessary competencies and ethical practice.

The bottom line is that **every suicide is preventable**. SB 833 is one step toward making suicide prevention in Oregon a serious priority.

Thank you for the opportunity to testify. I'm happy to answer any questions.