Date: February 22,2021
Re: Testimony in support of HB 3037

Respected Chair and Honorable members of the House committee on Behavioral Health:

I am a Board-Certified psychiatrist and have been practicing in various counties in Oregon since 2000 and have over thirty-three years of experience in the field. I am also the chair of Salem-Keizer school Board and we are the second largest school district in our state and a medical staff of Salem Hospital. In addition, my clinical work extends from Harney county to Douglas county.

I am testifying in support of the HB 3037.

In 2018 Youth suicide (24 years and less) became the leading cause of death in that age group and overtook accidental deaths in Oregon. The rate of suicide also doubled compared to 2003. We saw what appeared to be like two clusters of youth suicide in Marion county. In 2018 there were 20 completed youth suicide in Marion county.

While on call in Salem hospital, I have evaluated children as young as 12 years old who were brought after suicide attempt and during a call in February 2018, I had to evaluate around ten patients admitted following suicide attempt in one weekend call and most of them were youth. It is estimated that for every completed youth suicide, there is around 50-100 suicide attempts. In 2018 October-November, we had the second cluster of youth suicide in my county. We lost two youth to suicide 17 days apart from the Sprague high school in Salem. In our school district we lost nearly seven youth to suicide that year. I had accompanied one of those students as a parent chaperone along with my son and his jazz group to Seattle.

I learned that none of the 197 school districts in our state and the 65 schools in my school district have a suicide prevention policy. This was despite several laws passed since 2015 to prevent suicide contagion, postvention. It was then I decided to run for school board and campaigned on the platform of youth suicide prevention and got elected as a school board director in 2019. While campaigning I also learned from my son's high school counsellor that they had conducted 80 suicide risk assessment in one month that year.

It is estimated that nearly 5% of Youth suicide often follows a pattern of occurring in clusters and spreads like a contagious disease outbreak often referred to as suicide contagion. Yet youth as an age group is at high risk for suicide. The problem is bigger than what we see in the hospital, clinics, mental health centers. The recent Oregon Healthy Teens Survey finds Percentage of youths who seriously considered suicide in the past 12 months, in 2019: 20 percent of eighth graders, Percentage of youths who attempted suicide one or more times in the previous 12 months, in 2019: 10 percent of eighth graders and Percentage of lesbian and gay youth who contemplated suicide in the past 12 months, in 2019: 50 percent of eighth graders

Are we looking at the wrong places in our state?

This bill is one of the many steps where we can have accurate and timely epidemiological data to understand and hopefully address the problem. Having the Medical Examiner be the point of reporting to the database will likely yield accurate estimates of the magnitude of the problem and mitigate the gaps in timely reporting as was seen with the previous laws which did not serve the purpose for which it was intended nor allowed timely intervention. Many completed suicides is never reported to the local county mental health as the person may have private insurance, may be served in the Veterans Affairs or may have no insurance coverage at all and there is no standardized state level registry for completed suicide or suicide attempts if it happens outside the hospital setting.
Ideally this data along with other state mandated reporting data including hospital reports of suicide attempts, overdose deaths, county mental health agency reports of suicide, Oregon Healthy teens survey, violent and accidents reporting data can all be combined in a single dashboard so that we can connect the dots of various risk factors and the composite picture can help us with suicide prevention effort and help make youth suicide a never event in our state.

The second challenge would be who is going to use the data? Is this data going to benefit those from whom we collect the data? Suicide prevention is everyone's business.

Is the data is going to serve the purpose of implementation of postvention services, or for epidemiological purposes, planning and scaling up the services for suicide prevention at primary, secondary and tertiary levels of prevention throughout our state or to standardize the practice across the state and build in systems of accountability.

As a psychiatrist, I find the lack of timely access to data hampers my ability to take steps to contain the spread of youth suicide contagion or refer the suicide survivors to suicide bereavement services. Often the suicide contagion is not restricted to the boundaries of the school district or the county and the limit of the spread of the social contagion is wider due to the social network of the youth or due to the social media network. There is no easily available real time data dashboard or clearinghouse of postvention services for the medical practitioners, regional school districts, youth serving agencies, Veterans affairs, Indian health services, law enforcement services, faith-based organizations, funeral homes, community advocacy organizations and the communities with high risk for youth suicide etc. and this leaves the first responders, professionals, carers, families and communities affected by suicide with minimal options to process the complicated bereavement that comes with suicide or to implement gatekeeper services to intercept potential contagion. There is no standardization of information, postvention services in all the counties across the state.

Satya Chandragiri MD
Board Certified Psychiatrist
Chandras Clinic PC
PO Box 4060
Salem, OR 97302

Chair, Salem Keizer School Board

Salem, OR