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SUICIDE PREVENTION IN OREGON: A LANDSCAPE SCAN

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SUMMARY STATEMENT

The University of Oregon Suicide Prevention Lab (UOSPL) is an interdisciplinary research and evaluation lab that includes tenured faculty, early career research faculty, and graduate students. The work within the lab is driven by the tenets of implementation science, which is the study of methods and strategies to promote the uptake of evidence-based interventions into routine practice[1].

For the scope of this current project, the UOSPL was tasked with utilizing data from prior work (e.g., literature, statewide data dashboards and artifacts) and summarizing current efforts for:

- Supporting youth and rural Oregonians experiencing suicidal ideation
- Reducing stigma surrounding suicidal ideation
- Addressing barriers to suicide prevention support
- Obstacles to implementing suicide prevention best practices
- Supporting those experiencing SI across the lifespan

Given that many of the efforts identified above are nested within each other, the UOSPL lab examined: (1) what programs are being implemented by the state, (2) accessibility of program information, including implementation, and (3) whether the program is being implemented at scale. Additionally, Oregon efforts were mapped onto current best practices for suicide prevention, as defined by national experts. Findings and recommendations are discussed in detail.

OVERVIEW OF SUICIDE IN OREGON

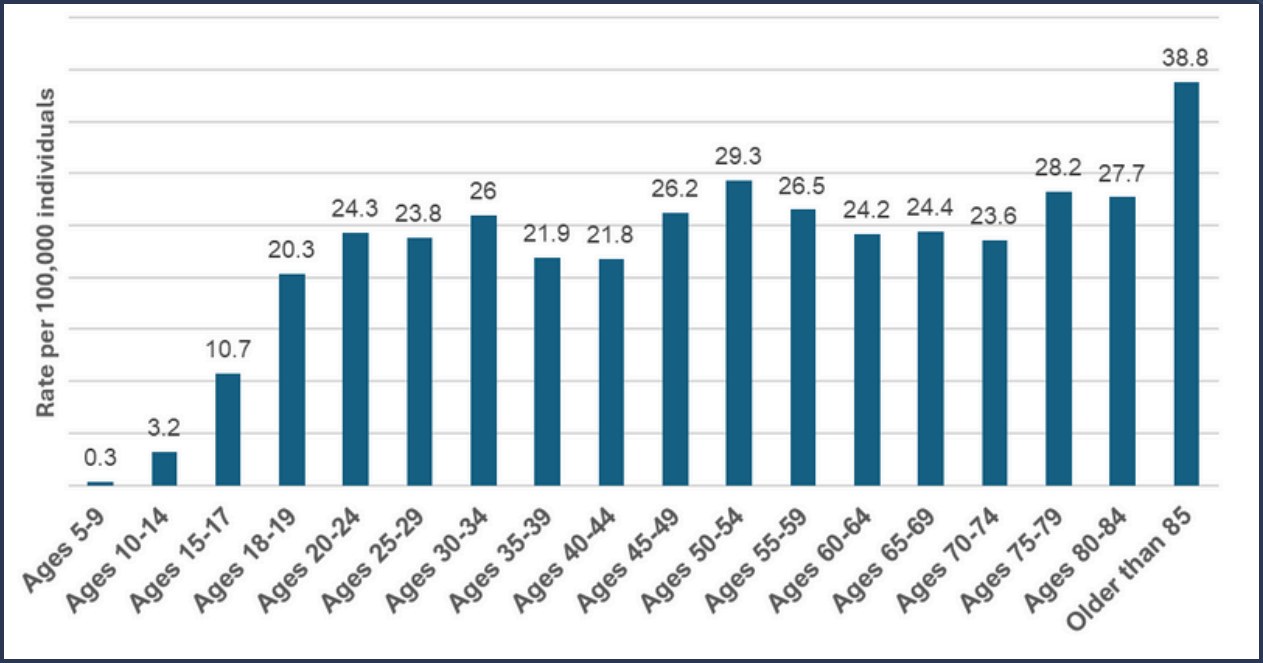
Suicide is a critical public health issue with long-lasting individual, community, and societal consequences. Recent national data found that suicide is the 11th leading cause of death in the United States, with 1.6 million suicide attempts and nearly 50,000 deaths by suicide[2]. The state of Oregon is unduly affected by this issue and ranks 14th in the nation for rate of deaths by suicide, making Oregon 34% above the national average[2].

For the last 30 years, suicide rates in Oregon have been higher than the national average. There were 883 suicide deaths in 2022, with a rate of 19.5 suicide deaths per 100,000 people in Oregon (compared to 14.2 per 100,000 people for the rest of the United States)[3]. Although suicidal thoughts and behaviors can affect all individuals, some groups are disproportionately represented in the data.

AGE

IIn the state of Oregon, the age group at significant risk for death by suicide are older adults (see Figure 1), with 24% of suicide deaths in Oregon during the period of 2018 through 2022 occurring in adults 65 and older[3]. Although comparatively lower rates were reported among those aged 10 through 24, suicide is the second leading cause of death of young people in Oregon, aged 5 through 24. For the past 10 years, Oregon's youth suicide rates have been higher than the national average[3].

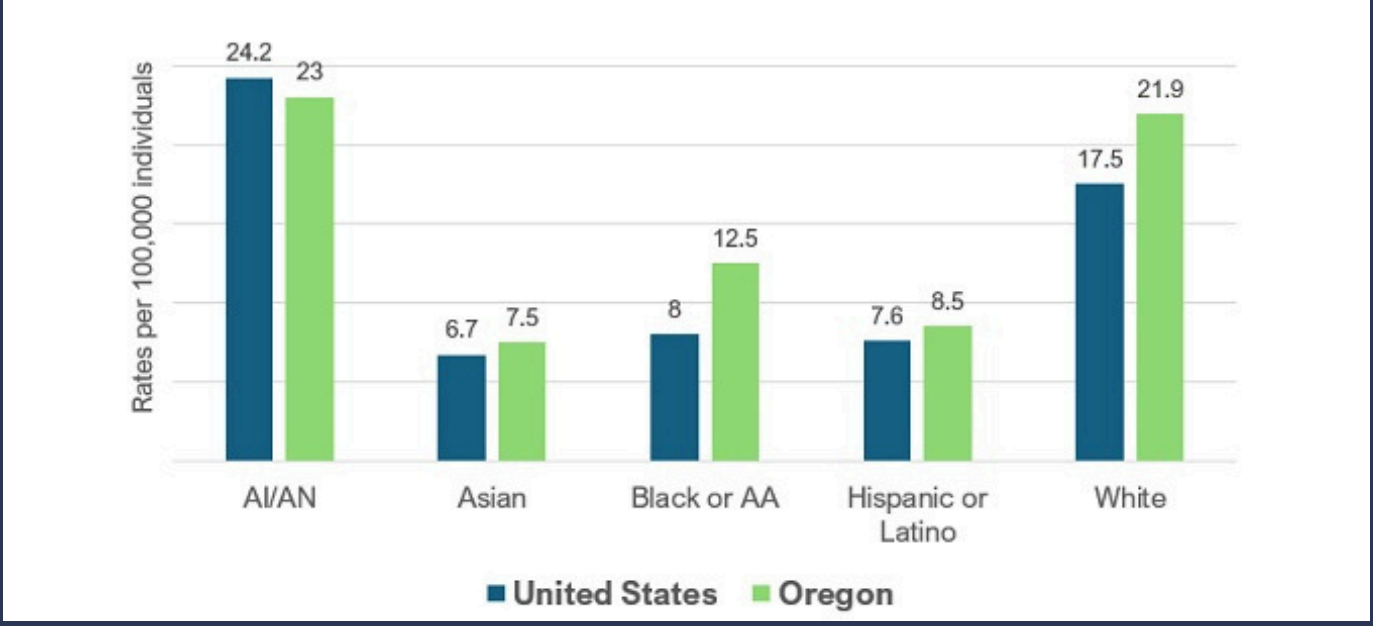
Figure 1. ***Suicide Rates by Age Group in Oregon from 2018 through 2022***



RACE AND ETHNICITY

Non-Hispanic American Indian and Alaska Native individuals have the highest rates of suicide in Oregon, with a rate of 23.0 per 100,000[3]. This aligns with national and international-level data[4], as Indigenous people throughout the world experience increased risk of suicide[5]. Native American and Alaska Native people face specific barriers to mental health service utilization, including lack of adequate services on reservations and lack of cultural relevance in suicide prevention and intervention programming[6]. It should be noted that many Native American communities view suicide as a community issue rather than individual pathology, so approaching suicide programming from an individual mental health perspective can create a disconnect[7,8].

Figure 2. ***Age-Adjusted Suicide Deaths by Race and Ethnicity from 2018 - 2022***

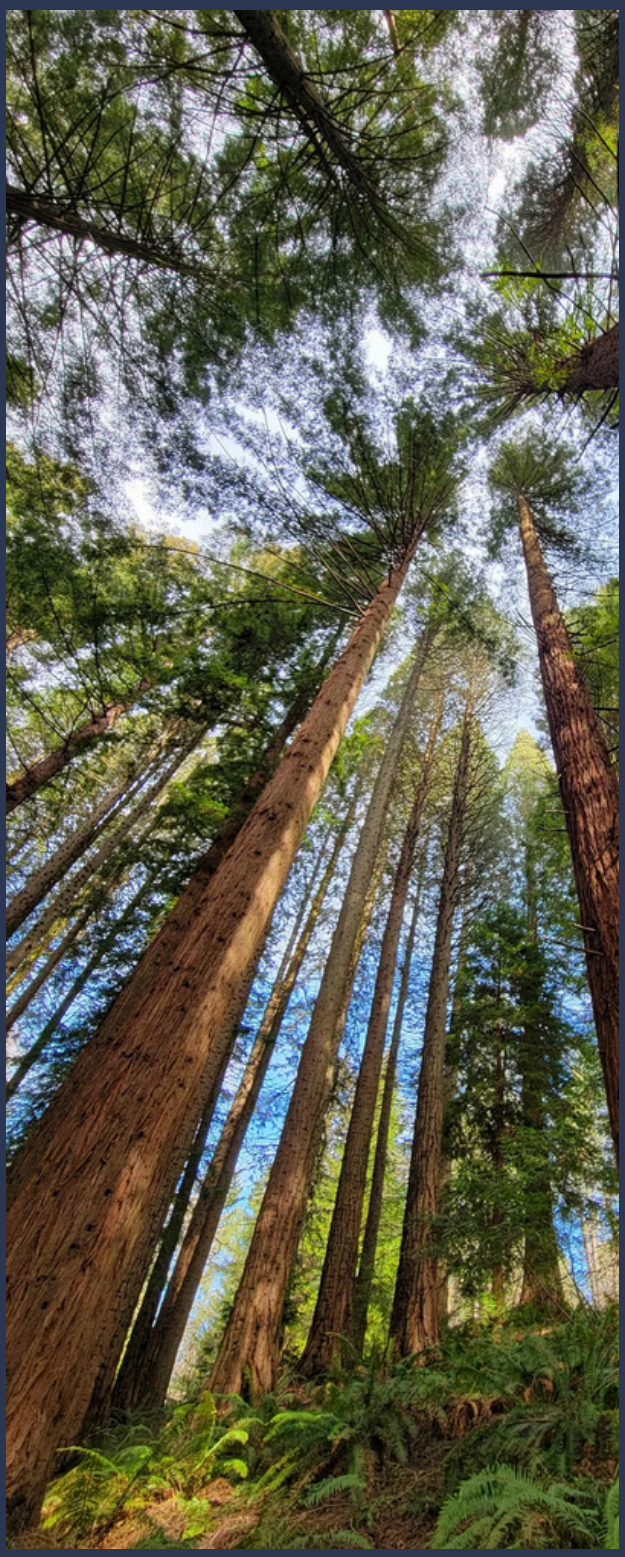


The next highest suicide rates in Oregon by ethnic group are Non-Hispanic White Oregonians, with a rate of 21.9 per 100,000[3]. Non-Hispanic Asian people had the lowest suicide rate, at 100,000. Black, Hispanic, Pacific Islander, and multi-ethnic Oregonians each had suicide rates between 12.8 per 100,000 and 8.5 per 100,000[3].

SEX AND GENDER

Current data has found sex differences between males and females, with adult males 75% more likely to die by suicide than adult females in Oregon[3]. These sex differences, specifically the higher risks for men, intersect with lethality of mechanism, Veteran status, occupation, and urbanicity. Men are more likely to use firearms, which has the highest lethality, and one systematic review found that suicide rates are similar between men and women when the same methods are used[9].

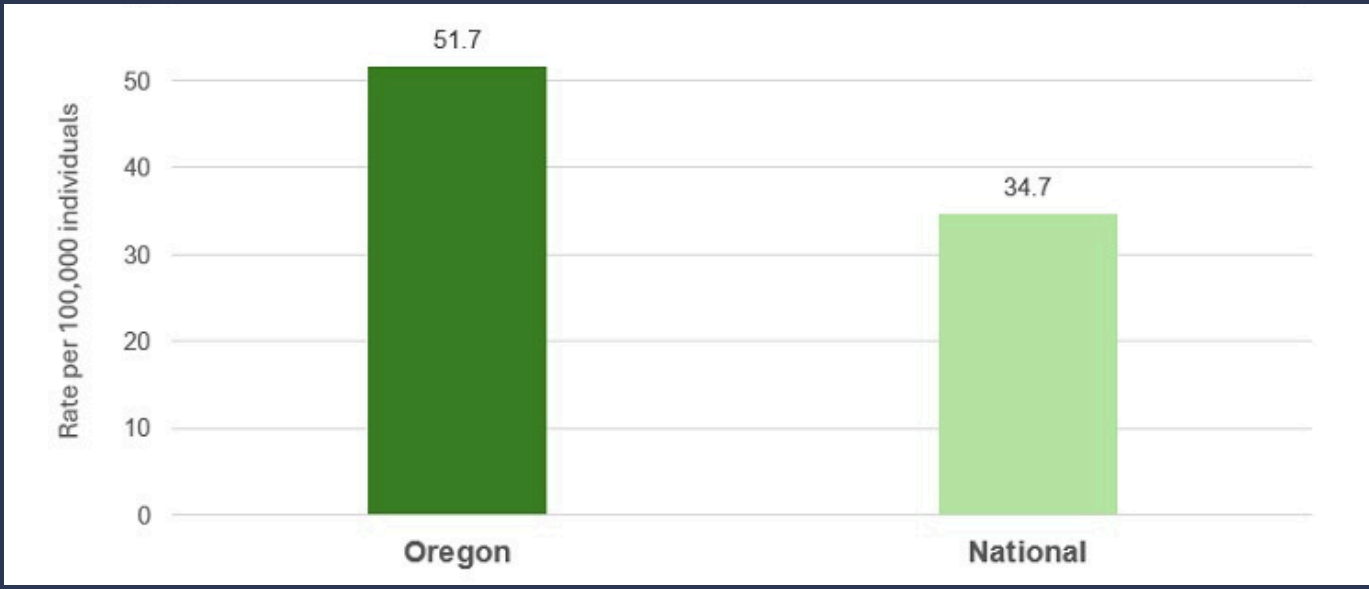
Although efforts have been made to expand the understanding between sex and gender, along with collection of gender identity data within the state of Oregon, to date there is no systematic process in place to collect an individual's gender identity at the time of their death. Prior research has established an exorbitant risk for suicidal thoughts and behaviors among transgender and non-binary individuals[10–12]. Moreover, data efforts tend to lump gender and sexual minorities into one group, although there are distinct differences in suicidal thoughts and behaviors between these groups[13].



VETERAN STATUS

State and national-level data from 2022 (see Figure 3) found that the veteran suicide rate in Oregon was significantly higher than the national veteran suicide rate[14]. Additionally, when examining method of veteran suicide in Oregon, veterans used firearms at higher rates compared to other mechanisms[14].

Figure 3. ***Oregon and National Rates of Veteran Suicide Deaths for 2022***



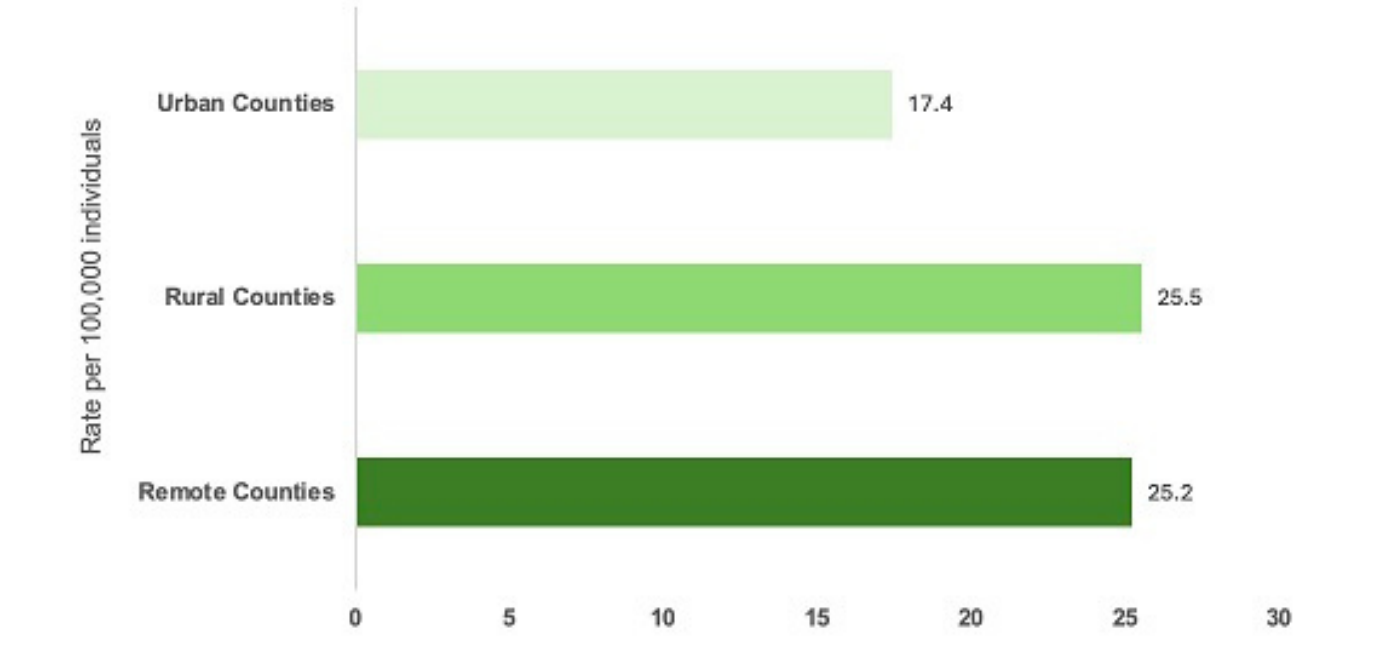
OCCUPATION

Data collected from 2018 through 2022 found that Farming, Fishing, and Forestry occupations in Oregon reported the highest death rates by suicide, with 122.4 deaths per 100,000 people. Other occupations with high death rates by suicide in Oregon are Arts, Design, Entertainment, Sports, and Media (with 91.9 deaths per 100,000 people) and Construction and Excavation occupations (with 90.7 deaths per 100,000 people)[3].

URBANICITY

Rural counties in Oregon are defined as geographic areas 10 or more miles from the center of a population center of 40,000 or more people[15]. Remote/Frontier counties are places with 6 or fewer people per square mile[15]. Recent data examining the location of suicide deaths in Oregon found that suicide rates for rural and remote Oregonians is higher than that of urban Oregonians[16] (see Figure 4). It should be noted that these data reflect similar findings across national-level data[17].

Figure 4. ***Suicide Rates Among Remote, Rural, and Urban Counties in Oregon***



METHOD

The most common mechanism for suicide in Oregon is by firearm (54%), with 85% of those who died by suicide using a firearm being male. Suffocation was the next most common mechanism for suicide (25%), followed by poisoning (13%), other (6%), and falling (2%)[3].

CURRENT PROGRAMMING FOR ADDRESSING SUICIDE IN OREGON

PRIMARY PREVENTION

Primary prevention efforts (or upstream efforts) in the field of suicide prevention are defined as activities that increase protective factors (i.e., access to basic needs, healthcare, social support, emotion regulation skills) and decrease risk factors (i.e., prior suicidal thoughts and behaviors, adverse childhood experiences, legal problems)[18]. In Oregon, laws such as the Youth Suicide Intervention and Prevention Plan and Adi's Act support implementation of primary prevention programming throughout the state.

PRIMARY PREVENTION STRATEGIES

Social Emotional Learning in Schools. Social Emotional Learning (SEL) curricula are designed to be a universal support for youth in building important skills that may prevent suicide. They are based on the belief that developing skills like stress tolerance, communication, problem solving, and emotional regulation in childhood will prevent suicide and other forms of violence throughout the lifespan, with an emphasis on youth suicide, especially for adolescent programs[19]. 24 counties in the state of Oregon are administering SEL in elementary schools and 28 are implementing in high schools with funding from OHA. ODE and ORS 329.045 mandate a framework for SEL education in public schools statewide, so it is likely that other districts are still implementing SEL without OHA support, but information about implementation of SEL programs without OHA support is not accessible.

Currently, OHA sponsors the implementation of Sources of Strength for social and emotional learning throughout the state. Sources of Strength operates as a positive youth development program at the high school level, where student leaders meet regularly to build skills to promote healthy behaviors throughout their social groups, with a goal of preventing suicide, substance use, and bullying[20]. A recent and rigorous study of Sources of Strength found that it reduced new suicide attempts by 29% at participating high schools compared to schools without Sources of Strength, even when accounting for factors like recent sexual violence[21].

The elementary school version of Sources of Strength is a classroom curriculum designed to teach students important skills, but only pilot studies have been conducted on its effectiveness[22]. Research has not yet shown whether elementary school programs can impact suicide, but other elementary school SEL programs do have evidence of effectiveness in impacting important skills that are known to be associated with a reduction in suicide risk[23].

Safe Storage Programs. Research has shown that having a gun in the home increases a person's risk for suicide, and that storing a gun unlocked or loaded increases that risk further[24]. In order to reduce these risks among gun owners, Safe Storage programming aims to remove barriers to accessing gun locks and other safe storage devices in order to reduce suicide and other gun-related deaths. In addition to providing the physical devices, many programs include or encourage some safe storage counseling, with the goal of increasing education on safe storage practices and suicide risks. Some programs have expanded to offer safe storage of other lethal means, such as medication.

We could locate counties that offer free safe storage programs, two through county behavioral health units and one through the local VA Center. In Clackamas County, individuals can receive secure firearm, ammunition, and medication storage device. Yamhill County's Public Health Lock Box Program only includes firearm lock boxes. The Roseburg VA in Douglas County offers gun locks and to veterans and their families. Additionally, veterans and their families are referred to a Suicide Prevention Care Coordinator or Case Manager. Other safe storage programs may exist, but we could not locate them through an internet search or through county health websites. This leaves much of the gun owning population in Oregon without easy or free access to safe storage devices

Enhanced Care Outreach Services. Enhanced Care Outreach Services (ECOS) is a collaborative program between OHA and Aging and People with Disabilities that provides intensive care at community-based treatment facilities with an aim of reducing risk of hospitalization at the Oregon State Hospital and increasing independence so that individuals with concerning psychiatric symptoms, including

suicidal thoughts and behaviors, can transition to a lower level of care. ECOS has not yet been evaluated for its impact on suicide specifically. It is being implemented in six counties in Oregon.

Outpatient Treatment Access. One clear way to prevent suicide is to increase access to outpatient mental health services. Studies have shown that the period just before initiation of treatment can be a particularly vulnerable time for suicide risk[25], so making the transition into treatment easy, quick, and accessible can be an important step in preventing suicide. Programs that are aimed at increasing access to outpatient mental health services may not present themselves as suicide prevention programming, but they have an important role in the reduction of suicide in Oregon. Rural access to mental health providers has been improving, especially with the spread of telemedicine, but there are still many barriers to accessing mental health treatment[26] and rural counties have a critical lack of mental health service providers[27]. Providers in Coos and Curry Counties aimed to remedy this by creating a Behavioral Health Hub website that connects individuals to local care providers. Additionally, eight counties provide outpatient mental and behavioral health services through their Public Health Departments that are available to all residents. County-provided services are especially notable, as research has found that an increase in county government social services spending is positively associated with healthcare use among older adults, and it is an way important to provide suicide prevention services to this under-served group[28].

REDUCING STIGMA

Stigma refers to a community norm that devalues a person or group of people based on a specific attribute or experience[29]. In the context of mental health, stigma typically refers to cultural norms which devalue a person for experiencing mental illness or suicidal thoughts and behaviors[30]. This type of stigma can lead individuals to delay or avoid treatment and can reduce treatment adherence. Stigma is often a barrier to social support and connection, which is a key protective factor for suicidal thoughts and behaviors[31].

Most suicide prevention programming is intended to increase knowledge on suicidal thoughts and behaviors, which inherently aims to reduce stigma related to suicide and mental illness. For example, gatekeeper trainings are specifically designed to reduce stigma that may prevent an individual from intervening when they see suicidal thoughts and behaviors[32]. However, literature reviews have found that there is variation in the measurement and effectiveness of these trainings on reducing stigma in different populations[33]. Information about the impact of the trainings in Oregon on mental health stigma is not available.

Additionally, there are many types of stigma that are relevant to suicide in Oregon which are not targeted by any programming, nor is there a deep understanding of the differing community norms across contexts in Oregon. For example, in some communities, owning a firearm carries a stigma, while in other communities, choosing not to own a firearm can carry a stigma, both of which impact conversations on firearm suicides. There can be stigma associated with working for the government or accepting help from the government, which can impact engagement with programming that is government-run. A better understanding of the differing community norms across Oregon could offer more direction in how to address these stigmas throughout the state.

INTERVENTION

Interventions (or downstream or secondary prevention efforts) in the field of suicide prevention are defined as direct efforts to intervene or prevent someone from attempting suicide[18]. Within the current scope of work in Oregon, statewide interventions include gatekeeper trainings, crisis services, inpatient and outpatient hospitalizations, or walk-in mental health clinics. It should be noted that although gatekeeper trainings often have both prevention and intervention components (i.e., increasing an individual's knowledge of suicide risk and protective factors while increasing self-efficacy to intervene with someone who is actively suicidal), the primary goal is better preparing gatekeepers to intervene when faced with signs of suicidality. Therefore, gatekeeper trainings are included with intervention strategies.

STATEWIDE INTERVENTION STRATEGIES

Zero Suicide. Zero Suicide is a program that provides training and ongoing support for the implementation of suicide prevention and intervention best practices in hospital settings, with a particular focus on assessment of data for continuous improvement in practices. It has been implemented in various hospitals and health systems throughout Oregon since 2018, though there has been differences in engagement consistency across systems between years. This program has been funded through a SAMHSA grant that will end in 2026, with no current plan for sustainment after that funding stream ends. Portland State University has been evaluating the implementation statewide, and a summative report on their evaluation will be produced when the grant ends next year.

Program	Description
Applied Suicide Intervention Skills Training (ASIST)	ASIST is a two-day, in-person workshop designed to help participants recognize when someone may be having suicidal thoughts and then respond by developing an individual safety. This intervention framework moves from identifying warning signs to partnering with the individual at risk, reinforcing skills that promote immediate safety and connection to further support
Question, Persuade, Refer (QPR)	QPR is a 90-minute suicide prevention community helper training that equips participants with the skills to recognize signs of suicide, ask directly about suicidal thoughts, persuade individuals to seek help, and refer them to appropriate community mental health resources
Youth Suicide Assessment in Virtual Environments (Youth SAVE)	Youth SAVE is virtual training that was developed by the Oregon Pediatric Society to equip school and community-based mental health professionals to virtually assess for and intervene with youth who are having thoughts of suicide
Mental Health First Aid (MHFA)	MHFA is a course that teaches how to identify, understand and respond to signs of mental illnesses and substance use disorders. The goal of MHFA is to equip individuals with the skills they need to intervene when someone is experiencing a mental health crisis
Counseling on Access to Lethal Means (CALM)	CALM is an intervention designed to increase the time and distance between individuals at risk of suicide and the most common and lethal methods of suicide, particularly firearms. CALM equips individuals with tools to intervene effectively with those at risk for suicide before a crisis hits, as well as in times of crisis.
Oregon Counseling on Access to Lethal Means (OCALM)	OCALM is an Oregon-adapted version of CALM. OCALM was developed to equip health care and direct service providers in approaching lethal means counseling from a collaborative and respectful perspective

Gatekeeper Trainings. With funding from the Oregon Health Authority, Big River Programming was developed as a statewide initiative to increase access to youth suicide prevention and intervention trainings. The trainings work to equip youth-serving professionals and community members with knowledge and skills to help prevent suicide.

In addition to the trainings that are included in Big River Programming, there are online courses available through OHA and PSU that are related to suicide prevention, such as "Suicide Prevention in Problem Gambling," "Suicide Intervention and Prevention in Latiné Communities," and "Military Culture Awareness and Suicide Training." These courses can be found online, but there is not much information about how or by whom they are currently used.

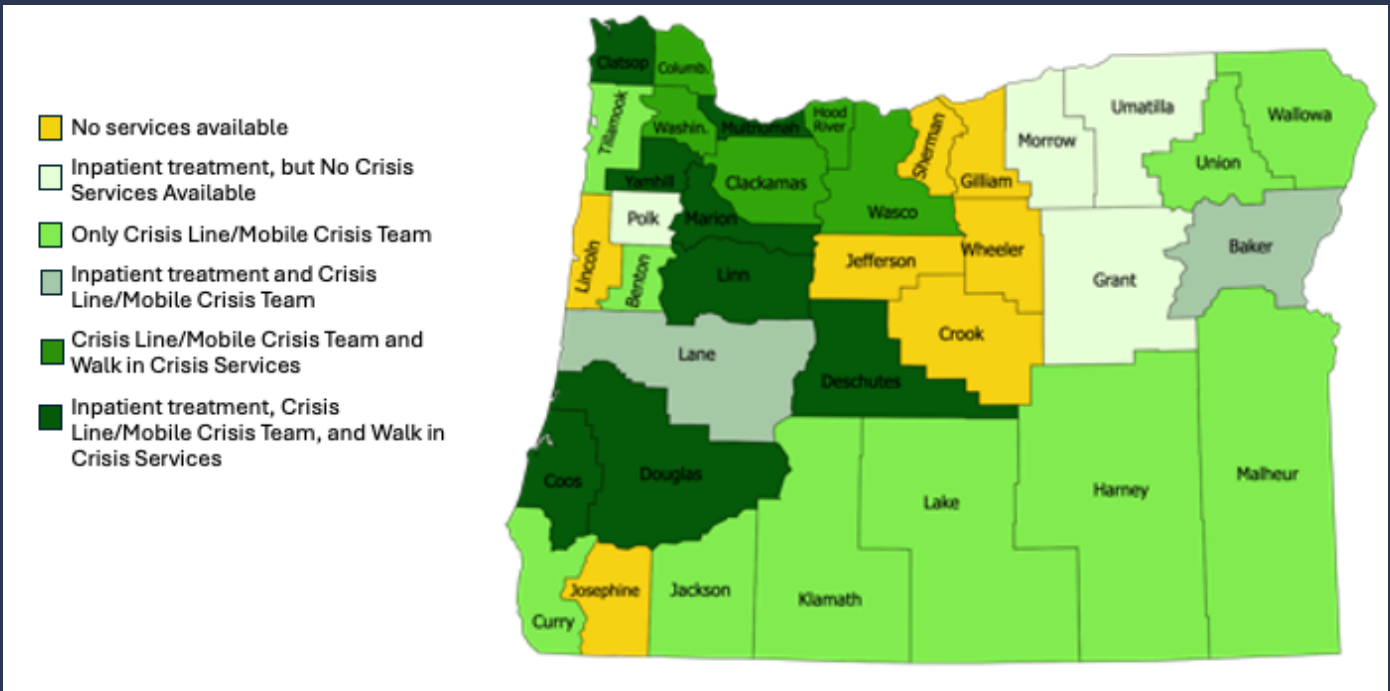
Statewide Crisis Lines. The state of Oregon has several crisis lines to offer phone or chat support to individuals experiencing a mental health crisis, with specific Crisis Lines for specific groups at risk of suicide. For example, The Oregon Agri Stress Helpline is a crisis line tailored to the culture, values, and stressors of agriculture, forestry, and fishing workers. The crisis specialists who field calls have access to a state-specific curated database of agricultural and health resources. Lines for Life operates specific crisis lines for military and veterans, seniors, people experiencing racism, and youth, as well as a general suicide crisis line. Additionally, many counties have crisis lines provided by community mental health providers or county staff.

Access to intervention services varies drastically based on geography, with many Oregonians only having access to statewide or national crisis phone lines when experiencing a mental health crisis. Both inpatient and outpatient crisis intervention services are offered throughout Oregon by community-based organizations or county government programs, but rural access to mental health intervention is of critical concern (see Figure 5).

Outpatient Crisis Intervention Services. Outpatient crisis intervention strategies offer immediate support to individuals who are experiencing a mental health crisis, including suicidal ideation. These services include local 24-hour crisis lines, which are available in 18 counties, with seven being provided by the county government and 11 managed by

Many are connected to 24-hour crisis lines, though others must be called by providers, emergency personnel, or 988 services. Most mobile crisis teams have 24-hour services. 11 counties have access to mobile crisis teams, with five managed by the county and six managed by community-based organizations. Lane County has two mobile response teams, one serving rural West Lane, and the other serving other rural parts of Lane County as well as Eugene and Springfield. Only Washington County Crisis Line and Mobile Team specified that translation services are available to those who speak a language other than English for crisis services.

Figure 5. ***Oregon Suicide-Specific Intervention Services by County***



Additionally, 13 counties have access to walk-in services during some daytime hours, which can vary from a few hours some days each week to daily 8:30am-6pm services. Six of these walk-in centers are run by the county and seven are run by community-based organizations. Some of these counties, such as Washington and Multnomah, serve rural Oregonians, but only those who are able to travel to the more populated parts of the county to actually access these services. Marion County and Deschutes County governments both offer 24-hour walk-in services in their biggest cities, Salem and Bend, but they also both have more rural locations that offer daytime walk-in services.

Unity Center for Behavioral Health is a psychiatric hospital in Portland that offers 24-hour walk-in services for adults, though travel to Portland is a barrier for many rural Oregonians. Benton County is in the process of building a new walk-in center in Corvallis, which is expected to be completed in 2025. 18 counties in Oregon offer no local 24-hour crisis services outside of 911. Four of those counties (Grant, Gilliam, Morrow, and Wheeler) have a mental health counselor follow up after a mental health related 911 call, and Sherman County is served by 24-hour crisis services in The Dalles, Wasco County. Additionally, two counties had some information about crisis services on their county website, but we could not determine how to access these services or if they were still in operation, making them inaccessible to a person in crisis.

Inpatient Mental Health Treatment. Inpatient intervention services can act as both suicide intervention and prevention programs, but access issues persist throughout Oregon, with 19 counties offering no inpatient services at all, and only five hospitals in Oregon offering inpatient psychiatric services for adults. It is certainly possible for an individual to receive inpatient services in a county different than where they reside, and several providers list surrounding counties as part of their services area. However, many studies have shown that individuals achieve much better outcomes if they can remain connected to their community[34] and long drives to treatment can be an additional barrier to accessing services, especially for those who do not drive or struggle to pay for gas. Additionally, driving can be dangerous for an individual in a mental health crisis.

Inpatient services can include short term respite or stabilization centers, longer term inpatient treatment programs that last for many months, and supportive housing for people with persistent mental illness, including those that considerably increase risk of suicide. Care facilities for individuals with physical or developmental disabilities and residential drug and alcohol treatment programs were not included, nor was Oregon State Hospital or other programs for those involved in the criminal justice system.

11 counties in Oregon currently have access to short term respite or stabilization inpatient care. Five of those facilities are community-based treatment centers, 5 are hospitals that offer short term psychiatric treatment. Yamhill County has two Respite Center locations that are run by the county's health services. 9 counties have access to long term residential treatment programs, though many have fewer than 20 beds. Seven are run by community organizations, with Community Counseling Services operating six facilities in four counties. Yamhill County Residential Treatment Facility is run by the county, and Polk County Supportive Housing is run by the county through Medicaid funding. Additionally, two hospital facilities are in development. The first is a new Behavioral Health Campus for the PeaceHealth Hospital in Lane County, which will triple the number of beds for adult mental health in the county and expand services to include youth. The second is a new 16-bed hospital facility in The Dalles, Wasco County. Currently Wasco County and the two nearest counties have no inpatient mental health services.

POSTVENTION

Postvention is defined as an organized response after a suicide[35]. These efforts often include immediate and long-term emotional support, contagion mitigation, and prevention of other harmful effects of suicide. Current postvention efforts in Oregon involve trainings, support groups, school-based postvention plans, and state policy.

STATEWIDE POSTVENTION STRATEGIES

CONNECT Postvention Training. OHA sponsors CONNECT Postvention Training as the primary postvention strategy throughout the state. CONNECT offers communities an opportunity for education on suicide and its impacts, community building, and guided strategic planning for coordinated suicide postvention response. Overall, postvention trainings like CONNECT do have limited evidence of effectiveness on overall suicide rates and risk[36], but they are still seen as important resources to the communities that receive them during an incredibly critical time[35].

Oregon Youth Suicide Postvention Leads. OHA has developed a local network of Postvention professionals throughout Oregon. Each county has an identified

Postvention Lead, who can apply for and coordinate support in the aftermath of the death of a youth by suicide. A full list of Postvention Leads, their positions, and their contact information is available through OHA. Some counties have postvention programs and policies that are easily accessible through their website, such as Clackamas County. Crook County's Postvention Plan (available on the County's website) is an exemplar policy, with clearly identified roles, suggestions for communication with families, and planned long term follow up with grieving families.

Lines for Life Youth Suicide Rapid Response. OHA sponsors Lines for Life's implementation of a Youth Suicide Rapid Response program, where county Postvention Leads can activate an assessment and response plan after a person 24 or younger dies by suicide. These supports can include grief support, outreach, communication support, logistical help, and financial support for families affected.

School-Based Postvention Plans. Under Adi's Act, all schools in Oregon are required to have a postvention plan, in addition to requiring certain student education, teacher training, prevention activities, and intervention plans. OHA offers a toolkit to help schools develop these plans.

Suicide Bereavement Groups. Bereavement refers to the long-term psychological distress that occurs as a result of loss[37] and suicide bereavement can have specific and complicated psychological implications for family and friends, especially guilt, which is associated with Post-traumatic Stress Disorder, depression, and other serious mental health concerns in someone who is in bereavement from a suicide[38]. Suicide Bereavement Support Groups offer survivors a safe space to seek and provide social support with others who have some idea of what they are going through and have been found to improve wellbeing among those who attend[39]. The Dougy Center in Portland offers Suicide Bereavement Support Groups online throughout Oregon (and the US). There is also a virtual Suicide Grief Support Group of Central Oregon that supports Baker, Jefferson, and Deschutes Counties and Lane County has the Jennifer Baker Fund Suicide Bereavement Group.

STATEWIDE POLICIES TO ADDRESS YOUTH SUICIDE

In 2014, the Oregon Legislature mandated development of a five-year Youth Suicide Intervention and Prevention Plan (YSIPP). The Oregon Health Authority worked with interested parties from across Oregon to adopt strategic directions, goals and objectives from the 2012 National Strategy for Suicide Prevention and develop actionable plans to implement YSIPP activities in 2016 through 2020. The first iteration of the YSIPP consisted of four priorities: (1) Healthy and empowered individuals, families and communities; (2) Clinical and community preventive services; (3) Treatment and support services; and (4) Surveillance, research and evaluation.

The most recent iteration of the YSIPP (2021 – 2025) was the result of a partnership between the Oregon Health Authority, the University of Oregon Suicide Prevention Lab, and over 100 individuals involved in suicide prevention efforts in the state of Oregon. The current YSIPP builds upon established initiatives that have been successful in addressing suicide in Oregon, while acknowledging new areas to focus on. The current YSIPP consists of 3 pillars: (1) Healthy and empowered individuals, families and communities; (2) Clinical and community preventive services; and (3) Treatment and support services. Within these 3 pillars there are 11 strategic goals, which consist of pathways and their initiatives. The pathways represent measurable areas of focus, with specificity given to different settings and populations. While the pathways are more concrete within the 5-year planning, initiatives can be adapted annually. At the heart of this framework are the foundations of equity, trauma informed practices, lived experience voice, collective impact, and collaboration.

The Black Youth Suicide Policy Coalition was formed in 2023 at the country's first-ever Black Youth Suicide Policy Academy, hosted by SAMHSA. The coalition has 11 members from across Oregon who are working together to develop an Oregon Black Youth Suicide Prevention Plan.

SB 52 (Adi's Act): The Department of Education shall develop and implement a statewide education plan for plan students who identify as LGBTQ2SIA+. The plan developed and implemented under this section must provide strategies to:

(a) Address the disproportionate rate of disciplinary incidents involving plan students as compared to all students in the education system;
(b) Increase parental engagement in the education of plan students;
(c) Increase the engagement of plan students in educational activities before and after regular school hours;
(d) Increase early childhood education and kindergarten readiness for plan students;
(e) Improve literacy and numeracy levels among plan students between kindergarten and grade three;
(f) Support plan student transitions to middle school and through the middle school and high school grades to maintain and improve academic performance;
(g) Support culturally responsive pedagogy and practices from early childhood through post-secondary education;
(h) Support the development of culturally responsive curricula from early childhood through post-secondary education;
(i) Increase attendance of plan students in early childhood programs through post-secondary and professional certification programs; and
(j) Increase attendance of plan students in four-year post-secondary institutions of education

SB 563 modifies laws relating to youth suicide prevention and intervention to include children 5 to 10 years of age. The Youth Suicide Intervention and Prevention Plan originally covered ages 10 to 24. Due to passage of this legislation, the age range was lowered to include ages 5 to 25 allowing for more upstream prevention work to be done.

HB 3139 addresses parental notification when a mental health care provider assesses a minor to be at imminent risk for a suicide attempt. If the minor's condition has deteriorated or the risk of a suicide attempt has become such that inpatient treatment is necessary, or if the minor's condition requires detoxification in a residential or acute care facility, the minor's mental health care provider may disclose

the relevant information regarding the minor's diagnosis and treatment to the minor's parent or legal guardian to the extent the mental health care provider determines the disclosure is clinically appropriate and will serve the best interests of the minor's treatment.

HB 3037 directs medical examiner or medical-legal death investigator to report deaths of decedents 24 years of age or younger to local mental health authority there is reasonable belief that the manner of death was suicide. This bill amends **SB 561** by adding the following elements: The Oregon Health Authority shall develop a plan for communication among local mental health authorities and local systems to improve notifications and information-sharing when a death that is suspected to be a suicide involves an individual who is 24 years of age or younger. The plan must address community suicide response and post-intervention efforts to address loss and the potential of contagion risk. The following entities may be involved in developing and implementing the plan:

(a) Public school districts;
(b) Public universities listed in ORS 352.002, if the death involves an individual who is 24 years of age or younger;
(c) Private post-secondary institutions of education, if the death involves an individual who is 24 years of age or younger; and
(d) Any facility that provides services or resources to runaway or homeless youth.

Within seven days after a death that is suspected to be a suicide of an individual 24 years of age or younger, the local mental health authority in the area where the suicide occurred shall inform the Oregon Health Authority, in a manner and in a format to be determined by the authority, of activities implemented to support local entities and individuals affected by the suicide and to prevent the risk of contagion.

STATEWIDE POLICIES TO ADDRESS SUICIDE AMONG ADULTS

The Adult Suicide Intervention and Prevention Plan (ASIPP) was published in April of 2023 by the Oregon Health Authority. Lead by members and staff of the Oregon Alliance to Prevent Suicide, this work is the product of over 100 community members representing 68 organizations across the state of Oregon. The ASIPP and the YSIPP share the same Oregon Suicide Prevention Framework (i.e., pillars, goals and strategic pathways), while the initiatives are different to accommodate for developmental differences. Additionally, the ASIPP is population-focused, meaning that it has prioritized certain populations that have been disproportionately affected by suicide and are considered historically underserved. These populations include: LGBTQ+ adults, young adults, individuals working in the construction industry, veterans and military-connected individuals, older adults (55+), adults with disabilities and/or chronic illness, BIPOC, men, and those living in rural or remote areas.

HB 2315 requires that OHA shall require a license regulated by the authority or the board to complete two hours every two years or three years of continuing education related to suicide risk assessment, treatment and management and report to the authority, or the board the licensee's completion of the continuing education described. OHA and a board shall approve continuing education opportunities that are applicable and relevant to the licenses regulated by the authority or the board. A board may encourage a license regulated by the board to complete continuing education opportunities recommended by the authority.

HB 2417 expands crisis stabilization services, including crisis stabilization centers meeting criteria adopted by Oregon Health Authority by rule, short-term respite facilities, peer respite centers, behavioral health urgent care walk-in centers and crisis hotline center. Appropriates moneys from General Fund to authority to provide funding to county community mental health programs to establish and maintain mobile crisis intervention teams. Requires authority, no later than January 1, 2022, to report to interim committees of Legislative Assembly related to mental or behavioral health, recommendations on policies and legislative changes, if any, needed to

implement National Suicide Hotline Designation Act of 2020 and establish statewide coordinated crisis services system. Specifies information that must be included in report. Limits liability of 9-8-8 coordinated crisis services system to conduct that is willful or wanton. Prohibits blocking delivery or forwarding to public safety answering point of 9-8-8 coordinated crisis services system information. Makes number identifications and subscriber information received by 9-8-8 coordinated crisis services system confidential and not subject to public disclosure unless specified criteria are met.

HB 3090 requires hospital emergency departments to develop policies to provide suicide prevention measures to adult patients who are experiencing a behavioral health crises prior to their release. This includes a requirement to conduct a behavioral health assessment and a suicide risk assessment and develop a safety plan and provide lethal means counseling to patients and their caregivers if suicidal ideation or previous suicide attempts are indicated. The policy must also include a process to coordinate care, and, if suicidal ideation is determined by the behavioral health assessment, initiate caring contacts with the patient within 48 hours after release, and have an appointment with a clinician within 7 days or requires the hospital to document why an appointment could not be made.

SUICIDE PREVENTION BEST PRACTICES

The Centers for Disease Control (CDC) developed specific strategies and approaches for achieving and sustaining notable reductions in suicide[40]. These strategies were developed by examining evidence of impact on risk and protective factors, suicide attempts, and deaths by suicide.

Figure 6. ***CDC Best Practices for Achieving and Sustaining Reduction in Suicide***

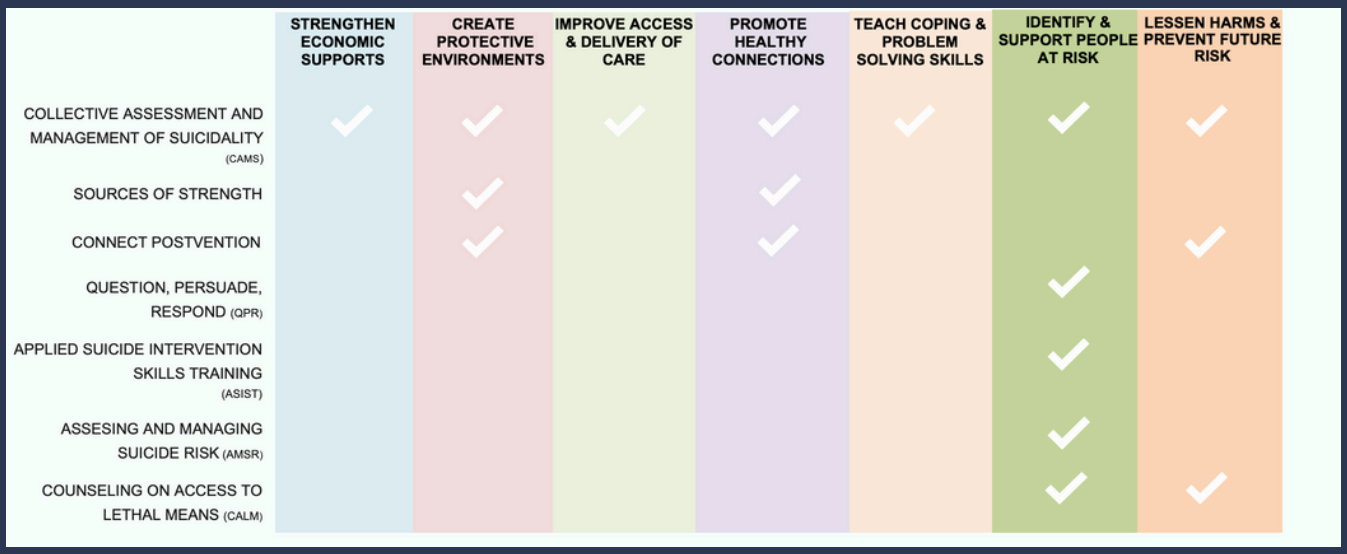
Strategies	Approaches
Strengthen Economic Supports	• Improve household financial security • Stabilize housing
Creative Protective Environments	• Reduce access to lethal means among persons at risk of suicide • Create healthy organizational policies and culture • Reduce substance use though community-based policies and practices
Improve Access and Delivery of Suicide Care	• Cover mental health conditions in health insurance policies • Increase provider availability in underserved areas • Provide rapid and remote access to help • Create safer suicide care through systems change
Promote Healthy Connections	• Promote healthy peer norms • Engage community members in shared activities
Teach Coping and Problem-Solving Skills	• Support SEL programs • Teach parenting skills to improve family relationships • Support resilience through education programs
Identify and Support People at Risk	• Train gatekeepers • Respond to crises • Plan for safety and follow-up after an attempt • Provide therapeutic approaches
Lessen Harms and Prevent Future Risk	• Intervene after a suicide (postvention) • Report and message about suicide safely

Along with input with subject matter experts and community-based leaders, a thorough review of suicide-relate literature published from 2016 through 2020 was reviewed, culminating in the following recommended strategies and approaches:

1) Strengthen economic supports
2) Create protective environments
3) Improve access and delivery of care
4) Promote health connections
5) Teaching coping and problem-solving skills
6) Identify and support people at risk
7) Lessen harms and prevent future risk

These best practices were cross-referenced with the Suicide Prevention Resource Center's (SPRC) Best Practice Registry[41]. All programming listed within the Best Practices Registry has shown effectiveness in preventing suicide or directly addressing factors that impact suicide prevention efforts. As shown in Figure 7, this cross-reference between SPRC's Best Practices Registry and programming in Oregon suggests that the Collective Assessment and Management of Suicidality (CAMS)[42] addresses each of the seven identified priority areas for suicide prevention best practices.

Figure 7. ***Oregon Programming and SPRC's Best Practices Registry***



IDENTIFIED GAPS TO ASSIST WITH MEANINGFUL CHANGE

Lack of true primary prevention. In Oregon, most suicide prevention programming aims to prevent people who are already experiencing suicidal thoughts from attempting suicide. Programs like safe storage, gatekeeper trainings, helplines, and crisis response all fall within this critical portion of the suicide prevention field. However, further "upstream" suicide prevention, also known as primary prevention, includes programs that aim to prevent people from becoming suicidal in the first place by reducing risk factors (e.g. housing instability, substance misuse, repeated trauma) and increasing protective factors (e.g. coping and emotional regulation skills, social support, sense of belonging)[21]. In Oregon, the only programs that truly fall into this category are school-based SEL programs. In order to truly reduce suicide in Oregon, primary prevention programming must reach all Oregonians, not just those who are currently in school.

Lack of youth inpatient treatment. As previously discussed, there is a severe lack of access to inpatient mental health services in rural Oregon, creating barriers to access and making family and community involvement in treatment much more difficult for those who have to travel for treatment. The issue is worse for youth, whose family and parental support is vital to the success of inpatient treatment and transition back to their community. Only six counties currently have inpatient treatment centers in Oregon that serve youth, excluding substance misuse treatment and treatment facilities for youth involved in the DHS or criminal justice systems. Unity Center for Behavioral Health in Portland offers long and short term inpatient hospitalization for youth ages 9 to 17 with referral by a mental health provider or emergency room visit. Other treatment centers are located in Deschutes County, Lane County, Yamhill County and Benton County. Along with Unity Center for Behavioral Health, Providence Willamette Falls Medical Center in Oregon City is the only other hospital in the state that currently offers youth inpatient services.

Lack of adult programming. ASIPP was created to address a key gap in Oregon's suicide prevention programming, which is suicides that occur after an individual turns 24. This framework is still early in its adoption, leaving many gaps. The ASIPP also does not have the same legislative support or funding as YSIPP, so many programs, including all state-funded postvention programs, are only available when the individual who died is under 24, even if the friend or loved one receiving services is within that age bracket. Additionally, community based prevention initiatives, especially those that aim to increase protective factors, are almost exclusively based in schools and Universities, so adult Oregonians without children have no connection to them. The only programs identified that focused on aging adults were specific to care facilities, leaving aging Oregonians with little suicide prevention or intervention access.

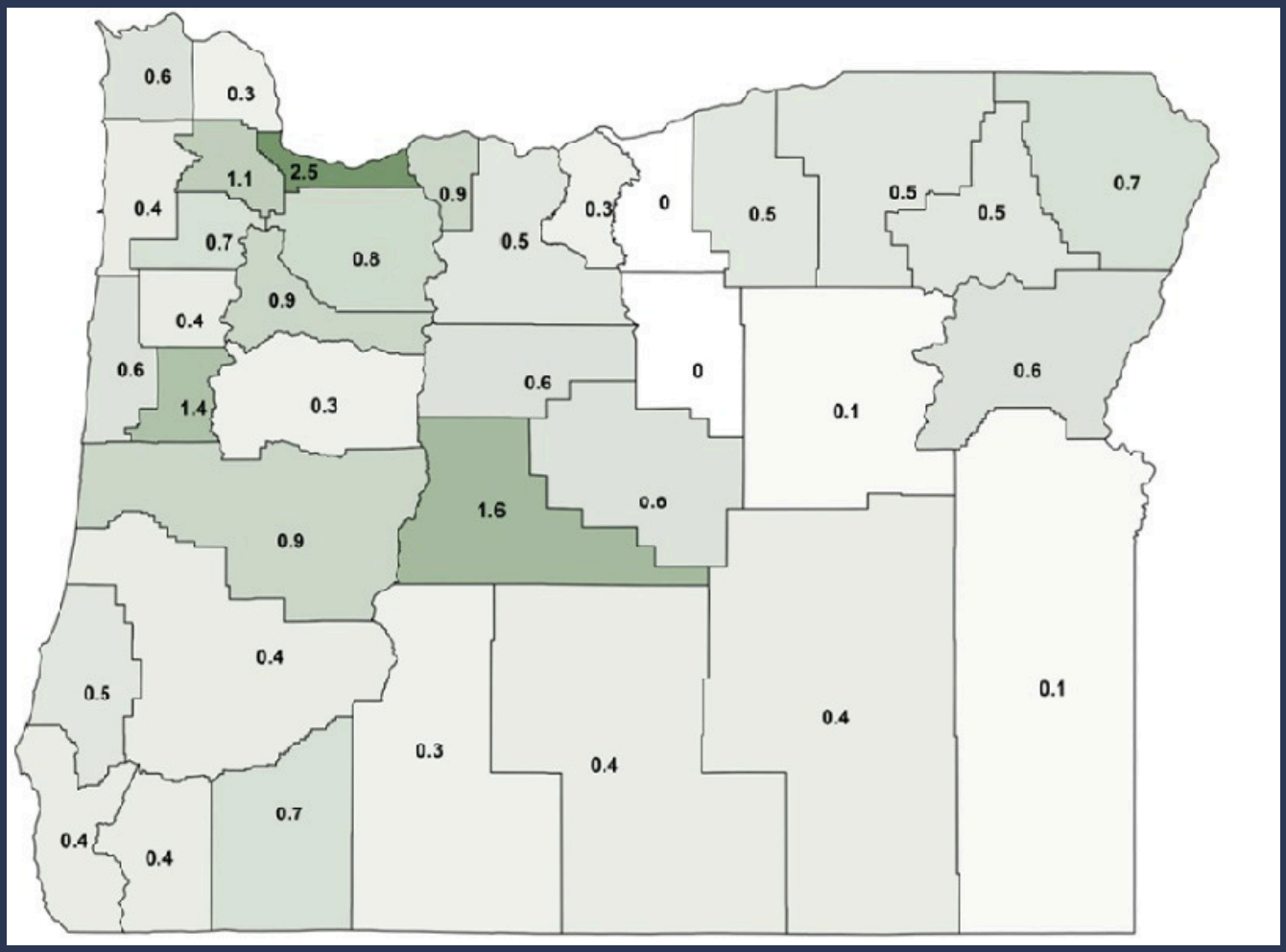
Lack of culturally specific programming. . OHA has been working to make suicide prevention programming in Oregon more culturally specific, aiming to address a key gap in programming across the state. With so many different cultural groups in Oregon, it is essential that programming can be tailored to individual communities, as each community sees suicide, mental health, and help-seeking differently[43,44]. Culturally specific suicide prevention and intervention programming is not yet being effectively implemented throughout the state.

Lack of firearm-specific suicide prevention programming. In Oregon, firearms are the most commonly reported method used in suicide deaths, and firearms are the most lethal of any method, with the highest case fatality rate[9]. Over 80% of gun deaths in Oregon are due to suicide[45]. Household firearm ownership data is scarce and difficult for researchers to access[46], but studies have shown that rural communities across the US experience higher rates of firearm suicide and unintentional firearm injury and death[47]. Only two programs in Oregon specifically focus on firearm suicides. There is one gatekeeper training, CALM, which aims to equip professionals to intervene and prevent access to firearms for suicidal patients. Safe storage programs are the only other program that specifically addresses suicide in firearm owners, and we could only locate 3 safe storage programs in Oregon.

Policy Implementation Issues. Though there are many policies through the Oregon legislature, OHA, and ODE that intend to reduce suicide and suicide risk, especially in youth, few of these policies have specific enforcement requirements, and there is little data on compliance with these policies. For example, in an OHA report on HB 3090, which requires emergency departments to create a policy for suicide prevention and safety planning for individuals experiencing a behavioral health crisis prior to release, state officials only had a 36% response rate from emergency departments when surveying to assess compliance with the law for the first evaluation report[48]. The follow up evaluation report had better response rate, but it still did not find full statewide compliance with the law[49]. Additionally, there were geographic disparities, with rural hospitals showing lower compliance than urban hospitals. There was no funding, training, or oversight to ensure compliance from hospitals that reported poor compliance, though they did identify hospital resources as the leading reason for poor compliance[49]. These were the only reports that could be located on compliance with any of the suicide prevention laws in Oregon, though superintendents are required to report their district's compliance with Adi's Act to ODE annually[50]. Additionally, Adi's Act, HB 3090, and many other policies are unfunded, making oversight difficult.

Workforce Shortage. A recent OHA report on the behavioral health workforce in Oregon[27] found that there is a significant workforce shortage in behavioral health across the state, with even greater shortages in rural communities. 32 of Oregon's 36 rural and frontier counties had fewer than 1 mental health provider per 1,000 residents (see Figure 6)[27]. The report identifies challenges to recruitment and retention of qualified staff in behavioral health, including low wages, limited career development opportunities, lack of clear career paths, cultural barriers, poor infrastructure, and traumatic workplace environments[27]. As a result of this report, Gov. Tina Kotek has created a council to address this crisis[51].

Figure 8. ***Mental Health Providers by County Per 1,000 Residents***[27]



Lack of Resources for Rural Oregonians. Geographic disparities in resource access exist throughout all aspects of suicide prevention and intervention in Oregon. Rural counties in Oregon have less access to mental health providers, crisis intervention services, inpatient treatment centers, and primary prevention programming.

Additionally, programming is rarely designed to align with the unique culture and values of rural Oregon, which will reduce engagement with suicide prevention and intervention strategies and their effectiveness in those communities.

STRATEGIES FOR IMPROVING SUICIDE PREVENTION EFFORTS IN OREGON

Strategies for improving and streamlining suicide prevention efforts in the state should entail a larger group conversation with stakeholders. However, from the research and data perspective, we offer the following items for suggestion:

Dissemination of Implementation Science Strategies. Dissemination of implementation science strategies and tools to support practitioners while they implement programs in their respective environments. The majority of evidence-based programs do not successfully transition from effectiveness trials to real-world implementation by practitioners. However, through the use of practical implementation science, teams can facilitate the successful scale-up efforts and sustainment of selected evidence-based programs.

Centralized Data Tracking System. The creation of a centralized database for surveilling the progress of suicide prevention activities across the state is needed. The database would be a shared resource for researchers and state and local agencies to collect, compare, and analyze data. This would result in cohesive monitoring and reporting of suicide prevention activities.

I**ncreased Documentation of Suicide Prevention Efforts.** There is a tremendous amount of impactful work being conducted by practitioners across a multitude of sectors. However, this work is often localized and the tools, protocols, and practices established by practitioners are not being documented or shared, leading to overlap in efforts and a lack of transparency. Having standardized documentation processes, tools, and practices (potentially nested in the database) would increase collaboration and knowledge sharing across sectors, greater community-building and trust, and easier sustainment during times of staffing issues.

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