Policy and Practice Recommendations for
Suicide Prevention Programming Across the State of Oregon

Data Sharing

A significant limitation to Oregon's suicide prevention programming is the inability to track prevention efforts and compliance across the state. Data is difficult to establish or access, and ODE, OHA, and other stakeholders do not yet have a cohesive and shared data tracking system. Although OHA has created a data repository, this repository is limited to specific agencies and prevention efforts. Furthermore, the incentive to provide updates to the repository is low, and many agencies do not update their data. Some data may be privately shared, or difficult for the general public to access. This allows programs, cities, and counties to delay program implementation and limit compliance with statewide mandates. Publicly available and accessible data allows for natural accountability to counties not fulfilling state requirements.

Compliance and Incentive

The state of Oregon has made significant progress in suicide prevention policies and mandates; however, there are many gaps in compliance and available data to track whether or how prevention programs are being implemented. The following section describes some areas where there are identifiable gaps in implementation and policy compliance. For example, 28 of 36 counties are compliant with ORS 329.04, which mandates SEL education in public schools across the state. Although the 8 remaining counties may have begun implementation, there is little or no data available to suggest compliance. Ideally, counties that are not in compliance with statewide initiatives and mandates would be held accountable.

Primary Prevention Programming

Within the current scope of work in Oregon, exemplary 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. These intervention strategies are essential for supporting high-risk individuals who are experiencing suicidal thoughts and/or behaviors. However, prevention efforts, which aim to prevent the onset of suicidal thoughts and behaviors, are currently limited in Oregon.

Recommendations for Policy and Practice

Oregon may want to consider expanding primary suicide prevention programs beyond school-based social-emotional learning to reach all populations, including adults, older adults, gun owners, and rural residents, by funding community-based prevention initiatives that address upstream risk factors such as housing instability, substance misuse, and trauma exposure.

Primary Prevention and Upstream Programming

- Oregon could expand primary suicide prevention programs beyond schools to reach all populations, including adults, older adults, and rural residents, through community-based initiatives addressing upstream risk factors such as housing instability, substance misuse, and trauma exposure.
- The state could implement universal primary prevention programs that promote protective factors—coping and emotional regulation skills, social support, and sense of belonging—across workplaces, community centers, housing programs, and other community settings.

Youth-Focused Services

- Oregon could increase the availability of youth inpatient mental health services by funding new treatment centers in counties lacking facilities, with special attention to rural areas.
- Youth inpatient programs could be designed to facilitate family and parental involvement to improve treatment outcomes and successful transitions back to the community.
- Access to youth inpatient care could be streamlined to allow direct referral from schools, community providers, or emergency services.

Adult and Aging Populations

- Suicide prevention programs for adults over 24 could be expanded through community-based initiatives that increase protective factors and provide accessible intervention and postvention services.
- Targeted programs could be developed for aging adults, including those not in care facilities, to ensure equitable access to suicide prevention and intervention services.

Culturally Specific and Community-Aligned Programming

- Oregon could invest in culturally specific suicide prevention programs by collaborating with tribal, Latiné, immigrant, and other diverse communities to ensure interventions are relevant, accessible, and effective.
- Rural-focused programming could be designed to reflect local cultural values and address geographic barriers to engagement and effectiveness.

Firearm-Specific Suicide Prevention

- Firearm-focused suicide prevention programming could be expanded statewide, including CALM gatekeeper trainings.
- Safe storage initiatives could be prioritized in rural areas with higher firearm ownership and suicide rates, utilizing police and sheriff departments as well as local Veterans Affairs.

Crisis Intervention and Walk-In Services

- Oregon should expand mobile crisis teams and walk-in mental health centers to all counties to ensure timely access, including self-referral options.
- 24-hour crisis services beyond 911 should be available statewide, including in rural and frontier counties.
- Translation and interpretation services could be required for all crisis lines and mobile crisis teams to ensure equitable access for non-English speakers.
- The state could increase capacity for short-term respite, stabilization centers, and long-term residential treatment, with coordination among inpatient, outpatient, and community-based services to improve continuity of care.

Outpatient and Telehealth Access

- Oregon should expand outpatient behavioral health services in rural areas through telehealth, loan repayment incentives, and provide support to reduce workforce shortages and increase timely access.
- Same-day or 24-hour intake services should be required for publicly funded mental health providers, with warm-handoff protocols to reduce gaps in care.

Workforce Development

- Comprehensive strategies could address behavioral health workforce shortages, including competitive wages, career development, culturally responsive training, and improved workplace infrastructure.

- Oregon could implement comprehensive recruitment and retention strategies, including competitive wages, career development opportunities, clear career pathways, culturally responsive training, improved workplace infrastructure, loan repayment, relocation support, and telehealth infrastructure to encourage providers to practice in rural and frontier counties.

Policy, Compliance, and Oversight

- Oregon could strengthen enforcement and compliance monitoring for existing suicide prevention policies, including Adi's Act and HB 3090, by providing dedicated funding, requiring regular reporting, and establishing accountability measures for hospitals, schools, and other relevant institutions.
- The state could require regular reporting on compliance, training, and outcomes to ensure effective implementation.

Data, Documentation, and Implementation Science

- Implementation science strategies could be disseminated to practitioners, with the goal of improving fidelity, scalability, and sustainability of evidence-based programs.
- A centralized data tracking system could be developed to monitor suicide prevention activities, outcomes, and resource allocation statewide.
- The state may want to incentivize local agencies and organizations to submit data and documentation to the centralized system by providing funding, technical support, or recognition programs.
- Standardized documentation protocols could be implemented for local suicide prevention initiatives to reduce duplication, facilitate knowledge sharing, and support sustainability.
- Incentives and technical support could be provided to encourage submission of data and documentation to the centralized system.