A Landscape Report of Oregon's Suicide Prevention Policies, Programs, and Practices, and the Primary Barriers to Implementation

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Introduction

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University of Oregon Suicide Prevention Lab 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 and specializes in research, implementation, and program evaluation.

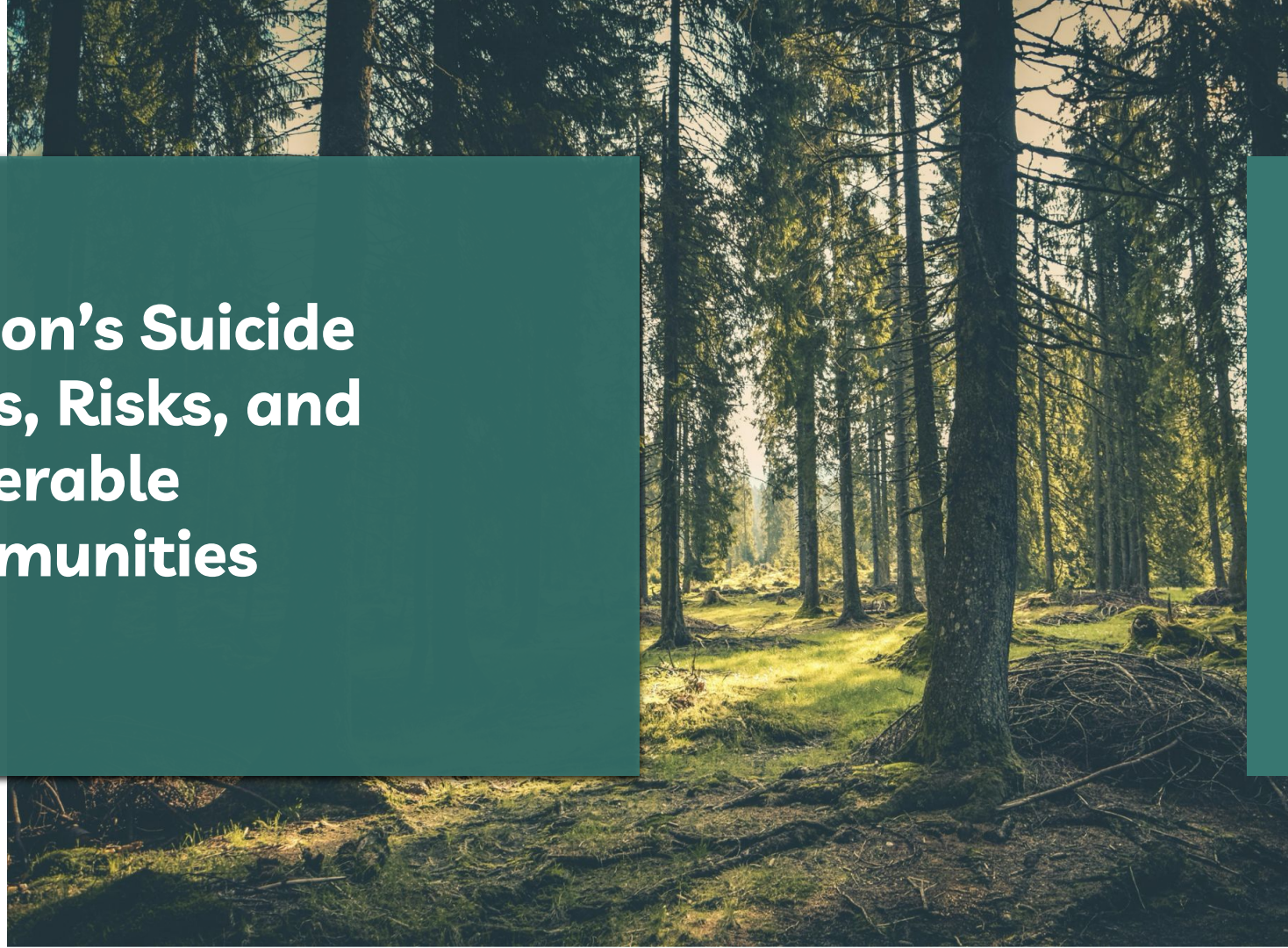
Goals & Objectives

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

The original report brought light to the gap between existing services and a lack of accessible information about them, as well as barriers in implementation. **The present report aims to highlight what's working well in Oregon, as well as barriers for current programming, and practical next steps to understand and address gaps in suicide prevention across the state.**

Oregon's Suicide Rates, Risks, and Vulnerable Communities



01

Oregon's suicide rates, risks, and vulnerable communities

- **Age:** Older adults (65+) are at the greatest risk for suicide. Oregon's youth suicide rates remain above the national average.

- **Race & Ethnicity:** Native & Indigenous individuals have the highest rate of suicide in Oregon at 23 per 100,000 people. There are also unique barriers to access and utilization of mental health services (e.g., lack of services on reservations, lack of cultural relevance in SP/I programming). White Oregonians are next, at 21.9 per 100,000.

- **Sex & Gender:** Adult males are 75% more likely to die by suicide in Oregon compared to adult females. This intersects with lethality of chosen method, veteran status, occupation, and rurality vs urbanicity. *In a systematic review comparing men and women who used firearms to attempt, the gap in death rates between the two groups closed.* There remains a lack of data on trans, gender non-conforming, non-binary, and gender fluid individuals.

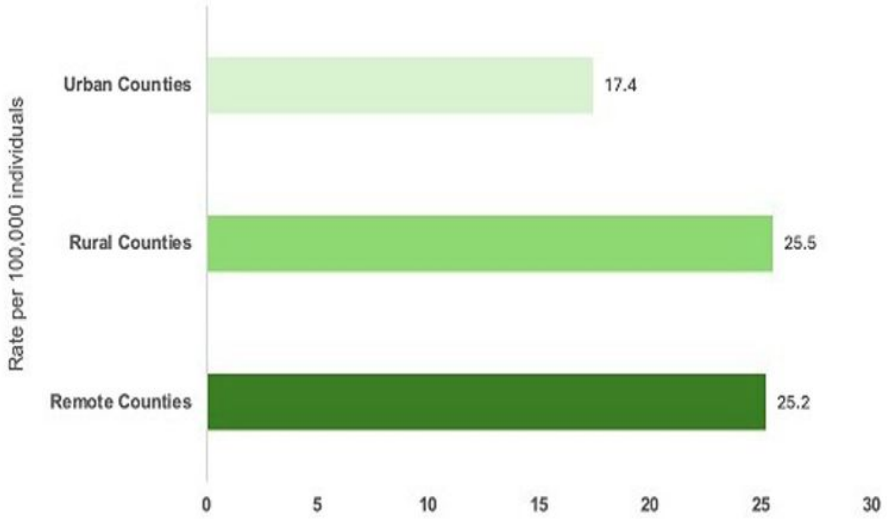
01

Oregon's suicide rates, risks, and vulnerable communities

- **Veteran Status:** Oregon veteran suicide (51.7 per 100,000) is significantly higher than the national average (34.7 per 100,000). Veterans use firearms at higher rates than non-firearm methods.

- **Occupation:** Farming, Fishing, and Forestry occupations in Oregon report highest death rates by suicide (122 deaths per 100,000). The second highest rates are among Arts, Design, Entertainment, Sports, and Media (91.9 deaths per 100,000), followed by Construction and Excavation (90.7 per 100,000).

- **Rurality & Urbanicity:** 65% of Oregonians live in urban areas, 33% in rural, and 2% in frontier. Rural residents are at higher risk for suicide, both nationally and statewide.



01

Oregon's suicide rates, risks, and vulnerable communities

- **Method:** The most common method for suicide in Oregon is by firearm (53%). Of Oregonians who die by firearm, 85% are male. The second most common method is suffocation (25.8%), followed by poisoning (12.6%), falling (2%), and other (8.6%).

- **Homicide-Suicide Deaths:** Current data from 2003 to 2022 suggest that 91% of homicide-suicide deaths occur by firearm, 4% by sharp instrument, 3% by other methods, and 2% by suffocation/strangulation.

Public Health Model and Suicide Prevention

02

Public Health Model and Suicide Prevention

- **Primary Prevention:** These are “upstream” activities that increase protective factors (e.g., access to basic needs, healthcare, social support, emotion regulation skills, etc.) and decrease risk factors (i.e., adverse childhood experiences, homelessness, food insecurity, etc.)

- **Secondary Prevention:** These are interventions designed for at-risk populations, including those who are at risk of or already experiencing suicidal ideation or behaviors.

- **Tertiary Prevention:** Prevention and postvention efforts designed to support individuals who have experienced a suicide attempt or crisis, as well as those impacted by a suicide. The goal is to promote recovery, reduce risk of attempts, and mitigate long-term negative outcomes. Efforts focus on continuity of care, stabilization, and healing following an acute crisis.

    - **Postvention:** Postevention is tertiary prevention, and it’s defined as an organized response to a suicide death. Efforts often include immediate and long-term emotional support, contagion mitigation, and prevention of other harmful effects of suicide for those bereaving, and community members who may be impacted.

02

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

SPRC Best Practice Registry

02

Programs/Trainings x SPRC Best Practice Registry

	Strengthen Economic Supports	Create Protective Environments	Improve Access & Delivery of Care	Promote Healthy Connections	Teach Coping & Problem Solving Skills	Identify & Support People at Risk	Lessen Harms & Prevent Future Risk
Collaborative Assessment and Management of Suicidality (CAMS)	X	X	X	X	X	X	X
Sources of Strength		X		X			
Connect Postvention		X		X			X
Question, Persuade, Respond (QPR)						X	

Oregon's Suicide Prevention Policies for Youth and Adults

03

Policies

Oregon's Suicide Prevention Policies for Youth and Adults

Oregon is keeping pace with—and in some areas exceeding—other states recognized for robust suicide prevention efforts by emphasizing comprehensive approaches that span from primary to tertiary interventions and postvention programming, with a particular focus on equity and population-specific needs.

Oregon's suicide prevention landscape extends beyond what is formally codified in statute or rule; many evidence-informed practices, programs, and partnerships are implemented through agencies, schools, health systems, and community-based organizations without being explicitly mandated by law.

As a result, the absence of statutory language in certain areas should not be interpreted as a lack of action, but rather as an indication of a flexible and adaptive system in which suicide prevention efforts are advanced through both policy and practice.

03

Youth

In 2014, the five-year **Youth Suicide Intervention and Prevention Plan (YSIPP)** was adopted from strategic directions and objectives from the 2012 National Strategy for Suicide Prevention. The first iteration of the YSIPP consisted of four priorities:

i. Healthy and empowered individuals, families, and communities
ii. Clinical and community preventive services;
iii. Treatment and support services; and
iv. Surveillance, research, and evaluation.

The current YSIPP consists of 3 pillars:

v. Healthy and empowered individuals, families, and communities;
vi. Clinical and community preventive services; and
vii. Treatment and support services.

Within these 3 pillars are 11 strategic goals, with pathways, which house hundreds of 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.

03

Youth

SB 52 (2019), "Adi's Act": requires all Oregon school districts to adopt and implement a Student Suicide Prevention Plan. Districts must make these plans available each year to students and the broader school community and post them on the district website when applicable. Plans should outline procedures for prevention, intervention, and postvention, center equity and racial equity, and include a staff training framework that specifies how and when students and families are connected to appropriate mental health and crisis resources.

- The administrative rule associated with Adi's Act (OAR 581-022-2510) further establishes expectations for inclusive supports across student populations, including LGBTQ+ youth, BIPOC and Tribal students, youth in out-of-home placements, students with disabilities, and other historically and currently underserved groups. This rule falls under the Division 22 Standards for Public Elementary and Secondary Schools, and district superintendents are required to report compliance on an annual basis.

03

Youth

SB 563 (2021): modifies laws relating to youth suicide prevention and intervention to include children 5 to 10 years of age.

HB 3139 (2021): 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.

03

Youth

HB 3037 (2021): directs medical examiners/medical-legal death investigators to report deaths of decedents 24 years of age or younger to local mental health authority if there is reasonable belief that the manner of death was suicide. This bill **amends SB 561 (2015)**, adding the following:

1. OHA 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.
2. 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.

03

Youth

HB 3037 (2021) *continued:*

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 OHA, 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.

03

Adult

The Adult Suicide Intervention and Prevention Plan (ASIPP) was published in April of 2023 by OHA. ***Oregon does not provide any funding for the ASIPP.*** Led 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. Populations disproportionately affected by suicide and historically underserved are highlighted, including

- 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
- People of color
- Men
- Those living in rural or remote areas.

03

Adult

HB 2315 (2021): 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.

03

Adult

HB 2417 (2021): expands crisis stabilization services, including crisis stabilization centers meeting criteria adopted by OHA 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 (by 1/2022) to report recommendations on policies and legislative changes, if any, needed to implement the National Suicide Hotline Designation Act of 2020 and establish statewide coordinated crisis services system to interim committees of Legislative Assembly related to mental or behavioral health. This policy specifies

1. What information that must be included in report,
2. Limits liability of 988 coordinated crisis services system to conduct that is willful or wanton,
3. Prohibits blocking delivery or forwarding to public safety answering point of 988 coordinated crisis services system information, and
4. Makes number identifications and subscriber information received by 988 coordinated crisis services system confidential and not subject to public disclosure unless specified criteria are met.

03

Adult

HB 3090 (2017): 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, 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 also includes a requirement process to coordinate care, and, if suicidal ideation is confirmed by the behavioral health assessment, requires initiating caring contacts with the patient within 48 hours after release, and setting an appointment with a clinician within 7 days or requires the hospital to document why an appointment could not be made.

03

Adult

HB 3091 (2017): expands healthcare coverage for individuals experiencing crises. Specifically, this law requires commercial health plans and the Oregon Health Plan to cover case management as well as care coordination for individuals seeking behavioral health services. HB3091 (2017) also requires specific facilities to provide care coordination to patients in behavioral crisis.

SB 48 (2017): mandates that licensees of specific licensing boards report the completion of any continuing education units (CEU) on suicide risk assessment, treatment, and management during license renewal. This bill aims to **improve reporting of trainings and does not require that licensees complete specific trainings.**

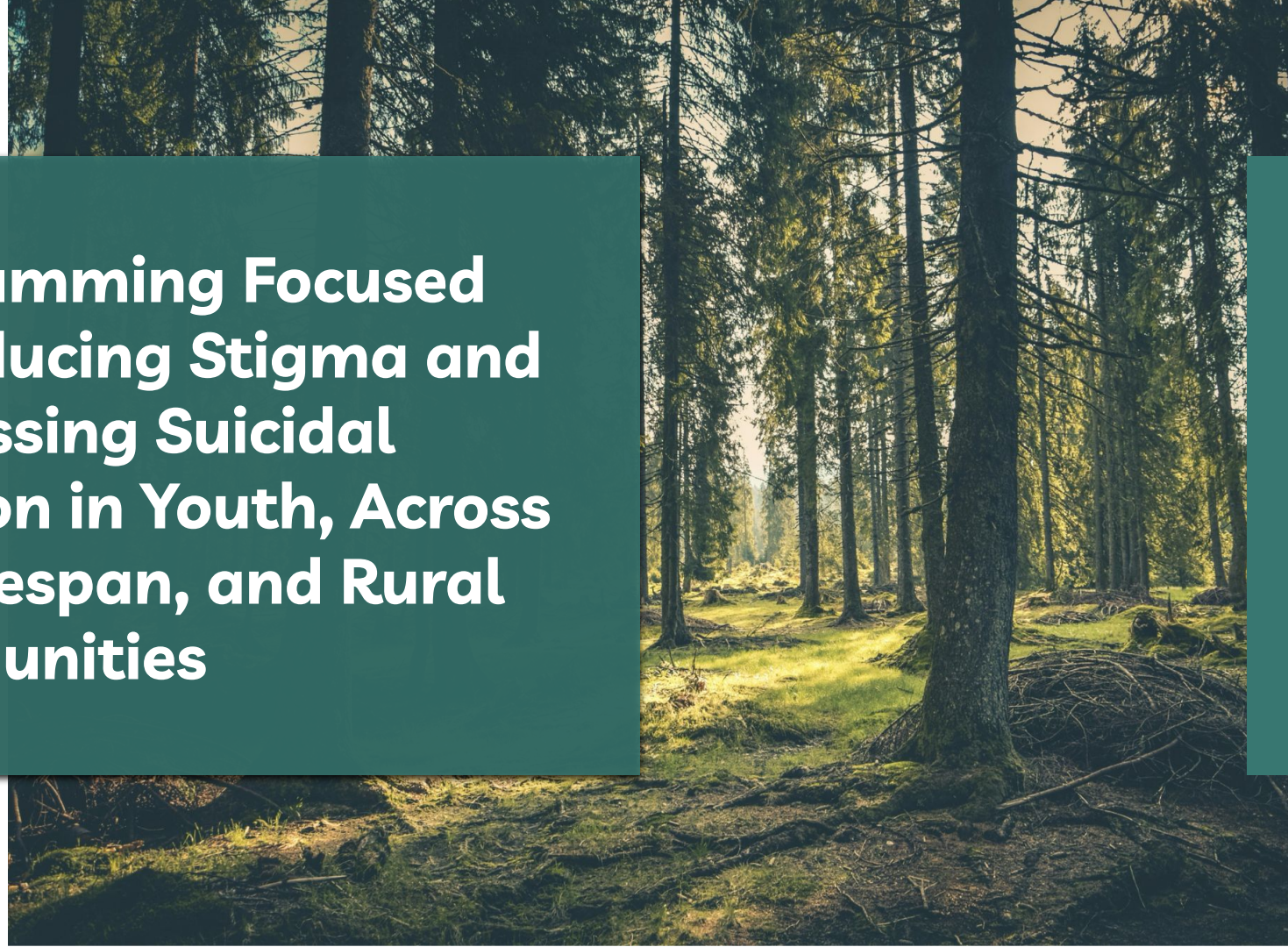
03

Adult

HB 2725 (2023): Establishes a permanent funding and governance structure for Oregon's statewide coordinated behavioral health crisis response system, centered on the 988 Suicide and Crisis Lifeline. The bill creates a dedicated 988 Trust Fund, funded in part through a monthly telecommunications surcharge, and requires that these funds be used exclusively to support crisis call center operations, mobile crisis intervention teams, crisis stabilization services, and related infrastructure without supplanting existing funding sources.

It mandates that the Oregon Health Authority implement, maintain, and continuously improve a statewide 988 hotline that operates 24/7, meets national operational and clinical standards, and is integrated with local crisis services, emergency response systems, and community mental health programs. The legislation further requires the establishment of standardized requirements for crisis stabilization centers, expansion of mobile crisis response capacity statewide, reimbursement mechanisms for crisis services across payers, annual reporting on revenues and expenditures, and the creation of an advisory committee to provide ongoing oversight, coordination, and stakeholder input into the operation and evolution of Oregon's coordinated crisis system.

Programming Focused on Reducing Stigma and Addressing Suicidal Ideation in Youth, Across the Lifespan, and Rural Communities



04 Reducing Stigma

Most stigma reduction programming is intended to increase knowledge on suicidal thoughts and behaviors, thereby reducing stigma.

Launch of the 988 Oregon: Connect to Hope public awareness campaign, which launched in July 2025.

- The state conducted focus groups among various communities and surveyed community-facing organizations to understand and monitor stigma-reduction efforts and suggestions in the development of the campaign, which aims to educate people in Oregon about the 988 hotline.
- Focused on community-informed campaign efforts on “lowering the bar” and encouraging people to reach out to 988 for reasons other than suicide, OHA believes the campaign can contribute to stigma reduction.
- Teams have also broadly shared information gathered in these initiatives to help other suicide prevention and intervention programs across the state address stigma in their communities

04 Reducing Stigma

Community helper trainings (gatekeeper trainings) are specifically designed to reduce stigma that may prevent an individual from intervening when they witness suicidal thoughts and behaviors. Ultimately, these trainings aim to reduce stigma and bystander behaviors.

- There is a lack of standardized measurement of participants, and some of this is due to these trainings focusing on different outcomes (i.e., knowledge increase verses skill adoption).
- Information about the impact of the trainings in Oregon on mental health stigma is not publicly available, although reports conducted by the UOSPL find that community helper trainings increase a participant's **confidence and comfortability** in asking others about suicide, which is believed to be related to a reduction in stigma.
- Increased focus on actual behavior change (i.e., reduced stigma and bystander behaviors and increased interventions) is necessary to show whether these trainings are making a meaningful difference in Oregon.

04 Programming

- Social emotional learning in schools (e.g., Sources of Strength)
- Safe storage programs
- Enhanced Care Outreach services
- Older Adult Behavioral Health Initiative (OABHI)
- Rural Older Adult Mini-Grants (ROAM)
- Zero Suicide
- Gatekeeper Trainings / Community Helper Trainings
- Statewide Crisis lines
- Inpatient mental health treatment
- Outpatient Crisis intervention services
- Connect Postvention training
- Oregon Youth Suicide Postvention Leads
- Lines of Life Suicide Rapid Response
- School-Based Postvention Plans
- Suicide Bereavement Groups

Barriers to Implementation

05

Barriers

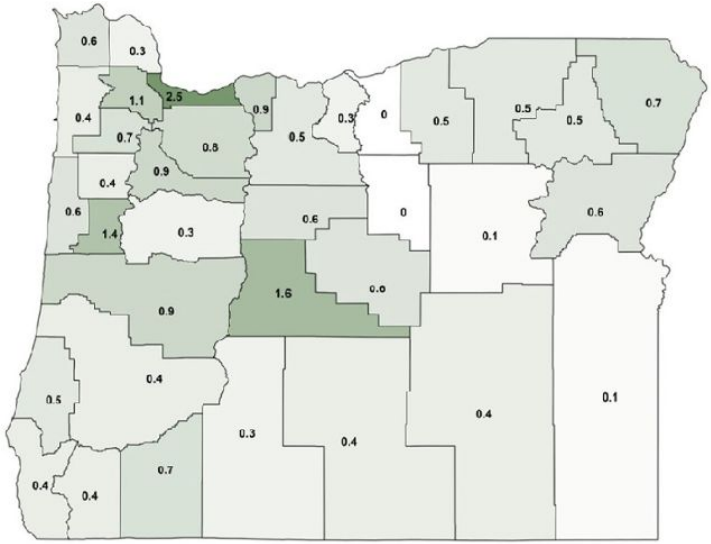
Universal Barriers to Implementation

- The universal limitation with suicide prevention programming is that **it can be difficult to prove programming is "working."** In part, this is because there is no way to know how many individuals are considering suicide at any given time, and therefore, whether programs such as campaigns, advertisements, or distribution of gun locks are effectively preventing individuals from moving beyond ideation to behavior enactment.
- It is also possible that the true rate of death has gone down, but that the number of reported deaths has increased as mental health awareness and reporting practices improve.
    - This is why it is crucial not to draw causal conclusions from correlational data!
    - Despite these universal limitations, **Oregon's barriers remain largely addressable.**

Workforce Shortage

There is a significant workforce shortage in behavioral health across the state, with even greater shortages in rural communities.

Thirty-two of Oregon's 36 rural and frontier counties had fewer than 1 mental health provider per 1,000 residents. Primary barriers include challenges to recruit and retain qualified staff in behavioral health (i.e., low wages, limited career development opportunities, lack of clear career paths, cultural barriers, poor infrastructure, and traumatic workplace environments.)



Mental Health Providers by County Per 1,000 Residents

05 Barriers: Programming

Geographic Disparities

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, the existing programming (e.g., community-helper trainings or policies requiring utilization of mental health professionals) 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.

Despite efforts such as ROAM, OCALM, and Community Calm, there remains a significant gap in support for many communities in Oregon.

05 Barriers: Programming

Challenges in Addressing Primary Prevention

Much of Oregon's suicide prevention programming addresses secondary prevention (supporting people who are already experiencing suicidal thoughts from attempting suicide), addressing the social determinants of health that can decrease the risk and likelihood of individuals developing suicidal ideation and behaviors (e.g., The JED Foundation)

Few programs provide primary interventions (e.g., school-based SEL programs, ROAM grants). Need for 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).

There are several policies aiming to address homelessness across the state, for example, SB 5701 (2024), which granted emergency funding to rehouse homeless families and provide up to 24 months of rental assistance. **However, these upstream efforts are rarely tied to suicide prevention programming or awareness, which leaves a gap in support for individuals at increased risk for developing SI/SB downstream.**

05 Barriers: Programming

Limited Hospital and Treatment Center Options

There is a severe lack of access to inpatient mental health services in rural Oregon, 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 are vital to the success of inpatient treatment and transition back to their community.

Only 8 facilities in Oregon currently offer residential psychiatric treatment for youth - all of these, but one, are located in the northwest corner of the state. Currently, these facilities have struggled with long waitlists for youth admissions and workforce shortages that hinder recruitment and retention of critical staff ratios. Furthermore, Unity Center and PFW are meant to be acute, short-term programs; however, given the long, congested waitlist for residential beds, some youth remain at hospital units for well past the recommended length of stay. Additionally, these providers only accept referrals from emergency departments, which means youth must present to an emergency department to access the process of applying for Unity or PWF.

The following is a list of psychiatric residential treatment programs by county and provider:

County	Provider (Number of Treatment Centers)
Benton County	Trillium Family Services Corvallis Campus (1)
Clackamas County	Monte Nido: Clementine Programs (2)
Deschutes County	Embark Behavioral Health (1)
Lane County	Looking Glass (2) Jasper Mountain (3)
Multnomah County	Albertina Kerr (1) Nexus (1) Trillium Family Services Portland Campus (1)
Washington County	Madrona Recovery (1)

05

Barriers: Programming

Lack of Funding for Adult Programming

The ASIPP was created to address a key gap in Oregon's suicide prevention programming - suicides that occur after an individual turns 24 years old. This framework is still in the early phases of adoption and is working to address the many gaps in support for adults in Oregon.

The ASIPP does not have the same legislative support or funding as the YSIPP, leaving significant gaps in support for individuals over 24 years old.

Specific programs such as the Sr. Loneliness Line, the ROAM mini-grant, and the Older Adult BH initiative aim to close the gaps in support; however, more funding is needed from the state in order to provide a robust and truly comprehensive suicide prevention approach. Most 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.

Unique Cultural Needs and Existing Bias

One particularly challenging cultural barrier in Oregon is within the firearm community. This community may feel particularly protective over their right to own and use firearms, which can create friction with suicide prevention efforts aiming to educate community members on the dangers of firearms and the risks of both accidental and intentional injuries. Research from Oregon State University found that suicide prevention messaging specifically tailored to the cultural needs of firearm owners in Oregon are the most successful.

There are also existing biases in Oregon that affect individuals seeking healthcare. These biases may in turn increase resistance to culturally responsive programing. Oregon's pervasive history of racism likely influences modern attitudes, perspectives, and biases, both consciously and unconsciously. Culturally specific suicide prevention and intervention programming is not yet being effectively implemented throughout the state.

05 Barriers: Programming

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. **Over 80% of gun deaths in Oregon are due to suicide.** Household firearm ownership data is scarce and difficult for researchers to access, but studies have shown that rural communities across the US experience higher rates of firearm suicide and unintentional firearm injury and death.

Only two programs in Oregon specifically focus on firearm suicides, though others may address it during conversations on lethal means. There are two gatekeeper trainings, CALM and OCALM, which aim 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 (public information about other safe storage programs is not available, which suggests if these programs do exist, Oregonians may not be aware of them)..

05 Barriers: Policies

Policy Barriers

The primary policy implementation barriers include a **lack of built-in enforcement mechanisms** (e.g., fines for compliance violations), **a lack of implementation support at local levels** (e.g., technical support), **and a lack of formal incentives** (e.g., funding).

Barriers: Policies 05

Policy Enforcement

- Few suicide prevention policies have specific enforcement requirements, making it difficult to ensure policies are being followed.
- Few policies have reporting requirements built in for local agencies, making it difficult for state agencies to collect data on compliance. For example, SB 52 (2019), "Adi's Act," is one of the few policies that require, in this case, superintendents, to report on their district's compliance with ODE annually.
- The lack of built-in communication between local institutions, such as emergency departments or school districts, and the state may contribute to a delay in policy and practice implementation, which may then lead to high-risk individuals falling through the cracks.

05 Barriers: Policies

Implementation Support

- Rural areas may need more support implementing new policies. For example, when evaluating the implementation of HB 3090 (2017), which requires emergency departments to create a policy for suicide prevention and safety planning for individuals experiencing a behavioral health crisis prior to release, rural hospitals showed lower compliance than urban hospitals.
    - Limited resources, lack of staffing, lack of implementation support, heightened stigma or fears around the legal implications of patients dying by suicide, or simply having limited time to incorporate new policies and subsequent staff trainings.

Barriers: Policies 05

Formal Incentives

The implementation of new policies, practices, and reporting methods requires significant **technical assistance,** particularly for under-resourced communities.

The **lack of funding** for communities further reduces the incentive for organizations to dedicate hours and staff to understanding, implementing, and complying with state policies.

The ASIPP is a prime example of key policies and initiatives that, due to a lack of funding, face significant implementation barriers.

05

Barriers: Treatment

Treatment Barriers

There are clear implementation barriers for treatment-focused suicide prevention practices across the state of Oregon. These barriers include both institutional barriers and individual-level barriers. The following section aims to provide context for why at individual and institutional levels in both the healthcare and mental health sectors.

05

Barriers: Treatment

Licensing Boards

Licensing Boards hold significant power and determine whether new requirements must be created for practitioners to attain, renew, and maintain their licensure. These entities have shown successful implementation and compliance with policies mandating boards to require specific reporting and training as part of licensure or license renewal for practitioners (e.g., SB 48 (2017), HB 2315 (2021)).

No policies currently exist that mandate medical boards to require training in suicide risk assessment, treatment, and management among healthcare professionals, even those which license providers who work with acute, high-risk patients or regularly have contact with suicidal individuals.

05

Barriers: Treatment

Beliefs about the Scope of Work

One reason medical boards and healthcare workers report being resistant to the idea of required suicide prevention trainings and CEUs is that **many healthcare professionals believe that mental and behavioral health concerns should be addressed with mental health professionals and not within the medical setting.**

- Roughly half of the individuals who die by suicide see their primary care provider within the month of dying.
- Many medical professionals are able to prescribe mental health medications, such as antianxiety and antidepressant medications. In fact, a 2015 study found that **75% of antidepressant prescriptions in the U.S. were written by non-psychiatrists.**

What is particularly concerning about these data is that **healthcare workers are treating patients for mental health concerns without receiving any form of standardized, evidence-based suicide prevention training.**

05

Barriers: Treatment

Concerns of Liability

Healthcare workers and mental health professionals have routinely shared fears about treating suicidal clients. This fear can develop from stigma about suicide, but often it comes from a lack of education and knowledge about codes of ethics and legal liability.

Healthcare workers share fears that if they treat a patient for suicidality and the patient dies, they will be found liable for that death.

This indicates healthcare and mental health professionals need to receive education and training on their own legal liabilities, the best practices for treating suicidal clients, and on-the-job training opportunities with experts who can provide real-time feedback, shadowing, and safe classroom settings for role-play practice with their peers.

Comparing Oregon to Other States

06

Comparing Oregon to Other States

To better understand what programming is missing from Oregon's current landscape, particularly for youth suicide prevention, **UOSPL conducted a 5 State Scan, comparing suicide prevention policies, practices, programs, and initiatives of the five states with the lowest youth suicide rates (ages 10 - 24) in 2023.** The Centers for Disease Control and Prevention reports that Connecticut (4.5), Massachusetts (4.8), New York (5.0), New Jersey (5.7), and Maryland (6.7) had the lowest death rates per 100,000 in 2023, compared to Oregon, which had 13.5 deaths per 100,000 the same year. The report can be examined in greater detail here. Below is a list of high-level findings from the report regarding what types of policies and practices worked best for these five states.

06

Comparing Oregon to Other States

- **Sustained Statewide Leadership and Coordination.** Effective suicide prevention strategies are anchored by permanent coalitions, commissions, or councils that provide centralized leadership, align efforts across sectors, and maintain continuity over time. Youth-specific advisory bodies and dedicated youth prevention plans further strengthen these efforts by ensuring developmental relevance and sustained focus on youth needs.
- **Required Suicide Prevention Training for School Personnel.** Successful approaches commonly include mandated suicide prevention training for school staff or licensed school professionals. Even when training is not required annually, consistent expectations for training help standardize knowledge, improve early identification of risk, and increase staff confidence in responding to warning signs.

06

Comparing Oregon to Other States

- **Formalized School-Based Suicide Prevention Policies.** States with stronger outcomes tend to require school districts to adopt suicide prevention policies, embedding prevention, intervention, and postvention practices into everyday school operations rather than relying on voluntary or ad hoc implementation.
- **Accessible and Anonymous Crisis Support for Youth.** Effective strategies prioritize low-barrier access to crisis support, including anonymous reporting and direct connections to counselors available around the clock. These mechanisms reduce fear of stigma or retaliation and increase the likelihood that youth will seek help for themselves or peers.
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06

Comparing Oregon to Other States

- **Integration of Suicide Prevention with Bullying Prevention Efforts.** Comprehensive suicide prevention strategies often address known upstream risk factors, such as bullying and cyberbullying, through clear reporting requirements, staff training, and accountability measures that support safer school environments.
- **Adoption of Evidence-Based Models of Care Within Health Systems.** Scaling evidence-informed frameworks, such as comprehensive suicide prevention models within outpatient mental health settings, strengthens continuity of care and improves identification, treatment, and follow-up for individuals at elevated risk.
- **Extension of Suicide Prevention Efforts into Higher Education Settings.** Successful strategies increasingly include requirements or supports for suicide prevention programming and continuous crisis response availability within colleges and universities, recognizing that suicide risk extends beyond K–12 settings.

Recommendations

07 Recommendations

Addressing Underlying Social Determinants of Health: A robust, comprehensive, and effective approach to suicide prevention should aim to address the social determinants of health which put Oregonians at greater risk of facing suicidal ideation, behaviors, and deaths (e.g., housing, food insecurity, truancy, etc.)

Culturally Responsive Suicide Prevention: Address gaps for high risk groups. For example, Native American and Alaska Native community members have expressed the need to address suicide as a community problem, rather than a problem of individual pathology. Firearm suicide prevention programming must gear messaging for the specific culture of firearm owners.

Leveraging Implementation Science Strategies. Across the state, community members, practitioners, and organizations are implementing evidence-based practices for suicide prevention. However, many evidence-based programs require specific implementation processes, and failure to implement these with fidelity can lead to an unsuccessful program. In fact, many evidence-based programs do not successfully transition from effectiveness trials to real-world implementation by practitioners.61 Supporting the use of implementation science strategies and tools will help to guide practitioners as they implement and sustain programs in their respective environments. Through the use of practical implementation science, teams can facilitate the successful scale-up efforts and sustainment of selected evidence-based programs.62

Recommendations 07

Increased Documentation and Visibility of Suicide Prevention Efforts. Practitioners, communities, and organizations across the state are engaging in meaningful and impactful work. However, **this work is often localized and the tools, protocols, and practices established by practitioners are not being documented or shared. This can lead to an overlap in efforts, a lack of transparency, accessibility challenges for community members, and difficulties obtaining funding.**

Centralized Data Tracking System. A centralized database would allow practitioners, policymakers, and key agencies to surveil the progress of suicide prevention activities across the state. Not only would this database allow community programs to track the implementation, evaluation, and effectiveness of their programs, but it could also improve intradepartmental communication and facilitate support between organizations across the state who may serve the same communities or face the same program challenges. The database would also 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.

Recommendations 07

Incentivization for Mental and Behavioral Health Professionals.

- Incentive programs to community members and activists to receive formal education and training in mental health professions and suicide prevention therapies.
    - This would both increase the number of professionals available to Oregonians and empower community members who are already well positioned to support their communities, given their relevant community and cultural knowledge and insight.
- Incentive program for out-of-state licensed professionals to practice in Oregon, either virtually or in person.
    - These incentives could be location-specific, which would help deter the significant desert of mental health resources in rural Oregon.
- Incentivize existing mental health professionals to receive formal training in suicide-specific interventions and therapies, such as DBT or CAMS.
    - Since most academic programs do not require students to receive suicide-focused training or education, it is vital that existing therapists and behavior specialists learn these interventions and have supervised clinical practice implementing them.
- Incentivize clinicians to move to areas of need, including rural areas, where many Oregonians have limited or no local mental health resources for crises.
- Expand the mental health workforce using existing resources, such as the Ballmer Institute.

Recommendations 07

Place the Burden on the Institution, not the Individual. Data indicate clear community contact points for individuals experiencing suicidal thoughts. Among youth, schools serve as primary settings where suicidality can be identified and addressed, while for adults, healthcare environments represent key points of contact. Across these high-impact sectors, however, professionals often cite limited time, burnout, and financial constraints as barriers to pursuing training opportunities. Rather than placing the responsibility on individual professionals to find, fund, and attend trainings, often on their own time, future policies should shift this burden to the institutions themselves. For instance, instead of expecting nurses to personally cover the cost and dedicate unpaid hours to crisis intervention and suicide prevention training, hospitals and clinics should be required to provide access to training and compensate staff for their participation. Assigning training responsibilities to institutions rather than individuals can reduce resistance, mitigate liability concerns, and help address burnout and financial strain.

Thank you!

Questions?
Comments?
Reflections?