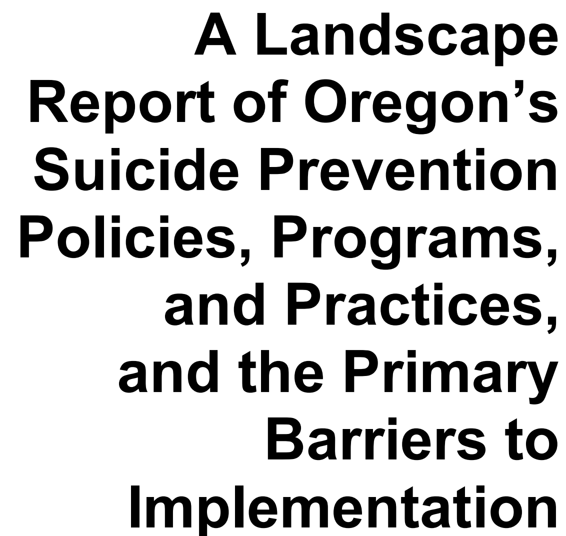

A Landscape Report of Oregon's Suicide Prevention Policies, Programs, and Practices, and the Primary Barriers to Implementation

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Preface

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
- 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

Given that many of the efforts identified above are nested within each other, the UOSPL lab organized the report into four sections: (1) Understanding the Context for Suicide Prevention (2) Addressing Suicidal Ideation and Behaviors Across Oregon (3) Barriers to Implementation, and (4) Strategies and Recommendations to Improve Suicide Prevention in Oregon

Oregon is a culturally diverse state that values local voice, policy, and data ownership. As such, many suicide prevention policies, practices, programming, and subsequent data may be localized. Furthermore, as sovereign nations, Oregon's nine tribes may also be implementing prevention practices on an individual basis, which are not reflected here. The present report aims to provide overarching summaries of prevention work across Oregon, providing specific examples for illustration. This report does not aim to provide a comprehensive list or extensive database for every suicide prevention-focused effort, practice, and organization from different communities in the state, and not every current suicide prevention program will be represented.

Part I: Understanding the Context for Suicide Prevention

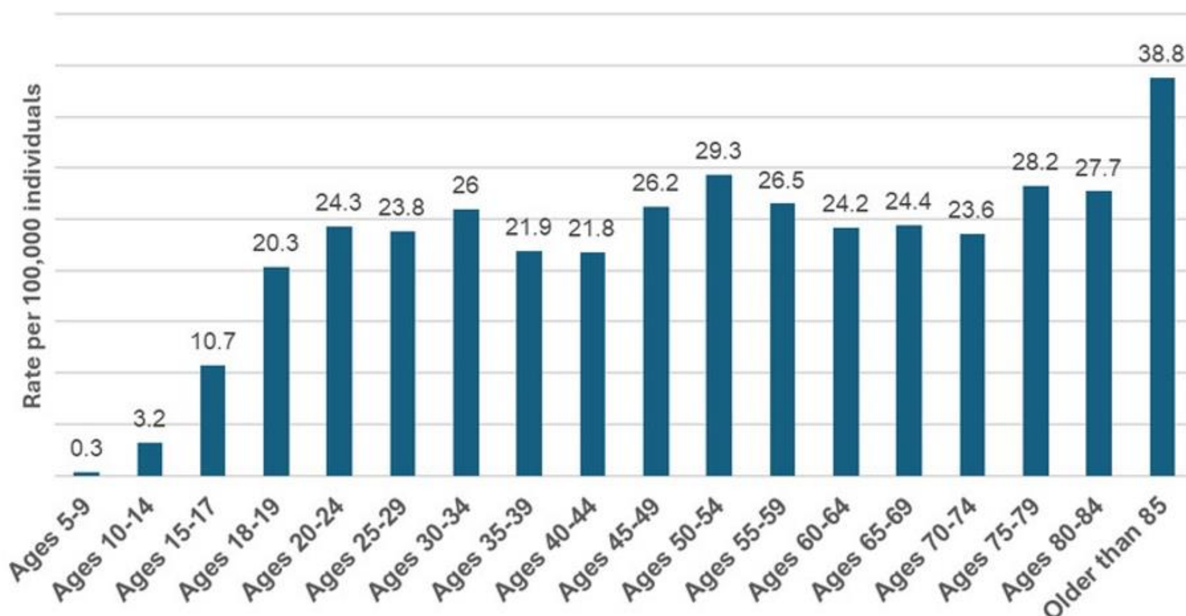
Overview of Suicide in Oregon

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 the 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. In 2024, there were 952 suicide deaths, and in 2023 there were 902.[3] There were 883 suicide deaths in 2022, with a rate of 19.5 suicide deaths per 100,000 people in Oregon (compared to14.2 per 100,000 people for the rest of the United States).[4] Although suicidal thoughts and behaviors can affect all individuals, some groups are disproportionately represented in the data. It is worth noting that the Oregon Health Authority (OHA) maintains a data dashboard that reports on deaths. Oregon may have better tracking systems in place to record and report suicide deaths compared to other states, contributing, in part, to above average rates.

Age. In the state of Oregon, older adults (65+ years old) are at the greatest risk for suicide (see Figure 1), making up 24% of suicide deaths in Oregon between 2018 and 2022.[4] For the past 10 years, Oregon's youth suicide rates have been higher than the national average.[4] According to Oregon Health Authority (OHA) and the most recent data, the youth suicide rate in 2022 was 14.2 per 100,000 in 2022. Suicide is the second leading cause of death of young Oregonians, aged 5 through 24.[5]

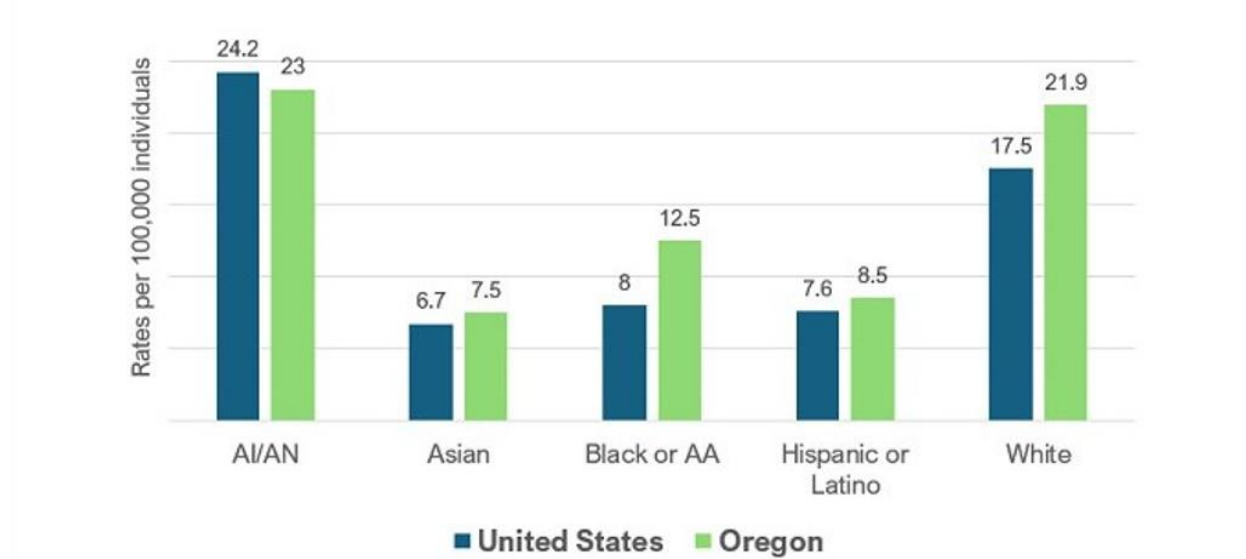
Figure 1. Suicide Rates by Age Group in Oregon from 2018 through 2022



Race and Ethnicity. Non-Hispanic American Indian and Alaska Native individuals have the highest rates of suicide in Oregon at 23.0 per 100,000.[4] This aligns with national level data,[6] suggesting Indigenous people throughout the U.S. experience increased risk of suicide.[7] Native American and Alaska Native people face specific barriers to accessing and utilizing mental

health services, including a lack of adequate services on reservations and a lack of cultural relevance in suicide prevention and intervention programming.[8] For example, 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 and barrier to service utilization.[9, 10]

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



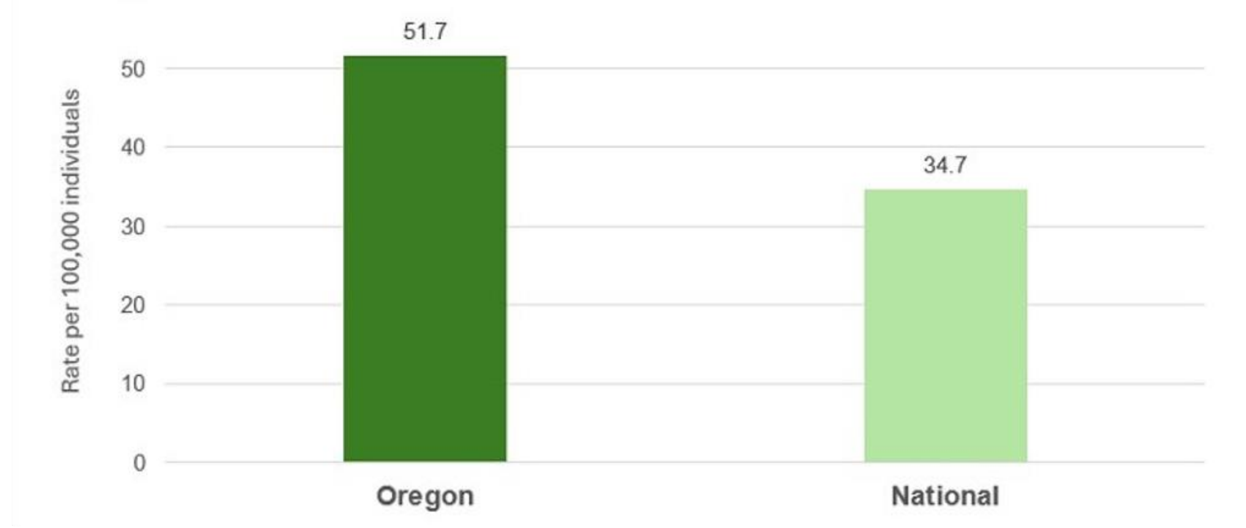
The next highest suicide rates in Oregon by ethnic group are Non-Hispanic White Oregonians, with a rate of 21.9 per 100,000.[3] Non-Hispanic Asian people had the lowest suicide rate, at 7.5 per 100,000. Black, Hispanic, Pacific Islander, and multi-ethnic Oregonians each had suicide rates between 8.5 -12.8.[4]

Sex and Gender. Current data has found sex differences between males and females. Adult males are 75% more likely to die by suicide in Oregon, compared to adult females.[4] These sex differences, specifically the higher rates for men, intersect with the lethality of chosen methods, Veteran status, occupation, and rurality/urbanicity. Men are more likely to use firearms, which have the highest lethality compared to other methods.[11] In a systematic review comparing men and women who used firearms to attempt, the gap in death rates between the two groups closed.[11]

Prior research has established an exorbitant risk for suicidal thoughts and behaviors among transgender and non-binary individuals.[12–14] Moreover, data efforts tend to aggregate gender and sexual minorities into one group, despite distinct differences in suicidal thoughts and behaviors between these groups.[15] Although efforts have been made to expand the understanding and differentiation between sex and gender across Oregon, particularly within data collection and tracking practices, there remain significant challenges. For example, due to continued societal and community bias, many individuals may choose not to disclose their identities, making it nearly impossible to track the true rate of suicidality among vulnerable communities.[16]

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.[17] Additionally, when examining method of veteran suicide in Oregon, veterans used firearms at higher rates compared to other methods.[17]

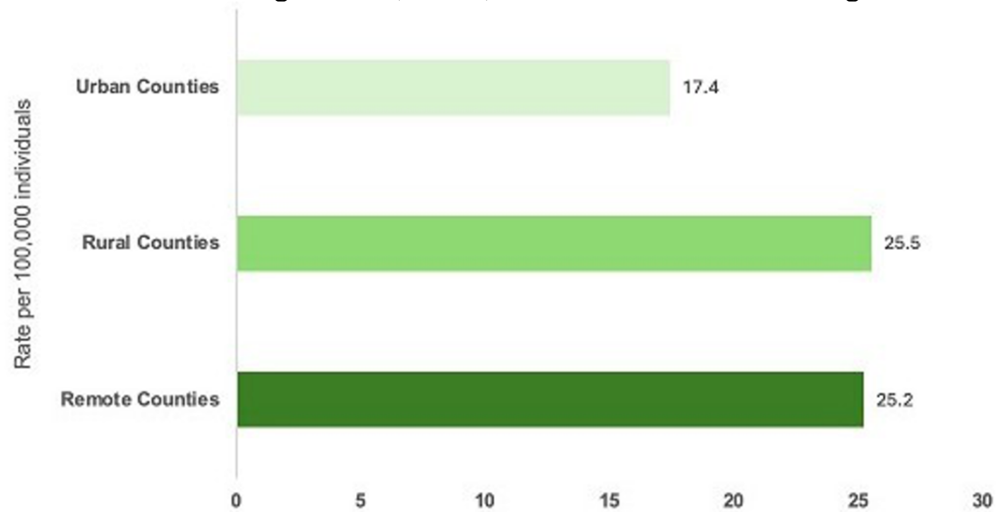
Figure 3. Oregon and National Rates of Veteran Suicide Deaths for 2022



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 deaths per 100,000 people.[6] 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).[4]

Rurality and Urbanicity. In Oregon, rural counties are defined as areas at least ten miles away from a population center with 40,000 or more people.[18] Remote or frontier areas are defined as counties with six or fewer people per square mile.[18] Approximately 65% of Oregonians live in urban areas; roughly 2,772,488 people as of 2024.[18] 35% of Oregonians live in rural (33%; 1,403,688 individuals) or frontier (2%; 97,666 individuals) areas. In other words, over 1.5 million Oregonians are at greater risk for suicide, as both statewide[19] and national[20] data show higher rates for suicide per 100,000 among rural residents (see Figure 4).

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



Method. The most common method for suicide in Oregon is by firearm (53%). Of Oregonians who die by firearm, 85% are male. Suffocation is the second most common method for suicide (25.8%), followed by poisoning (12.6%), other (8.6%), and falling (2%).[4] Firearms are the deadliest method for suicide.[11, 21] This is, in part, due to the short time it takes for an individual to move from contemplating suicide to enacting their plan. While other methods may take more time to plan out or use, giving individuals more time to process the decision or change their minds either before or during an attempt, firearms take little time to use, and the time between the attempt and the resulting death can be instantaneous.

Homicide - Suicide Deaths. Homicide-Suicide deaths involve complex, individual, relational, and societal dynamics. These deaths are outside the scope of the present report; however, to establish an accurate reflection of Oregon's landscape, some consideration must be made for such data. 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.[21]

Nationally Recognized Suicide Prevention Models and Practices

This report evaluates the current landscape of Oregon suicide prevention programming and practices, using national best-practice standards as a guide. The design of these practices is not accidental. Each of these approaches maps onto the public health model, which is used to develop prevention, intervention, and postvention programming for public health problems. Suicide prevention follows the public health model, focusing on primary, secondary, and tertiary interventions.

The Public Health Model

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, health care, social support, emotion regulation skills) and decrease risk factors (i.e., prior suicidal thoughts and behaviors, adverse childhood experiences, legal problems).[22] 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.

Secondary Prevention. 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.[22] Within the current scope of work in Oregon, statewide interventions include community helper trainings (referred to nationally as gatekeeper trainings; these can also be considered primary prevention depending on the implementation across populations), crisis services, inpatient and outpatient hospitalizations, and 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 training is included among intervention strategies as well as primary prevention.

Tertiary Prevention. Tertiary prevention efforts and postvention efforts in the field of suicide prevention are defined as activities that support individuals who have experienced a suicide attempt or suicidal crisis and those impacted by suicide, with the goal of promoting recovery, reducing the risk of attempts, and mitigating long-term negative outcomes.[22] These efforts focus on continuity of care, stabilization, and healing following an acute crisis. Within the current scope of work in Oregon, tertiary prevention includes follow-up care after emergency department visits or hospitalizations, ongoing outpatient mental health treatment, care coordination and safety planning, peer support services, and postvention supports for families, schools, and communities following a suicide death. By addressing the ongoing needs of individuals and communities after a crisis, tertiary prevention plays a critical role in reducing future suicide risk and supporting long-term well-being.

Postvention. Postvention is considered part of tertiary prevention, and it is defined as an organized response to a suicide death.[23] These 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. Examples of current postvention efforts in Oregon include trainings such as Connect Postvention, which focuses on increasing community response competency and supporting those bereaved, support groups,

school-based postvention plans, and state policy (e.g., Adi's Act). It is noteworthy that postvention work is often supported and implemented across the state, regardless of whether a community has policies or practices set in place to mandate postvention.

Nationally Recommended Practices

The Centers for Disease Control and Prevention (CDC) provides seven strategies for achieving and sustaining notable reductions in suicide (see Table 1).[24] These strategies were developed by examining evidence of impact on risk and protective factors, suicide attempts, and deaths by suicide.

Table 1. CDC Best Practices for Achieving and Sustaining Reductions 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

In collaboration with subject matter experts and community-based leaders, a thorough review of suicide-related literature published from 2016 through 2020 was conducted, aligning with the CDC strategies and approaches summarized in Table 1.

There are many practices and types of programs that address one or more of these target areas. The Suicide Prevention Resource Center's (SPRC) Best Practice Registry[25] lists trainings and

programs that range from primary to tertiary interventions. All programming listed within the Best Practices Registry has shown effectiveness in preventing suicide or directly addressing factors that impact suicide prevention efforts, and many of the listed trainings are used across Oregon, including, but not limited to, Sources of Strength; Connect Postvention; Question, Persuade, Refer (QPR); Applied Suicide Intervention Skills Training (ASIST); and Counseling on Access to Lethal Means (CALM). However, many of these practices do not address more than one or two of the CDC's seven recommended strategies. The Best Practice Registry[25] was cross-referenced with the CDC's recommendations to illustrate these gaps.

Figure 5. Oregon Programming and SPRC's Best Practices 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	
Applied Suicide Intervention Skills Training (ASIST)						X	
Assessing and Managing Suicide Risk (AMSR)						X	
Counseling on Access to Lethal Means (CALM)						X	
Mental Health First Aid (MHFA)						X	

As shown in Figure 5, this cross-reference between SPRC's Best Practices Registry and programming suggests that the Collaborative Assessment and Management of Suicidality (CAMS)[26] addresses each of the seven identified priority areas for suicide prevention best practices. While there are many valuable aspects to training and programming that focus explicitly on one or two areas of prevention, such as creative protective environments and promoting healthy connections, the most efficient and cost-effective approach is to focus on suicide prevention programming that is comprehensive. For example, CAMS provides programming that targets all seven best practices, making it both efficient and cost-effective.

Part II: Addressing Suicidal Ideation and Behaviors across Oregon

Statewide Policies to Address Suicide

Oregon has demonstrated a strong and sustained commitment to suicide prevention through a combination of legislative action, administrative guidance, and cross-sector coordination that aligns with best practices nationally.[27] Overall, the state 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. Importantly, 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.

Youth Suicide

In 2014, the Oregon Legislature mandated development of a five-year Youth Suicide Intervention and Prevention Plan (YSIPP). OHA worked with interested parties from across Oregon to adopt strategic directions 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 Oregon Health Authority (OHA) and the University of Oregon Suicide Prevention Lab (UOSPL), as well as over 100 individuals involved in suicide prevention efforts across 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 are 11 strategic goals. These 11 goals have specific 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.

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 that meet state standards 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.

SB 563 (2021): 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 (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.

HB 3037 (2021): 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 (2015) by adding the following elements: 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. 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:

1. Public school districts;
2. Public universities listed in ORS 352.002, if the death involves an individual who is 24 years of age or younger;
3. Private post-secondary institutions of education, if the death involves an individual who is 24 years of age or younger; and
4. 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 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.

Adult Suicide

The Adult Suicide Intervention and Prevention Plan (ASIPP) was published in April of 2023 by OHA. 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. 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, people of color, men, and those living in rural or remote areas. Despite efforts from OHA and partnering communities and agencies, Oregon does not provide any funding for the ASIPP. According to OHA, the adult suicide prevention coordinator is the only dedicated, funded role for the ASIPP, and this role is funded through other institutions (i.e., Child and Family Behavioral Health).[28]

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.

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, 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 the National Suicide Hotline Designation Act of 2020 and establish statewide coordinated crisis services system. This policy specifies that (1) 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.

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 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.

HB 3091 (2017): expanded 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): mandated 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. It should be noted that this bill aims to improve reporting of trainings and does not require that licensees complete specific trainings.

HB 2725 (2023): House Bill 2757 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.

Statewide Programming to Address Suicide

Reducing Stigma

Stigma is a complicated dynamic between individuals, groups, and communities. At its core, stigma happens when labelling, negative stereotyping, linguistic separation (i.e., the target is commonly referred to by a specific name), and power asymmetry converge.[29] Stigma is particularly common when an individual or group of people is perceived as violating dominant cultural norms[29]. In the context of mental health, stigma typically refers to the practice of identifying, stereotyping, and ostracizing a person who has or is associated with mental illness, suicidal thoughts or suicidal behaviors.[29, 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] It is noteworthy that stigma is not reserved for individuals experiencing mental health crises, but can also affect relatives, friends, acquaintances, and community members who are perceived as connected to an individual with a mental illness.

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, stigma encourages individuals to be bystanders during mental health crises, which is why community helper trainings are specifically designed to reduce stigma that may prevent an individual from intervening when they witness suicidal thoughts and behaviors.[32] However, the success of these trainings is mixed, with some studies finding that trainees change their attitudes and reduce stigma, and others do not.[33] At least some of this variation is due to 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).[33] 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.

The state of Oregon has made key efforts to reduce stigma through the 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. By focusing 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

Supporting Youth, Rural Residents, and Individuals Across the Lifespan

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. SEL curricula are an important primary prevention tool to prevent and address various forms of youth adversity, including youth suicide.[34] Through funding support by OHA, 24 counties in the state of Oregon are administering SEL in elementary schools by implementing Sources of Strength (Elementary). Although not considered SEL, it is worth noting that 28 counties in Oregon have implemented Sources of Strength (Secondary) into high schools. This data suggests that 12 counties have not yet implemented SEL programming. ODE and ORS 329.045 mandate a framework for SEL education in public schools statewide, so it is likely the remaining 12 districts are still in the process of implementing SEL.

Currently, OHA sponsors the implementation of Sources of Strength for social and emotional learning throughout the state. 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.[36]

Sources of Strength (Secondary) 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.[36]

Safe Storage Programs. Research continuously finds that keeping a firearm in the home increases a person's risk for suicide, and that storing a gun unlocked or loaded further increases that risk.[37] To reduce these risks among gun owners, Safe Storage programming aims to remove barriers to resources and increase access to gun locks and other safe storage devices. In addition to providing the physical devices, many programs include or encourage safe storage counseling, with the goal of increasing education on safe storage practices and suicide risks. Additionally, some programs have expanded existing safe storage resources to encompass other lethal means, such as medications, in addition to firearms.

OHA has set a goal of advancing "equity in lethal means reduction by expanding efforts beyond firearms and medications to include other lethal means methods commonly used in diverse communities," such as methods of suffocation. The Oregon Alliance to Prevent Suicide (Alliance) Lethal Means Subcommittee is currently working to develop recommendations for safe storage programs for firearms, medications, mind-altering substances, and other means used across cultural groups by consulting best practices and the current evidence base. The subcommittee also hopes to develop messaging protocols and practices as well as educational programming for children, focusing on the dangers of lethal means and safety planning. Notably, OHA has committed to promoting a course, "Addressing Firearm Safety with Patients at Risk of Suicide Rural Firearms Safety," among healthcare providers across Oregon to increase the number of trained providers and ensure training completion.

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 devices. Yamhill County's Public Health Lock Box Program only includes firearm lock boxes. The Roseburg VA in Douglas County offers gun locks to veterans and their families. Additionally, veterans and their families are referred to a Suicide Prevention Care Coordinator or Case Manager. However, much of the gun-owning population in Oregon still does not have 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.

The Older Adult Behavioral Health Initiative (OABHI). The OABHI is designed to improve older adults' access to collaborative care from qualified professionals. This initiative is funded

by OHA and supports mental health, substance use, physical disability supports, and dementia care to older adults by funding 24 Behavioral Health Specialists (BHS) across Oregon. These BHSs collaborate with community partners and work to increase the knowledge and skills of local providers, increase local awareness of signs of distress, and improve the accessibility of services.

Rural Older Adult Mini-Grants (ROAM). The Rural Older Adult Mini-grants (ROAM) focus on increasing social connections between rural older adults. ROAM grants are awarded by the Association of Oregon Community Mental Health Programs (AOCMHP), with funding from OHA. These grants cover an expansive range of community-based activities and outreach programs. Examples of ROAM-supported programs include a telephone reassurance program, arts and crafts events, and youth and older adult cross-socializing events. Due to their focus on reducing loneliness and isolation while increasing social connectedness and belonging, ROAM is helping to fill the gap in support for older adults, particularly in primary prevention.

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 have been differences in engagement consistency across systems between years. This program has been funded through a SAMHSA grant that ended in August 2025, 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 has been presented to the Task Force.

Community Helper Trainings (Gatekeeper Trainings). With funding from OHA, Big River Programming was developed as a statewide initiative to increase access to youth suicide prevention and intervention trainings. Descriptions of trainings and programs, including contact information to learn more, are available on the OHA Suicide Prevention website. The trainings work to equip both youth- and adult-serving professionals and community members with knowledge and skills to help prevent suicide (see Table 2). It is worth noting that 2025 marked a shift in Oregon Community Helper Training initiatives. In 2025, focus groups and surveys were launched to gather data on cultural needs and barriers in Oregon. Using this data, OHA and partners began supporting the implementation of more culturally responsive Community Helper Trainings, such as Be Sensitive, Be Brave, and reducing or eliminating funding for trainings such as ASIST and MHFA.

Table 2. Community Helper Trainings and Descriptions

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

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,” the “Rural Firearms Safety” course, and the “Addressing Firearm Safety with Patients at Risk of Suicide” course. These courses can be found online, in the YSIPP Annual Reports and initiative tracker. Efforts to collect training and evaluation data through an OHA Behavioral Health database are on pause and not available to the public. It is worth noting that information about courses, while available in the YSIPP Annual Reports, could be made more accessible for Oregonians by being included and advertised in other places.

Statewide Crisis Lines. The state of Oregon has several crisis lines to offer phone or chat support to individuals experiencing a mental health crisis and include tailored services for different communities. For example, The AgriStress Helpline for Oregon, contracted to operate in the state by Oregon State University Extension Service, 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 is one of two operators of the 988 Suicide & Crisis Lifeline in Oregon (Northwest Human Services answers 988 calls and texts in Marion and Polk Counties) and also operates specific crisis lines for military and veterans, seniors, people struggling with substance use, and youth. Additionally, many counties have crisis lines provided by community mental health

providers or county staff. While 988 can support anyone in Oregon, in July 2025, the federal government removed a "Press 3" option to 988 nationally, which connected LGBTQ+ youth and young adults directly with the Trevor Project and other affirming counselors. Additionally, every county in Oregon has crisis lines and mobile crisis provided by community mental health providers or county staff.

> ***Defining Inpatient, Partial-Hospitalization, and Outpatient Services.*** *Inpatient treatment* is the most intensive level of care in behavioral health. Individuals are admitted to a hospital or psychiatric facility and stay 24/7, under continuous supervision by medical and mental health professionals. Individuals may choose to admit themselves, and youth may admit themselves or be admitted by a legal guardian.[38] This level of care is typically recommended for people experiencing severe psychiatric symptoms, acute crisis situations, or safety risks to themselves or others. This type of treatment is ideal for individuals who are at extreme risk for suicide and do not have a safe, reliable resource to ensure safety throughout short or long-term crises. Inpatient treatment focuses on stabilization, safety, and medical management. Examples of inpatient treatment include overnight stays in a hospital or at a treatment center. Many individuals receive access to important management therapies, such as DBT, for the first time during inpatient treatment. *Partial hospitalization* provides intensive, structured treatment during the day while allowing individuals to return home in the evenings, making it a middle ground between inpatient and outpatient care. This form of treatment is often used when someone needs more support than typical outpatient therapy but does not require 24-hour supervision. Typical programming involves several hours of therapy each day across multiple days per week. *Outpatient treatment* is the least intensive level of care, involving regularly scheduled visits with mental health professionals while the individual lives at home and continues normal activities.[38] It is appropriate for people whose symptoms are less severe and who do not need daily monitoring or structured programs. Outpatient care can range from weekly therapy or psychiatric appointments to more frequent sessions based on need. Crisis intervention services, such as crisis lines, are often considered a form of outpatient service; however, it is notable that inpatient, partial-hospitalization, and outpatient services are defined by the settings, the lengths of time they are designed to be utilized, and insurance agencies. Access to these secondary and tertiary 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 6 and Table 3).

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 mental health 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 service area. However, many studies have shown that individuals achieve much better outcomes if they can remain connected to their community,[39]

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 who considerably increase the risk of suicide.

Eleven 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 operated by the county's health services. Nine 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.

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, according to information accessible through local and county public and behavioral health websites, are available in 18 counties, with seven being provided by the county government and 11 managed by community-based organizations.

Mobile crisis teams are groups of trained professionals who can be called to assist in a mental health emergency. 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. OAR 309-072 requires all counties to offer Mobile Crisis Intervention Services and Mobile Response and Stabilization Services.

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-6:00pm 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. Eighteen counties in Oregon offer no local 24-hour crisis services outside of 911 or 988. 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.

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,[40] but they are still seen as important resources to the communities that receive them during an incredibly critical time.[23] It is worth noting that OHA has sponsored the development and delivery of a Connect curriculum specific to service members, veterans, and their families.

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 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 exemplary policy, with clearly identified roles, suggestions for communication with families, and planned long-term follow-up with grieving families. All counties are required to submit their plan for establishing Postvention Leads to OHA, and, according to OHA, there are regular meetings between OHA and Leads.

Lines for Life 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 individuals, communities, and groups affected.

School-Based Postvention Plans. Under Adi's Act, all school districts in Oregon are required to have a school board suicide postvention plan which must include teacher and administrator training, prevention activities, and intervention plans. OHA offers a toolkit to help schools develop these plans, which include support from School Safety and Prevention Specialists and the School Suicide Prevention and Wellness Manager at Lines for Life.

Suicide Bereavement Groups. Bereavement refers to the long-term psychological distress that occurs as a result of loss[41] and suicide bereavement can have specific and complicated psychological implications for family and friends, especially guilt, which is associated with posttraumatic stress, depression, and other serious mental health concerns in someone who is in bereavement from a suicide.[42] 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.[43] 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.

Part III: Barriers to Implementation

Implementation Barriers for Best Suicide Prevention Programs and Practices

There are significant barriers to suicide prevention implementation facing Oregon's policymakers, organizations, practitioners, community members, and activists. The universal limitation with suicide prevention programming is that it is 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. Despite these limitations, Oregon's barriers remain largely addressable.

Workforce Shortage. A recent OHA report on the behavioral health workforce in Oregon[44] found that 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 (see Figure 6).[44] 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.[44] Governor Tina Kotek has since created a council to address this crisis.[45]

Figure 6. Mental Health Providers by County Per 1,000 Residents[44]

Geographic Disparities. Rural counties in Oregon have less access to mental health providers, crisis intervention services, inpatient treatment centers, and primary prevention programming.[46, 47] Geographic disparities in resource access exist throughout all aspects of suicide prevention and intervention in Oregon.[46, 47] 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.

Challenges in Addressing Primary Prevention. As previously noted, primary prevention emphasizes activities that increase protective factors (i.e., access to basic needs, health care, social support, emotion regulation skills, school connectedness, belongingness) and decrease risk factors (i.e., prior suicidal thoughts and behaviors, adverse childhood experiences, legal problems, access to mental health care, access to lethal means).[22, 48] In other words, while 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. The JED Foundation is an example of comprehensive, effective primary prevention in school settings. JED focuses on seven key domains: Fostering life skills, promoting connectedness and positive culture, recognizing and responding to signs of distress, reducing barriers to help-seeking, ensuring access to effective mental health care, establishing systems of crisis management, and reducing access to lethal means.[48]

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).[36] In Oregon, there are very few programs that provide primary interventions, such as school-based SEL programs and the ROAM grants, with intentional suicide prevention foci. To truly reduce suicide in Oregon, primary prevention programming must reach all Oregonians, not just those who are currently in school or in rural communities with older adults. This is not to say Oregon is not doing significant work to address social determinants of health and reduce risks. 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 uniquely at risk for suicide downstream.

Limited Hospital and Treatment Center Options. 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 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. In recent years, 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:

Table 3 Counties with In-Patient Treatment Centers for Suicidal Individuals

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)

Other treatment centers are located in Deschutes County, Lane 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 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.[49] 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, so many programs, including postvention programs, which are built into larger suicide prevention state-funded contracts, are only available when the individual who died is under 24 years old, 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. 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.

Unique Cultural Needs and Existing Bias. OHA has been working to make suicide prevention programming in Oregon more culturally responsive for communities of color, 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.[50, 51] One particularly challenging cultural barrier in Oregon is within the firearm community. This community may feel particularly protective of 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.[52] Research from Oregon State University found that suicide prevention messaging specifically tailored to the cultural needs of firearm owners in Oregon is the most successful.[52] There are also existing biases in Oregon that affect individuals seeking healthcare.[53] These biases may, in turn, increase resistance to culturally responsive programming. Oregon's pervasive history of racism likely influences modern attitudes, perspectives, and biases, both consciously and unconsciously.[54] 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.[11] Over 80% of gun deaths in Oregon are due to suicide.[55] Household firearm ownership data is scarce and difficult for researchers to access,[56] but studies have shown that rural communities across the US experience higher rates of firearm suicide and unintentional firearm injury and death.[57] 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.

Policy Implementation 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).

Policy Enforcement. Though there are many policies through the Oregon legislature, OHA, and ODE that intend to reduce suicide and suicide risk, few of these policies have specific enforcement requirements, making it difficult to ensure policies are being followed. Furthermore, it can be 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.[58] However, many policies do not require reporting in the statute. 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.

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.[59] Hospital resources were identified as the leading reason for poor compliance.[59] This indicates that the greatest policy implementation barriers experienced rural institutions, such as hospitals, may be due to a lack of staffing or implementation support, heightened stigma or fears around the legal implications of patients dying by suicide, or simply having less time and resources to incorporate new policies and subsequent staff trainings.

Formal Incentives. Finally, 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.

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.

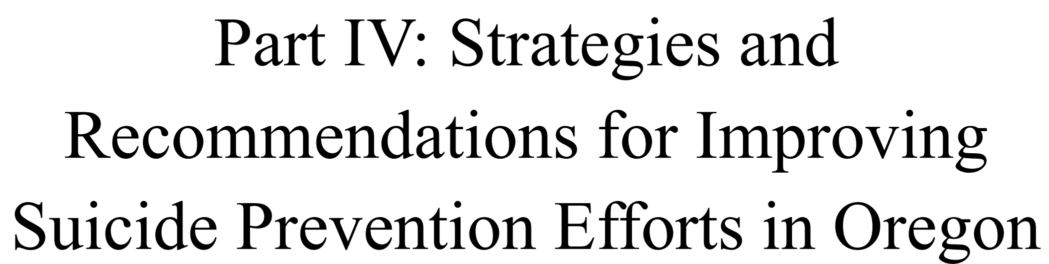
Licensing Boards. Licensing Boards hold significant power as they regulate the licensure requirements of Oregon practitioners, and, in accordance with national laws and codes of ethics, determine whether new requirements must be created for practitioners to attain, renew, and maintain their licensure. The following list includes many of the medical and mental health boards currently regulating Oregon licensures:

- Oregon State Board of Nursing
- Board of Naturopathic Medicine
- Occupational Therapy Licensing Board
- Oregon Board of Medical Imaging
- Board of Examiners for Speech-Language Pathology and Audiology
- Board of Psychology
- Board of Licensed Social Workers
- Board of Licensed Professional Counselors and Therapists

Generally, these boards require individuals to obtain specific degrees of education, complete a certain number of clinical and training hours each year, and meet additional requirements. Licensing boards 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. For example, SB 48 (2017), which requires specific licensing boards to report on suicide prevention trainings completed by their licensees, and HB 2315 (2021), which requires specific behavioral health boards to mandate suicide prevention trainings for licensees, have been successfully implemented. However, no policies currently exist that mandate medical boards to require training in suicide risk assessment, treatment, and management among healthcare professionals.

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. This belief about the scope of work for medical workers can be widespread. Unfortunately, the data shows that roughly half of the individuals who die by suicide see their primary care provider within the month of dying.[59] Furthermore, many medical professionals can and do 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.[60] This suggests that whether or not mental health concerns are philosophically considered within a healthcare practitioner's scope of work, the treatment of mental health concerns is at least partially, and legally, within scope, at least for prescribing healthcare workers. 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, and science-based training.

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. In an informal qualitative study conducted in partnership with the Oregon Alliance to Prevent Suicide, the UOSPL analyzed 11 interviews with health care workers on whether they believed suicide prevention trainings should be legally required to attain licensure, and what barriers they believed interfered with these trainings. Each professional highlighted the expected issues: limited time, a lack of financial support for paid trainings, and personal stigma leading to folks avoiding the topic of suicide. However, a key theme across the interviews was that healthcare workers fear liability. In other words, if they treat a patient for suicidality and the patient dies, are they 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.



Part IV: Strategies and Recommendations for Improving Suicide Prevention Efforts in Oregon

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.

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.

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.

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.

As described in this report, Oregon has successfully implemented or begun implementing several of these policies and practices. This is promising for Oregon's current landscape and position as a leader among other states in addressing suicide. To ensure Oregon's suicide prevention programming and policies are truly comprehensive, efforts should be made to close the gaps between our policies and those of states that have successfully maintained low suicide rates, particularly among youth, as Oregon's rates continue to be above the national average. The following section will provide greater detail on recommendations for next steps in Oregon's policies, practices, and programming.

Recommendations

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 suggest the following recommendations.

Addressing Underlying Social Determinants of Health. Suicide prevention does not simply address suicidality at its onset. 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.

> **Housing.** There is limited data on the rate of suicide among unhoused individuals in Oregon; however, some data from Multnomah County suggests that rates are high. Efforts to close this data gap, in addition to addressing the underlying issue of homelessness, will likely lead to a decrease in suicide deaths. According to the National Homelessness Assessment Report, the national average of homelessness is 168 per 100,000. Comparatively, Oregon's rate is more than two times larger at roughly 350 per 100,000 individuals.
>
> **Racial Disparities.** Bias and racial disparities continue to hurt the development and implementation efforts of effective, engaging suicide prevention across the state. By focusing on reducing risk factors and strengthening protective factors for communities and individuals of color, the state will likely have greater success in implementing culturally responsive secondary or tertiary prevention.

Culturally Responsive Suicide Prevention. Key agencies have worked to develop, improve, and begin implementing culturally responsive suicide prevention programming across the state of Oregon. Not only are specific initiatives oriented toward addressing this gap in support (see YSIPP's Clinical and community prevention services framework) but new community helper trainings are being implemented across the state that are designed to incorporate culturally aware strategies and prevention techniques (e.g., Be Sensitive, Be Brave). This report emphasizes the importance of cultural awareness and responsiveness in addressing suicide and suicide prevention programming across diverse communities. 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.[9,10] Effective suicide prevention programming will not only take this cultural perspective into account but also integrate this perspective into every aspect of the programming.

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]

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 attaining funding. Having standardized documentation processes, tools, and practices (potentially nested in a centralized database) would increase collaboration and knowledge sharing across sectors, greater community-building and trust, and easier sustainment during times of staffing issues. Furthermore, community members who are facing their first suicidal crisis may not be aware of the local support available to them or someone they know. Increasing visibility of resources, programs, and initiatives in communities across the state could serve as a suicide prevention tactic.

Centralized Data Tracking System. Although initial efforts have been made to establish and integrate a centralized data tracking system in Oregon to track suicide prevention programming, this effort has been placed on hold in order to prioritize higher need projects across the state. 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.

Incentivization for Mental and Behavioral Health Professionals. Oregon faces a large gap between the high demand and need for mental health providers and a low number of licensed and/or certified professionals. This gap grows even larger when considering that many mental health professionals are not trained in suicide-specific therapies. There are several strategies Oregon could employ to close these gaps and support Oregonians suffering from suicidal thoughts and behaviors. First, Oregon should offer 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. Second, Oregon should provide an 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. Third, Oregon could 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. Fourth, Oregon should incentivize clinicians to move to areas of need, including rural areas, where many Oregonians have limited or no local mental health resources for crises. Fifth, Oregon should expand the mental health workforce using existing resources, such as the Ballmer Institute.

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.

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