Task Force on Community Safety and Firearm Suicide Prevention, Part 2

July 2, 2026
Legislative Report Introduction

Introduction

The Task Force on Community Safety and Firearm Suicide Prevention (the "Task Force") was created by SB 1503 in the 2024 legislative session. The Task Force first met in October 2024 and has met monthly since.

The Task Force submitted an initial report in September 2025. This report expands on key policy recommendations and findings. The five key policy recommendations are:

- Mandatory County Suicide Fatality Review Boards
- Voluntary Firearm Storage
- Dedicated resources for OHA for ASIPP Implementation
- Creation of structures to support science-based suicide treatment
- Creation of sustainable state funding for community violence intervention (CVI) programs

Task Force Purpose

The purpose of the Task Force is to coordinate with the Department of Justice, the Oregon Health Authority, sheriff departments that provide for voluntary storage of firearms, federally recognized Indian tribes in this state, faith-based groups in this state, and the Oregon Alliance to Prevent Suicide to study best practices for reducing deaths from community safety threats and for suicide prevention. The Task Force brings together representatives with diverse experiences and areas of expertise to accomplish this purpose and is staffed by Oregon Department of Justice (DOJ). More specifically, the Task Force was directed to study:

- How to better support youth experiencing suicidal ideation;
- How to better support rural Oregonians experiencing suicidal ideation;
- How to reduce stigma on suicidal ideation;
- Barriers to suicide prevention support;
- Current community safety protocol across this state, including at hospitals and behavioral health facilities, and recommendations for improvement of the protocol;
- Locations and events most targeted in community safety threats;
- Rates of success for extreme risk protection orders and barriers to implementation and capacity for police stations or other entities to implement voluntary surrender or holding of firearms;
- Barriers to implementing best practices for community safety and suicide prevention;
- How domestic violence is a risk factor for community safety threats and suicide; and
- Risks to first responders.

Legislative History

The legislative history of SB 1503 can be viewed at the following link:
https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/SB1503

The text of SB 1503 can be viewed at this link:
https://olis.oregonlegislature.gov/liz/2024R1/Downloads/MeasureDocument/SB1503/Enrolled

Task Force Members

The following individuals served on the Task Force:

Non-voting members:

Sen. Floyd Prozanski	Democrat Senate member
Sen. David Brock Smith	Republican Senate member
Rep. Jason Kropf	Democrat House member
Rep. Rick Lewis	Republican House member

Voting members:

Dean Sidelinger	A representative of a state public health agency
Valerie Colas	A public safety policy advisor to the Governor
Donna-Marie Drucker, Co-Chair	A representative of a nonprofit organization focused on suicide prevention with experience in lethal means safety
Paul Kemp	A representative of a community-based firearm safety and protocols program
Kathleen Carlson	A representative of the public health research field
Vanessa Timmons	A behavioral health professional or provider
Emmy Ritter	An adult behavioral health provider
Matthew Crabtree	A medical provider who has worked with firearm violence victims
Andrew White, Co-Chair	A psychologist who works with youth
Andy Leonard	A tribal representative from a suicide prevention program

Jerome Sloan II	A person with lived experience with community safety threats or suicidal ideation
Chris Burley	A representative of law enforcement
James Dixon	A professional who works in veterans' mental health

Research

SB 1503 allocated $250,000, which could be expended for the purpose of paying a third party for research ordered by the Task Force.

A solicitation for research proposals was sent to the following institutions: Eastern Oregon University, Oregon State University, Portland State University, University of Oregon, Oregon Health & Science University, and the Oregon Council of Presidents (Oregon's voluntary association for public universities). The Task Force moved forward with projects from Oregon Health and Science University and University of Oregon. Research prepared for the Task Force includes topics of risks to first responders, the intersections of domestic violence and firearm access, mass violence and suicide risk, safety protocols at hospitals and behavioral health facilities, community safety best practices, methods to prevent access to firearms during times of increased risk, recommendations for suicide prevention programming, and a scan of suicide prevention programs in Oregon.

Website and Agendas

The Task Force website can be viewed at: Task Force on Community Safety and Firearm Suicide Prevention - Oregon Department of Justice. An agenda for each meeting can be found online. Below are the titles of the presentations given to the task force in 2025 and 2026.

January 2025: "Statewide Community Violence Prevention Efforts", Oregon Health Authority

February 2025: "Firearms, Injury Prevention, and Suicide". A perspective on why a public health approach has not been effective in addressing firearm injury. Presentation by Jeffery Sung, University of Washington

March 2025: "The Armory Project (TAP): Firearm Suicide Prevention for Veterans and Communities". Presentation by Dr. Gala True – the Richard A. Culbertson and Susan A. Leary Endowed Professor in Community and Population Medicine at the LSU School of Medicine and an Investigator with the VA's South Central Mental Illness Research, Education, and Clinical Center (MIRECC).

April 2025: "The Development of a Suicide Fatality Review Committee and Community Driven Suicide Prevention Strategic Plan". Presentation by Galli Murray, LCSW – the Suicide Prevention Coordinator for Clackamas County Health, Housing and Human Services

May 2025: "Best Practices for Suicide Prevention". Presentation by David A. Jobes, Ph.D., ABPP – Professor, Associate Director of Clinical Training at The Catholic University of America

June 2025: “What to Do About Gun Violence”. Presentation by Jens Ludwig, Ph.D.

July 2025: “How Primary Care Providers Can Help Reduce Firearm Death and Injury in Oregon”, Steve Schneider, Alliance for a Safe Oregon

September 2025: “Tribal Suicide Prevention and Treatment” Andy Leonard, Taskforce Member

October 2025: Presentation by OHSU Gun Violence Prevention Research Center, Rebecca Valek, MSPH Research Project Coordinator, Jenn Reed, PhD, MPH Postdoctoral Fellow

November 2025: “The Link Between Intimate Partner Violence and Suicide: Recommendations for Improving Suicide Prevention” Presented by Fernanda S. Rossi, PhD

January 2026: “Domestic Violence Information” Presented by Sarah Sabri, Sr. AAG and Domestic Violence Resource Prosecutor

March 2026: “A Landscape Report of Oregon’s Suicide Prevention Policies, Programs, and Practices, and the Primary Barriers to Implementation” Presented by Marielena McWhirter Boisen, MS

April 2026: Battered Women’s Justice Project “Dynamics of Intimate Partner Gun Violence and Promising Practices to Implement Policies Aimed at Reducing Firearm Lethality” Presented by Jennifer Becker, JD.

May 2026: “New Generation Treatments to Prevent Suicide” Presentation by Craig J. Bryan, PsyD, ABPP

June 2026: “People at Risk for Suicide: Free Tools, Peer Support and Recommended Standard Care” Presented by Ursula Whiteside, PhD

Background

The Task Force on Community Safety and Firearm Suicide Prevention was created via Senate Bill 1503 and has met monthly since October of 2024. This task force brought together individuals from the State of Oregon with expertise in areas such as suicide, lethal means management, violence prevention, tribal affairs, domestic violence, and mental health care. During the monthly meetings, the task force reviewed ways to collaborate in the area of policy related to suicide and firearms deaths and heard from national experts in the areas of science-based suicide care, science-based community violence reduction, domestic violence/intimate partner violence, firearms cultural competence, lethal means management, tribal health, and firearms storage. In addition, much of the testimony included the voices of individuals with lived experiences and the voices of diverse communities.

Firearm injury is a public health crisis impacting communities across Oregon, resulting in 663 deaths in Oregon in 2024 alone. The majority of these firearm-related deaths in Oregon were firearm suicides (79%). Suicide continues to be a significant public health issue in Oregon, with multiple challenges to policy change. For every person killed by a firearm, more will experience nonfatal firearm injuries. In 2024, there were a total of 660 firearm injury emergency department visits across Oregon. Firearm homicide occurs most often in the context of intimate partner

violence (IPV) and gang violence. More than 67% of IPV-related homicide victims were injured by a firearm. Nearly 90% of homicides related to gang violence had died of gunshot wound.

The following are findings and policy suggestions related to firearm suicide and community safety:

Findings

Firearms and suicide

- In 2024, 941 Oregonians died by suicide, with a rate of 19.9 deaths per 100,000 individuals. Oregon's suicide rate remains greater than the national rate, which was 13.9 deaths per 100,000 individuals in 2024.[1]
- Suicide is the 8th leading cause of death in Oregon overall, and the second leading cause of death among Oregonians ages 5 to 24.[2]
- Men continue to have the highest suicide rate across all age groups, with their risk peaking at age 85 and older. Women's suicide rates rise with age and peak between ages 55 to 59.[3] These trends are similar for firearm suicide, specifically, as well.[4]
- Non-Hispanic American Indian and Alaska Native individuals have the highest rate of suicide, and non-Hispanic White individuals have the highest rate of firearm suicide.[3-4]
- Between 2018-2024, 54% of all suicide deaths in Oregon involved the use of a firearm. In this same time, 78% of all firearm-related deaths were firearm suicides (19% homicide, 2.3% legal intervention, 0.8% unintentional, and 0.7% undetermined). Suicide deaths make up a larger proportion of all firearm deaths in Oregon (78%) than in the U.S. overall (58%).[1]
- Firearm suicide risk disproportionately impacts rural Oregonians and Veterans.[4-6] While this is driven in part by differential access to firearms, there are also various social determinants of health that contribute to these disparities in firearm suicide risk, including economic opportunity, education, housing, and access to behavioral health providers.[6-8]

Science-based approaches to suicide prevention and treatment

Multiple science-based approaches to suicide treatment exist, including:

- CAMS (Collaborative Assessment and Management of Suicidality), a 13-session protocol which "plugs in" to virtually any therapy modality to look at the drivers of suicide;[9-11]
- CRP (Crisis Response Plan), a short-form one-session intervention to increase hope, limit access to lethal means, and decrease suicidal urges;[12-13] and
- DBT (Dialectical Behavioral Therapy), a therapy modality focused on teaching skills for emotion regulation, distress tolerance, mindfulness, and interpersonal effectiveness.[14]

These approaches have robust evidence for the treatment of individuals experiencing suicidal crisis and ongoing suicidal ideation, have been developed with the voices of individuals with lived experience, and have demonstrated effectiveness with at-risk populations, across

languages and cultural groups, and with stigmatized and marginalized groups.[15-17] DBT is the only empirically validated treatment for teenagers experiencing suicidality.[18-19] Additionally, these treatments show robust cost-effectiveness compared to treatment as usual, meaning that implementation of these practices saves money across the health care and social service system, offsetting implementation costs.[20-23]

While psychiatric hospitalization is often considered the standard of care for high suicide risk, research on its effectiveness is limited. Some studies have documented reduced risk of suicide after hospitalization, but others report increased suicide risk immediately following hospitalization.[24-27] This increased risk of suicide post-hospitalization may be due to disruption of positive aspects of an individual's life, exacerbation of hopelessness, or stigmatization as someone with a mental illness. There is a need to support individuals following hospitalization as they transition to community care during a period of potentially elevated risk.

In addition to these treatment modalities, research shows that separating individuals in crisis from access to lethal means (e.g., firearms) can save lives.[28-29] Firearm use in suicidal behavior is highly lethal, with death resulting nearly 90% of the time. Multiple strategies exist to prevent access to firearms during times of increased risk including secure firearm storage, voluntary out-of-home storage, other voluntary gun removal, and extreme risk protection orders.[30]

Oregon has demonstrated a strong and sustained commitment to suicide prevention, but gaps remain in the funding and practices applied. The state has expanded screening for suicide and funding for youth suicide primary prevention programs, but adult suicide prevention and domestic violence services continue to be underfunded and unfunded. Additionally, actual treatment for suicide remains unfunded and unevenly expanded across the state. There is a need for additional funding for suicide prevention and treatment and mechanisms for ongoing training, support, and implementation of these efforts.

Firearms and Homicide

- In 2024, 70% of all homicides in Oregon involved a firearm, translating to a total of 120 deaths in that year alone.[1]
- Between 2014 and 2024, Oregon's firearm homicide rate increased by over 115%.[1]
- Community violence and firearm homicide disproportionately impact communities of color in Oregon. Black and African American Oregonians experience the highest rate of firearm homicide in the state.[1] These disparities are due in part to policies and practices such as sundown laws, redlining, restrictive zoning practices, neighborhood disinvestment, and gentrification that have created barriers to home ownership and contributed to economic instability, gaps in educational attainment and income, and unequal access to health care among Oregon's Black and African American population.[32-34]
- From 2013 to 2022, 386 Oregonians died due to domestic violence-related homicide.[35] 52% of these domestic violence-related homicides involved a firearm, primarily

handguns.[35] The presence of a firearm in intimate partner situations is associated with 5 times greater risk of intimate partner homicide.[36]

- There is a strong association between domestic violence and mass violence, with an estimated 35% of perpetrators of public mass shootings (i.e., those that occurred in public locations) in the U.S. from 1996-2024 having a history of DV.[37] Additionally, 59% of mass shootings that occurred in the U.S. between 2014-2019 involved the death of the perpetrator's intimate partner or family member. [38]
- From 2018 to 2023, there were 18 mass shooting incidents (i.e., an incident in which 4 or more individuals are killed or injured, excluding the shooter) in Oregon, resulting in 13 deaths and 73 nonfatal injuries.[39] The most common locations of these incidents included public streets or motor vehicles, commercial establishments (e.g., bars, gas stations), and public gatherings (e.g., concerts, protests).[39]

Existing Oregon policies to reduce firearm homicide and suicide

Oregon has existing laws around gun violence prevention that are shown to increase community safety and reduce suicide. At the time the Taskforce was meeting, M114 was passed by the voters but not yet implemented while it goes through the court process. The policy recommendations in this report assume M114 will go into place. The Taskforce agrees that successful implementation of permit to purchase will be critical once it goes into effect.

Existing gun violence prevention policies:

- Universal background checks (ORS 166.412), which require firearm sales and transfers to be conducted by or processed through a gun dealer;
- The secure storage law (ORS.166.395), which requires that firearm owners secure firearms when not in use to prevent access by minors and unauthorized users;
- Extreme Risk Protection Orders (ORS 166.527), which allow an individual's family or household members or law enforcement to obtain a civil court order to temporarily limit access to firearms or deadly weapons if a person is at imminent risk of harming themselves or others;
- The Family Abuse Prevention Act (ORS 107.700), which is Oregon's domestic violence restraining order law and includes a requirement for firearm dispossession; and
- Permit to purchase (Measure 114), which requires that individuals obtain a permit through local law enforcement every five years to purchase a firearm.

Research supports the use of these policies for preventing firearm homicide and suicide. For example, research estimates that one suicide was prevented for every 13-17 ERPOs issued.[40] Additionally, prohibiting individuals subject to domestic violence restraining orders from possessing firearms is associated with significant reductions in intimate partner homicide rates.[41] Secure firearm storage laws have been associated with reductions in firearm suicide and unintentional firearm injury and death among youth.[42] Interventions in healthcare and community settings that provide counseling on secure storage are associated with increases in secure storage practices, especially when firearm storage devices are distributed.[43-44]

Policy Suggestions

Policy suggestions have been developed in accordance with subject matter experts' presentation to the task force.

1. **Mandatory County or Regional Suicide Fatality Review Boards for Adults Over the Age of Twenty-Five**

Why:
Oregon needs a consistent statewide process to review suicide deaths and use findings to inform prevention. While Oregon has built strong youth suicide prevention infrastructure, adults ages 25 and older carry a significantly higher burden of suicide death and do not have the same level of systematic review, reporting, and response. County Suicide Fatality Review Boards would help identify local risk patterns, service gaps, missed intervention points, and system barriers—particularly among adults, veterans, older adults, domestic violence perpetrators and survivors, firearm owners, and rural communities. These boards could potentially provide information useful in regard to the assessment of “hidden homicides”. Given the known connections between domestic violence and suicide risk, as well as growing understanding of “hidden homicides” (deaths that appear to be suicides, unintentional, or undetermined, but may actually be homicides disguised or staged to look non-criminal, often in the context of domestic violence), there is a need to better understand the links between suicide and domestic violence in Oregon to inform prevention efforts.

Intent:
The intent is to establish a confidential, non-punitive, prevention-focused review process in every county to learn from suicide deaths and reduce future loss. Suicide fatality review boards would move Oregon beyond counting deaths by identifying preventable factors and producing actionable recommendations to strengthen behavioral health, crisis response, domestic violence safety planning, lethal means safety, care coordination, postvention, and community-based supports.

Implementation:
Each county would be required to establish or participate in a county or regional suicide fatality review board housed within existing local infrastructure, such as public health, the Local Mental Health Authority, or an existing suicide prevention coalition. Boards should include medical examiners, public health, behavioral health, domestic violence and community violence experts, crisis services, hospitals, law enforcement, coordinated care organizations, veteran and older adult partners, suicide loss and attempt survivors, and community representatives. OHA should provide statewide guidance, confidentiality and data-sharing templates, reporting tools, technical assistance, and funding for coordination. Each board should submit an annual de-identified report and implementation plan identifying recommendations, responsible parties, timelines, and progress on prior findings. The Task Force recognizes that requiring these boards may further strain already limited county resources—particularly in rural counties that often experience high suicide rates—and cautions that boards should not be mandated without adequate funding, staffing, and safeguards, including appropriate multidisciplinary representation, protection of next-of-kin permission for review, signed confidentiality agreements for all participants, a non-

blaming and systems-focused approach, and a clear process for translating findings into upstream prevention efforts.

2. **Voluntary Firearm Storage**

Why:
When individuals are experiencing a crisis, including suicidal ideation, it is important to further increase the time and distance between the individual and access to lethal means. Oregon has two critical policies in place to help an individual get distance from their weapon: secure storage laws and extreme risk protection orders. Another policy that has proven beneficial in other states is secure voluntary out-of-home firearm storage.
Oregon needs more trusted, voluntary options for firearm owners and families to store firearms outside the home during periods of crisis, suicide risk, hospitalization, military deployment, family conflict, IPV, or other temporary safety concerns. Voluntary offsite firearm storage is an evidence-based suicide prevention strategy because it creates time and distance between a person in crisis and a highly lethal means. Federally licensed firearms retailers (FFLs) are well positioned to provide secure community-based storage, but there are barriers to their participation, including cost for employee time and background checks, physical space to ensure safe storage and liability concerns about what the retailer is responsible for once a firearm is returned.[45] Several states, including Louisiana, Montana, Arkansas, Alabama, and Nevada, have passed limited liability laws to reduce barriers for firearm retailers and other partners that provide voluntary firearm storage.

Intent:
The intent is to increase access to trusted locations for safe, voluntary gun storage by removing barriers for FFLs. This approach supports suicide prevention and family safety, expands access to practical offsite storage options, and preserves firearm ownership rights by keeping participation voluntary for both firearm owners and retailers.

Implementation:
In order to enable FFLs to become sites for safe, voluntary storage, policymakers should address their barriers to participation. Legislation should create a framework for a voluntary storage program, clarify that participation is voluntary, allow reasonable storage fees, and direct an appropriate state agency to develop basic guidance, standard documentation, public education materials, and a statewide offsite firearm storage map or referral list in partnership with FFLs, firearm safety organizations, suicide prevention partners, counties, Department of Veterans Affairs/Oregon Department of Veterans' Affairs, law enforcement, and community organizations. The policy should also create clear, limited civil liability protections for FFLs that choose to provide voluntary firearm storage in good faith and in compliance with state and federal law.

3. **Dedicated Resources for Adult Suicide Intervention and Prevention Plan (ASIPP) Implementation**

Why:
Oregon needs dedicated resources at the Oregon Health Authority to move the Adult Suicide Intervention and Prevention Plan from planning to implementation. Youth suicide prevention has

received sustained funding, resulting in declines in the Oregon youth suicide rate since 2018.[3] Suicide deaths among older adults, however, continue to increase. Adults ages 25 and older carry the highest burden of suicide death in Oregon, yet adult suicide prevention does not have the same sustained funding through state general fund for infrastructure and coordination as youth suicide prevention. Without dedicated funding, ASIPP initiatives risk remaining uncoordinated and unevenly implemented across the state.

Intent:

The intent is to establish sustained, state funding to support the existing OHA Adult Suicide Prevention Coordinator to lead and coordinate statewide implementation of the ASIPP. This funding would ensure adult suicide prevention receives dedicated attention, accountability, and follow-through, with a focus on high-risk adult populations including older adults, veterans, rural residents, firearm owners, and adults experiencing substance use, chronic pain, isolation, or behavioral health challenges. Though victim service organizations could be included in the learning and implementation, they would need to engage differently due to their Federal and State mandates. Funding would support increased outreach/communication to the 9 Federally Recognized Tribes of Oregon and AI/AN tribal communities.

Implementation:

Oregon should provide sustained state funding to support implementation and evaluation of the Adult Suicide Intervention and Prevention Plan. With this funding, OHA should increase coordination with state and local partners, support counties and community-based organizations, including victim services align adult suicide prevention efforts across behavioral health, public health, crisis systems, CCOs, veteran services, and older adult systems, provide technical assistance, track progress on ASIPP priorities, and report annually on implementation, gaps, and outcomes.

4. **Creation of structures to support science-based suicide treatment**

Why:
While highly efficacious treatments exist to support individuals in both acute and chronic suicidal distress (e.g., CAMS, CRP, DBT), these treatments are difficult to access in Oregon. Additionally, previous attempts to scale these treatments have relied on voluntary clinician and agency training sign up with limited longer-term structures put into place. Additionally, the community standard of care for suicidal individuals in Oregon remains psychiatric hospitalization even though clinical data demonstrates that psychiatric hospitalization can increase risk of suicide post-discharge for some. Currently, not all licensing boards in Oregon mandate CE training in suicide CEs (the Oregon Social Work Board does not, while the Psychologists and Counseling Boards do). Additionally, publicly available listings for individuals certified in evidence-based modalities such as CAMS and DBT show low levels of individuals certified in these modalities in Oregon.

Intent:
The intent is to create structures which support the sustainable long-term access to science-based structures in Oregon and leverage multiple findings showing science-based practice for suicide significantly reduces mental health and health system costs.

Implementation:
Other states use a variety of methods to support science-based practice without creating new positions or increasing system wide costs. The Task Force calls upon individuals in the behavioral health care policy and contracting divisions in Oregon Health Authority to consider structures such as:

- Writing into contracts for agencies delivering mental health services (especially crisis services) that they must have staff who have been trained in science-based approaches to suicide and have a system for ensuring adherence and competency in these areas.
- Creation of billing procedure codes to allow clinics certified in science-based suicide practice to access increased billing and training opportunities and increase reimbursements to promote clinic longevity.
- Continued implementation across licensing boards of HB2135 (2021) to ensure continued education of behavioral health providers around suicide assessment and treatment

5. Creation of sustainable state funding for community violence intervention (CVI) programs

Why:
There is increasing recognition that relying solely on arrests, surveillance, and punitive measures will not achieve reductions in community violence.[46] Community violence intervention (CVI) programs employ individuals with lived experience of gun violence ("credible messengers") to build relationships with and address the needs of individuals at high risk for gun violence by providing connection to services and supports, conflict mediation, and mentoring.[46] These programs have been shown to be effective at reducing violence and related outcomes, with studies reporting a reduction in violent crime by an average of 30%.[47,48]

Dozens of CVI programs are being implemented across Oregon, but these programs require sufficient funding to sustain implementation over time and adequately pay and support their workers. CVI programs are often grant funded for 1-2 years and, after funding ends, programs stall along with the hard-won relationships that CVI workers have built with their communities.[46] Further, CVI workers are often underpaid and struggle with financial instability.[49] Along with regular exposure to violence and stressful situations inherent in working in CVI programs, burnout and turnover among CVI workers is common.[49]

Intent:
The intent is to establish sustainable funding sources to support CVI programs across the state. In 2023, the Oregon legislature allocated $10 million dollars to support CVI programs through grants administered by the Department of Justice, but funding to sustain this work was not included in the 2025-27 legislatively approved budget[50, 51]

Implementation:
In order to support the sustainability of the CVI programs across the state, policymakers should allocate dedicated funding to support these programs and explore options for ongoing, sustainable funding. Funding allocated in 2023 has been administered through grants through the Oregon Department of Justice, Crime Victim and Survivor Services Division.[52] Additional funding can support the continuation of this grant program.

Additional Policy Recommendations by the Task Force

General Suicide Policy Recommendations

- Integrated evidence-based suicide prevention trainings in standards for all health care education (counseling/therapy/psychology/nursing/victim advocates) programs across the state.
- Create central state repository where information on statewide suicide programming can be easily found by stakeholders
- Creation of state certification processes for evidence-based suicide treatment to create incentives for programs to expand and rollout evidence-based practices
- Inclusion of individuals with lived experience and from diverse populations when doing policy implementation and development
- Promote research on the prevalence of "hidden homicides" in Oregon.

Firearms Specific Policy Recommendations

- Recommendations related to the Extreme Risk Protection Order law:
    - Create funding streams or requirements for public education and professional training on Oregon's ERPO law.
    - Require that courthouses or regions have a navigator or support person available to support family/household members trying to petition for ERPOs (and other protection orders) and to provide follow up with petitioners and respondents (e.g., connections to services, following up on firearm surrender/compliance, etc.).
- Pass legislation creating a "Voluntary Do-Not-Sell" list, as has been passed in Washington and Virginia, to allow individuals to confidentially put their own names into the federal firearm background-check system to prevent firearm purchasing.
- Provide funding to support the infrastructure, resources, and personnel needed to create and implement the firearm purchaser licensing permitting system in a timely manner (e.g., funds for law enforcement agencies to develop and staff the permitting system, funds for the creation and staffing of the required training courses, etc.).
- Create and support educational campaigns on Oregon's secure storage law and to support secure storage device distribution (through tax credits, incentives, direct funds, etc.).

Primary Prevention and General Policy Recommendations

- Address social, structural, and economic drivers of violence (e.g., funding for education, public assistance programs, etc.).

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

Conclusion

While work is being done to expand access to behavioral health services and implement gun violence prevention policies, Oregon continues to have one of the highest rates of suicide in the nation and a firearm injury death rate higher than the national average. The evidence-based strategies shared with the Task Force and laid out in this report are working in other states, including states that have more firearms and yet significantly lower rates of suicide and firearm deaths. By implementing some of these policies–and by increasing awareness of and access to existing programs–we can reduce firearm injury and death in Oregon.

References

1. Centers for Disease Control and Prevention. (n.d.). Web-based Injury Statistics Query and Reporting System (WISQARS) Fatal and Nonfatal Injury Reports. Accessed July 14, 2026, at: https://wisqars.cdc.gov/reports/
2. Oregon Health Authority. Center for Health Statistics. (n.d.). Leading Causes of Death [Data dashboard]. Accessed July 15, 2026, at: https://visual-data.dhsoha.state.or.us/t/OHA/views/LeadingCausesDash/LeadingDash1?%3Aembed=y&%3AisGuestRedirectFromVizportal=y
3. Oregon Health Authority. (n.d.). Suicide Prevention. Accessed July 15, 2026, at: https://www.oregon.gov/oha/PH/PreventionWellness/SafeLiving/SuicidePrevention/Pages/index.aspx.
4. Oregon Health & Science University Gun Violence Prevention Research Center. (2025). Firearm Suicides and Suicide Attempts in Oregon, 2018-2021. Accessed July 15, 2026, at: https://ohsu-psu-sph.org/wp-content/uploads/2025/08/AVERT-Listening-Sessions-Firearm-Suicides-and-Suicide-Attempts-in-Oregon.pdf.
5. U.S. Department of Veterans Affairs. (2025). Oregon: Veteran suicide data sheet, 2023. Accessed July 15, 2026, at: https://www.mentalhealth.va.gov/docs/data-sheets/2025/State_Data_Sheets_2025_Oregon_508.pdf.
6. U.S. Department of Veterans Affairs Office of Suicide Prevention. (2024). 2024 National Veteran Suicide Prevention Annual Report. Accessed July 15, 2026, at: https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-1-of-2_508.pdf.
7. Denneson, L.M., Bollinger, M.J., Meunier, C.C., Chen, J.I., Hudson, T.J., Sparks, C.S., & Carlson, K.F. (2023). Veteran suicide and associated community characteristics in Oregon. Preventive Medicine, 170. https://doi.org/10.1016/j.ypmed.2023.107487.

8. Center for Health Systems Effectiveness. (2022). Behavioral health workplace report to the Oregon Health Authority and state legislature. Accessed July 15, 2026, at: https://oregonarchive.org/wp-content/uploads/2023/04/Behavioral-Health-Workforce-Wage-Study-Report-Final-020122.pdf.
9. U.S. Department of Health and Human Services, National Strategy for Suicide Prevention. Washington, DC: HHS, April 2024. Accessed July 15, 2026, at: https://www.hhs.gov/sites/default/files/national-strategy-suicide-prevention.pdf.
10. CAMS-Care. (n.d.). The CAMS Framework. Accessed July 15, 2026, at: https://cams-care.com/the-cams-framework/.
11. Tyndal, T., Zhang, I., & Jobes, D. A. (2022). The Collaborative Assessment and Management of Suicidality (CAMS) stabilization plan for working with patients with suicide risk. *Psychotherapy (Chic), 59*(2), 143–149. https://doi.org/10.1037/pst0000378.
12. Suicide Prevention Therapy. (n.d.). Proven Methods for Reducing Suicide Risk. Accessed July 15, 2026, at: https://suicidepreventiontherapy.com/.
13. Baker, J. C., Starkey, A., Ammendola, E., Bauder, C. R., Daruwala, S. E., Hiser, J., Khazem, L. R., Rademacher, K., Hay, J., Bryan, A. O., & Bryan, C. J. (2024). Telehealth Brief Cognitive Behavioral Therapy for Suicide Prevention: A Randomized Clinical Trial. *JAMA network open, 7(*11), e2445913. https://doi.org/10.1001/jamanetworkopen.2024.45913.
14. Linehan Institute. (n.d.). DBT at the Linehan Institute. Accessed July 15, 2026, at: https://www.linehaninstitute.org/what-is-dbt-skills.
15. Swift, J. K., Trusty, W. T., & Penix, E. A. (2021). The effectiveness of the Collaborative Assessment and Management of Suicidality (CAMS) compared to alternative treatment conditions: A meta-analysis. *Suicide & life-threatening behavior, 51*(5), 882–896. https://doi.org/10.1111/sltb.12765
16. Bryan, C. J., Khazem, L. R., Baker, J. C., Brown, L. A., Taylor, D. J., Pruiksma, K. E., Acierno, R., Larick, J. G., Baucom, B. R. W., Garland, E. L., & Rudd, M. D. (2025). Brief Cognitive Behavioral Therapy for Suicidal Military Personnel and Veterans: The Military Suicide Prevention Intervention Research (MSPIRE) Randomized Clinical Trial. *JAMA psychiatry, 82*(12), 1169–1176. https://doi.org/10.1001/jamapsychiatry.2025.2850
17. Haft, S. L., O'Grady, S. M., Shaller, E. A. L., & Liu, N. H. (2022). Cultural adaptations of dialectical behavior therapy: A systematic review. *Journal of consulting and clinical psychology, 90*(10), 787–801. https://doi.org/10.1037/ccp0000730.
18. Kothgassner, O. D., Goreis, A., Robinson, K., Huscsava, M. M., Schmahl, C., & Plener, P. L. (2021). Efficacy of dialectical behavior therapy for adolescent self-harm and suicidal ideation: a systematic review and meta-analysis. *Psychological medicine, 51*(7), 1057–1067. https://doi.org/10.1017/S0033291721001355.
19. Glenn, C. R., Esposito, E. C., Porter, A. C., & Robinson, D. J. (2019). Evidence Base Update of Psychosocial Treatments for Self-Injurious Thoughts and Behaviors in Youth. *Journal of clinical child and adolescent psychology, 48*(3), 357–392. https://doi.org/10.1080/15374416.2019.1591281.
20. McCutchan, P. K., Yates, B. T., Jobes, D. A., Kerbrat, A. H., & Comtois, K. A. (2022). Costs, benefits, and cost-benefit of Collaborative Assessment and Management of Suicidality versus enhanced treatment as usual. *PloS one, 17*(2), e0262592. https://doi.org/10.1371/journal.pone.0262592.

21. Bernecker, S. L., Zuromski, K. L., Curry, J. C., Kim, J. J., Gutierrez, P. M., Joiner, T. E., Kessler, R. C., Nock, M. K., Rudd, M. D., & Bryan, C. J. (2020). Economic Evaluation of Brief Cognitive Behavioral Therapy vs Treatment as Usual for Suicidal US Army Soldiers. *JAMA psychiatry, 77*(3), 256–264. https://doi.org/10.1001/jamapsychiatry.2019.3639.
22. Meuldijk, D., McCarthy, A., Bourke, M. E., & Grenyer, B. F. (2017). The value of psychological treatment for borderline personality disorder: Systematic review and cost offset analysis of economic evaluations. *PloS one, 12*(3), e0171592. https://doi.org/10.1371/journal.pone.0171592.
23. Washington State Institute for Public Policy. (2024). Dialectical behavioral therapy (DBT) for adolescent self-harming behavior. Accessed July 15, 2026, at: https://www.wsipp.wa.gov/BenefitCost/Program/752.
24. Ward-Ciesielski, E. F., & Rizvi, S. L. (2021). The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: A critical review and recommendations for research. *Clinical Psychology: Science and Practice, 28*(1), 60–71. https://doi.org/10.1111/cpsp.12332
25. Chung, D., Hadzi-Pavlovic, D., Wang, M., Swaraj, S., Olfson, M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. *BMJ open*, *9*(3), e023883. https://doi.org/10.1136/bmjopen-2018-023883.
26. Czyz, E. K., Berona, J., & King, C. A. (2016). Rehospitalization of Suicidal Adolescents in Relation to Course of Suicidal Ideation and Future Suicide Attempts. *Psychiatric services, 67*(3), 332–338. https://doi.org/10.1176/appi.ps.201400252.
27. Ross, E. L., Bossarte, R. M., Dobscha, S. K., Gildea, S. M., Hwang, I., Kennedy, C. J., Liu, H., Luedtke, A., Marx, B. P., Nock, M. K., Petukhova, M. V., Sampson, N. A., Zainal, N. H., Sverdrup, E., Wager, S., & Kessler, R. C. (2024). Estimated Average Treatment Effect of Psychiatric Hospitalization in Patients With Suicidal Behaviors: A Precision Treatment Analysis. *JAMA psychiatry, 81*(2), 135–143. https://doi.org/10.1001/jamapsychiatry.2023.3994.
28. Barber, C. W., & Miller, M. J. (2014). Reducing a suicidal person's access to lethal means of suicide: A research agenda. *American Journal of Preventive Medicine, 47*(3), S264-S272. https://doi.org/10.1016/j.amepre.2014.05.028.
29. Nevarez-Flores, A. G., Pandey, V., Angelucci, A. P., Neil, A. L., McDermott, B., & Castle, D. (2025). Means restriction for suicide prevention: An umbrella review. *Acta Psychiatrica Scandinavica*, *151*(6), 653-667. https://doi.org/10.1111/acps.13783.
30. Oregon Health & Science University Gun Violence Prevention Research Center. (2025). Methods to Prevent Access to Firearms During Times of Increased Risk. Accessed July 15, 2026, at: https://www.doj.state.or.us/wp-content/uploads/2025/07/Foci-3-Firearm-Surrender-Fact-Sheet-Updated.pdf.
31. Oregon Health Authority. (2025). Oregon faces challenges in addressing gaps in the behavioral health crisis system. Report 2025-14. Accessed July 15, 2026, at: https://sos.oregon.gov/audits/Documents/2025-14.pdf.
32. Oregon Bureau of Labor and Industries. (n.d.). Racial discrimination. Accessed July 15, 2026, at: https://www.oregon.gov/boli/civil-rights/Pages/racial-discrimination.aspx.
33. Gibson, K.J. (2007). Bleeding Albina: A history of community disinvestment, 1940-2000. Transforming Anthropology, 15(1), 3-25. https://doi.org/10.1525/tran.2007.15.1.03.

34. Oregon Health Authority, Public Health Division. (2022). Healthier Together Oregon Annual Report. Year 1: September 2020-December 2021. Accessed July 15, 2026, at: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le4220.pdf.
35. Oregon Health & Science University Gun Violence Prevention Research Center. (2025). Domestic violence in Oregon: Understanding the risks and risk factors. Accessed July 15, 2026, at: https://www.doj.state.or.us/wp-content/uploads/2025/07/Foci-5-Domestic-Violence-Fact-Sheet-Updated.pdf.
36. Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S. A., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk factors for femicide in abusive relationships: results from a multisite case control study. *American journal of public health, 93(*7), 1089–1097. https://doi.org/10.2105/ajph.93.7.1089.
37. The Violence Project. (2024). U.S. Mass Shootings and Shooters. https://www.theviolenceproject.org/mass-shooter-database/.)
38. Geller et al. (2021). The role of domestic violence in fatal mass shootings in the United States, 2014–2019. Inj Epidemiol, 8(1):38.
39. Oregon Health & Science University Gun Violence Prevention Research Center. (2025). Mass violence in Oregon: Remembering tragedies and exploring opportunities for prevention. Accessed July 15, 2026, at: https://www.doj.state.or.us/wp-content/uploads/2025/10/Foci-2_OR-Mass-Violence-Fact-Sheet.pdf.
40. Swanson, J. W., Zeoli, A. M., Frattaroli, S., Betz, M., Easter, M., Kapoor, R., ... & Wintemute, G. J. (2024). Suicide prevention effects of extreme risk protection order laws in four states. *J Am Acad Psychiatry Law*, *52*(3), 327-337. https://doi.org/10.29158/JAAPL.240056-24.
41. Zeoli, A.M., Malinski, R., & Turchan, B. (2016). Risks and targeted interventions: Firearms in intimate partner violence. *Epidemiologic Reviews, 38*(1), 125-39. https://doi.org/10.1093/epirev/mxv007.
42. Rand. (2026, January 29). The effects of child-access prevention laws. Accessed July 15, 2026, at: https://www.rand.org/research/gun-policy/analysis/child-access-prevention.html.
43. Rowhani-Rahbar, A., Simonetti, J.A., & Rivara, F.P. (2016). Effectiveness of Interventions to Promote Safe Firearm Storage. *Epidemiol Rev, 38*(1), 111-24. https://doi.org/10.1093/epirev/mxv006.
44. 7Runyan, C.W., Becker, A., Brandspigel, S., Barber, C., Trudeau, A., Novins, D. (2016). Lethal means counseling for parents of youth seeking emergency care for suicidality. *West J Emerg Med, 17*(1),8-14. https://doi.org/10.5811/westjem.2015.11.28590.
45. Barnard, L. M., Johnson, R. L., Brandspigel, S., Rooney, L. A., McCarthy, M., Meador, L., Rivara, F. P., Rowhani-Rahbar, A., Knoepke, C. E., Fortney, J. C., Peterson, R. A., & Betz, M. E. (2022). Voluntary, temporary out-of-home firearm storage: A survey of firearm retailers and ranges in two states. *Preventive medicine*, *165*, 107220. https://doi.org/10.1016/j.ypmed.2022.107220.
46. Buggs, S. (2022). Community-Based Violence Interruption & Public Safety. Arnold Ventures. https://assets.arnoldventures.org/uploads/AVCJIReport_Community-BasedViolenceInterruptionPublicSafety_Buggs_v2.pdf.

47. Braga, A.A., Weisburd, D., & Turchan, B. (2018). Focused deterrence strategies and crime control: An updated systematic review and meta-analysis of the empirical evidence. *Criminology and Public Policy, 17*(1), 205-250. https://doi.org/10.1111/1745-9133.12353.
48. Buggs, S., Webster, D. & Crifasi, C. (2022). Using synthetic control methodology to estimate effects of a Cure Violence intervention in Baltimore, Maryland. *Injury Prevention, 28*(1), 61-67. https://doi.org/10.1136/injuryprev-2020-044056.
49. Webster, D.W., Tilchin, C.G., & Douchette, M.L. (2023). Estimating the Effects of Safe Streets Baltimore on Gun Violence: Executive Summary. Johns Hopkins Center for Gun Violence Solutions. https://publichealth.jhu.edu/sites/default/files/2023-10/estimating-the-effects-of-safe-streets-baltimore-on-gun-violence-july-2023.pdf.
50. S.B. 5506, 82nd Oregon Legislative Assembly, 2023 Reg. Sess. (OR 2023). https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/SB5506.
51. Bernstein, M. (2025, June 15). Advocates urge Oregon lawmakers to restore $10M for community violence intervention. *The Oregonian.* https://www.oregonlive.com/crime/2025/06/advocates-urge-oregon-lawmakers-to-restore-10m-for-community-violence-intervention.html#:~:text=In%202023%2C%20the%20state%20awarded,according%20to%20the%20Justice%20Department.
52. Oregon Department of Justice, Crime Victim and Survivor Services. (n.d.). Community Violence Intervention (CVI) Program. https://www.doj.state.or.us/crime-victims/grant-funds-programs/community-violence-intervention-program/#:~:text=Where%20does%20the%20CVI%202025,prevention%20grants%20and%20their%20administration.