OREGON HEALTH AUTHORITY

Behavioral Health Division
Public Health Division

2026–2030

Youth Suicide Intervention and Prevention Plan

Contents

Acknowledgment of thanks

This iteration of the Youth Suicide Intervention and Prevention Plan is special because of the contributions of many people.

First, I want to thank Dr. Joyce Chu from the Culture and Suicide Prevention Institute at Community Connections Psychological Associates. Her consultation, passion, humor, and wisdom guided Oregon during the development of the YSIPP 26–30.

Second, thanks to the University of Oregon Suicide Prevention Lab and project lead Dr. Jonathan Rochelle. They helped:

- Tie the work together
- Analyze thousands of pieces of feedback from across Oregon
- Review known research
- Look at suicide prevention plans from around the United States to make recommendations.

Third, sincere gratitude to the hundreds of folks who contributed community feedback. Some lead YSIPP initiatives, some are youth or family members, some are providers or other youth-serving adults.

Thank you especially to:

- Those who contributed to the dozens of cultural infusion roundtable meetings and surveys with Dr. Joyce Chu
- The Oregon Alliance to Prevent Suicide
- The OHA Suicide Prevention Team
- The Black Youth Suicide Prevention Coalition
- Oregon Campuses United for Suicide Prevention
- The Big River coordinators
- Those who gave feedback at the 2025 Oregon Suicide Prevention Conference plenary session
- Oregon's Child and Adolescent Psychiatrists
- Those who joined the Nine Tribes Prevention feedback sessions.

With gratitude,

Jill Baker
Youth Suicide Intervention and Prevention Plan manager

Executive summary

This is a summary of the Youth Suicide Intervention and Prevention Plan (YSIPP) 2026–2030, as required by ORS 418.731 and House Bill (HB) 4124 (2014). The YSIPP 26–30 shows the community work and research the Oregon Health Authority (OHA) used to develop the plan. It describes the education, consultation, and teamwork the OHA suicide prevention team and partners used to align the Oregon Suicide Prevention Framework with OHA's 2030 equity goals.

This process included updating the Oregon Suicide Prevention Framework to infuse the Cultural Theory and Model for Suicide[1] in suicide prevention, intervention and postvention. These updates help the YSIPP 26–30 focus its priority strategies and initiatives on meeting the needs of Oregon youth ages 24 and younger. This work matters because Oregon's youth suicide rate has fallen since 2018, but most of that decrease is in white non-Hispanic youth. Suicide deaths for youth of other races and ethnicities have stayed about the same or have increased since 2018.[2]

The YSIPP 26–30 sets priorities for suicide prevention with:

- OHA and OHA contractors
- Oregon Alliance to Prevent Suicide (OHA advisory committee)
- Oregon Department of Education
- Oregon Youth Authority
- Youth Development Oregon
- Oregon Department of Human Services — Child Welfare
- Oregon Department of Human Services — Office of Developmental Disabilities
- Oregon Department of Human Services — Trauma Aware
- Oregon Department of Human Services — Self Sufficiency

Details and updates about this work are available on the online YSIPP 26–30 Tracker.

The 2025–27 state budget added $1 million for culturally specific youth suicide prevention. This is the first new state investment in suicide prevention since 2019.

1 Chu J, Maruyama B, Batchelder H, Goldblum P, Bongar B, Wickham RE. Cultural pathways for suicidal ideation and behaviors. Cultur Divers Ethnic Minor Psychol. 2020 Jul;26(3):367-377. doi: 10.1037/cdp0000307. Epub 2019 Nov 7. PMID: 31697100.

2 https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8874a_24.pdf

Introduction letter

To my fellow people of Oregon:

Oregon Health Authority is proud to share the state of Oregon's third Youth Suicide Intervention and Prevention Plan (YSIPP), outlining our recommended strategies and vision for 2026 through 2030.

Since the first YSIPP (2016–2020), significant progress has been made in legislation, programming, training, coalition-building and diversifying the suicide prevention field. Some key signs of progress include:

- More than 25% of Oregon K–12 students now attend a school with a Sources of Strength program.
- Thousands of educators, youth-serving adults and community members are trained to train others in suicide prevention, intervention and postvention.
- Local suicide prevention coalitions meet regularly to plan and run critical suicide prevention activities around the state.
- 988 is now available 24/7 and the state launched the 988 Oregon: Connect to Hope campaign, raising awareness of this critical resource.
- The Oregon Alliance to Prevent Suicide helps OHA stay accountable and brings in voices of people with lived expertise.
- OHA's cross-agency suicide prevention team has increased its focus on culturally specific suicide prevention efforts, including on Black, African and African-American, Latine and Tribal youth suicide prevention.

Through ongoing community and statewide efforts, the youth suicide rate in Oregon decreased by approximately 20.1% from 2018 to 2023. While Oregon's youth suicide prevention work is strong, more work remains. Oregon's youth suicide rate remains above the national average. Suicide rates among youth of color have not declined like they have for white, non-Hispanic youth.

OHA's suicide prevention team relies on local prevention champions in schools, counties, Tribal communities and community-based organizations. Suicide prevention works best when it is local and led by and for the community.

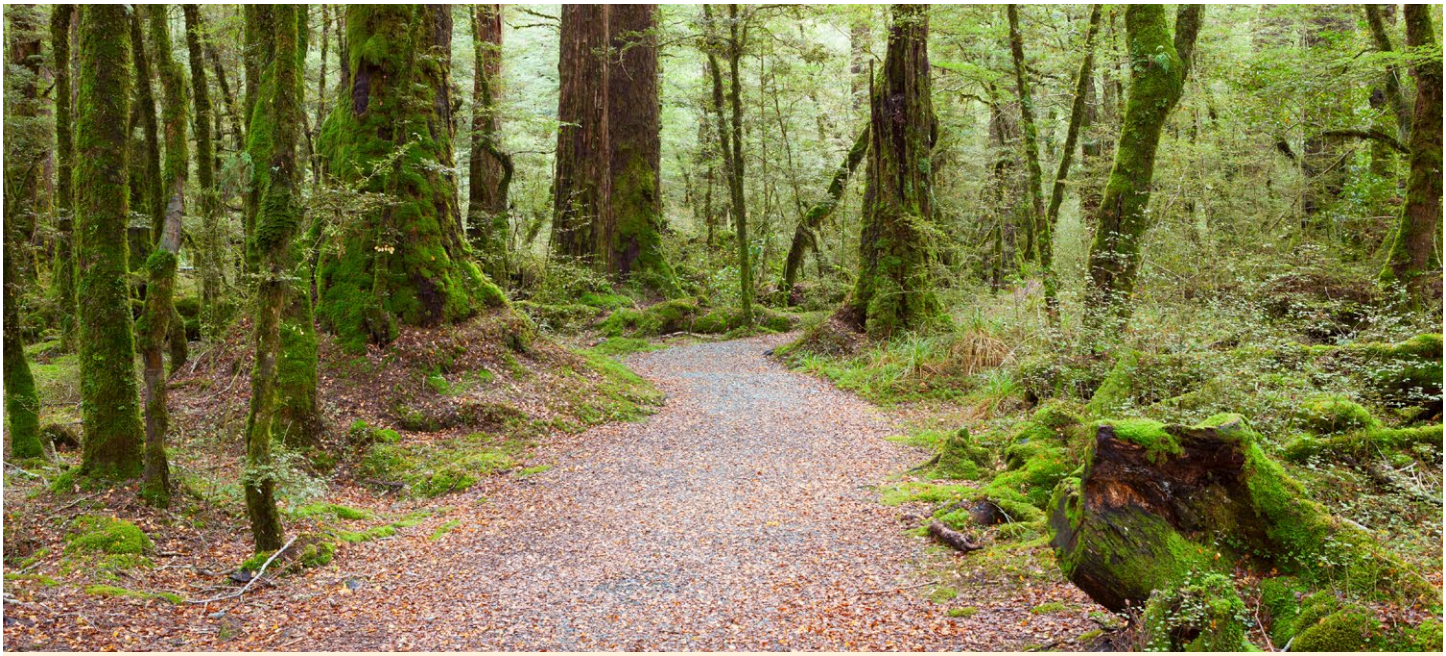
This updated plan was co-developed with many of those champions. It especially considers how culture affects how young people build mental wellness, show signs of suicidality, respond to suicide treatment and find healing and hope. It also outlines strategies to increase and strengthen culturally specific youth suicide prevention programming.

While the YSIPP has never been fully funded, the most recent Legislatively Approved Budget included an additional $1 million to support culturally specific suicide prevention due to the ongoing advocacy of our partners and collective efforts made to raise awareness of inequities in suicide in Oregon. OHA will continue to work to address this resource gap over the life of the 2026–30 YSIPP.

We know that every suicide is one too many. OHA and our partners will keep working tirelessly to increase supports and programming to help protect youth in Oregon from suicide.

Sincerely,

Ebony Clarke
Behavioral Health Director
Oregon Health Authority



The journey to get to the YSIPP 26–30

Background

In 2018, the Oregon youth[3] suicide rate was the highest ever. Since then, the overall rate has dropped. However, racial disparities have emerged. Deaths by suicide for white youth have gone down from 74.5 percent of total deaths in 2018 to 57.5 percent in 2023. Youth of other races and ethnicities have not seen the same decrease. Hispanic youth suicide deaths rose from 13 deaths in 2020 to 24 deaths in 2023, an 85% increase. White youth suicide deaths decreased from 78 deaths in 2020 to 59 in 2023, a 24% decrease.

OHA has a goal to end health inequities by 2030. The decreasing trend in white youth suicides is positive. However, the emerging racial gap shows the need to do better for all youth in Oregon. This plan represents years of work in:

- Relationship-building
- Personal and group learning
- Asking hard questions
- Advocating for resources
- Centering equity

> ***There's something about what we're doing in suicide prevention that isn't working for everybody.***
>
> -Dr. Joyce Chu

3 Unless otherwise noted, "youth" in this document refers to those ages 5–24

What is cultural infusion?

YSIPP 26–30 is more culturally infused than any previous plan. OHA relied on the Cultural Theory and Model of Suicide for Youth,[4] which shows that culture:

- Influences the **types of stressors** that lead to suicide
- Shapes the **meanings associated with stressors** and the risk of suicide
- Directs **how suicidal thoughts and behaviors are experienced and expressed**
- **Affects the suicide help-seeking** and connection with resources

"Culturally infused" means an approach that actively embeds preferred languages and cultural values, practices, beliefs, behaviors and research into its youth suicide prevention efforts. Cultural infusion addresses diverse identities and equity needs.

The OHA suicide prevention team and contractors needed to learn how culture shapes suicide to better serve all youth.

May–June 2024: Cultural Theory and Model Learning Series

OHA contracted with the Culture and Suicide Prevention Institute (CSPI) to provide webinars and consultation calls. These deepened the understanding of cultural infusion and how culture affects suicide prevention work. OHA suicide prevention team and partners from across Oregon took training available from CSPI's parent organization, Community Connections Psychological Associates (CCPA), including:

- Be Sensitive, Be Brave: Mental Health
- Be Sensitive, Be Brave: Suicide Prevention
- Suicide Prevention 201: Advancing Suicide Prevention & Management for Diverse Clients
- Suicide Prevention 202: Case Conceptualization with a Culturally Infused Lens

4 Chu, J., O'Neill, S. E., Ng, J. F., & Khoury, O. (2022). The cultural theory and model of suicide for youth. In Youth suicide prevention and intervention: best practices and policy implications (pp. 99-106). Cham: Springer International Publishing.

July 2024–March 2025: Oregon Suicide Prevention Framework—cultural infusion

The OHA suicide prevention team reviewed the Oregon Suicide Prevention Framework line-by-line to culturally infuse the pillars, goals and pathways. The Framework guides the YSIPP and the Adult Suicide Intervention and Prevention Plan. Thinking about culture across the framework expanded strategies for all youth.

Cultural infusion does not reduce the efforts for white youth. Instead, it builds on existing successes to reach all youth.

Example: A cultural consideration within lethal means is that people of color are more likely to die by hanging as a method of suicide than by firearms.[5] Nearly all the focus in YSIPP 21–25 was safe medication and firearm storage.

Original framework	Culturally infused framework (new)
2.2.1 "Safe storage access" All Oregonians experiencing a behavioral health crisis have access to safe storage for medicine and firearms.	**2.2.1 "Access to means reduction resources"** All people in Oregon at risk for suicide have access to safe storage or other lethal means reduction options.

YSIPP 21–25 initiative that continues in the YSIPP 26–30 plan	YSIPP 26–30 additional initiative
2.2.1.2 Safe storage items and information about how to utilize them safely will be made available to key sectors and partners.	2.2.1.3 OHA will advance equity in lethal means reduction by expanding efforts beyond firearms and medications to include other methods commonly used in diverse communities, beginning with community-engaged learning and planning around suicide-safer approaches to hanging means reduction.

5 Clark, K. A., Mays, V. M., Arah, O. A., Kheifets, L. I., & Cochran, S. D. (2022). Sexual Orientation Differences in Lethal Methods Used in Suicide: Findings From the National Violent Death Reporting System. Archives of suicide research: official journal of the International Academy for Suicide Research, 26(2), 548–564. https://doi.org/10.1080/13811118.2020.1811181

January–March 2025: Community input initial process

CCPA designed and shared a survey to gather feedback on the strengths and areas for improvement in Oregon youth suicide prevention efforts. It focused on how to better address cultural needs. The survey included several areas of focus, such as training, services and school-based efforts.

CCPA also hosted several focus groups for youth, family members and providers. The University of Oregon Suicide Prevention Lab (UOSPL) analyzed the data. Key findings were used to prepare for roundtable consultation meetings between YSIPP initiative leaders and Dr. Chu.

Insights from the input guided the development of culturally responsive strategies and help shaped the YSIPP 26–30 plan priorities.

Community input key findings: needs and strengths

Overall needs and gaps	• More awareness of what resources and trainings are available is needed, particularly in culturally specific communities. • Communities need to lead their suicide prevention work. • There is a lack of resources for communities to lead their suicide prevention work. • There are general barriers to accessing care. • Data limitations exist due to small populations and the inability to provide meaningful statistical analysis.
Overall strengths	• There are high efforts to improve suicide prevention for all youth. • Racism and its impact on youth suicide is being acknowledged. • OHA has prioritized financial compensation for individuals sharing lived expertise. • The youth suicide prevention programming is comparatively well resourced. • There is a good level of trust with the people leading the work of youth suicide prevention.

K–12 School Suicide Prevention	• Providing upstream trainings in schools is important and effective. • More efforts need to be made to increase trainings and programming outside of the school setting.
Big River Suicide Prevention Training	• More diversity in trainers and facilitators is needed. • More cultural considerations within existing trainings are needed. • More input from youth is needed.
Services for suicide treatment	• Some providers and levels of care are better equipped to address cultural considerations. • There is a lack of services in rural areas. • Treatment offered is sometimes misaligned with cultural norms. • More recognition and efforts are needed to address cultural stigma around mental health.
Postvention (after a suicide death)	• There is a specific need for more Spanish-language support in training and services. • More postvention services are needed. • Cultural grief and death practices need to be learned and honored.
Policy, advocacy and collaborative work	• Relationships are vitally important and are overall healthy in Oregon's suicide prevention work. • Action is needed, not just words. • More focus on meeting basic needs such as income, housing and reliable food is needed. • Legislation and resource allocation can help protect culturally specific suicide prevention.

April 2025–June 2025: Cultural Infusion Roundtables

Using the new culturally infused Oregon Suicide Prevention Framework, several groups met with OHA suicide prevention staff and Dr. Chu. They used key findings from the community survey and focus groups to identify which areas of work needed focus in YSIPP 26–30. The goal was to weave culture into the work and expand what key YSIPP initiative leaders would do.

Each person in the roundtable groups was given a survey with Dr. Chu's recommendations for YSIPP initiatives. They submitted final recommendations to the YSIPP manager for consideration in this plan.

Roundtable groups:

- Oregon Alliance to Prevent Suicide Executive Subcommittee
- Oregon Alliance to Prevent Suicide Equity Subcommittee
- Big River coordinators
- Lethal means reduction leaders
- Postvention leaders
- Retrospective Suicide Analysis team
- School suicide prevention leaders
- Treatment-focused leaders
- OHA suicide prevention team

Most of the initiatives included in the YSIPP 26–30 came from this roundtable process. Other initiatives came from the subcommittees of the Oregon Alliance to Prevent Suicide.

Gathering feedback from the broader field (research methods)

To better include the Oregon suicide prevention community in the development of the YSIPP 26–30, OHA gathered qualitative feedback from:

1. The Oregon Alliance to Prevent Suicide Executive Subcommittee
2. Oregon Suicide Prevention Conference (OSPC) 2025 attendees
3. Oregon's Nine Federally Recognized Tribes prevention staff
4. Child and Adolescent Psychiatrists (CAP) of Oregon workgroup
5. Big River suicide prevention training coordinators

Five questions guided the qualitative feedback process:

- What do I want to be able to say is true about youth suicide prevention in 2030?
- What do we need to reach that goal?
- What should be started?
- What should be continued?
- What should be stopped?

The UOSPL helped OHA analyze YSIPP-related qualitative feedback data. The UOSPL team led inductive and deductive qualitative analyses to identify overall themes (inductive) and map feedback data onto YSIPP pathways (deductive). A full report of this analysis is available.

Deductive analysis of ideal and need

The UOSPL team members matched each feedback response from the five groups to the pathways in the Oregon Suicide Prevention Framework. This helped OHA know whether the Framework should remain the foundation for the YSIPP 26–30.

The UOSPL team focused on coding responses to the question, **"What do I want to be able to say is true about youth suicide prevention in 2030?"** (ideal) and **"What do we need to reach that goal?"** (need).

Multiple coding rounds were completed. Lab members discussed findings and agreed on where each response fit best. Responses that were too broad for a specific pathway were coded at the next level up of YSIPP goals (e.g., 1.2). Once all response data was matched across the five groups, frequency counts were tabulated, and bar charts were created to visualize those counts.

Inductive analysis and YSIPP mapping of start, stop and continue

The UOSPL team members coded responses for the other three questions: **what to start, what to stop, and what to continue.** No prior framework was used. Codes and themes were developed directly from the data.

Once themes were identified and defined, individual responses were listed below each theme and color-coded by data source. Frequency counts and bar charts were created for each theme and its subthemes.

Themes and subthemes were matched to YSIPP pathways using the same method as the deductive analysis. This confirmed that no new pathways were needed for the framework, However YSIPP 26–30 needed more focus on the theme of **youth leadership and engagement.**

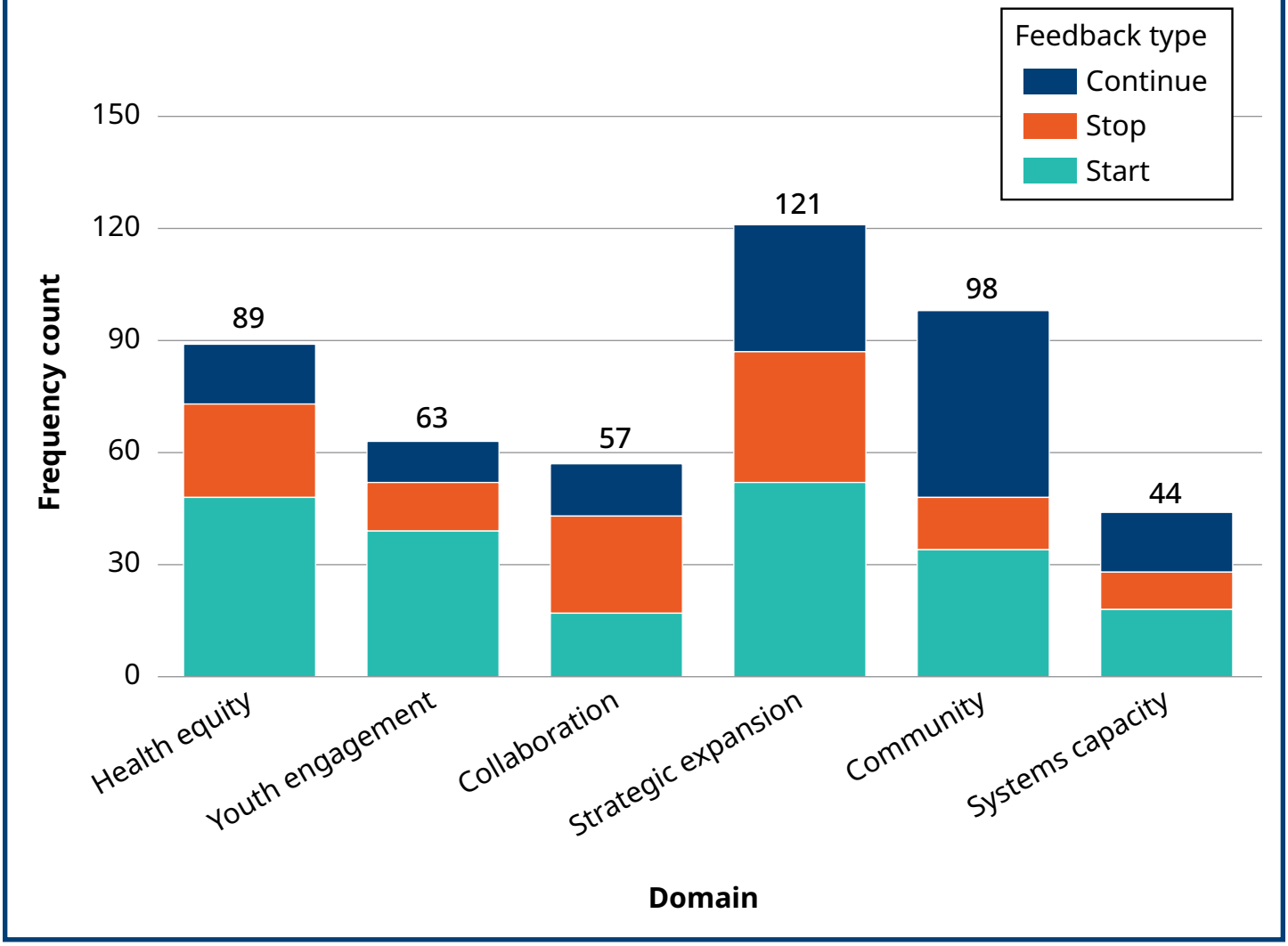
Analysis results and focus areas

The start, stop and continue feedback showed six focus areas for the YSIPP 26–30.

- **Strategic expansion had 121 responses.** This feedback had the most responses, showing strong support for scaling effective programs and events. Respondents also noted the need to reduce inefficiencies and misaligned investments.
- **Community engagement and cultural relevance had 98 responses.** Feedback identified the importance of culturally informed prevention strategies and diverse leadership.
- **Health equity and representation had 89 responses.** Feedback underscored the need to advance equity.
- **Youth leadership and engagement had 63 responses.** Feedback highlighted the need to elevate youth voice and eliminate tokenism.
- **Collaboration and system integration had 57 responses.** Feedback pointed to the value of cross-sector partnerships and the need to overcome fragmentation.
- **Systems capacity and sustainability had 44 responses.** Feedback showed the importance of infrastructure, workforce support and technical assistance for long-term impact.

Each of the above focus areas contained feedback about what should start, stop and continue. This indicates that current work in suicide prevention is largely on the right track. Communities want more of it, and there are still barriers or inefficiencies. OHA used this feedback to revise the YSIPP 26–30 strategies and initiatives.

YSIPP feedback cross-cutting themes by domain



Scanning for promising practices

The UOSPL reviewed:

- States with the lowest rates of youth suicide
- States with the largest decreases in youth suicide rates since 2018
- Research on social media impacts on youth suicide

Key findings and recommendations from these reviews led to several new YSIPP 26–30 initiatives. Many of these focused on sleep and social media. Reports are in Appendices C, D and E in this document. Some recommendations were already strongly represented in the YSIPP 26–30. OHA added strategies and initiatives to the YSIPP 26–30 that were not strongly represented.

Prioritization of initiatives and goal areas

The YSIPP manager completed an ease versus impact analysis to determine which recommendations could be reasonably achieved over this five-year plan.

Most, but not all, of the recommendations from the cultural infusion roundtables, the Oregon Alliance to Prevent Suicide, the scans, the community input and the feedback from the field are included in this plan. OHA documented the initiatives that are not fully included and will revisit them during each annual YSIPP workplan.

OHA assigned each initiative in the YSIPP 26–30 to a lead person or entity.

Funding for this plan

In the 2025–27 legislatively approved state budget, youth suicide prevention programming in the Behavioral Health Division received about $11 million. This includes $1 million in new funding to sustain culturally specific suicide prevention work that OHA began with one-time federal grant dollars.

Oregon Suicide Prevention Framework and YSIPP 26–30 simple view

The chart below shows the strategies in the YSIPP 26–30. Each strategy has a four-part numbering system:

1 = Pillars

1.1 = Goals

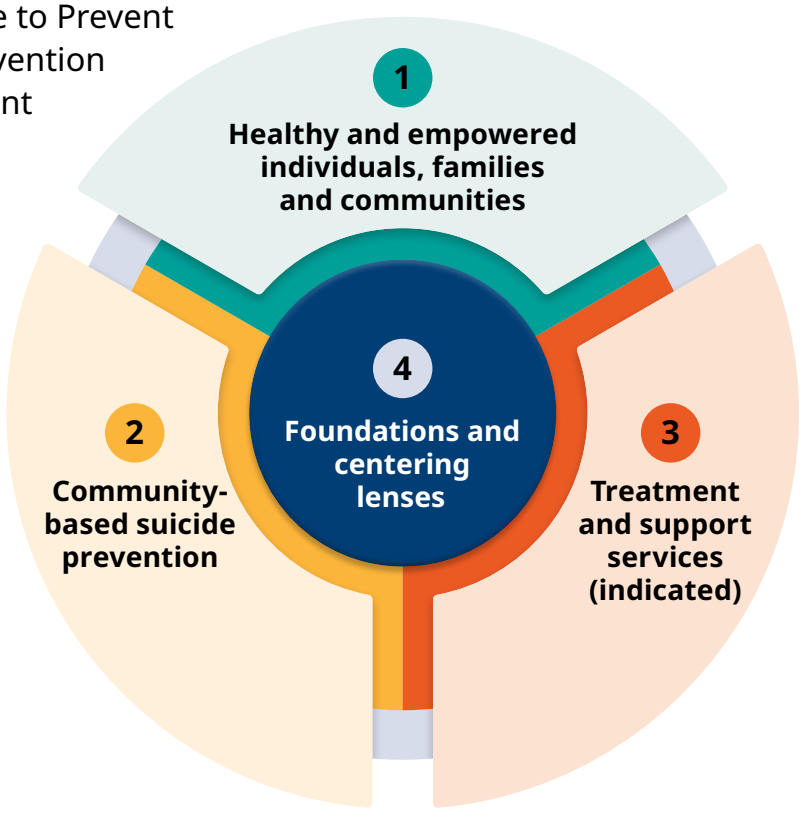
1.1.1 = Pathways

1.1.1.1 = Strategies

There are hundreds of initiatives listed under the strategies. OHA, the Oregon Alliance to Prevent Suicide, youth-serving state agencies and OHA contractors will lead these initiatives during the five years of this plan. All the details are found on the publicly available YSIPP 26–30 tracker.

This document includes examples of YSIPP 26–30 initiatives led by the Oregon Alliance to Prevent Suicide, the Black Youth Suicide Prevention Coalition and the Oregon Department of Education on pages 34–48.

People often ask about what Oregon is doing for specific populations and topic areas. The online YSIPP 26–30 tracker lets users filter by population or area of focus, such as “18–24 year olds” or “LGBTQIA2S+.” It also lets users filter by the Oregon Suicide Prevention Framework centering lens, such as “equity” or “lived experience voice.”



Oregon Suicide Prevention Framework and YSIPP 26–30 simple view

1

Healthy and empowered individuals, families and communities

These goals and pathways seek to reduce suicide risk by promoting well-being and creating supportive communities for all people in Oregon. Other terms you might recognize here are “universal,” “primary prevention,” “upstream prevention,” or “tier 1 strategies.”

1.1 Integrated and coordinated activities

1.1.1 “Coordinated Activities and Organizations” – Suicide prevention programming is coordinated between Tribes, state, county, local leaders, and leaders in cultural communities to maximize reach and equitable access for all Oregonians. Organizations across diverse cultural communities are coordinated and are able to define their role in suicide prevention.

1.1.1.1 Contact information for key partners is updated and accessible

1.1.1.2 Regular, organized, responsive meetings are held to coordinate and collaborate on the work of youth suicide prevention.

1.1.1.3 New partnerships and relationships are nurtured to expand the field of suicide prevention.

1.1.2 “Resourced Coalitions” – Regional suicide prevention coalitions are informed and resourced to address their local needs and priorities in a culturally infused way.

1.1.2.1 Suicide Prevention Coalitions receive information, education and updates from the broader field.

1.1.2.2 Suicide Prevention Coalitions receive funding and resources.

1.1.3 “Equipped Advisories” – Advisory groups are well supported, equipped, and function efficiently to make meaningful change and have diverse inclusion throughout the group, including leadership positions.

1.1.3.1 The Oregon Alliance to Prevent Suicide is the primary advisory group for Oregon’s youth suicide prevention field.

1.1.3.2 OHA will continue to provide coordination for the Children's System Advisory Council.

1.1.3.3 The System of Care Advisory Council is staffed and receives updates about youth suicide prevention.

1.1.4 "Voice of Lived Experience" – People with lived experience have meaningful voice in Oregon suicide prevention, including influence in programming decisions and connection to and representation in key leadership.

1.1.4.1 The Oregon Alliance to Prevent Suicide will support meaningful ways to elevate youth voice and lived experience voice.

1.1.4.2 OHA will require diverse youth engagement, a meaningful feedback loop, and evidence of feedback integration in all relevant OHA suicide prevention contracts.

1.2 Media and communications

1.2.1 "Involved Leaders" – Key decision-makers are consistently informed and/or involved with suicide prevention efforts (i.e., cultural leaders; legislators; Tribal, state, and county leaders).

1.2.1.1 OHA will develop a workplan to improve communication to and involvement with key leaders.

1.2.1.2 Reports are published and sent to key decision-makers.

1.2.2 "Promoting Wellness Widely" – Organizations and agencies promote wellness, emotional strength, and protective factors utilizing culturally infused strategies.

1.2.2.1 Education-focused settings (including K–12 schools and postsecondary institutions) will promote wellness widely.

1.2.2.2 Non-education focused settings (including workplaces, community-centered and health settings) will promote wellness widely.

1.2.3 "Information Dissemination" – Culturally infused safe suicide prevention programming, information and resources are widely disseminated.

1.2.3.1 A variety of culturally infused communications strategies will be used to disseminate information.

1.2.3.2 Websites are digestible, updated, and contain useful information.

1.2.3.3 Tools, guidance documents, and templates are provided to the field of suicide prevention.

1.3 Social determinants of health

1.3.1 "Clear Links" – Highlight clear links between how social determinants of health (SDOH; such as economic stability, education, access to health care, stable housing, and strong and connected communities) influence individual and communities' mental health and risk for suicide, including disparities in SDOH.

1.3.1.1 Use a shared risk and protective factor approach to broaden the scope of what is considered suicide prevention.

1.3.1.2 Highlight the impact of increased mental health in programs and projects that address SDOHs. Clearly name them as suicide prevention efforts.

1.3.2 "Supporting Partners" – Create diverse, multi-sector partnerships to impact SDOH and disparities across multiple health and suiciderelated outcomes.

1.3.2.1 Youth Development Oregon will continue to discuss, and support suicide prevention information, resources, and training with YDO Youth Grantees through the biannual Reengagement Collaboratives and other grantee meetings, with OHA suicide prevention team support.

1.4 Coping and connection

1.4.1 "Positive Connections" – People in Oregon have access to meaningful and culturally-preferred spaces to facilitate community based connection and support.

1.4.1.1 Oregon youth and their caregivers have supportive places to connect with others and feel belongingness connected to school settings

1.4.1.2 Oregon youth and their caregivers have supportive places to connect with others and feel belongingness within school settings.

1.4.2 "Coping Strategies" – People in Oregon understand and have access to what helps them to cope with hardship as an individual and within their community including culturally-preferred strategies.

1.4.2.1 Oregon youth and their families receive information about and opportunities to practice coping strategies in school settings.

1.4.2.2 Oregon youth and their families receive information about and opportunities to practice coping strategies in other-than-school settings.

1.4.3 "Support Roles" – People, family and caregivers in Oregon are empowered and equipped in their roles to prevent suicide for diverse communities in Oregon.

1.4.3.1 Family members and caregivers have opportunities to strengthen their skills around being a trusted adult for youth.

1.4.3.2 Youth have opportunities to strengthen their skills around being a positive friend in the context of suicide prevention.

1.4.3.3 Adults who interface with youth in their community or workplace have opportunities to strengthen their skills around being a trusted adult for youth.

2 Community-based suicide prevention

These goals and pathways seek to reduce suicide by focusing on strategic locations, groups, and sectors to promote well-being, to help navigate challenges, to decrease risk, and to recognize warning signs early. Other terms you might recognize here are "selected," "prevention," "primary intervention," or "tier 2 strategies".

2.1 Community helper trainings

2.1.1 "Appropriately Trained Community" – People in Oregon receive the appropriate level of ongoing training for their roles in culturally infused suicide prevention.

2.1.1.1 There are recommendations for culturally infused suicide prevention training by sector and by provider role.

2.1.1.2 Trainings are offered regularly in local communities and organizations.

2.1.1.3 OHA sponsored trainings will be provided in non-English languages, as aligned with the linguistic and cultural needs of the surrounding community, using translated and culturally adapted materials delivered by fluent, representative trainers when possible. All OHA sponsored trainings will have simultaneous translation available.

2.1.2 "Supported Training Options" – Culturally infused suicide prevention community helper training is widely available at low or no cost for Oregon communities.

2.1.2.1 OHA will support Big River Programming by providing low or no cost access to Train-the-Trainer events, statewide coordination, evaluation support, and limited course support for the following programs: Sources of Strength (K-Postsecondary), MHFA (through June 2027), ASIST (through June 2027), Youth SAVE, Youth SAVE for Young Adults, Youth SAVE for Primary Care,

Oregon CALM, Oregon Community CALM Conversations, BSBB for SP, BSBB for MH, and Connect Postvention.

2.1.2.2 Big River program coordinators will provide support to deliver trainings in culturally preferred locations, with (material or non-material) incentives that fit cultural practices.

2.1.2.3 OHA will support stand-alone trainings in suicide prevention, intervention, and postvention as need arises. These trainings will offer interpretation services as requested.

2.1.2.4 OHA and the Big River coordinators will seek ways to enhance Big River training accessibility through technology and infrastructure.

2.1.3 "Representative Trainers" – The trainer pool in Oregon for suicide prevention programming represents the cultural and linguistic diversity of the communities in which they train.

2.1.3.1 In collaboration with cultural brokers, all Big River statewide coordinators will continue to assess the gaps in availability of culturally and linguistically diverse trainers and trainings and will recruit and provide support accordingly and in collaboration with other Big River statewide coordinators.

2.1.3.2 Trainers who identify as culturally or linguistically specific trainer will receive support.

2.1.4 "Culturally Infused Training" – Suicide prevention programming is regularly evaluated and updated to ensure that cultural infusion and linguistic needs are addressed.

2.1.4.1 All OHA Youth Suicide Prevention contracts will require all contractor's staff to be trained in cultural agility, humility, anti-racism, and how culture influences suicide prevention.

2.1.4.2 Big River statewide coordinators are equipped and required to regularly assess, evaluate and address the gaps in the cultural relevance, cultural infusion and accessibility of their program(s). Big River statewide coordinator meetings include regular and ongoing assessment of opportunities to increase cultural relevance, availability and adapting training delivery components to meet the needs of culturally and linguistically diverse communities, including the effects of minority stress and systemic barriers.

2.1.4.3 OHA and its contractors will support professional development and resources for Big River trainers to increase their skills and knowledge on culturally specific resources, cultural humility, anti-racism and ways culture impacts suicide.

2.2 Culturally infused means reduction

2.2.1 "Access to Means Reduction Resources" – All people in Oregon at risk for suicide have access to safe storage or other lethal means reduction options.

2.2.1.1 The Alliance's Lethal Means Subcommittee will continue to work towards recommendations in the Lethal Means workplan. This Subcommittee will revise the Lethal Means workplan to reflect changes in the lethal means landscape and will include cultural considerations for populations disproportionately impacted by suicide

2.2.1.2 Safe storage items and information about how to utilize them safely will be made available to key sectors and partners.

2.2.1.3 OHA will advance equity in lethal means reduction by expanding efforts beyond firearms and medications to include other methods commonly used in diverse communities, beginning with community-engaged learning and planning around suicide-safer approaches to hanging means reduction.

2.2.2 "Means Reduction Education" – Diverse communities in Oregon are educated and equipped with culturally infused means reduction strategies and resources.

2.2.2.1 OHA supports and recommends trainings specific to means reduction.

2.2.2.2 OHA-sponsored education, lethal means reduction media and communications materials will be linguistically and culturally infused by: reflecting culturally congruent values, using effective cultural framing, engaging trusted messengers, addressing communityspecific barriers, affirming cultural strengths, incorporating culturally informed storage strategies, and delivering messages in preferred languages.

2.2.3 "Means Reduction Promotion" – Culturally infused means reduction practices are promoted regularly in Oregon and are linked to suicide prevention.

2.2.3.1 Legislation and policies about means reduction will be monitored and assessed from a culturally infused suicide prevention lens.

2.2.3.2 OHA will identify and support initiatives that normalize dialogue about safe storage practices in diverse communities through culturally infused, community-led education and outreach.

2.2.3.3 OHA will build collaborative, equitable, compensated partnerships with culturally diverse community leaders to co-create lethal means reduction efforts, while taking care not to overburden those already disproportionately asked to lead.

2.3 Protective programming

2.3.1 "Available Support" – People in Oregon who need immediate support have access to culturally-congruent mental health and crisis response services.

2.3.1.1 Support lines are available for diverse needs and cultural groups.

2.3.1.2 Mobile Crisis intervention services are available.

2.3.2 "Culturally Specific Programming" – People within communities disproportionately impacted by suicide risk have access to culturally infused protective programming driven by their communities.

2.3.2.1 OHA will support relevant and culturally responsive small group lessons and activities for elementary students. Materials will be made available in English and Spanish. Additional language needs and translations will be tracked and shared. Evaluation will inform annual revisions and updates to resources.

2.3.2.2 OHA will support culturally specific youth suicide prevention programming led by community partners.

2.3.3 "Protective Policies" – Organizations have policies and procedures that increase protection against suicide risk (including passive risk, active risk, and crisis intervention), and those policies are implemented.

2.3.3.1 Oregon requires (through Adi's Act) that every school district in Oregon adopt a policy requiring a comprehensive suicide prevention, intervention, and postvention district plan. Adi's Act receives support for implementation.

2.3.3.2 Targeted educational opportunities and technical assistance will be provided to enhance suicide prevention and intervention practices in a variety of sectors.

2.3.3.3 Direct support will be offered to K–12 school buildings and postsecondary institutions to support their suicide prevention and intervention practices.

3 Treatment and crisis services

These goals and pathways seek to reduce suicide by focusing services and policies for those who experience suicidality or have been impacted by suicide loss. Other terms you might recognize include “indicated,” “Tier 3 strategies,” “intervention,” or “postvention.”

3.1 Healthcare Coordination

3.1.1 “Coordinated Transitions” – People in Oregon with suicide risk who access healthcare receive culturally responsive coordination between levels of care, tailored to culturally preferred pathways of help-seeking.

3.1.1.1 Policies and legislation about care transitions and coordination will be monitored and assessed through a culturally infused suicide prevention lens.

3.1.1.2 Programming and services specific to culturally infused coordinated transitions will be supported.

3.1.2 “Collaborative Communication” – There is collaborative, culturally responsive communication among the individual at risk, healthcare providers, and social, school, and family supports.

3.1.2.1 OHA supports Young Adults Hubs which are designed to engage and support extremely distressed or marginalized youth ages 14–25 by coordinating behavioral healthcare components including outreach, brief crisis services, community-based supports, peer support, and clinical and other health related services.

3.1.3 “Substance Use Services” – Services for substance use and mental health are integrated when possible and coordinated when not fully integrated, consistent with culturally responsive approaches to care.

3.1.3.1 OHA will support the development of a culturally infused SUD and Suicide Prevention training.

3.1.3.2 The SUD Prevention Coordinator of the Child and Family Behavioral Health team will attend SPIP meetings and develop action steps in collaboration with the YSIPP manager.

3.1.4 “Integrated Care” – People in Oregon will receive culturally infused integrated care between primary care and behavioral healthcare (including school-based care for youth).

3.1.4.1 OHA will support the development of tools, resources, and processes for culturally infused suicide screening, risk assessments, and safety planning across sectors. These will integrate culturally responsive resources and referral processes, and integrate cultural idioms of distress into standard protocols for screening for suicide risk in schools to reduce cultural, linguistic, and systemic barriers to care for youth and their families.

3.2 Healthcare capacity

3.2.1 "Accessible Services" – People in Oregon can access culturally responsive services on the continuum of care when needed and for as long as needed, regardless of health insurance.

3.2.1.1 Child and Family Behavioral Health will identify opportunities for improvement in how diverse clients are received and engaged with treatment services – exploring ideas such as collaboration with cultural brokers, alternative places and structures of treatment, culturally responsive intake procedures, referral procedures, and/or psychoeducation and treatment orientation approaches, and others.

3.2.1.2 OHA supports Young Adults in Transition (YAT) Residential Treatment Homes (RTH) for young adults (17 to 25 years old) who experience complex behavioral health challenges. YAT RTHs provide 24-hour supervision and support, focusing on helping residents develop the skills needed to manage their mental health symptoms and transition into adulthood.

3.2.1.3 OHA will support the launch of The Hope Institute in Lane County in 2026.

3.2.1.4 OHA will support 8 health system's mini-grants to launch new or support existing Zero Suicide Initiative efforts following participation in an Oregon Zero Suicide Academy and ensure those efforts are culturally infused to the greatest extent possible.

3.2.2 "Equitable and Right Sized Workforce" – The healthcare workforce is sufficient to meet community needs, with particular attention to underrepresented cultural and non-English speaking communities.

3.2.2.1 OHA supports the development of a diverse behavioral health workforce through scholarships, loan repayment, retention and peer workforce development.

3.2.2.2 OHA provides enhanced payments for those providing culturally and linguistically specific services.

3.2.3 "Organizational Structures, Policies, and Procedures" – Healthcare organizations have organizational structures, policies, and procedures that ensure the provision of comprehensive and culturally infused evidence-based suicide safer care.

3.2.3.1 OHA will explore opportunities to culturally infuse clinical service systems and suicide care through Oregon's Zero Suicide efforts – such as through cultural content in the Zero suicide academy, cultural infusion into the Zero suicide assessment tools, implementation of Zero Suicide components, and others.

3.2.3.2 OHA will maintain and expand a strategic list of state-level routes and mechanisms to integrate cultural infusion into children's behavioral health service systems, to support ongoing system improvement and equity-driven action.

3.3. Appropriate treatment and care of suicidality

3.3.1 "Equipped and Well Workforce" – The healthcare workforce is equipped, trained, and supported to address the suicide-related needs of the diverse communities they serve.

3.3.1.1 Oregon requires behavioral heath providers to receive suicide prevention training upon re-licensure.

3.3.1.2 Behavioral health providers (including Peer Support workforce) in Oregon have access to low or no cost courses in culturally infused evidence-based treatment of suicidality that address various levels of risk of suicide and teach interventions accordingly.

3.3.1.3 Healthcare providers and health systems in Oregon have access to low or no cost courses in culturally infused evidence-based suicide prevention training and tools.

3.3.1.4 The suicide prevention workforce has access to support for their wellbeing.

3.3.2 "Culturally-congruent Care Options" – People in Oregon have access to culturally-congruent care options (e.g., whole-person approaches, voice and choice in treatment, collaboration with traditional and spiritual healing, strengths-based and recovery-based approaches, and others).

3.3.2.1 OHA will support culturally and linguistically responsive approaches to services that address diverse cultural conceptualizations of suicide, including body work, movement work, cultural healing practices, sleep therapy, tribal-based practices, and other evidenceinformed treatments for reducing suicidality.

3.3.3 "Core Competencies" – People in Oregon receive comprehensive and culturally infused care across all competencies of suicide screening, assessment, safety planning, lethal means counseling, crisis response, and treatment.

3.3.3.1 OHA will support children's behavioral health service organizations in conducting needs assessments to identify strengths, gaps, and priorities related to cultural infusion across the service continuum (i.e., outreach, screening, assessment, safety planning, crisis response, and treatment/recovery), guided by the Cultural and Suicide Prevention Institute's (CSPI) system change framework.

3.3.3.2 Culturally infused youth-facing screening tools, policy/procedure/workflow samples, and safety planning templates and examples will be identified to assist School-based Health Centers (SBHCs) in meeting new certification standards requiring screening for suicide risk and safety planning.

3.3.3.3 EASA's Center of Excellence will develop and implement a culturally infused EASA model that integrates culture, diversity, and equity into EASA's screening, assessment, safety planning, and intervention practice guidelines, protocols, trainings, and conferences/events.

3.4 Postvention Services

3.4.1 "Equipped and Resourced Communities" – Oregon communities are equipped to provide trauma-informed and culturally responsive postvention care for those impacted by a suicide death.

3.4.1.1 OHA will support Connect: Postvention training by providing low or no cost access to Train-the-Trainer events, statewide coordination for local training needs, evaluation support and course support.

3.4.1.2 OHA will support and equip postvention teams and programs to provide culturally responsive postvention care.

3.4.1.3 OHA will provide youth postvention services and support in coordination with postvention response teams.

3.4.2 "Postvention Response Leads" – Postvention Response Leads (PRLs), teams, and policies support culturally responsive postvention for diverse communities in Oregon.

3.4.2.1 Suicide Rapid Response program is accessible, responsive to community needs, and centers culture in all responses.

3.4.2.2 OHA hosts a variety of learning and networking opportunities for Postvention Response Leads.

3.4.3 "Fatality Reviews" – Suicide fatality data is gathered, analyzed, and used for future system improvements and prevention efforts.

3.4.3.1 Establish Retrospective Suicide Analysis (RSA) services as a core component of Oregon's postvention suicide response system/offerings, tailored to the cultural needs of local communities.

3.4.3.2 Death review teams meet (county and state level) to analyze child fatalities, including suicide deaths, and produce system recommendations for prevention opportunities

4 Foundations and centering lenses

4.1 Data and research

4.1.1 "Data Integration" – Suicide data includes as much demographic detail as possible and is gathered, analyzed, disseminated, and used for future system improvements and prevention efforts.

4.1.1.1 Data gathering and dissemination efforts are strategically planned, routinely assessed for health disparity impacts, and adapted as needed.

4.1.1.2 Surveillance data around suicide related injuries and services is available and analyzed.

4.1.1.3 Data related to suicide deaths is available and analyzed.

For a better sense of what is being done to address data needs, filter the "Foundation or Centering Lens" by "Data/Research" in the YSIPP 26–30 tracker.

4.2 Evaluation

4.2.1 "Culturally responsive Evaluations" – Suicide prevention efforts are regularly evaluated and updated to ensure cultural infusion and linguistic needs are addressed.

4.2.1.1 The University of Oregon Suicide Prevention Lab receives funds to support evaluation efforts of OHA's Suicide Prevention team and the priorities named by the Alliance's Executive Subcommittee and provide implementation technical assistance across the YSIPP initiatives where possible.

4.2.1.2 OHA will develop a workplan to track and publicly report culturally relevant suicide prevention metrics throughout the YSIPP.

4.2.1.3 Big River training data and evaluation efforts use methods that capture cultural nuances and assess effectiveness in diverse communities, including community-based participatory approaches, qualitative approaches such as storytelling, interviews, and focus groups, and a focus on the lived experiences of culturally diverse people, LGBTQ2SIA+, and other marginalized youth.

4.2.1.4 OHA will increase culturally specific suicide prevention evaluation efforts.

For a better sense of what is being done to evaluate the work, filter the "Foundation or Centering Lens" by "Evaluation" in the YSIPP 26–30 tracker.

4.3 "Policy Needs/Gaps" – The field of suicide prevention regularly assesses the need for changes in current policies (including legislative concepts, Oregon Administrative Rules, and organizational policies), accounting for equity-driven needs.

4.3.1 The Oregon Alliance to Prevent Suicide will develop recommendations for policy priorities to OHA by Oct 1 annually.

4.3.2 Youth Development Oregon will develop future steps for suicide prevention efforts for the 2025–2027, with a focus on YDO grantee workforce training.

4.3.3 Certification standards focused on suicide prevention, screening and assessment will be developed for School-based Health Centers (starting in 2025).

4.3.4 OHA's YSIPP manager will lead a strategic planning process to annual update the YSIPP priority initiatives to "start, stop and continue" in a culturally infused way.

For a better sense of what is being done to address policy needs, filter the "Foundation or Centering Lens" by "Policy" in the YSIPP 26–30 tracker.

4.4 "Funding and Resources" – The Oregon Suicide Prevention workforce has the resources needed to provide comprehensive, culturally infused suicide prevention.

4.4.1 "Funding Needs" – The field of suicide prevention regularly assesses the need for adjustments in current funding allocations and advocates for additional resources as needed so that organizations and agencies have resources to implement comprehensive culturally infused suicide prevention, accounting for equity-driven needs.

4.4.1.1 OHA's Suicide Prevention team will maintain a list of funding needs related to YSIPP strategic initiatives.

4.4.1.2 OHA's suicide prevention team will maintain a prepared request and rationale for full funding for the YSIPP and initial funding for the ASIPP.

4.4.1.3 OHA's suicide prevention team will pursue federal grant opportunities.

4.5 "Equity" – Oregon's field of suicide prevention remains committed to eliminating health inequities. Eliminating health inequities means ensuring that all people in Oregon can reach their full health potential and well-being, and that they do not face disadvantages due to their race, ethnicity, language, disability, immigration status, age, gender, gender identity, sexual orientation, geography, social class, or other cultural identities.

4.5.1 Materials and communications are linguistically translated and culturally infused to fit the needs of diverse communities in Oregon.

4.5.2 Suicide prevention related strategic plans, organizational missions, values, commitment, leadership, and committee structures are culturally infused

For a better sense of what is being done to center equity, filter the "population focus" by Health Equity or "Foundation or Centering Lens" by "Equity" in the YSIPP 26–30 tracker*.*

4.6 “Trauma informed practices” – The six key principles of trauma informed care are considered, including: Safety; Trustworthiness and Transparency; Peer Support; Collaboration and Mutuality; Empowerment, Voice, and Choice; and Cultural, Historical, and Gender Issues.

4.6.1 Trauma Informed Oregon will continue to be available for consultation and special projects related to suicide prevention.

For a better sense of what is being done to center Trauma Informed Practices, filter the “Foundation or Centering Lens” by this topic.

4.7 “Lived Experience Voice” Diverse people with suicide-centered lived experience have key roles in suicide prevention efforts and their authentic perspectives are incorporated into all evaluation, oversight, and implementation initiatives.

For a better sense of what is being done to center the voices of lived experience, filter the “Population Focus” or “Foundation or Centering Lens” by Lived Experience in the YSIPP 26–30 tracker.

Example 1: YSIPP 26–30 Oregon Alliance to Prevent Suicide

This chart shows the YSIPP 26–30 initiatives led by the Oregon Alliance to Prevent Suicide, in the YSIPP 26–30 simple view. You can view this chart on the online YSIPP 26–30 Tracker using the "Alliance" filter.

1

Healthy and empowered individuals, families and communities

These goals and pathways seek to reduce suicide risk by promoting well-being and creating supportive communities for all people in Oregon. Other terms you might recognize here are "universal," "primary prevention," "upstream prevention," or "tier 1 strategies.

1.1 Integrated and coordinated activities

1.1.1 "Coordinated Activities and Organizations" – Suicide prevention programming is coordinated between Tribes, state, county, local leaders, and leaders in cultural communities to maximize reach and equitable access for all Oregonians. Organizations across diverse cultural communities are coordinated and are able to define their role in suicide prevention.

1.1.1.3 New partnerships and relationships are nurtured to expand the field of suicide prevention.

1.1.1.3.2 The Oregon Alliance to Prevent Suicide will continue to identify and engage with key partners for equity work to address disparities in youth suicide based on community and identity.

1.1.1.3.3 OHA and The Alliance will maintain a list of priority youth-serving, culturally diverse community-based organizations and partnerships with which to develop or maintain pathways for meaningful engagement.

1.1.2 "Resourced Coalitions" – Regional Suicide Prevention Coalitions are informed and resourced to address their local needs and priorities in a culturally infused way.

1.1.2.1 Suicide Prevention Coalitions receive information, education and updates from the broader field.

1.1.2.1.1 The Alliance staff will host learning opportunities at least twice a year to provide networking support and to highlight equity considerations for regional suicide prevention coalitions and other local suicide prevention champions.

1.1.6.2 At least twice per month, the Alliance will share statewide culturally infused resources, educational opportunities, safe messaging and policy updates to regional suicide prevention coalition leaders via a list serve.

1.1.3 "Equipped Advisories" – Advisory groups are well supported, equipped, and function efficiently to make meaningful change and have diverse inclusion throughout the group, including leadership positions.

1.1.3.1 The Oregon Alliance to Prevent Suicide is the primary advisory group for Oregon's youth suicide prevention field.

1.1.3.1.1 The Alliance will continue to be staffed at 2.0 FTE, including dedicated FTE for youth engagement.

1.1.3.1.2 The Alliance Executive Committee will reassess, reset, and clarify the Alliance's advisory pathways and organizational structure to ensure that culturally infused, responsive, equity issues are introduced, elevated and effectively advanced.

1.1.3.1.2.1 In addition to existing efforts that center disparities impacting BIPOC, tribal and other culturally specific suicide prevention strategies, the Alliance will increase focus on and improve accountability to the following youth populations across the work of its subcommittees: LGBT2SIA+; immigrants, migrants and refugees; intersectional identities.

1.1.3.1.2.2 The Alliance will increase focus on and improve accountability to the 18–24 year old population across the work of its subcommittees.

1.1.3.1.4 The Alliance will systematize the use of culturally infused practices—such as equity impact analyses, disaggregated data, input from cultural brokers, and community narratives—when making policy recommendations to OHA, with the equity subcommittee and its equity tool empowered to guide this work.

1.1.3.1.4.1 The Alliance's Data and Evaluation Subcommittee will partner with the Alliance's Executive Subcommittee to create a logic model to guide the Alliance's operations, including culturally infused practices.

1.1.3.1.4.2 The Alliance Executive Subcommittee will strengthen recruitment and retention of culturally diverse, geographically representative, and underrepresented members in Alliance's leadership and membership, subcommittees, and time limited workgroups.

1.1.3.1.4.3 The Alliance Executive Subcommittee will provide ongoing training, reflective learning spaces, and access to expert facilitation to deepen Alliance members' skills in cultural bias work, cultural frameworks, anti-oppression, and equity-focused leadership.

1.1.3.1.4.4 The Alliance's Executive Subcommittee will work with the Alliance Equity Subcommittee to establish transparent accountability mechanisms—including community feedback loops, equity audits, and reporting—to ensure the Alliance remains aligned with cultural equity goals and community trust.

1.1.3.1.4.5 The Alliance Workforce Subcommittee will evaluate current data collection and reporting mechanisms to determine if our work is reaching intended outcomes and make recommendations to OHA on how to better meet our outcomes if needed.

1.1.3.1.5 The Oregon Alliance to Prevent Suicide organizes subcommittees and workgroups to align with annual YSIPP priority initiatives.

1.1.3.1.6 The Alliance Equity Subcommittee will solidify their operational structure as a central driver of cultural infusion strategy, coordination, and accountability across the Alliance.

1.1.3.1.6.1 The Alliance Equity Subcommittee will systematize cultural infusion checkpoints in which other Alliance subcommittees regularly engage with the Alliance Equity Subcommittee for cultural infusion input, feedback, support, and alignment.

1.1.3.1.6.2 The Alliance Equity Subcommittee will create and carry out an implementation workplan for 1.1.3.7 through full engagement of its members, exploring strategies such as establishing Alliance Equity subcommittee liaison roles with other Alliance subcommittees, creating a brief equity tool for all Alliance meetings and initiatives, offering technical assistance, or others.

1.1.3.1.7 OHA's suicide prevention team will inform the Alliance Subcommittees of workgroups, communities of practice, or decisions pending on topics relevant to their scope and connected to suicide prevention topics broadly. The Alliance's subcommittees and quarterly meetings will include time for OHA updates on this topic.

1.1.4 "Voice of Lived Experience" – People with lived experience have meaningful voice in Oregon suicide prevention, including influence in programming decisions and connection to and representation in key leadership.

1.1.4.1 The Oregon Alliance to Prevent Suicide will support meaningful ways to elevate youth voice and lived experience voice.

1.1.4.2.1 Youth representatives (including at least one person that has not yet reached age 18) serve on The Alliance.

1.1.4.3 The Alliance will continue to engage youth and young adults through town halls, connections with local coalitions, and other culturally congruent outreach strategies identified by young people.

1.2 Media and communications

1.2.1 "Involved Leaders" – Key decision-makers are consistently informed and/or involved with suicide prevention efforts (i.e., cultural leaders; legislators; Tribal, state, and county leaders).

1.2.1.2 Reports are published and sent to key decision-makers.

1.2.1.2.1 An annual YSIPP report to the legislature is published and disseminated widely by March.

1.2.2.2.1.1 The Alliance's Data and Evaluation Subcommittee will review OHA's YSIPP Annual and Evaluation Reports each year to provide recommendations to both the Alliance and OHA based on trends found in those reports with particular focus on disparities.

1.2.2 "Promoting Wellness Widely" – Organizations and agencies promote wellness, emotional strength, and protective factors utilizing culturally infused strategies.

1.2.2.3 The Alliance's Workforce Subcommittee will expand the reach and impact of the Small Steps Project across the state of Oregon through partnership with other Alliance Subcommittees, community advocates, and cultural brokers. The Subcommittees will think through cultural considerations for future iterations of the Project.

1.2.2.4 The Alliance's Workforce Subcommittee will request technical assistance from the University of Oregon's Suicide Prevention Lab and other partners to conduct a statewide landscape scan to better understand how to expand and increase efforts in workforce suicide prevention for populations and sectors identified by the subcommittee.

1.2.2.4.1 The Alliance's Workforce Subcommittee will create recommendations around evaluating work that is currently being done to improve the function of workforce suicide prevention to have a better understanding of what is going well and help guide future efforts.

1.2.3 "Information Dissemination" – Culturally infused safe suicide prevention programming, information and resources are widely disseminated.

1.2.3.2 Websites are digestible, updated, and contain useful information.

1.2.3.2.1 Alliance to Prevent Suicide website will continue to make information available regarding Alliance activities, legislative recommendations to OHA, opportunities for community members to be involved, and resources.

2

Community-based suicide prevention

These goals and pathways seek to reduce suicide by focusing on strategic locations, groups, and sectors to promote well-being, to help navigate challenges, to decrease risk, and to recognize warning signs early. Other terms you might recognize here are “selected,” “prevention,” “primary intervention,” or “tier 2 strategies”.

2.2 Culturally infused means reduction

2.2.1 “Access to Means Reduction Resources” – All people in Oregon at risk for suicide have access to safe storage or other lethal means reduction options.

2.2.1.1 The Alliance’s Lethal Means Subcommittee will continue to work towards recommendations in the Lethal Means workplan. This Subcommittee will revise the Lethal Means workplan to reflect changes in the lethal means landscape and will include cultural considerations for populations disproportionately impacted by suicide

2.2.1.1.1 The Alliance’s Lethal Means Subcommittee will develop recommendations for safe storage programs for firearms, medications, mind-altering substances, and other means used across cultural groups using summarized and citation-specific evidence to be shared with state and county-level elected officials; developing suggested messaging and educational programming for explaining to children what the dangers are and develop safety planning.

2.2.1.3 OHA will advance equity in lethal means reduction by expanding efforts beyond firearms and medications to include other methods commonly used in diverse communities, beginning with community-engaged learning and planning around suicide-safer approaches to hanging means reduction.

2.2.1.3.1 ORBHIT will research and submit recommendations to OHA around safe storage for lethal means for culturally informed means reduction. These recommendations will be presented to the Oregon Alliance to Prevent Suicide’s Lethal Means Committee.

2.3 Protective programming

2.3.3 “Protective Policies” – Organizations have policies and procedures that increase protection against suicide risk (including passive risk, active risk, and crisis intervention), and those policies are implemented.

2.3.3.3 Oregon Department of Education will support a team of School Safety and Prevention Specialists assigned to support school districts with Adi's Act plans and implementation (in addition to other safety and prevention topics).

2.3.3.4 The Alliance's Schools Subcommittee will continue to monitor ongoing barriers, identify successful strategies, and assist in the distribution of options for better support used by districts to address suicide prevention, intervention, and postvention activities in their Adi's Act plans with a specific focus on populations named in the Student Success Act plans and students with disabilities.

2.3.3.4.1 The Alliance Schools Subcommittee will request an annual data presentation from OHA and ODE on student health, wellness, and educational experiences

2.3.3.5 LGBTQ2SIA+ Student Success Program, codified by SB 52 (2021), funds 1.0 FTE and $2M per biennium in grant funding to support Oregon communities to implement the LGBTQ2SIA+ Student Success Plan, which includes protective policies and increasing mental health supports for LGBTQ2SIA+ population Pre-K, K–12, and Post-Secondary.

2.3.3.5.2 ODE LGBTQ2SIA+ Student Success Coordinator will serve on and collaborate with the Oregon Alliance to Prevent Suicide's LGBTQ+ Advisory Group.

3 Treatment and crisis services

These goals and pathways seek to reduce suicide by focusing services and policies for those who experience suicidality or have been impacted by suicide loss. Other terms you might recognize include "indicated," "Tier 3 strategies," "intervention," or "postvention."

3.1 Healthcare coordination

3.1.1 "Coordinated transitions" – People in Oregon with suicide risk who access healthcare receive culturally responsive coordination between levels of care, tailored to culturally preferred pathways of help-seeking.

3.1.1.1 Policies and legislation about care transitions and coordination will be monitored and assessed through a culturally infused suicide prevention lens.

3.1.1.1.1 OHA will continue to implement and bring awareness to the recommendations of the 2022 HB 3090 Report in partnership with state partners (including Hospital Association of Oregon and Oregon Alliance to Prevent Suicide, etc.) and understanding of national partners.

3.1.1.1.1.1 The Alliance's Transitions of Care Subcommittee will continue to monitor recommendations from OHA's HB 3090 Resurvey Project report and work with OHA to recommend a follow-up Survey to be completed including attention to culturally infused strategies to determine current barriers to implementation of recommendations.

3.1.1.1.1.2 The Oregon Alliance to Prevent Suicide's Transitions of Care Subcommittee will create a workplan to assess challenges in transitions of care between systems and develop culturally congruent recommendations for 18–24-year-olds in these systems with particular focus on health disparities.

3.1.4 "Integrated care" – People in Oregon will receive culturally infused integrated care between primary care and behavioral healthcare (including school-based care for youth).

3.1.4.1 OHA will support the development of tools, resources, and processes for culturally infused suicide screening, risk assessments, and safety planning across sectors. These will integrate culturally responsive resources and referral processes, and integrate cultural idioms of distress into standard protocols for screening for suicide risk in schools to reduce cultural, linguistic, and systemic barriers to care for youth and their families.

3.1.4.1.3 OHA will facilitate a workgroup to develop culturally infused tools for school counselors and other mental health professionals in schools to equip them to screen for suicide risk.

3.1.4.1.3.1 OHA will consult with the Alliance's School Subcommittee on the development and ongoing updates of the toolkit.

3.3. Appropriate treatment and care of suicidality

3.3.1 "Equipped and well workforce" – The healthcare workforce is equipped, trained, and supported to address the suicide-related needs of the diverse communities they serve.

3.3.1.1 Oregon requires behavioral heath providers to receive suicide prevention training upon relicensure.

3.3.1.1.2 The Alliance's Workforce Subcommittee will monitor implementation of HB 2315 (2021) by reviewing OHA's annual report. The Alliance will submit recommendations regarding implementation of this legislation, including recommendations around expanded evaluation efforts.

3.3.1.1.3 The Alliance's Workforce Subcommittee will distribute a policy paper outlining pathways to equip physical health providers with training in suicide risk screening, assessment, treatment, and management. The paper will be used to educate legislators, community groups, and other stakeholders and will serve as the basis for recommendations to OHA. The Subcommittee will add addendums to future versions of the report so it is a living document.

4

Foundations and centering lenses

4.2 Evaluation

4.2.1 "Culturally responsive evaluations" – Suicide prevention efforts areregularly evaluated and updated to ensure cultural infusion and linguisticneeds are addressed.

4.2.1.1 The University of Oregon Suicide Prevention Lab receives funds to support evaluation efforts of OHA's Suicide Prevention team and the priorities named by the Alliance's Executive Subcommittee and provide implementation technical assistance across the YSIPP initiatives where possible.

4.3 "Policy needs/gaps" – The field of suicide prevention regularly assesses the need for changes in current policies (including legislative concepts, Oregon Administrative Rules, and organizational policies), accounting for equity-driven needs.

4.3.1 The Alliance will develop recommendations for policy priorities to OHA by Oct 1 annually.

4.3.1.1 The Alliance will identify needs and resources in culturally specific communities, service members and veterans, young people of color and rural women, around safe storage, suicide prevention and access to lethal means.

4.3.1.2 The Alliance will institutionalize the use of culturally infused practices—such as equity impact analyses, disaggregated data, input from cultural brokers, and community narratives—when making policy recommendations to OHA, with the equity subcommittee and its equity tool empowered to guide this work.

Example 2: YSIPP 26–30 Black Youth Suicide Prevention Coalition

This chart shows the YSIPP 26–30 initiatives led by the Black Youth Suicide Prevention Coalition (BYSPC), in the YSIPP 26–30 simple view.

You can view this chart on the online YSIPP 26–30 Tracker using the "BYSPC" filter.

2 Community-based suicide prevention

These goals and pathways seek to reduce suicide risk by promoting well-being and creating supportive communities for all people in Oregon. Other terms you might recognize here are "universal," "primary prevention," "upstream prevention," or "tier 1 strategies."

2.3 Protective programming

2.3.2 Culturally specific programming: People in communities disproportionately affected by suicide risk have access to culturally infused protective programming driven by their communities.

2.3.2.2 OHA will support culturally specific youth suicide prevention programming led by community partners.

2.3.2.2.4 OHA will support limited staffing and initiatives for BYSPC. BYSPC will develop a work plan for initiatives.

2.3.2.2.4.1 BYSPC will create and maintain The BYSPC Oregon Green Book, a culturally responsive guide that highlights:

- Black-centered mental health resources
- Local community organizations
- Curated Black history, literature and film.

2.3.2.2.4.2 BYSPC will host a cookout for Black youth to gather in community with no expectations beyond joy and presence.

2.3.2.2.4.3 BYSPC will support school-based chapters grounded in Black mental health awareness. These chapters will use culturally specific curriculum and training.

2.3.2.2.4.4 BYSPC will host an annual town hall focused on Black youth suicide prevention.

Example 3: YSIPP 26–30 Oregon Department of Education

This chart shows the YSIPP 26–30 initiatives that are led by the Oregon Department of Education (ODE), in the YSIPP 26–30 simple view.

You can also view this chart on the online YSIPP 26–30 Tracker by using the "ODE" filter.

1

Healthy and empowered individuals, families and communities

These goals and pathways seek to reduce suicide risk by promoting well-being and creating supportive communities for all people in Oregon. Other terms you might recognize here are "universal," "primary prevention," "upstream prevention," or "tier 1 strategies."

1.1 Integrated and coordinated activities

1.1.1 "Coordinated activities and organizations" – Suicide prevention programming is coordinated between Tribes, state, county, local leaders, and leaders in cultural communities to maximize reach and equitable access for all Oregonians. Organizations across diverse cultural communities are coordinated and are able to define their role in suicide prevention.

1.1.1.2 Regular, organized, responsive meetings are held to coordinate and collaborate on the work of youth suicide prevention.

1.1.1.2.2 The OHA-hosted Suicide Prevention, Intervention and Prevention team (SPIP) is established, and each subgroup meets quarterly. The three established subgroups are: OHA Suicide Prevention Coordinators, Youth Focused: State Agency Partners, and Youth Focused: OHA Partners.

1.1.1.2.2.2 "SPIP – State Agency Partners – Youth Focused": OHA hosts a quarterly meeting with state agencies to discuss Suicide Prevention initiatives and needs. State agency representatives from Oregon Youth Authority, Youth Development Oregon, Oregon Department of Education, Oregon Department of Human Services – Self Sufficiency, Oregon Department of Human Services – Child Welfare, and ODHS – Office of Developmental Disability Services.

1.1.1.2.3 Regular coordination meetings between contracted coordinators and specialists supporting Adi's Act implementation, Oregon Department of Education, and OHA coordinators are scheduled with each Education Service District.

1.1.3 "Equipped advisories" – Advisory groups are well supported, equipped, and function efficiently to make meaningful change and have diverse inclusion throughout the group, including leadership positions.

1.1.3.1 The Oregon Alliance to Prevent Suicide is the primary advisory group for Oregon's youth suicide prevention field.

1.1.3.1.3 The Oregon Department of Education and the Oregon Youth Authority will maintain a representative member on the Oregon Alliance to Prevent Suicide.

1.4 Coping and connection

1.4.3 "Support Roles" – People, family and caregivers in Oregon are empowered and equipped in their roles to prevent suicide for diverse communities in Oregon.

1.4.3.3 Adults who interface with youth in their community or workplace have opportunities to strengthen their skills around being a trusted adult for youth.

1.4.3.3.2 ODE will offer an annual suicide prevention educational opportunity to the Student Success Plan's Community of Practice that covers trainings available and suicide prevention policies and protocol resources for grantees.

2

Community-based suicide prevention

These goals and pathways seek to reduce suicide by focusing on strategic locations, groups, and sectors to promote well-being, to help navigate challenges, to decrease risk, and to recognize warning signs early. Other terms you might recognize here are "selected," "prevention," "primary intervention," or "tier 2 strategies".

2.3 Protective programming

2.3.3 "Protective Policies" – Organizations have policies and procedures that increase protection against suicide risk (including passive risk, active risk, and crisis intervention), and those policies are implemented.

2.3.3.1 Adi's Act requires that every school district in Oregon adopt a policy requiring a comprehensive suicide prevention, intervention, and postvention district plan. ODE will continue to support implementation of this important legislative mandate, including ways schools can address ways culture impacts suicide.

2.3.3.1.1 Provide implementation support to schools and districts to help translate Adi's Act suicide prevention plans into culturally infused practice, using partnership-driven strategies and practical tools such as a "10 Ways to Culturally Infuse Your Adi's Act Plan" guide.

2.3.3.1.2 ODE will empower School Safety and Prevention Specialists (SSPSs) to offer direct support to districts by reviewing Adi's Act plans and providing specific recommendations and teaming strategies for cultural infusion.

2.3.3.1.3 ODE will support initiatives that improve how well Adi's Act resources, policies, and plans equip schools to meet the needs of culturally diverse and high-risk student populations named in the legislation, including LGBTQ+ students, Native American/American Indian students, foster youth, youth with disabilities and others.

2.3.3.1.4 OHA and ODE will identify ways to highlight the importance of teaming as a key element of highly successful Adi's Act plan implementation.

2.3.3.1.5 The Willamette ESD and ODE will host a learning community focused on school-based crisis response. This meeting series will include at least two sessions focused on suicide postvention response and include scenarios and prompts that increase cultural considerations.

2.3.3.3 Oregon Department of Education will support a team of School Safety and Prevention Specialists assigned to support school districts with Adi's Act plans and implementation (in addition to other safety and prevention topics).

2.3.3.3.1 ODE will identify ways to increase school systems knowledge about potential increased risk for students involved with behavioral threat assessments and bullying incidents through training opportunities, and by adding culturally infused warning signs and screening questions to behavioral threat assessment checklists, protocols, policies, workflows, etc.

2.3.3.3.2 ODE will provide ongoing training, support, and collaboration to equip SSPSs to serve their region's districts by providing/facilitating trainings (including Big River programming) and offering resources and guidance in the areas of suicide prevention, intervention and postvention, Behavior Safety Assessments, and the prevention of bullying, harassment, intimidation, and sexual violence. Within the School Safety and Prevention System, SSPSs ensure that all supports are accessible to historically, traditionally, and currently underserved and marginalized students and youth through the development and implementation of the System in a manner that is designed to result in fewer disproportionate and more equitable outcomes.

2.3.3.5 LGBTQ2SIA+ Student Success Program, codified by SB 52 (2021), funds 1.0 FTE and $2M per biennium in grant funding to support Oregon communities to implement the LGBTQ2SIA+ Student Success Plan, which includes protective policies and increasing mental health supports for LGBTQ2SIA+ population Pre-K, K–12, and Post-Secondary.

2.3.3.5.1 ODE will release and fund the LGBTQ2SIA+ Student Success Grant Program through June 30, 2028.

2.3.3.5.2 ODE LGBTQ2SIA+ Student Success Coordinator will serve on and collaborate with the Oregon Alliance to Prevent Suicide's LGBTQ+ Advisory Group.

3

Treatment and crisis services

These goals and pathways seek to reduce suicide by focusing services and policies for those who experience suicidality or have been impacted by suicide loss. Other terms you might recognize include "indicated," "Tier 3 strategies," "intervention," or "postvention."

3.1 Healthcare coordination

3.1.4 "Integrated Care" – People in Oregon will receive culturally infused integrated care between primary care and behavioral healthcare (including school-based care for youth).

3.1.4.1 "Common tools" – OHA will support the development of tools, resources, and processes for culturally infused suicide screening, risk assessments, and safety planning across sectors. These will integrate culturally responsive resources and referral processes, and integrate cultural idioms of distress into standard protocols for screening for suicide risk in schools to reduce cultural, linguistic, and systemic barriers to care for youth and their families.

3.1.4.1.3 OHA and ODE will co-facilitate a workgroup to develop culturally infused tools for school counselors and other mental health professionals in schools to equip them to screen for suicide risk.

Appendix A

Definitions

Community helper

A person who:

- Watches for the well-being of others in places where people live, work, learn, play, or worship
- Notices people in suicidal distress
- Connects people with support and resources

“Community helper” is a preferred term instead of “gatekeeper.”

Cultural broker

A person who bridges cultural perspectives between communities and systems. They:

- Help ensure that suicide prevention efforts fit community culture
- Interpret language, values, beliefs and practices
- Interpret lived experiences that shape how people understand suicide risk, prevention, help-seeking, grief and healing

This role should be relational rather than transactional. It is built on mutual respect, ongoing collaboration and empowerment. It is not a one-time consultation or a symbolic gesture. Cultural brokers should be supported as partners, and not expected to represent entire communities on their own.

Cultural community

A group of people who may share a common identity based on:

- Race
- Ethnicity
- Sexual orientation
- Gender identity
- Religion
- Ability

Members may also share:

- Experiences
- Language
- Traditions
- Values
- Customs
- Beliefs
- Practices

Culturally congruent care

Health care that:

- Fits a person's cultural beliefs, values and practices
- Meets a person's needs and preferences
- Improves understanding, trust and effectiveness

Cultural infusion

As an approach, system or practice that:

Embeds preferred languages, cultural understandings, beliefs, values, practices and behaviors into its core foundation

- Incorporates research into its core foundation
- Addresses the lived experiences of diverse identities
- Promotes equity

Culturally responsive

An approach that:

- Recognizes and values diverse cultural understandings, beliefs, values, practices behaviors and research
- Goes beyond awareness of and sensitivity to act
- Adapts programs and methods to meet a person's cultural and linguistic preferences, contexts and needs
- Address the lived experiences of diverse identities
- Promotes equity

Equitable workforce

An approach that:

- Builds a workforce that reflects the cultural identities and needs of diverse and underserved people
- Ensures fair access to employment, advancement and pay
- Removes disparities and systemic barriers

Equity-driven

An approach that:

- Removes barriers and addresses inequities based on race, income, sexual orientation, gender, ability, or other cultural identities
- Supports empowerment for communities that have been historically underserved, oppressed or disproportionately affected

Healthcare providers or providers

People whose job involves providing services to people at risk for suicide, such as:

- Medical professionals
- Behavioral health clinicians
- Crisis response workers
- Peer support specialists
- Other direct service providers

Lethal means or means reduction

Refers to limiting or removing access to the methods used in suicide, which may include:

- Firearms
- Suffocation or hanging
- Poisoning or overdose
- Jumping from heights
- Carbon monoxide poisoning
- Intentional traffic collisions

The meaning and use of methods or locations can vary by culture. Effective suicide prevention requires addressing all methods to provide culturally responsive care for all communities.

Lived experience

Firsthand knowledge, understanding, and expertise gained through personal experiences with:

- Health inequities and challenges
- Social disparities and issues
- Other life experiences
- Lived experience within diverse cultural communities is invaluable in suicide prevention work and in reducing inequities.

Peripheral components of a training

Elements that make a training more welcoming and relevant for a specific community. These may include ways to:

- Register, recruit and orient participants
- Retain participants in ways that fit cultural practices and needs
- Use cultural examples and themes
- Choose materials, language, setup and structure that reflect community preferences

Suicidal ideation (cultural rationale)

The term “suicidal ideation” may be preferred to “suicide ideation” because:

- “Suicidal” covers a broader range of thoughts and behaviors
- Some cultures express distress indirectly through thoughts of death or self-destructive behaviors
- It includes experiences that may not explicitly mention suicide

Suicide safer care

An approach that reduces suicide risk. People at risk get care that is continuous, evidence-based and complete. Most often refers to health care settings. Key actions include:

- Make suicide prevention a responsibility for all staff
- Train staff to identify and respond to suicide risk
- Use clear policies and procedures to guide care
- Identify, treat, and follow up with people at risk for suicide

Appendix B

Additional resources

These resources are required in legislation to be included in any Oregon Youth Suicide Intervention and Prevention Plan. This list does not include all resources available for youth suicide prevention.

For more information on adult communities, refer to the Oregon Adult Suicide Intervention and Prevention Plan (ASIPP) 2023–2027.

Training

- "Youth Suicide Prevention Programming: The Big River"
- "Which Training Should I Take?"
- "Which Training Should I Take for School Staff?"

Schools

- "Suicide Prevention, Intervention, and Postvention: Step by Step" (includes postvention resources)
- "Suicide Screening Brief for School Counselors"
- Oregon Suicide Prevention Resource Directory, also called the "Resource Library" (includes postvention resources)

Appendix C

Social media use, youth mental health and suicidality: Key research findings and recommendations

Prepared for OHA by the University of Oregon Suicide Prevention Lab

The relationship between social media and youth mental health is not neutral. Evidence shows that excessive or harmful use of social media can increase risks of depression, anxiety and suicidality. This especially includes:

- Cyberbullying
- Exposure to self-harm content

However, social media can also offer connection, validation and support for vulnerable youth when used thoughtfully. A systems approach is needed addressing:

- Personal use
- Family support
- School policies
- Platform accountability
- Public regulation

Research from 2019–2025 shows key findings about the link between social media use and youth mental health and suicidality. The next sections list these findings and shares recommendations and best practices for the future.

Research findings

1. **Social media increases depression and suicidality**
    - A 2025 study of over 11,000 youth ages 9–10 found that increases in daily social media use (from 7 to 73 minutes) predicted higher depressive symptoms over three years (Nagata et al., 2025a).
    - Baseline depression did not predict future social media use (Nagata et al., 2025a).
2. **Amount and type of social media use affect risk**
    - Adolescents ages 14–17 who use social media more than 3 hours daily are twice as likely to experience depression and anxiety as youth who use it less (Twenge et al., 2018).
    - How youth ages 10–24 use social media strongly affects suicidality.

- Passive scrolling, negative social comparison and exposure to harmful content are particularly risky. These patterns predict suicidality more strongly than frequency alone (Keles et al., 2020; Marchant et al., 2018).

3. **Cyberbullying increases suicide risk**
   - Youth ages 11–12 who experienced cyberbullying were 2.6 times more likely to attempt suicide one year later (Nagata et al., 2025b).
   - Meta-analysis of more than 150,000 youth younger than 25 found that victims of cyberbullying had higher odds of suicidal ideation, attempts and self-injury (John et al., 2018).
4. **Online racism increases suicide risk**
   - Black adolescents ages 11–15 who experienced online racial discrimination had more post-traumatic stress disorder (PTSD) symptoms. This fully explained the link to suicidal ideation (Tynes et al., 2024).
   - College students who faced online racial discrimination showed more suicidal ideation and alcohol misuse (Polanco-Roman et al., 2023).
5. **Exposure to self-harm content increases suicide risk**
   - Youth ages 11–17 who were exposed to self-harm and suicide-related content had higher risks of ideation, planning and behavior (Daine et al., 2013; McTernan & Ryan, 2020).
   - Normalization of self-injury online further heightens risk (Mars et al., 2015).
6. **Girls, LGBTQIA2S+, and at-risk youth face higher risks**
   - Girls and LGBTQIA2S+ youth ages 11–22:
     - Engage more with emotionally charged content
     - Face more online harassment
     - Experience stronger mental health impacts from social media (Rideout et al., 2022; Gini et al., 2022)
   - Clinically vulnerable youth younger than 25:
     - Use social media more intensively
     - Engage with more negative content (Huang, 2022)
7. **Algorithms and new rules are starting to help**
   - Algorithms can push high-engagement, emotionally intense content. This can increase exposure to self-harm and disordered behavior for adolescents ages 13–19 (Montag et al., 2021).

- Policymakers are pushing for:
  - Age-appropriate defaults
  - Greater platform transparency
  - Content moderation standards (Nagata et al., 2025a)

8. **Trouble managing emotions increases suicide risk**
   - Difficulties regulating emotions link social media use to increased suicide risk. This is especially true for adolescents ages 14–18 who engage in emotionally intense or late-night use (Verma et al., 2023).
9. **Late-night social media use affects sleep and suicide risk**
   - Nighttime social media use shifts sleep to later times and makes for poorer sleep quality. This increases suicidal ideation in youths ages 12 to 17 (Hamilton et al., 2024).
10. **Too little sleep increases suicide risk**
    - Adolescents sleeping less than 8 hours on weekdays at age 11 had nearly twice the risk of suicide attempts by age 18. This is compared with youth sleeping more than 9 hours (Morthorst et al., 2025).

Social media best practices and recommendations

1. **Set usage boundaries**
   - Encourage teens to use social media for less than 30 minutes a day (AAP, 2021).
2. **Promote healthy nighttime habits**
   - To help teens get enough sleep and manage their emotions:
     - Limit social media use at night.
     - Set screen curfews.
     - Keep bedrooms free of devices (Verma et al., 2023; Hamilton et al., 2024; Morthorst et al., 2025).
3. **Monitor and respond to cyberbullying**
   - Use school-based digital tools to promote ethical behavior and report bullying.
   - Treat cyberbullying as a suicide risk factor.
4. **Reduce harmful content**
   - Platforms should block self-harm material.
   - Promote recovery-focused messages.
   - Use parental controls and artificial intelligence flagging tools.

5. **Address online racism**
    - Teach students to recognize and respond to online racism.
    - Track and stop race-based cyberbullying and microaggressions, especially in school and community platforms.
6. **Support safe and inclusive online communities**
    - Foster moderated peer support groups.
    - Train peer ambassadors.
    - Build inclusive spaces for LGBTQIA2S+ youth with anti-harassment protections.
7. **Teach digital literacy and emotional skills**
    - Include social media literacy in school lessons.
    - Teach youth to recognize algorithms, manage emotions and seek help.
8. **Support safe policies and regulations**
    - Require age restrictions, safety audits and platform transparency.
    - Encourage safety defaults for minors.

Key takeaways

- **Social media can both increase risk and offer protection for youth.**
    - This is especially true for those experiencing suicidality or self-harming behaviors.
    - Youth ages 25 and younger who self-harm tend to be more active online (Memon et al., 2018; Sedgwick et al., 2023).
- Platforms can:
    - Provide peer support
    - Offer opportunities for emotional expression
    - Share recovery stories
- These experiences help promote connection and reduce isolation (Balt et al., 2023; Daine et al., 2013; Rideout et al., 2022).
- **Social media can also expose youths to serious risks.**
    - Online communities may normalize or even promote self-harm and suicidal ideation.
    - Risks increase when users share:
        - Graphic content
        - Detailed self-harm methods

        - Messages that discourage help-seeking (Mars et al., 2015; Sedgwick et al., 2023)
    - Viewing this type of content can increase self-harming behaviors.
    - Youth are especially vulnerable when they feel emotionally overwhelmed or lack support offline.
    - Repeated exposure to suicide-related content can spread these behaviors, especially in emotionally charged and unmoderated spaces (Marchant et al., 2020; Nagata et al., 2025a).
- **Cyberbullying further increases risks.**
    - Victims of cyberbullying are much more likely to experience:
        - Depression
        - Self-injury
        - Suicidal thoughts and attempts (John et al., 2018; Nagata et al., 2025b)
    - LGBTQIA2S+ and female youth ages 11–18 face higher rates of cyber harassment. They also may experience more emotional harm from online interactions (Gini et al., 2022).
    - Trouble managing emotions and poor sleep link social media use to suicide risk in teens ages 16–19 (Chamarro et al., 2024).
    - Teens ages 14–17 who use social media late at night are more likely to have insomnia and difficulty coping with stress. Both increase suicide risk.
    - Prevention efforts should promote healthy sleep and limit nighttime screen use (Hamilton et al., 2024).
- **Overall key points**
    - Social media has both risks and benefits for youth mental health.
    - Platforms can support connection and healing if they are moderated and structured thoughtfully.
    - Platforms can also reinforce harmful behaviors and increase distress when risks are unchecked.
    - The connection between social media, vulnerable youth and suicidality is complex and changing.
    - There is no singular solutions Progress requires strategies to:
        - Reduce harm
        - Build digital skills
        - Provide emotional support

Appendix D

Scan of five states with the lowest rates of youth suicide: Lessons learned

Prepared for OHA by the University of Oregon Suicide Prevention Lab

UOSPL reviewed the policies, practices, programs and initiatives in the five states with the lowest youth suicide rates as of 2023 for ages 10–24. The five states ranked by the Centers for Disease Control and Prevention (CDC) crude suicide deaths per 100,000 youths, were:

- Connecticut (4.5)
- Massachusetts (4.8)
- New York (5.0)
- New Jersey (5.7)
- Maryland (6.7)

For comparison, Oregon had 13.5 deaths by suicide per 100,000 youth as of 2023.

The UOSPL scan used state-specific resources and materials collected from:

- The American Foundation for Suicide (AFSP) State Facts sheets
- The Suicide Prevention Resource Center (SPRC) State Suicide Prevention Infrastructure
- State-developed primary materials, such as suicide prevention plans, coalition websites and other state resources

Key findings of the scan

- All five states have suicide prevention coalitions, commissions, or councils with responsibilities and goals similar to the Oregon Alliance to Prevent Suicide. New Jersey and Oregon also have a youth-specific councils and plans (Youth Suicide Prevention Advisory Council; New Jersey Strategy for Youth Suicide Prevention 2015).
- Four states (Connecticut, Massachusetts, Maryland and New Jersey) require school staff or licensed school personnel to complete suicide prevention training (Krueze et al., 2018). Those states do not require training annually. New York has proposed legislation (Assembly Bill A1613) that requires annual suicide prevention training for school staff.

- Three states (Connecticut, New Jersey and New York) require school districts to have suicide prevention policies (National Association of State Boards of Education, 2020).
- Connecticut offers the Sandy Hook Promise program. This program connects students anonymously with crisis counselors 24 hours a day and 7 days a week. The program also allows for anonymous reporting.
- New Jersey passed the Anti-Bullying Bill of Rights in 2011. It includes strict reporting protocols, staff training and anti-cyberbullying measures.
- New York has the Zero Suicide Initiative in more than 500 mental health outpatient clinics that use the Zero Suicide model of care.
- New Jersey passed legislation (A1176) in 2023. It requires colleges and universities to provide:
  - Suicide prevention programs on campus
  - Crisis counselors for students at all times, in person or remotely

Appendix E

Scan of states with greatest decreases in youth suicide since 2018: Lessons learned

In addition to the scan of the five states with the lowest youth suicide rates as of 2023, a separate scan reviewed five states that had overall decreases in crude rates from 2018–2023. (Figure 2). These states include:

- Colorado (decrease of 3.5)
- Idaho (decrease of 4.4)
- South Dakota (decrease of 9.7)
- Utah (decrease of 4.1)
- West Virginia (decrease of 6.2)

Figure 2 shows how these five states compare to Oregon. Oregon had a decrease of 3.4 deaths per 100,000 youths from 2018–2023.

Key findings on the practices, policies, activities and initiatives of these five states

- All five states have a council, advisory board, non-profit or commission responsible that supports and coordinates suicide prevention and implements a state plan:
  - Colorado — Suicide Prevention Commission established in 2014
    - "Office of Suicide Prevention Annual Report (2021–22)"
  - Idaho — Idaho Council on Suicide Prevention established in 2006
    - "Idaho Suicide Prevention Plan (2019–2023)"
  - South Dakota — South Dakota Suicide Prevention (non-profit organization)
    - "South Dakota Suicide Prevention Plan (2020–25)" — Not available
  - Utah — Utah Suicide Prevention Coalition established in 2013
    - "Utah Suicide Prevention State Plan (2022–26)"
  - West Virginia — Prevent Suicide WV (Resource hub)
    - "West Virginia Prevention Strategic Plan (2021–24)"
- Three states (South Dakota, Utah and West Virginia) require non-annual suicide prevention training of licensed school staff. Idaho requires annual suicide prevention training for its school staff.

Colorado has its Sources of Strength program in more than 250 schools statewide.

The Utah Suicide Prevention Coalition LGBTQ+ workgroup developed the Utah "LGBTQ+ Suicide Prevention Plan (2020–2023)." It provides resources and an education hub for practitioners and community members to reduce the risk of suicide among the LGBTQ+ community in Utah.

Appendix F

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