



**Western University**  
OF HEALTH SCIENCES

College of Osteopathic Medicine of the Pacific  
COMP-Northwest

# Strengthening Community Suicide Intervention: A Cross-Sector Review for Rural Oregon Counties

Cecelia Mans OMS-III<sup>1, 2</sup>, Apoorva Singh OMS-III<sup>1</sup>, Gabriel Blanchet OMS-III<sup>1</sup>, Dr. Gina Miller, MD<sup>1</sup>

1. Western University of Health Sciences COMP– Northwest, Lebanon, OR
2. Claremont Graduate University, Claremont, CA

## OBJECTIVE

This review combines current evidence regarding suicide intervention approaches implemented across medical, educational, and first-responder systems to better address local suicide interventions in collaboration with the Suicide Care Coalition within Linn, Benton, and Lincoln Oregon counties.

## INTRODUCTION

- Suicide remains a leading cause of preventable death in the United States<sup>1</sup>
- Rural communities face unique barriers to timely and coordinated intervention<sup>1</sup>
- Primary care medicine frequently serves as the first point of contact for individuals in crisis, making cross-sector community collaboration essential<sup>15</sup>
- Understanding how communities function across medical, school, and first-responder systems is critical for improving early intervention and care continuity within suicide intervention services<sup>5</sup>

## METHODS

- Peer-reviewed articles published between 2015 and 2025 were identified through searches of PubMed using combinations of the following terms: “suicide intervention,” “best practice,” “suicidal ideation,” “self-harm,” and “suicide risk management” with Boolean operators (AND, OR) to narrow results
- Grey literature included practice guidelines and implementation frameworks not typically indexed in traditional databases
- Included publicly available resources from governmental public health agencies, international healthcare organizations, suicide prevention organizations, and institutional websites, including those of state and local public health departments
- Literature was included if it (1) focused on intervention rather than suicide prevention or management, (2) was peer-reviewed, (3) involved human participants, and (4) was published in English. Studies were excluded if they were (1) editorials, letters, or commentaries; (2) animal studies; (3) focused solely on non-suicidal self-injury without suicide outcomes; or (4) duplicates
- Grey literature sources were included if they provided evidence-based intervention guidelines, implementation frameworks, or practice recommendations from recognized public health authorities or suicide prevention organizations. Also reviewed for relevance to community-based suicide intervention implementation and evaluated for authority and credibility based on organizational reputation

## CONCLUSION

The evidence reviewed here supports a vision of suicide intervention that is integrated, continuous, and shared across institutional boundaries. The most effective interventions identified in this review operate with intersectionality that connects individuals in crisis to an unbroken chain of assessment, planning, treatment, and follow-up care. Advancing this model in Oregon will require evidence-based practices within each sector and sustained investment in cross-sector coordination, training infrastructure, and rural service capacity.

## SCHOOL- BASED INTERVENTION

### Results

- Universal student-centered programs (YAM, SOS) reduced suicide attempts by over 50% in randomized controlled trials<sup>12</sup>
- YAM’s five-session model significantly reduced both incident suicide attempts (OR 0.45) and severe suicidal ideation (OR 0.50) at 12-month follow-up in a sample of 11,110 participants<sup>12</sup>
- Gatekeeper training (QPR) and professional screening interventions did not significantly reduce suicide attempts compared to control conditions in the SEYLE trial<sup>12</sup>
- Of 14 school-based suicide intervention practices identified through the Best Practices Registry, only 3 were treatment-focused<sup>49</sup>

### Discussion

- Universal, student-centered approaches appear more effective than adult-mediated or screening-based models, suggesting that direct student engagement is a critical component of effective intervention
- Programs addressing both internalizing and externalizing symptoms may offer broader protective effects across diverse student populations
- Oregon’s Adi’s Act provides a strong statutory foundation, but implementation quality likely varies across districts, particularly in rural areas with fewer behavioral health resources
- Reentry planning and mandatory same-day parental notification reflect best practices for continuity of care following acute crisis contact

Qualities	Program		
	SAIT	SafeSide Program	PREPaRE Crisis Prevention and Intervention
Type	Education/Training	Education/Training	Education/Training
Setting	Online, Community, Healthcare facility, Mental health facility, School	Online, Community, healthcare facility, Mental health facility, Residential facility, School, transition between setting	Community, School
People	Mental Health professionals	Mental Health professionals, Medical professionals	Mental Health professionals
Prevention Level	Treatment Care	Prevention, Treatment Care, Maintenance	Prevention, Treatment Care
Language	English	English	English
Study Method	Mixed Methods	Quantitative, Qualitative, Mixed Methods	Quantitative, Mixed Methods
Implementer Requirement	Experts through lived experience, Mental health providers	Adults, experts through lived experiences, peer consultants	Professional educators, higher education or postsecondary programs, mental health providers
Training Requirement	Yes	Yes	Yes
Delivery Options	In-person, virtual, hybrid	In-person, virtual, hybrid	In-person, virtual, hybrid
Topics	Improve provider attitudes, knowledge skills	Reduce risk factors, promote protective factors, improve community factors, improve healthcare system quality, improve communication about suicide, improve provider attitudes, knowledge, skills	Improve suicide care, improve provider attitudes, knowledge, skills

Table 1: Comparison of Suicide Intervention Training Programs for School Settings

	Crisis Intervention Team (CIT)	Co-responder Model	Safety Planning Intervention (SPI)
Model type	Law enforcement training program (40-hour)	Officer + mental health clinician joint response	Structured brief intervention tool (patient-centered)
Primary setting	Patrol response / street crisis	Patrol response / street crisis	Emergency department; first responder handoffs
Evidence strength	Moderate	Strongest	Strongest
Key outcomes	↑ De-escalation (OR 2.00); ↑ referrals (OR 1.70); ↓ arrests (OR 0.47)	↓ ED admissions (32% vs 45%); ↓ use of force; ↑ community referrals	~30–45% reduction in suicidal behaviors vs usual care
Suicide-specific impact	Mixed — limited effect on crisis outcomes in isolation	Positive — benefits sustained at 1-month follow-up	Positive — strongest evidence base for acute suicide risk
Known gaps	Inconsistent training; QPR improves attitudes but not behaviors	Rural access limited; requires sustained interagency coordination	EMS protocols rarely include SPI; ~1/3 of WA counties lack suicide-specific protocols

Evidence drawn from Compton et al. 2014; Marcus & Stergiopoulos 2022; Every-Palmer et al. 2023; Stanley et al. 2018; Douplik et al. 2020; DeCou et al. 2020. Table 2: Comparison of First Responder-Based Suicide Intervention Models

## FIRST RESPONDER- BASED INTERVENTION

### Results

- Co-responder models reduced emergency department admissions from 45% under usual care to 32%, with benefits sustained one-month follow-up<sup>32</sup>
- Crisis Intervention Team (CIT) trained officers were significantly more likely to use verbal engagement (OR 2.00), refer individuals to mental health services (OR 1.70), and less likely to make arrests (OR 0.47)<sup>33, 34</sup>
- Structured follow-up contact and caring text messages over one year reduced subsequent suicide attempts by approximately 50%<sup>41</sup>
- Only one-third of EMS counties in Washington State had suicide-specific protocols, with most guidance limited to scene safety and transport<sup>43</sup>

### Discussion

- Co-responder models consistently outperform CIT-only approaches, suggesting that embedding mental health professionals directly into crisis response produces superior outcomes compared to training law enforcement alone
- The near-absence of suicide-specific EMS protocols represents a critical and under-addressed gap, given that EMS personnel are frequently the first clinical contact in a suicidal crisis
- Warm handoffs, advance communication with receiving facilities, and structured follow-up should be standardized across all first responder disciplines rather than left to individual discretion
- Rural access to mobile crisis teams and co-responder programs in Oregon remains inconsistent, creating geographic disparities in the quality of acute crisis intervention available to Oregon residents

## MEDICAL- BASED INTERVENTION

### Results

- 79.2% of Joint Commission-accredited hospitals screen all patients for suicide risk, and 65.1% have implemented comprehensive suicide prevention frameworks<sup>25</sup>
- Only one study demonstrated that universal screening combined with safety planning and follow-up reduced suicide attempts and deaths, limited by small sample size<sup>23, 26</sup>
- Safety Planning Intervention (SPI) outperforms no-suicide contracts across acute care settings, supporting its use in risk stratification, discharge planning, and lethal means counseling<sup>23, 28, 29</sup>
- Lithium reduces suicide attempts and mortality in mood disorders; SSRIs are preferred over tricyclics due to lower overdose lethality<sup>23, 28</sup>
- Outpatient follow-up within seven days of discharge is associated with decreased suicide risk in children and adolescents<sup>23, 30</sup>

### Discussion

- The widespread adoption of universal screening currently outpaces the evidence supporting it, highlighting the need for larger trials before universal screening can be recommended with confidence
- Safety planning should be treated as a required discharge component rather than an optional supplement, given its consistent evidence base across settings
- Psychiatric bed shortages and prolonged emergency department boarding represent systemic barriers to timely intervention that pharmacologic and psychotherapeutic evidence alone cannot address
- Oregon’s statutory requirements (ORS 441.053, OAR 333-520-0070) align well with evidence-based practices, providing a regulatory framework that supports clinician accountability and patient safety<sup>23, 30</sup>

## REFERENCES

Scan QR code



Or email [cecilia.mans@westernu.edu](mailto:cecilia.mans@westernu.edu) for list of references