2016

House Bill 4124: Annual Youth Suicide Intervention and Prevention Plan Report to the Legislature

Oregon Health Authority

HEALTH SYSTEMS DIVISION

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Executive summary

This report provides an annual update to the Legislature concerning implementation of the Oregon Youth Suicide Intervention and Prevention Plan 2016–2020 as mandated by ORS 418.704.

It is too soon to see measurable impacts resulting from the implementation of the state Youth Suicide Intervention and Prevention Plan. The five-year plan is designed to decrease the risk and increase protective factors in youth's lives and change how health systems address the problem of suicide among their patients, staff and medical and behavioral health professionals. Some activities in the plan have begun, however, the overall scope is very broad and a variety of the strategies will need additional resources to implement statewide. The plan anticipates simultaneously reaching children, youth and young adults, their parents, and communities in a set of interrelated activities where youth touch systems, caregivers and their communities. The plan also calls for implementation of a Zero Suicide initiative in health systems and in other institutions. Zero Suicide, an aspirational goal of the plan, is a promising strategy that brings high level institutional leadership and support to reduce suicide through top-down, comprehensive, systems-wide interventions.

In September of 2016, the Oregon Health Authority (OHA) chartered and convened the Oregon Alliance to Prevent Suicide (Alliance) to assist OHA in full implementation of the state plan. The plan is funded in some counties by the Garrett Lee Smith Memorial Act Youth Suicide Prevention and Early Intervention grant. It is also funded through community mental health programs that receive state and federal grants to provide services and outreach to high-risk youth. Counties are beginning to use post-suicide interventions (postvention) to aid those left behind with grieving and to reduce the high risk of suicide experienced by those living with that loss.

In November of 2016, the Director of the Oregon Health Authority chartered and launched an agency-wide suicide prevention initiative to elevate the issue of suicide. The members guiding this initiative, in collaboration with the Alliance, will begin meeting monthly in January 2017. The initiative will use data and measurement strategies to focus, monitor and coordinate progress.

Introduction

Oregon's rate of youth suicide per 100,000 population ranked 12th highest among U.S. states in 2013–2014. Oregon's rate of completed suicide among 10–24 year olds remained stable in 2015, with a slight decrease in overall deaths (90 in 2014 compared with 84 in 2016). The slight decrease in the number of deaths as of December 2015 did not include deaths among Oregon resident youth outside of Oregon.

It is too soon to see measurable impacts resulting from the implementation of the state Youth Suicide Intervention and Prevention Plan. The five-year plan is designed to decrease the risk and increase protective factors in youth's lives and change how health systems address the problem of suicide among their patients and families, staff, and medical and behavioral health professionals. Some activities in the plan have begun, however, the overall scope is very broad and a variety of the strategies will need additional resources to implement statewide. The plan anticipates simultaneously reaching children, youth and young adults, their parents and communities in a set of interrelated activities where youth touch systems, caregivers and their communities. The plan also calls for implementation of a Zero Suicide initiative in health systems and in other institutions. Zero Suicide, an aspirational goal of the plan, is a promising strategy that brings high level institutional leadership and support to reduce suicide through top-down, comprehensive, systems-wide interventions.

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State Suicide Intervention and Prevention Plan implementation

Section 2 of HB 4124 (2014) requires the Youth Suicide Intervention and Prevention Plan be updated at a minimum of every five years. Significant progress has been made with funding provided by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) through the Garrett Lee Smith Memorial Act (see below). Additionally, Alliance committees have been formed and are actively addressing continuity of care, workforce development, outreach and awareness, policy and legislation, and data and evaluation. An ad hoc committee will review Alliance recommendations or policy proposals for relevancy to cultural issues pertaining to groups at disproportionate risk of suicide, including Native Americans; lesbian, gay, bisexual, transgender and queer (LGBTQ) populations; young military members, veterans and their families; people who have experienced the death of a loved one (loss survivors); individuals who have survived a suicide attempt; and racial and ethnic minorities. The full plan is available at www.tinyurl.com/hr94228.

Subject matter experts from geographically diverse areas who volunteer for the Alliance include:

- Parents and youth
- Suicide loss and attempt survivors
- Legislators
- Clergy
- Law enforcement
- Coordinated care organizations (CCOs) and private insurers
- Behavioral health and primary care providers
- Health systems and hospitals
- Foster parents
- Prevention specialists
- Substance abuse providers

- Adults living with behavioral health issues
- Community mental health programs
- Oregon Department of Education, education service districts and schools
- School-Based Health Centers (SBHCs)
- LGBTQ individuals
- Tribal members, African Americans and Latinos
- Oregon National Guard and the state Department of Veterans Affairs
- Oregon Department of Human Services, Child Welfare
- Oregon Youth Authority

Other activities in 2016 (Items in parentheses refer to specific objectives in the plan.)

- Trauma Informed Oregon is working on materials analyzing impacts of trauma and suicide and will update its trainings to include trauma and suicide in 2017. (6.1.j., 7.2.b., 9.1.c., 9.1.d.)
- The Oregon Pediatric Society is expanding its provider training program to include suicide risk assessment, safety planning and lethal means counseling in at least five classroom trainings and webinars in 2017–2019. (6.1.i.)
- Lines for Life, Youth MOVE Oregon, Reachout.com, a team of youth and other stakeholders are developing a youth-informed strategic plan by September 2017 to promote safe online spaces for youth. (2.3.a.)
- SB 561, which mandates post-suicide information-sharing and response activities in all Oregon counties (4.1.d.) is being implemented. Rules were promulgated in 2016. Forty four suicides of individuals 24 years of age and younger were reported to OHA within seven days of death, as required by law. As the program ramped up in 2016, OHA identified communities with disproportionate suicide rates and has provided technical assistance.
- The Sources of Strength peer-led school prevention program is underway in Linn and North Clackamas school districts. (6.1.c.)
- Three pilot sites have been identified for the CONNECT suicide postvention training program (6.1.k.), Linn-Benton-Lincoln, Umatilla and Malheur counties. All three counties will implement CONNECT by summer 2017 and a train-the-trainer program will allow expansion over time.

Report on Garret Lee Smith Grant activities in 2016

There are many action items in the plan related to the Garrett Lee Smith (GLS) federal grant to Oregon. The following section reports on activities completed in year 2 of the five-year SAMHSA GLS Youth Suicide Prevention and Early Intervention grant.

There are four Oregon Caring Connections Initiatives (OCCI) under the Garrett Lee Smith grant. The initiatives are funded in Deschutes, Jackson, Josephine and Washington counties with Umatilla joining on Oct. 1, 2016.

The prevention activities in the OCCI include:

1. Gatekeeper training through Applied Suicide Intervention Skills Training (ASIST), Question, Persuade and Refer (QPR) and web-based training known as Kognito (Each training focuses on skills needed by the public or professionals in assessing suicide risk.)
2. Clinical professionals trainings in Assessing and Managing Suicide Risk (AMSR)
3. Improving county crisis response plans and continuity of care
4. Implementing Zero Suicide through health systems in one large urban county
5. Promoting the National Suicide Prevention Lifeline (NSPL)

Each county achieved and exceeded the target for one training per quarter (below).

Completed QPR, ASIST and safeTalk trainings and persons trained in year 2				
County	**QPR**	**ASIST**	**safeTALK**	**Total**
Deschutes	10 (376)	2 (74)		12 (450)
Jackson	14 (358)	9 (205)*	1 (17)	24 (580)
Josephine	2 (42)	3 (61)		5 (103)
Washington	*Funded by other sources*			
YSP Conference	1 (17)			
Total	**27 trainings (793 people)**	**14 trainings (340 people)**	**1 training (17 people)**	**41 trainings (1,133 people)**

* Includes one ASIST training of trainers with 15 participants

The OCCI provides Kognito gatekeeper training through web-based services.

Kognito gatekeeper training			
Type of setting	Locations	Licenses activated	Users completed training
Schools (Y1 and 2)	16+	341	234
Emergency departments (Y2)	3	5	4
Josephine	2 (42)	3 (61)	
Primary care providers/School Based-Health Centers (Y2)	5+	31	17
Total	**26+**	**380**	**255**

County projects completed other types of trainings in prevention and early intervention skills for persons who work with youth at risk for suicide. Trainings highlight best practices such as CALM (Counseling on Access to Lethal Means), suicide prevention programs and Response prevention planning in school settings, and Mental Health First Aid gatekeeper training for an overview of mental health problems in children and youth.

	Type of training			
County	CALM	School-based response	Mental health first aid	Year 2 total
Jackson	1 (22)		Data collection not complete	1 (22)
Josephine	1 (30)	11 (376)		12 (406)
Washington	2 (38)			2 (38)
Other	2 (50)*			2 (50)
Total	**6 (140)**	**11 (376)**		**17+ trainings (516+ people)**

* Includes one CALM training of trainers with 32 participants

AMSR trainings		
Date	**Location**	**Clinicians trained**
07/12/2016	Deschutes	49
10/30/2015	Jackson	42
03/30/2016	Josephine	41
08/05/2016	Malheur	47
09/16/2016	Lane	51
09/22/2016	Multnomah	46
Year 2 total	**6**	**276**
2/27/2015	Washington	49
Total to date	**7**	**325**

Target: Complete 11 trainings and 550 participants by Dec. 29, 2019

The project received permission in June 2016 from SAMHSA to redirect unspent funds from the first year of the grant to host a statewide youth suicide prevention conference held in Portland on Sept. 22 and 23, 2016. The conference was sited in Portland to coincide with the convening of the Alliance meeting that was also held that week. This enabled Alliance members who were participants and presenters at the conference to attend both events. There were 17 sessions held during the conference with 607 participants.

Statewide Youth Suicide Prevention Conference participants per session	
17 sessions	**Participants**
Zero Suicide	140
Youth Voices: Hearing from Young People on the Front Lines	51
Lessons from Teens After a Suicide	49
AMSR	46
School & Mental Health Suicidal Ideation Protocol	41
Connect: Suicide Postvention	38
CALM training of trainers	32
Senate Bill 561	27
Dialectic Behavioral Therapy	25

Statewide Youth Suicide Prevention Conference participants per session	
17 sessions	Participants
Safety Planning & Means Restriction	24
Intervention Skills Training: ASIST, QPR, Response, Youth MHFA	24
Native American Evidence Based Practices	21
Zero Suicide: Boots on the Ground, a Local Perspective	19
Providers & Family Communicating to Save Lives	19
CALM	18
QPR	17
Cumulative total	**607**

Cumulative initiative accomplishments from October 2014 through September 2016 include work in five key strategies:

1. **Gatekeeper trainings:**
   - ASIST, QPR, safeTALK: 1,333 gatekeepers at 41 trainings
   - Kognito: 255+ gatekeepers at 24 schools, emergency departments and SBHCs
   - Other: Counseling on Access to Lethal Means (CALM), school-based response, Mental Health First Aid, Youth Suicide Prevention Conference
2. **Clinical trainings:**
   - AMSR: 278 clinicians at six locations
3. **Crisis response and continuity of care:**
   - Enhancing plans and systems in more than four counties
4. **Zero Suicide:**
   - Currently in one large urban county and elsewhere around state
5. **National Suicide Prevention Lifeline (NSPL):**
   - Ongoing promotion in multiple venues around state

The impact of the GLS grant spans a variety of service delivery systems. Two GLS counties have embedded mental health professionals in hospitals, schools and, in one case, a primary care clinic to ensure youth at risk of suicide are identified, treated and followed-up. Another has intensive follow-up care for youth who have been seen in an emergency department for suicide attempts,

and for their families. Lifeworks Northwest, the behavioral health agency for Washington County, is implementing Zero Suicide. These counties are ensuring suicidal patients have counseling to reduce access to lethal means. A grant-funded education consultant is working with schools statewide to increase use of suicide prevention protocols, guidelines, training and education. Some hospitals and behavioral health agencies now use evidence-based screening tools. The grant has paid for statewide ASIST and AMSR trainings to increase the ability and confidence among mental health professionals to recognize, treat and manage suicidal patients. (Education and training for suicide prevention generally is not offered in graduate programs for mental health and social work.) The funding is used for evidence-based practices across health systems and additionally, has reached beyond to other counties and the state level.

Report on specific action items in the plan

Listed below are the legislatively mandated sections of the plan, followed by a bulleted list of action items underway.

Section 1

Section 1 (2)(a): A suicide intervention and prevention coordinator was hired as of Dec. 1, 2014.

Section 1 (2)(b): Outreach to special populations

OHA is collaborating with a wide range of special populations, including members of the Alliance (see above).

Section 1 (2)(c): Identify barriers to accessing intervention services

Action items in the plan address barriers to accessing intervention services. This includes:

1. Improving discharge and safety planning for youth in emergency or inpatient care.
    - Rules for Psychiatric Emergency Services promulgated in 2016 include best practices in safety planning, lethal means counseling and risk assessment.
2. Training for behavioral and physical health providers in conducting timely best practice suicide risk assessments, intervention and treatments.
    - Oregon Pediatric Society and Trauma Informed Oregon are working on curriculum changes to include suicide best practice risk assessment, lethal means counseling and safety planning.

3. Welfare checks with youth and families within 48 hours after being seen for suicidal ideation or an attempt.
    - Assigned to Alliance.
4. Determining the length of time between emergency department release and the initiation of outpatient therapies after assessments.
    - Pending.
5. Establishing guidelines for use of peer and family support for at-risk youth.
    - Assigned to Children's System Advisory Committee, underway.

Section 1 (2)(d): Technical assistance

Status: Ongoing

Progress:

Section 1 (2)(d): Requires the HSD suicide intervention coordinator to provide technical assistance to state and local partners. Since December 2014, the coordinator has provided technical assistance on best practices to the Youth Suicide Prevention Listserv moderated by the Public Health Division, which reaches more than 300 individuals statewide. Technical assistance has been offered to community mental health programs with SB 561 (2015) and best practices in suicide postvention. Additional technical assistance was provided to behavioral health staff and providers, suicide prevention advocates and prevention specialists, parents, youth organizations, state programs, adults living with mental illnesses, attempt and loss survivor support group leaders, among others.

Section 2

Section 2 (1): Recommendations for access to mental health intervention, treatment and supports for depressed and suicidal youth.

Status: Ongoing

Progress:

- An Emergency Department Diversion pilot project (EDD) is underway to follow up with youth and families after release from emergency departments in Multnomah, Clackamas, Marion and Deschutes counties. The pilot aims to ensure safety and warm handoffs to outpatient care and family support services and to avoid readmittance to an emergency department in the future. The pilot will expand to Washington, Benton and Jackson counties and the Oregon Health Science University will evaluate the pilots in 2017.

- A diverse work group formed by Rep. Alissa Keny-Guyer is looking at ways to address discharge planning at release from emergency departments.
- Guidelines are being developed by the Children's Services Advisory Committee concerning use of peer and family supports in suicide intervention and treatment.

Section 2 (2): Recommendations to improve access to care and supports, including affordability, timeliness, cultural appropriateness and availability of qualified providers.

Status: Ongoing

Progress:

- The Alliance is establishing priorities and a public policy agenda to guide implementation of the plan over five years, including recommendations for provision of consistent statewide use of suicide risk assessment and crisis counseling tools.
- The Alliance will review all recommendations for cultural appropriateness.
- Trauma Informed Oregon is supplementing trauma-informed care with suicide prevention strategies.

Section 2 (3) Recommendations including best practices to identify and intervene with youth who are depressed, suicidal or at risk of self-injury.

Status: Ongoing

Progress:

- The Oregon Pediatric Society's trainings for primary care physicians on depression and substance use screening are being expanded to include best practices in risk assessment, safety planning and lethal means counseling.

Section 2 (5): Recommendations for use of social media for intervention and prevention of youth suicide and self-inflicted injury.

Status: Ongoing

Progress:

- A work group is developing a youth-informed strategic plan by September 2017 for safe online spaces for youth.

Section 2 (6): Recommendations to respond to schools and communities following completed youth suicides.

Status: Ongoing

Progress:

- The youth suicide intervention and prevention coordinator provides technical assistance and disseminates best-practice guidelines on activities after a suicide (postvention) to schools, community groups and a wide range of community members.
- The coordinator works with community mental health programs to establish information-sharing protocols at the local and state levels. These postvention activities (SB 561), include rulemaking and reporting deaths of individuals 24 years old or younger to OHA within seven days of the death.

Section 2 (7-8). An analysis of intervention and prevention strategies used by states with the five lowest suicide rates.

Status: Completed

Progress:

- A comparison of Oregon's youth suicide rates with other states was provided in the plan. Current rankings are included in the statistics reported below.

Section 2 pending action items requiring additional resources to complete

Section 2 (4). Recommendations for collaborations among schools, school-based health clinics and CCOs for school-based programs.

Status: Pending

Progress:

- Stakeholders are examining laws on confidentiality to promote information sharing across systems (mental health, substance use treatment and schools) and with families and families of choice.

Section 2 (3) Recommendations including best practices to identify and intervene with youth who are depressed, suicidal or at risk of self-injury.

Status: Ongoing

Progress:

- An analysis is needed to determine the types of risk assessments used in medical and behavioral health care settings and to disseminate best practices.
- Limited training is underway and additional training, including continuing education, is needed for medical and behavioral health providers in best practices for assessing, managing and treating individuals at risk for suicide or self-harm, and best practice risk assessment, safety planning and lethal means counseling
- Counties participating in the Garrett Lee Smith suicide prevention grant are offering Assessing and Managing Suicide Risk (AMSR) trainings to clinicians.

Section 3

Section 3: Review data and prepare an annual report to the Legislature

Status: Ongoing

Progress:

The following data analysis addresses Section 1 (3)(a-g) as specified in the legislation. The data below include the number of youth and young adults aged 10 to 24 who completed suicide and who were hospitalized due to self-inflicted injury.

Basic facts*,†

- Suicide is the second leading cause of death among youth aged 10 to 24 years in Oregon.
- Overall, Oregon suicide rates were higher than the U.S. rates in the past decade; Oregon suicide rates rose after 2011 (Figure 1).
- From 2013 to 2014, Oregon youth suicide rate ranked the 12th highest among all U.S. states.
- Male youth were four times more likely to die by suicide than female youth.
- Suicide rates increased with age. The rate increased from approximately 1.0 per 100,000 among youth aged 10 to 14 years to 16.0 per 100,000 among youth aged 20 to 24 years.
- Suicide rate among male veterans was more than four times higher than non-veteran males.

* Oregon Public Health Division, Oregon Violent Death Reporting System. Suicides in Oregon: Trends and Associated Factors, 2003-2012.

† The CDC WISQARS

Figure 1. Suicide rates among youth aged 10 to 24 years, U.S. and Oregon, 2003–2015**

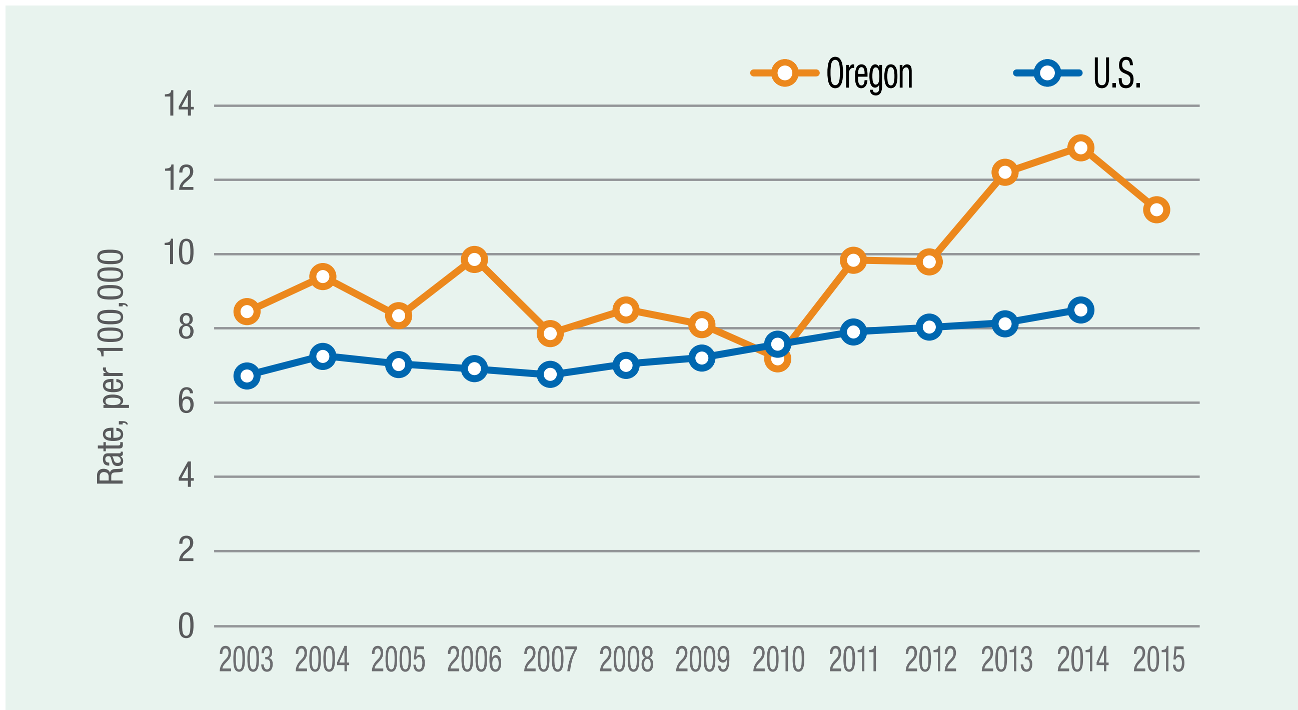

Table 1. Comparison of suicide completion rates per 100,000, Oregon and the U.S., 2003–2015**

Year	Oregon	U.S.
2003	8.4	6.74
2004	9.4	7.26
2005	8.3	7.04
2006	9.9	6.9
2007	7.9	6.75
2008	8.5	7.04
2009	8.1	7.21
2010	7.2	7.57
2011	9.8	7.91
2012	9.8	8.02
2013	12.2	8.15
2014	12.9	8.51
2015	11.2	*

Rates are deaths per 100,000

* 2015 U.S. data are not available.

** Preliminary 2015 data available at publication may not reflect deaths of Oregon youth occurring out of state.

Source: accessed online CDC WISQARS

Common risk factors:

- Mental illness and substance abuse
- Previous suicide attempts
- Interpersonal relationship problems/poor family relationships
- Recent criminal legal problem
- School problem
- Exposure to a friend or family member's suicidal behavior

Table 2. Common circumstances surrounding suicide incidents, Oregon, 2013–2014

Circumstance	Count	%
Mental health status		
Mentioned mental health problems*	139	76
Diagnosed mental disorder	80	44
Problem with alcohol	18	10
Problem with other substance	34	19
Current depressed mood	107	58
Current treatment for mental health problem**	51	28
Interpersonal relationship problems		
Broken up with boy/girlfriend, Intimate partner problem	59	32
Suicide of family member or friend within past five years	5	3
Family stressor(s)	38	21
History of abuse as a child	10	5
Life stressors		
A crisis in the past two weeks	53	29
Job problem	15	8
Recent criminal legal problem	17	9
School problem	14	8
Suicidal behaviors		
History of expressed suicidal thought or plan	74	40
Recently disclosed intent to die by suicide	49	27
Left a suicide note	59	32
History of suicide attempt	43	23

* Include diagnosed mental disorder, problem with alcohol and/or other substance, and/or depressed mood.

** Include treatment for problems with alcohol and/or other substance

Source: Oregon Violent Death Reporting System, Injury and Violence Prevention Program, Public Health Division, OHA

In 2014:

- Eighty-four suicides occurred among Oregon youth aged 10 to 24 years.
- The majority of suicides occurred among males (77%), Whites (80%) and those aged 20–24 years (55%). Thirty-eight of them were elementary, middle school and high school students.
- Firearms, suffocation (hanging) and poisoning are the most frequently observed mechanisms of injury in suicide deaths. Firearms alone accounted for 48% of deaths.

Table 3. Characteristics of suicide completions among youth aged 10 to 24, Oregon, 2014

Age	10–14	5	6%
	15–19	33	39%
	20–24	46	55%
Sex	Male	65	77%
	Female	19	23%
Race/ethnicity	White	67	80%
	African American	4	5%
	Am. Indian/Native Alaskan	3	4%
	Asian/Pacific Islander	6	7%
	Multiracial	4	5%
	Other/unknown	0	0%
	Hispanic	6	7%
Student status	Middle school	4	5%
	High school	14	17%
Mechanism of death	Firearm	40	48%
	Hanging/suffocation	29	35%
	Poisoning	5	6%
	Other	10	12%
Other	Veteran	5	6%

Source: Oregon Violent Death Reporting System

Suicide attempts‡

- Each year, more than 500 Oregon youth aged 10 to 24 years are hospitalized for the self-inflicted injury/attempted suicide. There were 529 youth hospitalizations in 2015 (Table 4).
- In contrast to suicide, females were far more likely to be hospitalized for suicide attempt than males.

Table 4. Numbers and percentage of self-harm hospitalizations and completed suicide deaths among youth aged 10 to 24 years by county and statewide, Oregon, 2015

County	Hospitalizations*		Deaths**	
	Count	% of total	Count	%
Baker	2	0.4	1	1.2
Benton	6	1.1	3	3.6
Clackamas	51	9.6	10	11.9
Clatsop	8	1.5	0	0.0
Columbia	11	2.1	0	0.0
Coos	14	2.6	2	2.4
Crook	1	0.2	1	1.2
Curry	1	0.2	1	1.2
Deschutes	27	5.1	3	3.6
Douglas	9	1.7	2	2.4
Gilliam	0	0.0	0	0.0
Grant	0	0.0	0	0.0
Harney	1	0.2	1	1.2
Hood River	0	0.0	0	0.0
Jackson	31	5.9	9	10.7
Jefferson	2	0.4	1	1.2
Josephine	10	1.9	2	2.4
Klamath	8	1.5	3	3.6
Lake	1	0.2	0	0.0
Lane	49	9.3	3	3.6
Lincoln	8	1.5	2	2.4
Linn	16	3.0	3	3.6
Malheur	0	0.0	2	2.4

‡ Oregon Public Health Division, Injury and Violence Prevention Program. Injury in Oregon, 2013 injury data report.

County	Hospitalizations*		Deaths**	
	Count	% of total	Count	%
Marion	44	8.3	6	7.1
Morrow	5	0.9	1	1.2
Multnomah	108	20.4	17	20.2
Polk	14	2.6	0	0.0
Sherman	0	0.0	0	0.0
Tillamook	1	0.2	1	1.2
Umatilla	4	0.8	0	0.0
Union	1	0.2	2	2.4
Wallowa	1	0.2	0	0.0
Wasco	2	0.4	0	0.0
Washington	76	14.4	6	7.1
Wheeler	0	0.0	0	0.0
Yamhill	17	3.2	2	2.4
State	*529*	*N/A*	*84*	*N/A*

* Due to switch from ICD-9 to ICD-10 CM after Oct. 1, 2015, counts only include from January to September in 2015.
** Deaths among Oregon residents that occur out-of-state may not be included.
Source: Injury and Violence Prevention Program, Oregon Public Health Division; Oregon Hospital Discharge Index

Suicidal ideation§,**

- Approximately 17% of eighth graders and 11th graders reported seriously considering suicide in the past 12 months in 2013.
- Nearly 10% of eighth graders and 8% of 11th graders self-reported having attempted suicide one or more times in the previous 12 months in 2013.
- Female students were more likely to report seriously considering suicide and having attempted suicide than male students.

§ Oregon Health Authority, Health Systems Division. 2014 Student Wellness Survey.

** Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance – United States, 2013.

Suicide rates among youth aged 10 to 24 years by state, U.S. 2013–2014

State	Deaths	Crude Rate
Alaska	83	25.52
North Dakota	67	20.72
South Dakota	70	20.06
Montana	79	19.71
Wyoming	45	19.12
New Mexico	132	15.25
Vermont	38	15.09
Idaho	101	14.51
Utah	204	14.19
Colorado	293	13.67
Maine	61	12.88
Oregon	**189**	**12.56**
Oklahoma	197	12.18
Arkansas	143	11.83
Hawaii	60	11.17
West Virginia	74	10.74
Iowa	135	10.47
Arizona	292	10.46
New Hampshire	53	10.23
Minnesota	220	10.21
Wisconsin	234	10.1
Washington	272	9.9
Michigan	407	9.89
Nevada	108	9.81
Missouri	240	9.8
Kansas	120	9.68
Kentucky	168	9.49
South Carolina	182	9.4
Indiana	255	9.17
Louisiana	175	9.1
Tennessee	234	8.96
Nebraska	70	8.91

State	Deaths	Crude Rate
Virginia	282	8.48
Pennsylvania	418	8.4
Ohio	377	8.1
Texas	941	8.03
Alabama	158	7.98
North Carolina	320	7.93
Mississippi	96	7.48
Florida	539	7.43
Georgia	316	7.38
Maryland	166	7.09
Illinois	367	6.97
Delaware	24	6.6
California	930	5.74
Massachusetts	149	5.53
Connecticut	78	5.38
New Jersey	182	5.27
Rhode Island	22	5.04
New York	392	5.03
District of Columbia	10	4.1

Rates are deaths per 100,000

Source: CDC WISQARS

Limitations of data used for suicide surveillance

Suicide in Oregon is monitored and tracked using a variety of existing administrative data sets, surveys and active surveillance efforts. Administrative data sets include death certificates collected by local health departments and sent to the Center for Health Statistics at the Public Health Division, and hospitalization discharge data from the Oregon Association of Hospitals and Health Systems. Survey data come from the Oregon Healthy Teen Survey, the National Household Survey on Drug Use and Health, and the American Community Survey. Active surveillance data are collected by the Oregon Violent Death Reporting System and the Oregon Child Fatality Review data system.

These data sets, surveys and surveillance activities include variables of interest to policy makers, but may fall short in other areas. Data not available include information on sexual orientation, transgender status, school attended, primary spoken language of a youth and foster care status. Another limitation that affects data availability is funding and staff resources to conduct systematic, ongoing suicide surveillance in public health. Routine suicide surveillance in the past 12 months does not include requests for depression-related intervention services, previous attempts, emergency department visits or hospitalizations. Producing these types of complex analyses of large administrative data sets would involve linking, deduplication and analysis tasks, and would require additional funding and position authority. Other data components would need active in-person case investigation, data entry and database management. Both would require significant resources and planning.

The Oregon Health Authority, Public Health Division has made a request through Health Analytics and Policy to obtain a complete standardized set of emergency department discharge data from the Association of Hospitals and Health Systems. These data are one of the major missing pieces needed to provide population-based estimates that examine how past attempts treated at emergency departments might be associated with hospitalizations and deaths. Obtaining a standardized emergency department discharge data set is an objective of the State Health Improvement Plan and a high priority for the Oregon Health Authority.

HEALTH SYSTEMS DIVISION
503-947-2340

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