OREGON HEALTH AUTHORITY

Behavioral Health Division

2024

Youth Suicide Intervention and Prevention Plan

Annual Report

Oregon Health Authority Suicide Prevention Team

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Please cite this publication as follows:

Oregon Health Authority, Behavioral Health Division. Youth Suicide Intervention and Prevention Plan 2024 Annual Report. Oregon Health Authority, Portland, OR. March 2025.

Contents

Dear people of Oregon:

Youth suicide is a serious issue that needs everyone's attention. The 2024 Youth Suicide Intervention and Prevention Plan (YSIPP) Annual Report shares what Oregon Health Authority (OHA) and OHA partners are doing to prevent suicide and support young people. It also looks at 2023 youth suicide data to see what is working and what needs to improve. The data shows progress. However, it also shows that racial differences in youth suicide remain a big problem. OHA thanks the thousands of dedicated people who have worked so hard to support this effort.

The good news is that youth suicide deaths in Oregon dropped from 109 deaths in 2022 to 102 in 2023. This continues a downward trend since 2018. However, the data also shows a troubling fact. Suicides among youth of races and ethnicities other than non-Hispanic white have increased from 32 in 2018 to 43 in 2023. This is a national trend for Black, African or African American youth and American Indian and Alaska Native youth. This is deeply troubling and requires urgent action.

OHA is committed to addressing these disparities. OHA asked for an additional $1 million in the Governor's proposed 2025–2027 budget. Funds requested would expand culturally specific suicide prevention efforts. OHA has also started working with Dr. Joyce Chu, a national expert. This is to ensure cultural factors are in the YSIPP for 2026–2030 and the Oregon Suicide Prevention Framework.

This report shares progress made in 2024. These include efforts to save lives by:

- Working with local communities
- Funding organizations with strong ties to the community
- Focusing on youth leadership in suicide prevention programs, and
- Expanding training and services in different languages and cultures.

Some key achievements in 2024:

- **OHA-led suicide prevention training:**
  - Doubled the number of trainers connected to the Nine Federally Recognized Tribes or Tribal organizations, and
  - Nearly doubled the number of trainers who speak Spanish.
- **The Big River initiative "Be Sensitive, Be Brave" statewide training:**
  - This training focuses on culturally relevant suicide prevention
  - It is available in seven languages, and
  - It helps community members recognize warning signs and connect people to help.
- **Black youth suicide prevention and cultural efforts:**
  - These efforts received national recognition.
- **Big River celebrated five years of training and support:**
  - There are nearly 2,000 trainers statewide.

This report shows how important it is to keep working together. Suicide is a preventable tragedy. The pain it causes is immense. This report encourages everyone to think about how they can help prevent suicide. OHA looks forward to working with you in this critical effort.

Sincerely,

Ebony Clarke
Behavioral Health Director
Oregon Health Authority

Executive summary

This is an executive summary of the Youth Suicide Intervention and Prevention Plan (YSIPP) Annual Report. This report is produced as required by Oregon Revised Statute (ORS) 418.731 and directed in House Bill (HB) 4124 (2014). It includes information about the progress made in implementing the YSIPP. It also includes updated data on youth suicide in Oregon.

The data in the report shows:

- A decrease in age 24 and younger youth suicides in Oregon in 2023. This continues an overall decreasing trend in youth suicide in Oregon since a peak in 2018. Preliminary 2024 youth suicide deaths appear similar to 2023 deaths.*
- In 2023, 102 Oregon youths died by suicide, compared to 109 in 2022.
- Suicide remains the second-leading cause of death among people aged 5 to 24.
- Racial disparities remain in the most recent finalized data. Specifically, deaths by suicide among non-Hispanic white youth have decreased overall since 2018. However, the number of youth suicides of other races and ethnicities has remained similar to 2018 levels or has increased.
- Oregon's numbers are too small from a statistical standpoint to have reliable data for rates of suicide. However, national data shows that American Indian and Alaska Native youth continue to have the highest rates of youth suicide. Also, Black, African, and African American youth suicide rates are increasing faster than any other race or ethnicity.
- The national rate for youth suicide remained stable between 2022 and 2023 (10 per 100,000 in 2022 vs. 9.9 per 100,000 in 2023). The 2023 data show that Oregon had the 11th highest youth suicide rate in the United States (tied with Kentucky).
- Oregon's rate of youth suicide in 2023 was 13.5 per 100,000 compared to 14.2 in 2022. This remains above the national average (9.9 per 100,000).
- There is more work to do to ensure our progress in past years is not lost, as the risk of youth suicide continues to be a concern in Oregon.

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* Data for 2024 will not be official until late spring 2026. This is when the Centers for Disease Control and Prevention (CDC) releases finalized data.

The report details the progress that the Oregon Health Authority (OHA), OHA's contractors, the Oregon Alliance to Prevent Suicide, and youth-serving state agency partners have made on 189 initiatives in 2024. This demonstrates an increase in the amount of youth suicide prevention programming; the number of initiatives was 117 in 2022 and 159 in 2023. These initiatives include work in suicide:

- Prevention
- Intervention, and
- Postvention (caring response after a suicide death).

It also includes work led by OHA, the Oregon Alliance to Prevent Suicide, and youth-serving state agencies. In 2024, Oregon added 425 new trainers to Big River suicide prevention programs. The total number of active trainers statewide is 1,992. In Oregon, 21 of 36 counties have active trainers in all nine Big River programs.

These are the initiative statuses as of December 2024:

- 117 (62 percent) initiatives represent ongoing, sustained, on-track work
- 45 (24 percent) initiatives have more work to be done but are on track
- 13 (7 percent) initiatives were one-time projects and are complete
- 10 (5 percent) initiatives are one-time projects that are not complete, and
- 4 (2 percent) initiatives represent ongoing work that is not on track.

There are 185 youth suicide prevention, intervention and postvention initiatives for 2025. Overall, 93 percent of the 2024 priority initiatives were on track. To learn more about YSIPP priority initiatives, visit the OHA Youth Suicide Prevention website.

Oregon Suicide Prevention Framework

The Youth Suicide Intervention and Prevention Plan (YSIPP) (2021–2025) was built using the Oregon Suicide Prevention Framework blueprint. OHA developed this framework with the University of Oregon Suicide Prevention Lab (UOSPL) under the leadership of Dr. John Seeley. The 2012 National Strategy for Suicide Prevention and the Centers for Disease Control and Prevention (CDC) Technical Package for Suicide Prevention provides the grounding for this plan. The San Diego Suicide Prevention Plan informed the framework. Hundreds of feedback responses from collaborators and partners across Oregon also helped shape it. OHA's suicide prevention team plans to align the framework to the 2024 National Strategy for Suicide Prevention.

Framework components:

Strategic pillars, strategic goals, centering values and foundation

These will not change over the five-year lifespan of the plan. They are the starting point for all suicide prevention work in Oregon.

Strategic pathways

The pathways are not likely to change over five years. These are rooted in the centering values and foundation. They represent measurable focus areas. These pathways are more specific to populations or settings. For example, under the goal of "means reduction," one pathway is: "All Oregonians experiencing behavioral health problems will have access to safe storage of lethal means."

Strategic priority initiatives

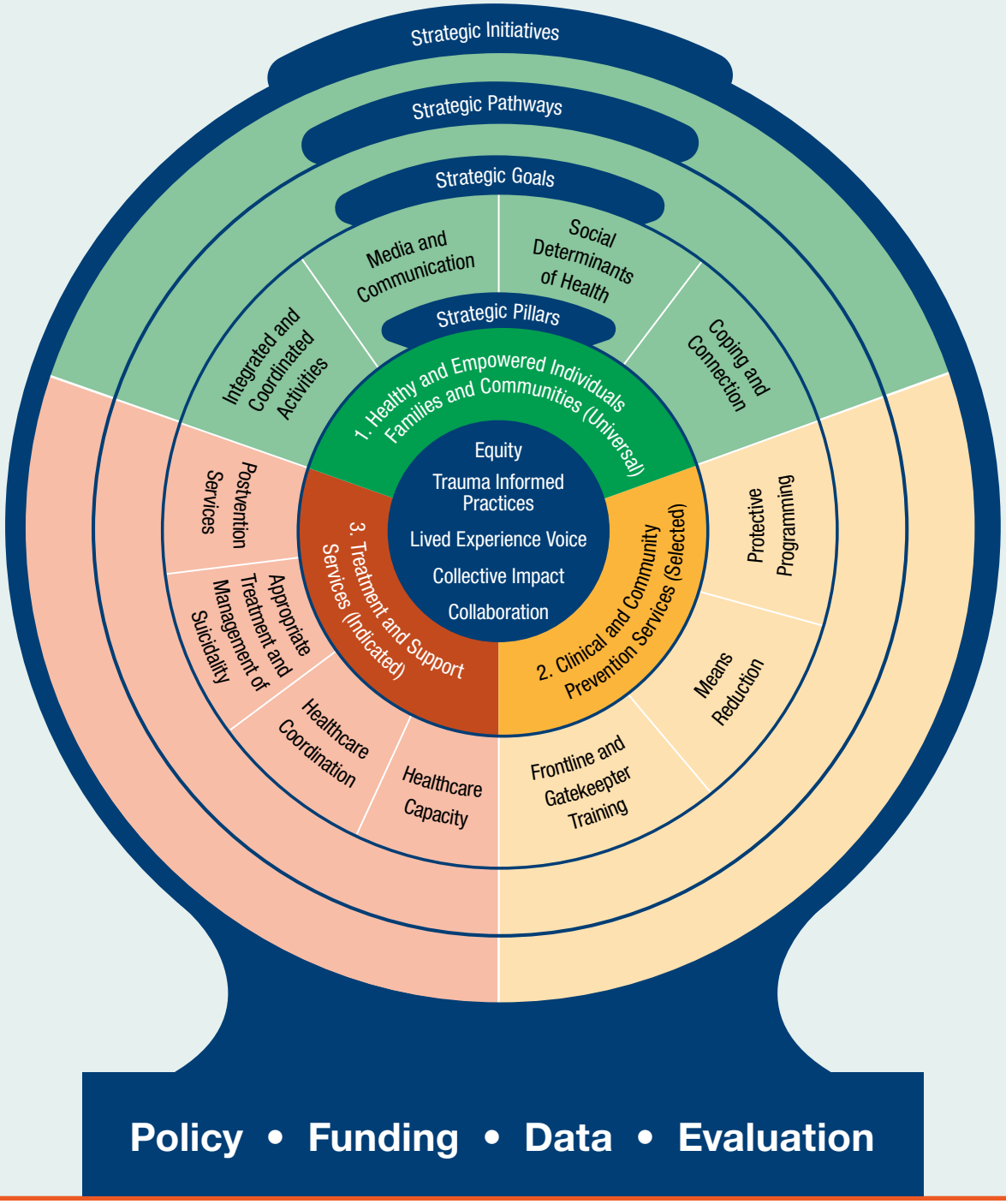
These initiatives will be adapted, adjusted and added to each year. They are specific actions designed to support the broader pathways and goals. In 2023, Oregon's youth suicide prevention efforts included 159 priority initiatives. For more details on YSIPP priority initiatives, please visit the OHA Youth Suicide Prevention website.

OHA built the five-year YSIPP on the strategic goals and pillars, centering values and foundation. The strategic pathways and priority initiatives comprise the YSIPP 2021–2025.

In the reports before 2023, OHA included detailed updates of all initiatives in the YSIPP. Based on feedback from the Oregon Alliance to Prevent Suicide, this report offers an overview and summary of the progress. For more about YSIPP priority initiatives and detailed updates, visit the OHA Youth Suicide Prevention website.

Click on this infographic for an interactive version.

Oregon Suicide Prevention Framework



The Big River programming summary

A large part of the youth suicide prevention work involves statewide programming for suicide:

- Prevention
- Intervention
- Treatment, and
- Postvention (support after a suicide loss).

This approach is called Big River programming. The suicide prevention team developed an interactive map of Big River Programming options. This team makes training recommendations for both school related staff and non-school settings. OHA's suicide prevention team supports the programs below by:

- Contracted statewide coordination
- Hosted learning groups, and
- Train-the-trainer support when needed.

The University of Oregon's Suicide Prevention Lab supports OHA's evaluation efforts for implementation Big River programming. full report of their evaluation in 2024 full report of their evaluation in 2024.

Before 2019, OHA had limited support for these program options.

In 2024, OHA offered stand-alone, no-cost training options in addition to the core Big River training programs. (Table 1)

Table 1: Additional OHA-sponsored implementation training programs

Training	Details
Suicide Prevention and Intervention for Latine Communities	3-hour online course for any level of provider or youth-serving adult
Suicide Prevention: Responding with Care	3-hour online course for traditional health workers
Counseling on Access to Lethal Means	2-hour online course offered through support from the Substance Abuse and Mental Health Services Administration (SAMHSA)
Addressing Firearm Safety with Patients at Risk of Suicide	A one-hour course for medical providers

The Big River programming added 425 trainers or coaches in suicide prevention, intervention and postvention training programs in 2024. This makes the total of trainers statewide 1,992.

Table 2: Big River implementation 2024

Program name	Number of active trainers statewide	New trainers added in 2024	Number of counties with trainers	Available in Spanish	Tribal specific adaptations	Youth engagement efforts included
Sources of Strength: Elementary grades K–6	327	73	27	Yes	No	Yes
Sources of Strength: Middle, high, and college	154	59	27	Yes	Yes	Yes
Mental Health First Aid	283	108	30	Yes	Yes	Yes
QPR (Question, Persuade, Refer)	985	149	36	Yes	Yes	Yes
ASIST (Applied Suicide Intervention Skills Training)	108	0	22	No	No	No
Youth SAVE (Suicide Assessment in Various Environments)	34	17	10*	No	No	Yes
Youth SAVE (Suicide Assessment in Various Environments): Primary Care	4	0	4*	No	No	No
Oregon CALM (Counseling on Access to Lethal Means)	10	17 (not yet certified)	15*	No	No	No
Connect: Postvention (Oregon adaptation)	87	19	21	No	Yes	No
Total	**1992**	**425**	**NA**	**4**	**4**	**5**

* This training has trainers that serve all counties. This number indicates their county of residence.

2024 Big River Trainers

A brief look at the numbers for suicide prevention programming in Oregon.

New trainers in 2024 • **425**

Total active trainers statewide:

Local communities equipped • **1,992**

Oregon's 36 counties each have training availability or access. 18 counties have active trainers in **all** Big River programs

• **126**

Trainers who speak languages other than English

• **48**

Trainers who are Tribal or Indigenous

Equipped workforce • **12,072***

People trained in Big River programs this year

* This number does not include the thousands trained in QPR by Lines for Life.

Working toward equity 2024 highlights

Local communities equipped

- OHA and partners took part in extensive continuing education from Drs. Joyce Chu, Chris Weaver and Brandon Hoeflein.
- Each Big River program assessed short- and long-term options for cultural infusion opportunities.

Increased diversity of trainers

- The number of trainers connected to Tribes more than doubled. There was an increase from 22 to 48.
- The number of counties with trainers increased from 18 to 21.

Increased language accessibility

- Each Big River program increased the availability of Spanish language materials and Spanish-speaking trainers to support wider community access.
- Spanish language training the trainer sessions were held for Mental Health First Aid (MFHA) and Question, Persuade, Refer (QPR).
- The number of trainers who speak languages other than English nearly doubled, from 67 to 126.
- ASIST is now offered with Spanish translation in a Spanish-speaking cohort.
- Eighteen Spanish-speaking providers were trained in grief group facilitation.

Culturally specific suicide prevention

- Black Youth Suicide Prevention Coalition added 12 youth.
- The Lifesustaining Practices Fellowship project completed Phase 1 in which 17 youth-serving adults completed extensive learning and began developing an educator toolkit.
- Over 700 people trained in the Latine suicide prevention considerations course
- OHA provided a collective $475,000 to:
  - The Nine Federally Recognized Tribes in Oregon, and
  - Native American Rehabilitation Association of the Northwest, Inc (NARA NW)
- Each Big River program worked to expand culturally relevant Spanish language materials, training and Spanish-speaking trainers.

Highlights youth voice 2024

Focus groups:

- Alliance to Prevent Suicide
- Question, Persuade, Refer
- Sources of Strength

Sources of strength

- Peer Educator positions
- Statewide postcard exchange
- Zine of Strength created statewide

QPR

for teens with youth trainers

Coalition youth members

State, local, population areas

YOUTHLINE

leadership development

Awards for youth-led projects

Sources Showcase

$ Grants for youth-led projects

Youth suicide prevention funding

In 2024, the Behavioral Health Division (BHD), Child and Family Behavioral Health (CFBH) unit's budget for suicide prevention was about $5 million in general funds. They also earned a $250,000 grant to support school suicide prevention implementation.

The Public Health Division (PHD) Injury and Violence Prevention Program (IVPP) manages several federal grants that support YSIPP efforts. These come from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC).

IVPP staff working on these YSIPP grant initiatives are part of the OHA suicide prevention team. They coordinate state and federal funding streams to meet grant and YSIPP goals. These grants include the following:

SAMHSA Garrett Lee Smith Memorial Act (GLSMA) (Oregon GLS): This grant funding expires in June 2024. OHA intends to apply for the new round of GLSMA funds for September 2024 through September 2029. Oregon received $736,000 a year through this grant mechanism. Currently, this funding supports suicide prevention capacity grants in select Oregon counties and through the Oregon Department of Human Services (ODHS). It also supports community and clinical training to reduce suicides of youth 10–24 years old.

SAMHSA Zero Suicide in Health Systems Grant: OHA receives this funding stream for September 2020 through August 2025. Oregon gets $700,000 a year through this grant mechanism. This grant supports OHA working with Oregon health systems to provide safer specific suicide care for adults aged 25 and older using a nationally recognized model, Zero Suicide. This grant allowed IVPP to hire a dedicated Zero Suicide in Health Systems coordinator to develop a Zero Suicide program. The grant focuses on reducing suicide risk for adults 25 and older. Additionally, the position supports existing Oregon Zero Suicide work in health systems that focus on youth populations. It also expands learning and training opportunities for all health systems using Zero Suicide, including youth-focused initiatives. The Zero Suicide in Health Systems coordinator sits on the Alliance's Transitions of Care Committee to ensure program coordination.

Grant accomplishments include:

- Hosting a virtual Zero Suicide Summit for Oregon health systems featuring local and national presentations on practical applications of Zero Suicide and suicide safer care strategies.

- Providing five mini-grants totaling $139,737 to health systems implementing Zero Suicide and safer suicide care initiatives.
- Continued support for Community Counseling Solutions serving Gilliam, Grant, Morrow, Umatilla and Wheeler counties to advance their Zero Suicide Initiative.
- Providing a Zero Suicide plenary and breakout sessions at the 2023 Oregon Suicide Prevention Conference.

CDC Advancing Violence Epidemiology in Real-Time (AVERT): OHA received this new funding stream for September 2023 through August 2028. It continues work established through the previous Firearm Injury Surveillance Through Emergency Rooms (FASTER) grant that:

- Increases the quality and timeliness of surveillance data on emergency department visits for firearm injuries.
- Adds new work focused on data related to other violence-related injuries and mental health conditions.

CDC Comprehensive Suicide Prevention: OHA was one of six awardees in the second round of funding. The grant funds are for September 2022 through August 2027. It provides $855,000 a year. Led by the OHA PHD in partnership with the BHD, the grant provides funds to implement and evaluate a comprehensive public health approach to suicide prevention in Oregon. The aim is to reduce suicide attempts and deaths in rural areas and adults aged 55 and older by 10 percent. There is a focus on culturally responsive interventions to reduce the higher burden of suicide in firearm owners and service members, veterans and their families (SMVF). Additional grant activities include creating awareness of the connection between suicide and alcohol use. The Adult Suicide Prevention coordinator actively coordinates grant work in the OHA Adult Suicide Intervention and Prevention Plan. The grant focuses on adults. However, grant activities contribute to creating protection for youth through well-informed adults and communities. Grant accomplishments include:

- Established a grant project advisory committee that meets regularly.
- Initial development of an alcohol outlet density map that will layer with suicide-related data.
- Provided culturally adapted suicide prevention community helper training to firearm owners, assisted living community members and their caregivers.
- Held 12 Oregon Counseling on Access to Lethal Means (OCALM) trainings and train-the-trainer events to increase the OCALM trainer pool.
- Provided a total of $84,000 for mini-grants to increase social connections for older adult Oregonians living in rural and remote communities.

YSIPP 2024 initiatives progress report

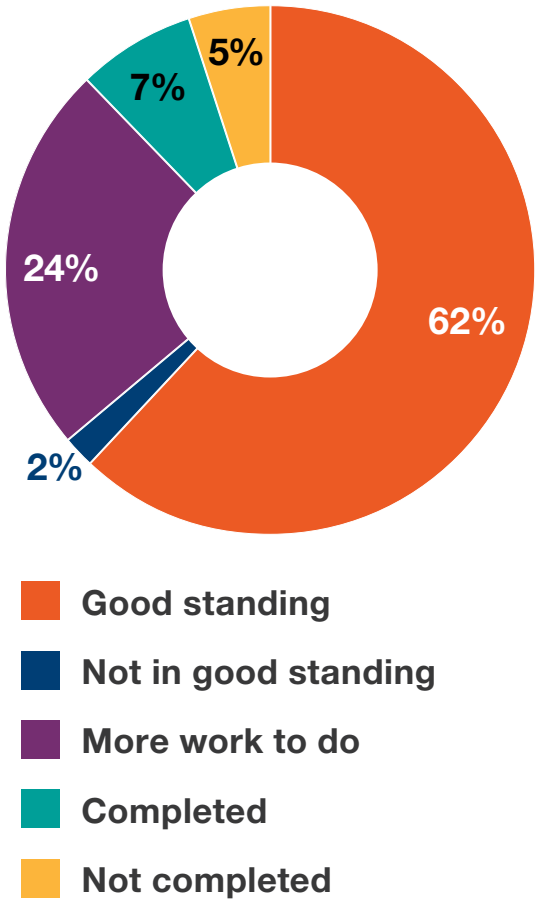
This section outlines the progress and status of each YSIPP 2024 priority initiative at the time of this report. The OHA suicide prevention team and the Oregon Alliance to Prevent Suicide provide a detailed update of all 189 initiatives from 2024 and YSIPP priority initiatives for 2025 on the Youth Suicide Prevention website.

Status updates:

- **Good standing — ongoing work:** These initiatives are ongoing, supported, and on track.
- **Not in good standing — ongoing work:** These initiatives are intended to be ongoing and supported but are not currently on track.
- **More work to do — not necessarily behind:** Progress has been made and is on track. However, the initiative is not fully completed.
- **Completed — time-bound:** These initiatives were one-time projects and have been fully completed.
- **Not completed — time-bound:** These initiatives are one-time projects that are not fully completed but were projected to be completed.

In 2024, 175 of the 189 initiatives (93 percent) were on track or completed. In 2025, 185 initiatives are being carried out.

Figure 1: YSIPP 2024 status of all initiative (189)



Data

This report contains program updates for 2024 and final data from 2023.

Suicide numbers, rates and rankings change from year to year. The best way to study the data is by tracking trends long-term. Between 2011 and 2018, Oregon youth suicide deaths increased significantly. Since its peak in 2018, Oregon's youth suicide rate has had a decreasing trend. In 2023, there were 102 youth suicide deaths, compared to 109 in 2022. In 2023, Oregon's suicide rate was the 11th highest in the nation, tied with Kentucky. (Table 3).

Table 3. Oregon suicide deaths and rates among those aged 10 to 24 compared to the national rate

Year	Number of youth suicides	Suicide death rate (per 100,000)	Rank among 50 states (50 is lowest rate)
2014	97	12.9	12
2015	90	12	16
2016	98	13	15
2017	107	14.1	17
2018	129	16.9	11
2019	116*	15.3	11
2020	101†	13.3	18
2021	95	12.4	22
2022	109	14.2	12
2023	102	13.5	11 tied with another state

Source: WONDER and OPHAT

* In addition to these deaths among youths in Oregon aged 10–24, there were two suicide deaths among children younger than 10 in 2019.

† In addition to these deaths among youth in Oregon aged 10–24, there was one suicide death among children younger than 10 in 2020.

This report follows Oregon Revised Statute 418.731. It focuses on Oregon youth aged 5–24 who:

- Died by suicide
- Were hospitalized due to self-inflicted injury, or
- Had suicidal thoughts, behaviors or both

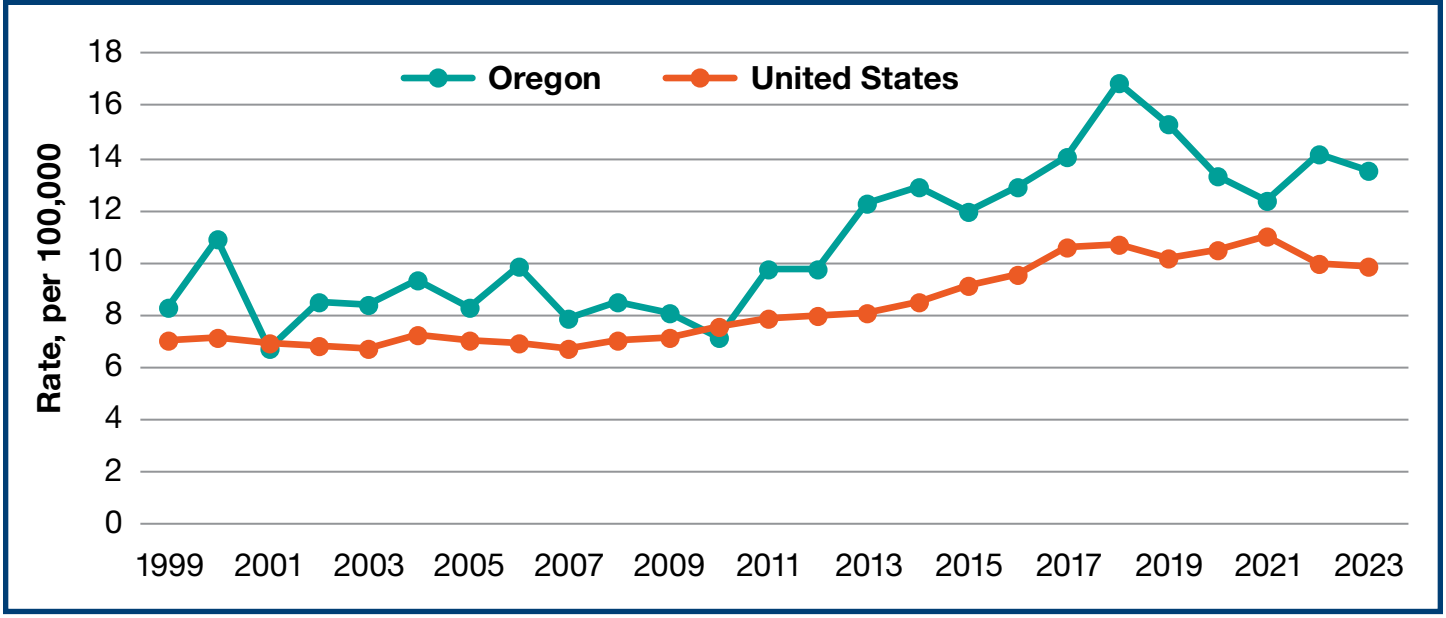
In 2023, suicide was the second leading cause of death for youth younger than 25 in Oregon. (CDC WONDER, 2024). Oregon youth suicide rates continue to be higher than the United States average. Rates have stayed that way for the past decade.

Key findings:

- Male youth were more than three times more likely to die by suicide than female youth. (Figure 3)
- Suicide rates increased with age among youth. (Figure 3)
- From 2018 to 2022, the Oregon Violent Death Reporting System (ORVDRS) identified:
  - 23 suicides among transgender youth
  - 8 suicides among youth who identified as lesbian, gay, bisexual or who had a sexual orientation other than straight or heterosexual

These deaths made up 5 percent of Oregon youth suicides between 2018 and 2022. However, this is likely an undercount of LGBTQIA2S+ youth who died by suicide due to existing data collection methods. Oregon House Bill 3159 (2021) requires OHA to build data collection systems to collect sexual orientation and gender identity (SOGI). You can learn more about these efforts on the OHA website.

Figure 2: Suicide rates among youth aged 10 to 24 years, United States and Oregon, 1999–2023



Source: WONDER

Table 4. Comparison of suicide death rates per 100,000 among youth aged 24 and under in Oregon and the United States, 2003–2023*†

Year	Oregon	United States
2003	8.4	6.7
2004	9.4	7.3
2005	8.3	7.0
2006	9.9	6.9
2007	7.9	6.8
2008	8.5	7.0
2009	8.1	7.2
2010	7.2	7.6
2011	9.8	7.9
2012	9.8	8.0
2013	12.3	8.1
2014	12.9	8.5
2015	12.0	9.2
2016	13.0	9.6
2017	14.1	10.6
2018	16.9	10.7
2019	15.3	10.2
2020	13.3	10.5
2021	12.4	11.0
2022	14.2	10.0
2023	13.5	9.9

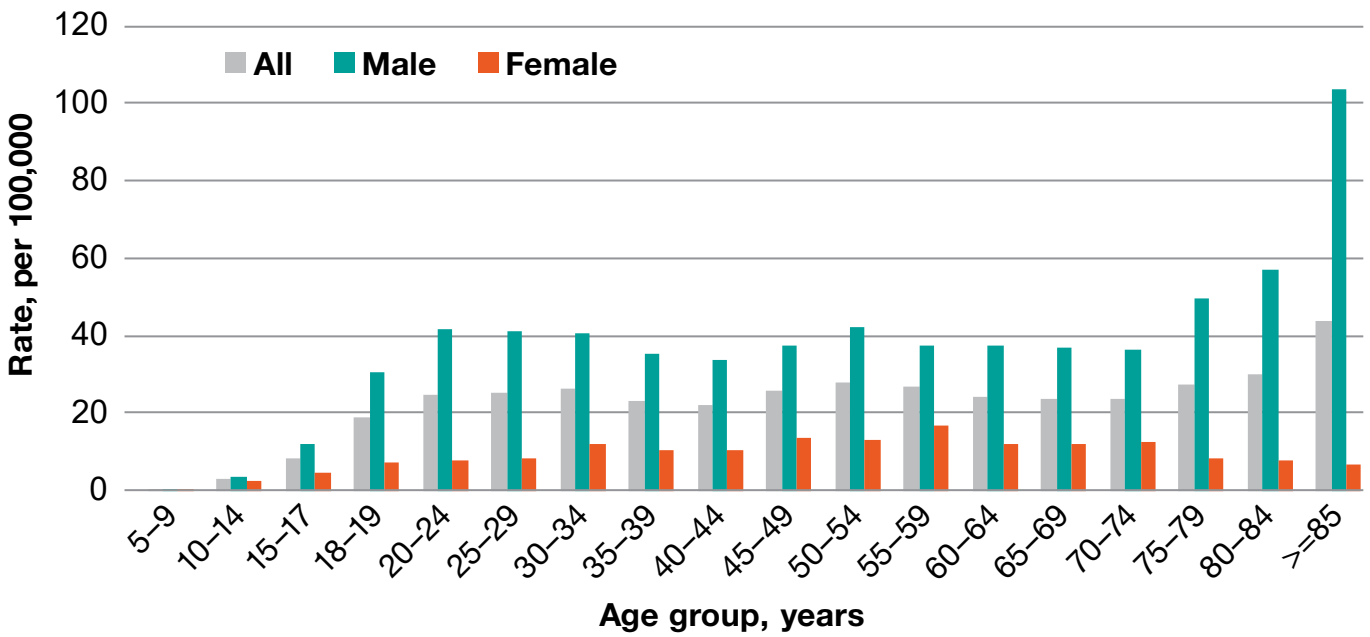
Sources: WONDER

* Rates are deaths per 100,000

† https://www.oregon.gov/oha/ei/pages/reald.aspx

Note: This does not include deaths under age 10. There was 1 death in 2007, 2 deaths in 2019 and 1 death in 2020 of children under age 10.

Figure 3. Age-specific rate of suicide by sex, Oregon, 2019–2023



Source: OPHAT

Common circumstances for youth suicide

Table 5 shows common circumstances for age 5–24 suicide deaths. Understanding patterns can inform prevention and support efforts. These factors can vary by age group. However, in Oregon, between 2018–2022, the most common ones were:

- Mental health concerns or current depressed mood
- History of suicidal thoughts or attempt
- Family stress
- School problems (for youth aged 5–17), and
- A crisis in the past two weeks.

Table 5. Circumstances surrounding suicide incidents, by age group and sex, Oregon, 2018–2022

Circumstances	Aged 5–17			Aged 18–24		
	All sexes (n=129)	Males (n=86)	Females (n=43)	All sexes (n=439)	Males (n=367)	Females n=72)
Diagnosed mental disorder, % of total suicides	51.2	44.2	65.1	49.0	43.9	75.0
Alcohol problem, % of total suicides	4.7	2.3	9.3	12.3	13.4	6.9
Non-alcohol substance use problem, % of total suicides	9.3	7.0	14.0	20.5	20.4	20.8
Current depressed mood, % of total suicides	27.1	30.2	20.9	31.2	30.2	36.1
Current treatment for mental health or substance use problem, % of total suicides	36.4	30.2	48.8	23.0	19.9	38.9
Recently disclosed intent to die by suicide, % of total suicides	17.1	17.4	16.3	18.7	18.8	18.1
History of suicide attempt, % of total suicides	21.7	16.3	32.6	25.5	21.0	48.6
Left a suicide note, % of total suicides	40.3	43.0	34.9	33.7	31.9	43.1
History of expressed suicidal thought or plan, % of total suicides	47.3	41.9	58.1	48.1	46.3	56.9
Intimate partner problem, % of total suicides	16.3	19.8	9.3	28.5	27.5	33.3
Family stressors, % of total suicides	22.5	20.9	25.6	8.0	7.9	8.3
Recent criminal or non-criminal legal problem, % of total suicides	3.1	3.5	2.3	5.5	6.5	0.0
Financial or job problem, % of total suicides	0.0	0.0	0.0	6.2	7.1	1.4
Physical health problem, % of total suicides	1.6	1.2	2.3	1.6	1.6	1.4

Table 5. Circumstances surrounding suicide incidents, by age group and sex, Oregon, 2018–2022 (cont.)

Circumstances	Aged 5–17			Aged 18–24		
	All sexes (n=129)	Males (n=86)	Females (n=43)	All sexes (n=439)	Males (n=367)	Females n=72)
Death of a family member or friend within the past five years, % of total suicides	3.1	2.3	4.7	4.1	4.9	0.0
Suicide of a family member or friend within the past five years, % of total suicides	2.3	3.5	0.0	2.1	1.6	4.2
School problem, % of total suicides	18.6	22.1	11.6	1.8	1.9	1.4
Experienced a crisis within two weeks, % of total suicides	16.3	19.8	9.3	17.3	15.5	26.4
Crisis related to a problem with intimate partner, % of total suicides	6.2	7.0	4.7	10.9	9.0	20.8
Crisis related to physical health problems, % of total suicides	0.0	0.0	0.0	0.0	0.0	0.0
Crisis related to recent criminal or civil legal problem, % of total suicides	0.8	1.2	0.0	1.6	1.9	0.0
Crisis related to family stressors, % of total suicides	4.7	5.8	2.3	2.3	2.2	2.8
Crisis related to financial or job problem, % of total suicides	0.0	0.0	0.0	0.9	1.1	0.0
Crisis related to eviction, % of total suicides	0.0	0.0	0.0	0.7	0.5	1.4
Suspected alcohol use before the incident	8.5	10.5	4.7	22.3	23.2	18.1

Sources: ORVDRS

2023 youth suicide data

In 2023, *there were 102 suicides among Oregon youth younger than 25* reported. No suicides were reported for youth younger than 10. Details for characteristics and location are not available for three youths who were out of the state at the time of their death by suicide. As shown in Table 6, most suicides were among the following youth:

- Males (83 percent)
- White non-Hispanic (57 percent), and
- Aged 18 to 24 (80 percent).

Eighteen deaths were among middle school and high school students (Table 6).

Table 6. The characteristics of youth suicides, Oregon 2023*

		Deaths*	% of total
Age	5–17	20	20%
	18–24	79	80%
Sex	Male	82	83%
	Female	17	17%
Race and ethnicity	White non-Hispanic (NH)	56	57%
	African American NH	5	5%
	Am. Indian or Alaska Native NH	0	0%
	Asian NH	5	5%
	Native Hawaiian or Pacific Islander NH	2	2%
	More than one race NH***	7	7%
	Hispanic, all races**	24	24%
Student status	Middle School	3	3%
	High School	15	15%
Mechanism of death	Firearm	60	61%
	Hanging or suffocation	26	26%
	Poisoning	3	3%
	Other	10	10%

Sources: Oregon Violent Death Reporting System

* Three out-of-state deaths are not included because their death certificate information is not accessible.

** includes any race.

*** Deaths are not counted in other race categories.

Note: According to the CDC's WONDER, there were 102 suicides aged 5 to 24 in 2023.

Youth racial disparities

The data shows racial disparities. Deaths by suicide for non-Hispanic white youth have decreased. Between 2018–2023:

- Non-Hispanic white youth suicide deaths decreased by 38.5%
- Among youth of color (Hispanic, Asian, Black, Pacific Islander, two or more races) and American Indian or Alaska Native increased by 34%

Table 7. Numbers and percentages of suicides among youth aged younger than 25 years by year and race and ethnicity, Oregon 2018–2023

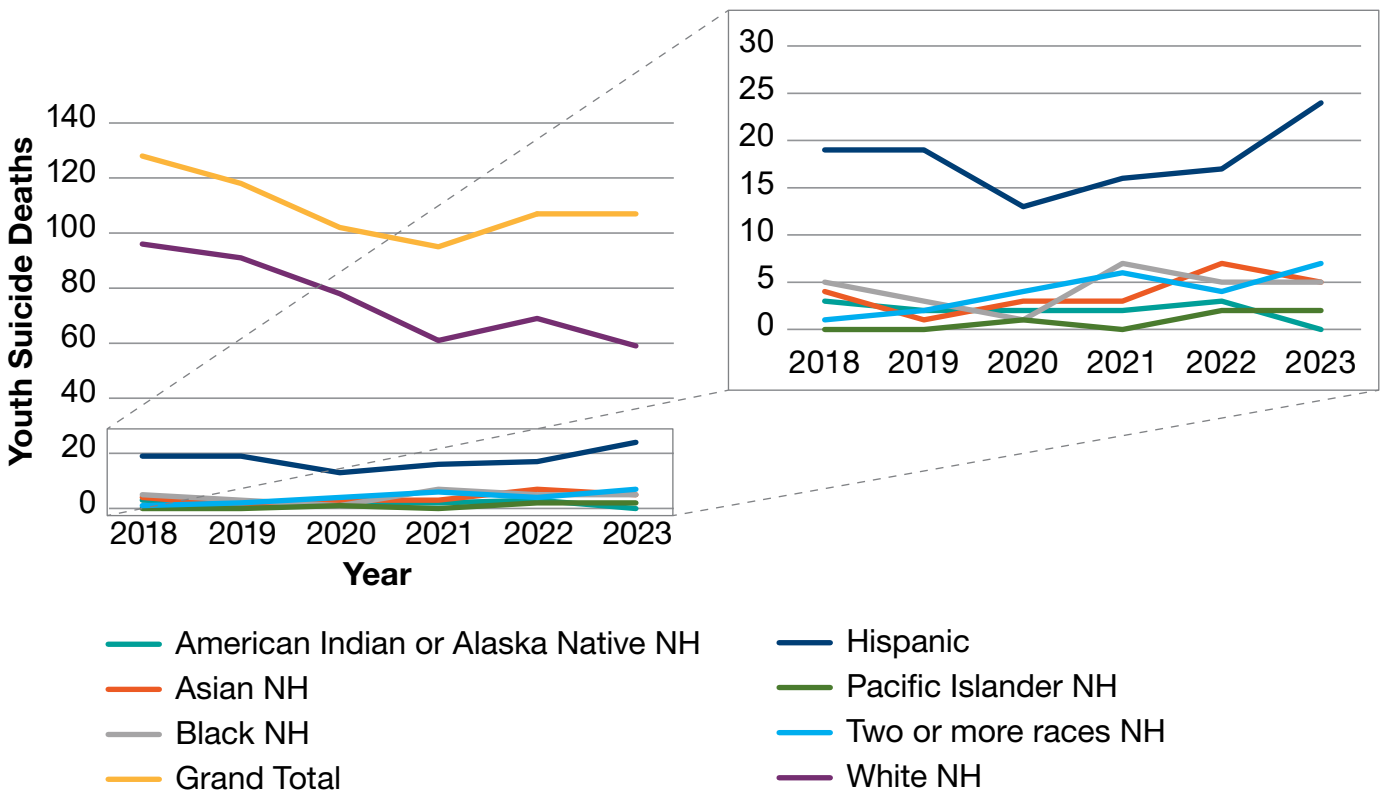
	2018		2019		2020		2021		2022		2023	
Race or ethnicity	**Deaths**	**% of total**	**Deaths**	**% of total**	**Deaths**	**% of total**	**Deaths**	**% of total**	**Deaths**	**% of total**	**Deaths**	**% of total**
American Indian or Alaska Native NH	3	2.5	2	1.5	2	2.0	2	2.0	3	3.0	0	0.0
Asian NH	4	3.0	1	1.0	3	3.0	3	3.0	7	6.5	5	4.9
Black NH	5	4.0	3	2.5	1	1.0	7	7.5	5	4.5	5	4.9
Hispanic*	19	14.5	19	16.0	13	12.5	16	17.0	17	16.0	24	23.5
Native Hawaiian or Pacific Islander NH	0	0.0	0	0.0	1	1.0	0	0.0	2	2.0	2	2.0
Two or More Races NH	1	1.0	2	1.5	4	4.0	6	6.5	4	3.5	7	6.9
White NH	96	74.5	91	77.0	78	76.5	61	64.0	69	64.5	59	57.8
Non-White, includes Hispanic, all races	32	24.8	27	22.9	24	23.5	34	35.8	38	35.5	43	42.2
Total	**129**	**NA**	**118**	**NA**	**102**	**NA**	**95**	**NA**	**107**	**NA**	**102**	**NA**

Sources: OPHAT

* Includes any race.

Figure 4 shows these trends. To better see the differences and trends, a close-up of this chart removes the total and non-Hispanic white deaths.

Figure 4. Youth Suicide Deaths by race and ethnicity, Oregon 2018–2023



In 2023:

- White non-Hispanic youth made up 57.8 percent of suicide deaths in 2023. Yet, they are 62.1 percent of the population.
- Youth of color (Hispanic, Asian, Black, Pacific Islander and two or more races) and American Indian or Alaska Native youth made up 42.2 percent of suicide deaths in 2023. Yet, they are 37.9 percent of the population.

Table 8. Youth aged 10 to 24: 2023 suicide numbers and percentages compared to the percentage of the Oregon population

Race or ethnicity	2023		2023 population
	Deaths	% of total	% of population
American Indian or Alaska Native NH	0	0	1.1
Asian NH	5	4.9	4.9
Black NH	5	4.9	2.4
Hispanic*	24	23.5	23
Native Hawaiian/Pacific Islander NH	2	2	0.5
Two or More Races NH	7	6.9	6
White NH	59	57.8	62.1
Non-white, includes Hispanic, all races	43	42.2	37.9
Total	**102**	**NA**	

Sources: OPHAT

* Includes any race.

The ways youth die by suicide vary by male and female. Table 9 shows how the youths died by suicide by age group in Oregon between 2018 and 2022.

Aged 10 to 17:

- **Males:** Most died by firearm (48.8 percent), then by hanging (38.4 percent).
- **Females:** Most died by hanging (65.1 percent), then by poisoning (16.3 percent).

Aged 18 to 24:

- **Males:** Firearms were the most common method (61.9 percent), then hanging (22.3 percent).
- **Females:** Hanging was the most common method (38.9 percent), then poisoning (26.4 percent) and firearms (22.2 percent).

Table 9. Mechanism of injury among suicide deaths, by age group and sex, Oregon, 2018–2022

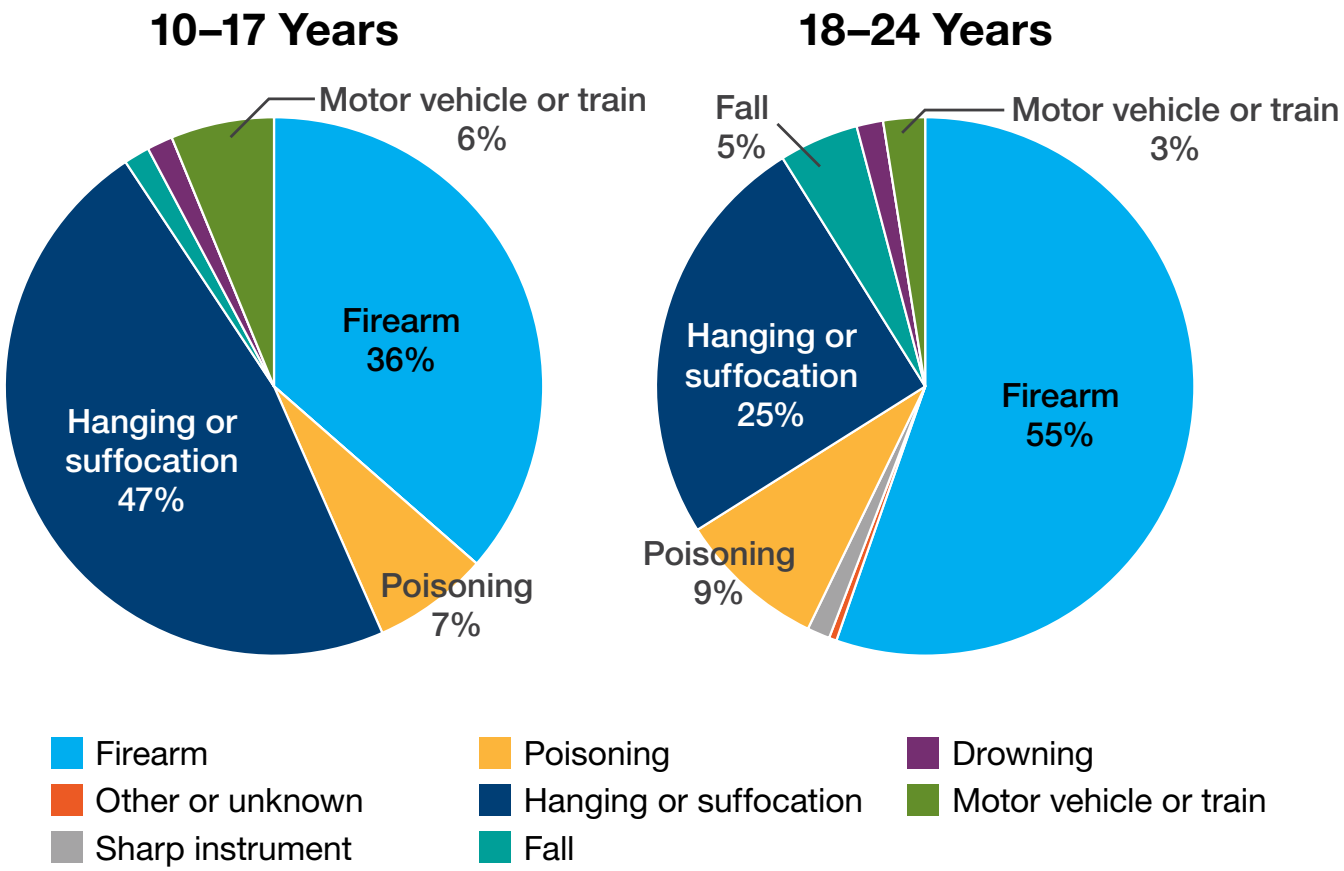
Age group	Mechanism of injury	Males	%, Males	Females	%, Females	All sexes*	%, All
10–17 years	Firearm	42	48.8	5	11.6	47	36.4
	Other or unknown	0	0.0	0	0.0	0	0.0
	Sharp instrument	0	0.0	0	0.0	0	0.0
	Poisoning	2	2.3	7	16.3	9	7.0
	Hanging or suffocation	33	38.4	28	65.1	61	47.3
	Fall	2	2.3	0	0.0	2	1.6
	Drowning	2	2.3	0	0.0	2	1.6
	Fire or burn	0	0.0	0	0.0	0	0.0
	Motor vehicle or train	5	5.8	3	7.0	8	6.2
	Total	**86**	**NA**	**43**	**NA**	**129**	**NA**
18–24 years	Firearm	227	61.9	16	22.2	243	55.4
	Other or unknown	2	0.5	0	0.0	2	0.5
	Sharp instrument	4	1.1	2	2.8	6	1.4
	Poisoning	20	5.4	19	26.4	39	8.9
	Hanging or suffocation	82	22.3	28	38.9	110	25.1
	Fall	17	4.6	4	5.6	21	4.8
	Drowning	6	1.6	1	1.4	7	1.6
	Fire or burn	0	0.0	0	0.0	0	0.0
	Motor vehicle or train	9	2.5	2	2.8	11	2.5
	Total	**367**	**NA**	**72**	**NA**	**439**	**NA**

Sources: ORVDRS

* Includes unknown sex.

Youth aged 18–24 are more likely to die by firearm suicide (55 percent) than youth aged 10–17 (36 percent). Youth aged 10–17 are most likely to die by suffocation suicide (47 percent).

Figure 5. Mechanism of injury among suicide deaths, Oregon, 2018–2022



Suicide data by county

In 2023, a total of 3,829 youth younger than 25 were admitted to the emergency department or hospital for suicide attempts, suicide thoughts or self-harm. This was lower than the 4,229 in 2022 (Table 10). Females were far more likely than males to be hospitalized for these.

COVID-19 had a significant effect on emergency department and hospital admissions. There was a significant overall drop in both non-COVID-19 emergency department and hospitalization visits in 2020 and 2021. Consider any trending data with caution, as these are still lower numbers compared to 2018 and 2019. Table 11 shows youth suicide deaths by county in 2023. There are differences by area.

The following applies to years 2019–2023 (many more years of data analysis are needed):

- **Rural counties:** Had a **higher** rate of suicide (11.9 per 100,000) than the state youth suicide rate (10.4 per 100,000).
- **Urban counties:** Had a lower rate of suicide (9.8 per 100,000) than the state youth suicide rate.

It is not possible to provide a rate for frontier counties due to small numbers in the overall population.

Table 10. ED and hospitalization admission numbers for suicide attempt, suicide ideation or self-harm, 2023.*

County	Count	% of total
Baker	---	---
Benton	82	2.1%
Clackamas	345	8.9%
Clatsop	53	1.4%
Columbia	47	1.2%
Coos	52	1.3%
Crook	32	0.8%
Curry	12	0.3%

* Oregon Hospital Discharge Index. Please note that a new methodology to calculate 2018 youth self-harm hospitalizations was implemented based on CSTE (Council of State and Territorial Epidemiologists) guidelines. Therefore, 2018–2023 data is not comparable to previous years. Counts less than 10 and not 0 (between 2 and 9) are not reported due to low counts and are represented by a line in a table.

Table 10. ED and hospitalization admission numbers for suicide attempt, suicide ideation or self-harm, 2023*. (cont.)

County	Count	% of total
Deschutes	178	4.6%
Douglas	84	2.2%
Gilliam	---	---
Grant	---	---
Harney	---	---
Hood River	20	0.5%
Jackson	169	4.4%
Jefferson	41	1.1%
Josephine	70	1.8%
Klamath	97	2.5%
Lake	---	---
Lane	407	10.5%
Lincoln	45	1.2%
Linn	135	3.5%
Malheur	19	0.5%
Marion	399	10.3%
Morrow	---	---
Multnomah	640	16.5%
Polk	112	2.9%
Sherman	0	0.0%
Tillamook	28	0.7%
Umatilla	63	1.6%
Union	24	0.6%
Wallowa	---	---
Wasco	26	0.7%
Washington	525	13.6%
Wheeler	0	0.0%
Yamhill	124	3.2%
Total	**3,829**	**NA**

* Oregon Hospital Discharge Index. Please note that a new methodology to calculate 2018 youth self-harm hospitalizations was implemented based on CSTE (Council of State and Territorial Epidemiologists) guidelines. Therefore, 2018–2023 data is not comparable to previous years. Counts less than 10 and not 0 (between 2 and 9) are not reported due to low counts and are represented by a line in a table.

Table 11. Numbers of suicides among youth aged 5 to 24 by county, Oregon, 2023

County	Youth (5–24) suicide deaths		Youth (5–24) population
	Count	% of total suicides	% of total population
Baker	0	0.0	0.4
Benton	1	1.0	3.4
Clackamas	10	9.8	9.8
Clatsop	0	0.0	0.8
Columbia	1	1.0	1.2
Coos	2	2.0	1.3
Crook	0	0.0	0.6
Curry	0	0.0	0.4
Deschutes	5	4.9	4.3
Douglas	6	5.9	2.4
Gilliam	0	0.0	0.0
Grant	0	0.0	0.1
Harney	0	0.0	0.2
Hood River	1	1.0	0.6
Jackson	2	2.0	5.1
Jefferson	1	1.0	0.6
Josephine	5	4.9	1.8
Klamath	2	2.0	1.7
Lake	0	0.0	0.2
Lane	12	11.8	9.9
Lincoln	1	1.0	0.9
Linn	2	2.0	3.2
Malheur	1	1.0	0.9
Marion	9	8.8	9.4
Morrow	0	0.0	0.4
Multnomah	21	20.6	16.4
Polk	2	2.0	2.5
Sherman	0	0.0	0.0
Tillamook	2	2.0	0.5
Umatilla	2	2.0	2.2

Table 11. Numbers of suicides among youth aged 5 to 24 years by county, Oregon, 2023 (cont.)

County	Youth (5–24) suicide deaths		Youth (5–24) population
	Count	% of total suicides	% of total population
Union	1	1.0	0.7
Wallowa	0	0.0	0.2
Wasco	2	2.0	0.6
Washington	11	10.8	14.5
Wheeler	0	0.0	0.0
Yamhill	0	0.0	2.8
State	**102**	**NA**	**NA**

Source: OPHAT

Suicide-related measures from the 2022 Student Health Survey

Oregon's Student Health Survey (SHS) was created by the Oregon Health Authority (OHA) and the Oregon Department of Education (ODE). The survey is a comprehensive, school-based, anonymous and voluntary health survey for sixth, eighth and 11th graders.

The 2022 SHS replaces OHA's two previous youth surveys:

- The Oregon Healthy Teens (OHT) survey, and
- The Oregon Student Wellness Survey (SWS).

Combining the two youth surveys is part of OHA's ongoing efforts to make Oregon's public health system more efficient. This reduced the time and resource burdens on schools and students. However, SHS data are not directly comparable to prior surveys due to differences such as:

- Methodology
- Grades surveyed
- Learning environment
- Data collection period, and
- Recruitment.

For more information, view the full 2022 SHS State Profile and County Profile Reports on the OHA SHS webpage.

SHS asked several questions about youth suicide and mental health, described below. Not every grade was asked all SHS questions. If a grade level is not included below (sixth, eighth or 11th), then it was not asked the question.

- Percentage of youth who seriously considered attempting suicide:
  - 7.2 percent of sixth graders
  - 11.6 percent of eighth graders
  - 14.6 percent of 11th graders
- Percentage of youth who attempted suicide at least once:
  - 4.3 percent of sixth graders
  - 5.6 percent of eighth graders
  - 6.6 percent of 11th graders

Suicide attempts involving firearms are more likely to result in injury or death than other methods, such as suffocation, hanging or poisoning. Firearms are a major cause of youth suicide deaths. So, easy access to firearms may increase the risk. More than 65 percent of eighth graders (69 percent) and 11th graders (66 percent) said they could not access a firearm.* However, approximately 11 percent said they could get access to one and be ready to use it in less than 24 hours. Another 16 percent said they could get access to one and be ready to use it in less than 10 minutes.

Data sources and limits for suicide tracking

Refer to the OHA Injury and Violence Prevention Program Data Glossary for more details on the data used in this report. OHA recently released the Injury and Violence Prevention Program Dashboard Overview. This overview describes the dashboards maintained by the OHA that are important to suicide prevention and injury prevention work. Suicide is a major cause of death in Oregon. It is the second leading cause of death among people in Oregon aged 10 to 24. Preventing suicide is a top priority for OHA.

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* 2022 Student Health Survey: How long would it take you to get and be ready to fire a firearm? The firearm could be yours or someone else's. Sixty-nine percent of eighth graders and 65 percent of eleventh graders selected one of the following responses: "I could not get a firearm"; "I am not sure"; "I don't know what this question is asking"; or "I prefer not to answer".

Suicide is a complex behavior and is linked to many factors. These include:

- Mental health
- Substance use
- Physical health
- Relationships
- Life events
- Social isolation
- Community support
- Childhood trauma, and
- Access to mental and behavioral health care.

Data sources and gaps

Oregon uses various existing data sets, surveys and active surveillance efforts. The purpose is to monitor and track suicide and some risk and protective factors that lead to or prevent suicide. These sources include data elements of interest to policymakers. However, these data sources have some gaps:

- Standard data sets used to track outcomes, such as death certificates, hospitalizations or emergency department visits, do not usually collect:
  - Data on risk and protective factors for suicide, for example, depression
  - Past medical and behavioral histories, for example, treatment episodes
  - Data elements that can tie personal risk and protective factors to suicidal behaviors, or
  - Outcomes among persons, for example, the number of previous suicide attempts among persons who died by suicide.
- The following data are not available for each youth who died by suicide:
  - School attended
  - Past admissions or treatment for depression or suicidality
  - Primary spoken language
  - Disability status
  - Foster care status
  - Depression-related intervention services in the past 12 months, and
  - Past suicide attempts, emergency department visits or hospitalizations in the last 12 months.

There would need to be changes and more resources to fill these gaps. It would include:

- Linking many databases
- In-person case interviews
- Getting more data from law enforcement, health providers and hospitals, and
- Staffing for data entry and database management.

Hospital and emergency department discharge data considerations

OHA analyzes hospital and emergency department (ED) discharge data available for 2018 from the Hospital Association of Oregon. These data sets typically capture population data for all admissions. However, tracking public health trends is not their primary function. For example, these data sets do not capture all deaths or suicide attempts within Oregon. This data is limited because:

- Not everyone in Oregon has access to an ED
- Not everyone seeks medical help for suicidal thoughts
- Many may never be admitted to the emergency department or hospital before death, and
- The data does not always show what may have led the person to suicide, such as stress or untreated depression.

Still, the data does capture all diagnosed self-harm, suicidal thoughts and suicide attempt admissions.

The International Classification of Diseases, 10th Revision (ICD-10) added code R45.88 in October 2022. It was added to differentiate self-harm without suicidal thoughts (for example, self-cutting as a coping mechanism) from self-harm with suicidal intent. This code is vital for tracking youth suicide prevention. The addition of R45.88 will likely increase reported cases, especially among youth. OHA is studying the use of R45.88 in hospitals and EDs. This is to understand how it will affect programs.

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) is a data tool for EDs and urgent care centers across Oregon. This report does not include ESSENCE data as it is available through the OHA Suicide-Related Public Health Data Updates Dashboard.

Specific considerations for survey data

Survey data can capture information on factors associated with suicide, such as depression. However, they have limits. They use sample populations, not specific persons.

- Survey data come, in part, from the following:
  - The Behavioral Risk Factor Surveillance System (BRFSS)
  - The Student Health Survey (SHS)
  - The National Survey on Drug Use and Health (NSDUH), and
  - The American Community Survey (ACS).

These surveys are both state and nationally administered. Surveys sometimes include questions about suicidality or mental health issues. However, the findings are limited:

- Surveys often depend on funding from separate programs (for example, BRFSS and SHS) to continue data collection for specific questions year-to-year
- Recent response rates to telephone surveys have been low, sometimes less than 50 percent, and
- Low response rates affect how well the data reflects the general population.

Some active surveillance data sources and systems link outcomes to a person's risk.

Death certificate data considerations

The Center for Health Statistics (CHS) at the OHA Public Health Division collects death certificate data. The data have been traditionally used for public health surveillance. The data provide:

- Detailed demographics
- General injury method
- Health outcome, and
- Geographical information.

However, the data:

- Do not explain why the people die by suicide, and
- Do not include what may have led persons to suicide, such as stress or untreated depression.

Oregon Violent Death Reporting System (ORVDRS) data considerations

ORVDRS data link suicide deaths to the medical examiner and law enforcement reports, giving a fuller picture. This includes:

- Detailed demographics
- Method of death
- Circumstances, and
- Risk factors.

However, there are challenges:

- There are no standard forms or investigations of deaths, so data collection and reporting are not always consistent
- Some details, such as LGBTQIA2S+ status, may be missing, and
- The data comes from witnesses and contacts of a person who died by suicide, which means some information may not be complete or is underestimated.

Appendix: 2023 youth suicide rates by state

Table 12. Suicide rates among youth aged 10 to 24 years by state, U.S. 2023

State	Deaths	Crude Rate
Alaska	44	30.1
Wyoming	31	26.6
New Mexico	101	24
Montana	42	19.6
Idaho	80	19.1
North Dakota	31	18.3
Oklahoma	128	15.1
Colorado	167	15
South Dakota	28	15
Kansas	89	14.2
Kentucky	119	13.5
Oregon	102	13.5
Maine	30	13.1
Utah	110	13
Nevada	73	12.6
Arkansas	77	12.5
Nebraska	52	12.5
Iowa	82	12.4
Tennessee	167	12.3
North Carolina	258	12.2
Alabama	122	12.1
Missouri	146	12.1
Arizona	173	11.9
New Hampshire	28	11.6
Georgia	252	11.2
Mississippi	68	11.2

Table 12. Suicide rates among youth aged 10 to 24 years by state, U.S. 2023 (cont.)

State	Deaths	Crude Rate
Ohio	250	11.1
Indiana	154	11
Virginia	184	11
Washington	156	11
Hawaii	27	10.9
Michigan	209	10.9
Minnesota	119	10.7
Texas	690	10.6
Wisconsin	122	10.6
Louisiana	88	9.7
South Carolina	97	9.5
Pennsylvania	210	8.7
West Virginia	26	8
Florida	302	7.8
Illinois	179	7.4
California	518	6.8
Maryland	77	6.7
New Jersey	97	5.7
New York	179	5
Massachusetts	63	4.8
Connecticut	31	4.5
Delaware	15	Unreliable
Vermont	13	Unreliable
Rhode Island	<10	Suppressed
District of Columbia	<10	Suppressed

Rates are deaths per 100,000.

Source: CDC WONDER.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Behavioral Health Division at kids.team@odhsoha.oregon.gov or 503-945-5763 (voice). We accept all relay calls.

Oregon Health Authority
Behavioral Health Division

https://www.oregon.gov/oha/hsd/bh-child-family/pages/youth-suicide-prevention.aspx

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200-170251_OHA 8874a_24 (04/2025)