OREGON HEALTH AUTHORITY

Behavioral Health Division

2024

# Adult Suicide Intervention and Prevention Plan

## First Year Progress Report

# Acknowledgments


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# Contents

**To the people of Oregon:**

This year's Adult Suicide Intervention and Prevention Plan (ASIPP) report includes updates on adult suicide prevention initiatives that Oregon Health Authority (OHA) and its partners worked on between spring 2023 and summer 2024. This report includes the most recent finalized adult suicide data for deaths (2023), attempts and hospitalizations (2023–2024), and evaluation summaries and analysis (2023–2024). In the following pages, you will find evidence of hard work by people in Oregon to create safety against suicide. We know that hope, help and healing are possible.

Before you read on, I want to acknowledge the weight that every death by suicide in Oregon carries. This report and others like it represent information and data corresponding to real people — parents, children, friends, and community members. These tragic deaths have long-lasting ripple effects in our communities.

While suicide remains a persistent cause of death, in many instances, it is preventable. At OHA, we're making progress through support from the Centers for Disease Control and Prevention (CDC) Comprehensive Suicide Prevention (CSP) grant, and other Public Health Division grants, several ASIPP initiatives have progressed. This work prioritizes adult populations that have:

- Disparate rates of suicide
- Increasing rates of suicide, or
- Populations that have been historically and systemically marginalized.

Based on those three criteria, we've focused dedicatedly on reaching older adults and service members, veterans and their families living in rural and remote locations, all of whom are at increased risk. To do this, OHA works

in partnership with hundreds of suicide prevention trainers, advocates, community members and champions around the state. Together, we conduct trainings, distribute community mini-grants that reduce isolation and increase connection, lead safe firearm storage and medication lock box initiatives, organize upstream alcohol prevention activities, and strengthen Programs to Encourage Active, Rewarding Lives (PEARLS) and Connect postvention trainings.

This work is an important step toward hope, increasing resiliency and saving lives, but we know there is more to be done. Reversing rising trends will require focused and sustained effort, including adequate and predictable funding for adult suicide prevention programming. We have to continue to pave the way forward together.

As you are reading this, if you or someone you know is struggling or in crisis, know that help is always available. Trained counselors in Oregon are available 24/7 to talk, text or chat in English, Spanish and American Sign Language. Simply call or text 988 or chat online at 988lifeline.org. You are not alone.

Ebony Clarke
Behavioral Health Division director
Oregon Health Authority

# Executive summary

**This Adult Suicide Intervention and Prevention Plan (ASIPP) Progress Report summary includes information about the progress of ASIPP initiatives as well as updated data on adult suicide in Oregon.**

The data in the report shows:

- In 2023, 868 Oregonians, ages 18 years and older, lost their lives to suicide, the 11th highest adult rate in the nation.
- The 23-year trend shows that the age-adjusted rate for suicide in Oregon (19.4 per 100,000) is significantly higher than the United States rate (14.1 per 100,000).
- The suicide death rate is highest among males throughout the lifespan. The highest is among older men, reaching a rate of 93.7 per 100,00 for men ages 85+.
- The suicide death rate for females increases with age until age 59. The highest rate for women is between ages 55-59 (17.07 per 100,000). But it declines with age thereafter.
- Veteran suicide rates continue to be significantly higher than non-veteran rates.
- In 2024, more women (53.7 percent) presented in Emergency Departments (EDs) and Urgent Care Centers (UCCs) for suicide-related visits than males (46.3 percent).

Despite limited funding for adult suicide prevention, there have been some notable accomplishments within the past year. The CDC Comprehensive Suicide Prevention federal grant is what mainly helped fund these.

The report details the progress made on the 95 initiatives listed in the 2023–2027 Adult Suicide Intervention and Prevention Plan (ASIPP) through the following:

- The Oregon Health Authority (OHA)
- OHA's contractors
- Community partners, and
- Adult-serving state agency partners.

Several initiatives were chosen for first-year implementation from ASIPP. Many initiatives had to be modified or eliminated due to funding limitations. In a fully funded ASIPP, an evaluation team and an advisory committee would have been in place before other work. State investment has yet to come for all ASIPP work.

However, some initiatives were funded by federal grants and braiding of other OHA funding sources. This includes some not initially selected as year-one ASIPP initiatives.

# Oregon Suicide Prevention Framework

The Oregon Suicide Prevention Framework is a big part of this plan. OHA developed this framework with the University of Oregon Suicide Prevention Lab under the leadership of Dr. John Seeley. It is grounded in the 2012 National Strategy for Suicide Prevention and the CDC Technical Package for Suicide Prevention. The framework was informed by the San Diego Suicide Prevention Plan and hundreds of pieces of feedback from collaborators and partners across Oregon. OHA's suicide prevention team plans to align the framework to the 2024 National Strategy for Suicide Prevention and CDC's Suicide Prevention Resource for Action.

## Framework:

### Strategic pillars, strategic goals, centering values and foundation

OHA built ASIPP 2023–2027 based on strategic goals, strategic pillars, centering lens (equity, trauma informed, collaboration) and foundation (policy, funding, data, evaluation). These parts of the framework will not change over the five-year lifespan. They are the starting point for all suicide prevention work in Oregon. These terms are referenced in ASIPP 2023–2027 and are defined in its appendix.

### Strategic pathways

Strategic pathways are not likely to change over five years. They represent measurable focus areas. They 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."

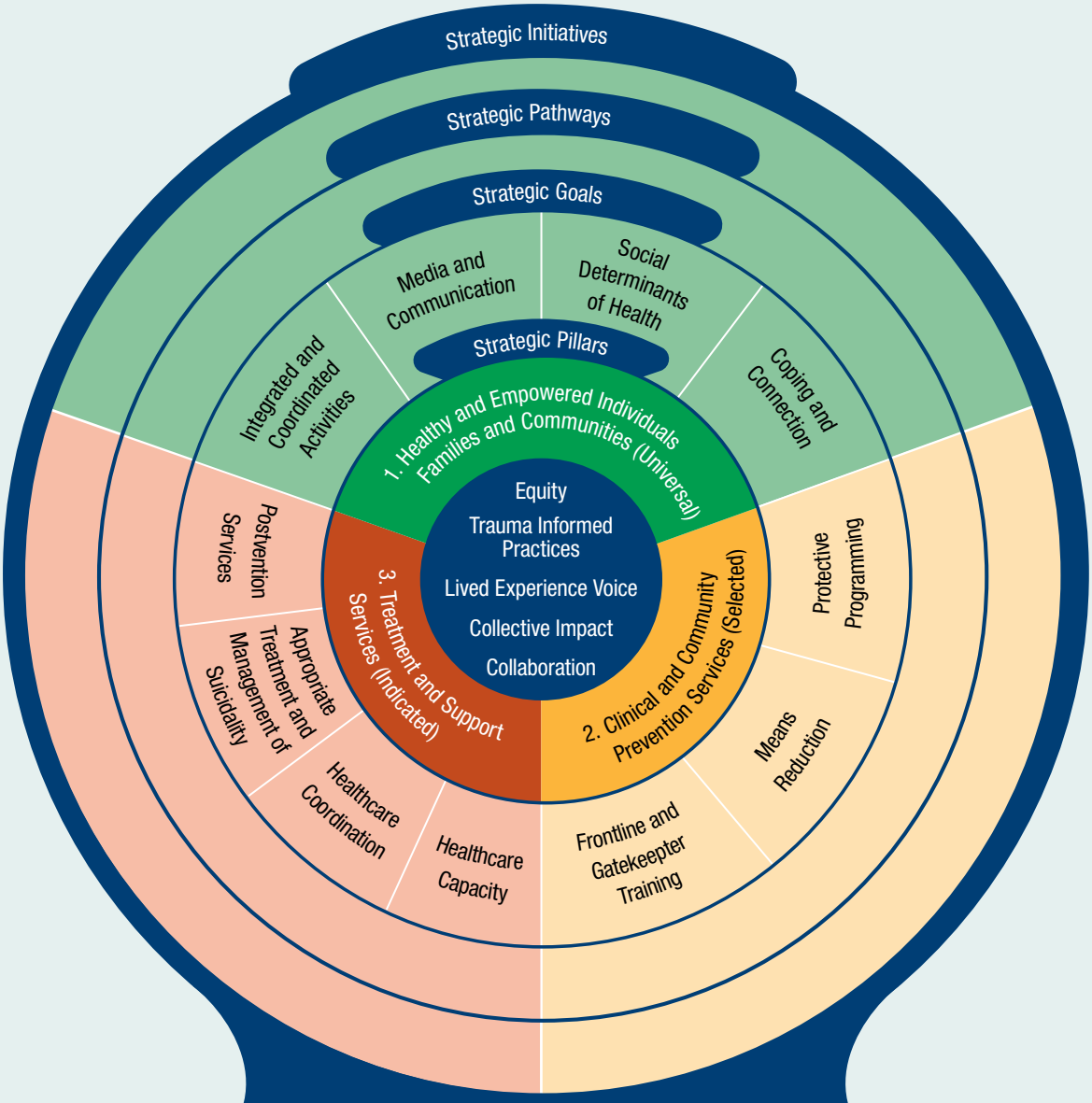
### Strategic priority initiatives

When ASIPP is fully funded, these initiatives will be adapted, adjusted and added to annually. They are specific actions that support the broader pathways and goals. Due to a lack of state investment in 2023-2024, priority initiatives were selected by those with objectives matching grant funding.

The strategic pathways and priority initiatives together comprise ASIPP 2023–2027.

**Click on this infographic for an interactive version.**

# Oregon Suicide Prevention Framework



# Adult suicide prevention funding

Funding identified to support initiatives was critical to the success of those that moved forward. There were zero general fund dollars dedicated to suicide prevention in the Behavioral Health Division (BHD) Adult Mental Health unit's budget in 2023. There have been three separate efforts since 2021 to garner state funding to support ASIPP:

- 2022 policy options package (POP) request
- 2023, Senate Bill 514, and
- 2024 POP request.

However, these efforts have failed to move forward. The only dedicated position to this work, the adult suicide prevention coordinator, is funded through BHD, Child and Family Behavioral Health (CFBH) (POP, 2019).

In addition to the Adult Suicide Prevention position funded by CFBH, several "across the lifespan" suicide prevention initiatives are funded by the 2019 CFBH POP. These are detailed under the "Programming section" of this report.

Most ASIPP initiatives are funded through federal grants awarded to the Public Health Division (PHD) Injury and Violence Prevention Program (IVPP). These are funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC). OHA Suicide Prevention Team members coordinate state and federal funding streams to meet grant and ASIPP goals. These grants include the following:

- **SAMHSA Garrett Lee Smith Memorial Act (GLSMA) (Oregon GLS)**

  OHA PHD IVPP has had an Oregon GLS grant since the initial ASIPP. This funding expired on June 29, 2024. In May, OHA wrote to apply for more GLSMA funding. In September 2024, OHA was awarded an Oregon GLS grant of $735,000 a year for five years through SAMHSA. This Oregon GLS grant is set to run from Sept. 30, 2024 to Sept. 29, 2029. However, there was a funding gap from June 29 to Sept. 29, 2024.

This grant targets youth 24 and younger. However, this funding supports suicide prevention in the critical 18–24-year-old range. The funding will support suicide prevention activities in Deschutes, Lane and Multnomah counties for the first two years. It will also provide statewide training from the Oregon Department of Human Services and Oregon Youth Authority staff and culturally specific suicide prevention work.

- **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 ages 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 Zero Suicide in Health Systems coordinator sits on the Alliance's Transitions of Care Committee to ensure coordination across programs.

  Grant accomplishments include:

  - Facilitating an ongoing Oregon Zero Suicide Community or Practice for health systems to share successes and learn from local and national experts on practical application of Zero Suicide Initiative implementation.
  - Worked with Oregon ECHO (Extension for Community Healthcare Outcomes) Network to develop and implement a 8-session Suicide Prevention ECHO for primary care clinicians, behavioral health providers and other healthcare team members. Evaluation results from this first ECHO will be used to inform a second Suicide Prevention ECHO to be provided later in 2025.
  - Providing a second round of mini-grants totaling $83,107 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.

- **CDC Advancing Violence Epidemiology in Real-Time (AVERT)**

  OHA received this funding stream for September 2023 through August 2028. This work builds on previous CDC funding to demonstrate the feasibility of monitoring and gathering data on nonfatal firearm injuries, including suicide-related data. This grant continues the work by:

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

- **CDC Comprehensive Suicide Prevention (CSP)**

  OHA was one of six awardees in the second round to get a CSP grant in September 2022. This grant provides $855,000 yearly to suicide prevention efforts across the state through August 2027. Specifically, the grant provides funding to implement and evaluate a comprehensive public health approach to suicide prevention in Oregon. The goal 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 rural areas. Attention is toward older adults and service members, veterans and their families (SMVF). CSP grant activities include several ASIPP-related initiatives:

## June 2023 – September 2024 Reporting Period

| ASIPP Initiative | CDC-CSP Grant Initiative | ASIPP and CDC-CSP Progress |
|---|---|---|
| OHA will serve as a clearinghouse for suicide prevention activities and provide timely information to counties throughout the state. | Update and implement coordinated multi-sectoral partnership plan. | **ASIPP:** The Adult Suicide Prevention Coordinator maintains an e-mail list of 125 internal and external partners that receive weekly information regarding training and employment opportunities.<br>**CDC-CSP:** 30 partners are involved in the CSP grant including 7 contractors, 17 external partners and 7 OHA internal partners. |
| Increase collaboration and coordination among other prevention activities in categories such as Alcohol and other Drugs, tobacco, gambling, and violence. | Enhance partnerships and infrastructure to increase the price of alcohol and reduce outlet density; describe the impact of alcohol on suicide morbidity and mortality in Oregon and disseminate data to raise awareness of the impact of alcohol upon suicide. | **ASIPP:** The Adult Suicide Prevention Coordinator attends the Substance Use Alignment monthly meetings. The manager of Health Promotion and Chronic Disease Program (HPCDP) serves as an advisory member for the CDC-CSP grant and provides monthly updates.<br>**CDC-CSP**: 1) There is $13.7 M in new funding for alcohol and other drug primary prevention (approved in May 2024). Six sessions were facilitated with local community prevention liaisons to determine formula for distribution. These recommendations were due to the Opioid Settlement Prevention Treatment and Recovery Board (OSPTR) Board for final approval in September 2024. OHA PH submitted recommendations related to alcohol pricing and prevention programming that could be funded through an increase in the alcohol tax, to the Task Force on August 2 2024. HB 3610 passed legislation in 2023. 2) HPCDP presented at 8/6 Tri-County Excessive Alcohol Community Conversation on Rethink the Drink (RtD) and strategies for advancing alcohol prevention and policy efforts statewide. During Summer 2024, RtD project team has conducted formative assessment activities with LGBTQI+ community partners and groups to inform a potential LGBTQI+ RtD Campaign in 2024. 3) Pending review by OHA External Relations and leadership, anticipated release of the mapping project is projected for September 2024. |

## June 2023 – September 2024 Reporting Period (cont.)

| ASIPP Initiative | CDC-CSP Grant Initiative | ASIPP and CDC-CSP Progress |
|---|---|---|
| An advisory group will be established to monitor and advise the implementation of the ASIPP. | Hold quarterly CDC-CSP advisory meetings. | **ASIPP: unfunded, no progress.**<br>**CDC-CSP:** Quarterly Advisory meetings are held. There are 30 members of the advisory with an average of 22 in attedence. There is representation from 3 universities, 2 counties, OHA and other state departments, 5 non-profits and the VA. |
| OHA will develop media and communication campaigns that promote hope, healing, and wellness and portray suicide as both a public health and behavioral health issue. | Develop, implement, and evaluate a communication and dissemination plan for stakeholders. | **ASIPP: unfunded, no progress.**<br>**CDC-CSP:** The Communications and Dissemination plan was approved the the grant advisory in April of 2023. |
| Increase opportunities and programming to reduce social isolation with older adults. | Release and award a low-barrier small grant opportunity to support community engagement activities and structures among older rural adults, including firearm owners and veterans | **ASIPP: unfunded**<br>**CDC-CSP:** 19 mini-grants have been awarded representing 28 of the 36 Oregon Counties. Some of the projects include: horse, gardening, music and art therapies, meal education and prep, World Cafe style Aging, Death and memory events, and wellness programs. |
| Promote and support programs such as Program to Encourage Active, Rewarding Lives (PEARLS) Options for People for Alternatives to Loneliness and Connection Planning for older adults. | Train Older Adult Behavioral Health Specialists as PEARLS depression management coaches and conduct group sessions in non-traditional settings such as assisted living and nursing facilities, libraries, senior centers, churches, etc. | **ASIPP: unfunded**<br>**CDC-CSP:** 23 Older Adult Behavioral Health Specialist were trained as PEARLS Coaches across the state. A total of 25 PEARLS six session groups have been completed statewide with 72 participants in attendence. PHQ- 9 depression scores decreased 29% and UCLA Loneliness Scale scores decreased by 18%. |

## June 2023 – September 2024 Reporting Period (cont.)

| ASIPP Initiative | CDC-CSP Grant Initiative | ASIPP and CDC-CSP Progress |
|---|---|---|
| Increase suicide prevention training's for family and friends of Older Adults and Veterans. | Conduct culturally adapted QPR trainings, ASIST trainings for rural older firearm owners and veterans; Certified Older Adult Peer Specialists, members of assisted living communities and caregivers; Develop, promote and Conduct Oregon CALM Conversations. | **ASIPP: unfunded**<br>**CDC-CSP:** 1) QPR curriculum was developed that included a firearms module. 2) QPR is being replaced by CALM Conversations which is projected to be available in early 2025. 3) ASIST 7 ASIST trainings that focused specifically on older adults or veterans were completed with a total of 137 participants. |
| Promote and provide Counseling on Access to Lethal Means (CALM) training to gatekeepers and health care professionals. | Promote and Conduct OR Calm trainings. | **ASIPP: unfunded**<br>**CDC-CSP** |
| Increase the number of suicide prevention trainers in rural and remote areas. | Deliver one OCALM T4T training and two QPR - Firearm module T4T's in rural settings. | **ASIPP: unfunded**<br>**CDC-CSP:** 1) QPR curriculum was developed that included a firearms module. Two T4T sessions were held to train already existing QPR trainers in this additional firearm module with 20 participants in attendance with 95% serving rural communities. |
| Increase the number of suicide prevention trainers in rural and remote areas. | Deliver one OCALM T4T training and two QPR - Firearm module T4T's in rural settings. | **ASIPP: unfunded**<br>**CDC-CSP:** 1) QPR curriculum was developed that incleuded a firearms module. Two T4T sessions were held to train already existing QPR trainers in this additional firearm module with 20 participants in attendance with 95% serving rural communities. |
| Counseling on Access to Lethal Means (CALM) is available online at no cost. | Promote and Conduct OR Calm trainings. | OCALM is promoted at conferences etc. OCALM is available on-line |

## June 2023 – September 2024 Reporting Period (cont.)

| ASIPP Initiative | CDC-CSP Grant Initiative | ASIPP and CDC-CSP Progress |
|---|---|---|
| OHA will increase the availability of Oregon CALM (in-person). | Promote and Conduct OR Calm trainings. | OCALM is promoted at conferences etc. OCALM is available in person. |
| Promote safe storage of medicine and firearms to the general population with a focus on older adults. | Create Protective Environments; Reduce Access to Lethal Means among People at Risk for Suicide; Safe Storage (e.g., locking devices). | **ASIPP: Unfunded**<br>**CDC-CSP:** Older Adult Behavioral Health Specilists throughout the state are distributing medication and firearm lock boxes. |
| Increase proactive forms of outreach which may include mobile crisis, home-based care, street outreach, drop-in centers, and Program to Encourage Active, Rewarding Lives (PEARLS) programs. | Train Older Adult Behavioral Health Specialists as PEARLS depression management coaches and conduct group sessions in non-traditional settings such as assisted living and nursing facilities, libraries, senior centers, churches, etc. | **ASIPP: Unfunded**<br>**CDC-CSP:** PEARLS has been implemented statewide and held in several non-traditional settings including assisted living and nursing facilities, libraries, churchs, AAA, senior public housing, fire stations, senior centers and primary care centers. |
| Increase culturally responsive postvention services across Oregon with a focus on Black, Indigenous, and People of Color, American Indian/Alaska Native people, people who identify as Lesbian, Gay, Bisexual, Transgender, and Queer+, veterans, and older adult populations. | Lessen Harms and Prevent Future Risk; Intervene After a Suicide; Other evidence-based intervention. | **ASIPP: Unfunded**<br>**CDC-CSP:** Connect: Postvention curriculm for a CONNECT specific to SMVF is in the process of being developed. |
| OHA will design an evaluation plan, including a contract for services, to monitor ASIPP progress. | Outcomes and Comprehensive Evaluation as per required by CDC | **ASIPP: Unfunded**<br>**CDC-CSP:** PSU and U of O are evaluating all aspects of the CSP grant. |

## June 2023 – September 2024 Reporting Period (cont.)

| ASIPP Initiative | CDC-CSP Grant Initiative | ASIPP and CDC-CSP Progress |
|---|---|---|
| Increase coordination and collaboration between OHA's suicide prevention plan and activities and counties' plan and activities. OHA will serve as a clearinghouse on suicide prevention and provide timely information to counties throughout the state. | Create an inventory of suicide prevention programs ongoing in the jurisdiction and identify prevention gaps and opportunities. | **ASIPP: Unfunded**<br>**CDC-CSP:** The CDC-CSP grant has a Partnership Plan that includes an Advisory consisting of 37 members. |

Adult suicide prevention work has progressed only because of grant funding. Without substantial state investment, adult-focused work is not likely to make significant progress. Investments can create sustainable outcomes to protect well-being and reduce suicidality across the lifespan.

# Progress report on ASIPP 2023–2024 initiatives

Due to the lack of dedicated state General Funds, many proposed first-year ASIPP initiatives published in Spring 2023 were replaced. These replacements could be funded with the grants previously stated. The initiatives proposed in ASIPP published in 2023 are listed in a Smartsheet. Grant funding helped to push some ASIPP initiatives forward. However, overall, ASIPP did not move forward in order. Many initiatives that should have been completed first were put on hold such as convening an ASIPP advisory group and creating an evaluation plan. The effect of not having funds to develop an advisory group or contract with an evaluation team to implement initiatives and measure outcomes was substantial. The CDC–CSP grant was able to provide limited funding specific to reducing the higher burden of suicide in rural areas. There is a population focus on older adults and service members, veterans and their families (SMVF).

## Data section

The following data analysis updates the data from the state's first Adult Suicide Intervention and Prevention Plan released in 2023. Data are for Oregon residents ages 18 and older, unless otherwise specified, who:

- Died by suicide
- Were hospitalized due to self-inflicted injury, or had suicidal ideation and behaviors or both.

Suicide numbers, rates and rankings by county or state vary by year. Oregon's suicide rates across all ages have fluctuated in the past five years. There was:

- A statistically significant decrease between 2019 and 2020
- An increase from 2020 to 2021,
- A slight decrease again from 2021 to 2022, and
- A slight increase from 2022 to 2023

Comparatively, the number of suicide and rates were as follows:

- 868 adult (18 and older) suicide deaths, for a rate of 25.5, in 2023, and
- 860 adult suicide deaths, for a rate of 25.3, in 2022.

Oregon's suicide rate for adults was the 11th highest in the nation in 2023. (Table 1) Overall, adult suicide deaths and rates increased from 2015 to 2023.

### Table 1. Oregon suicide deaths and crude rates among those age 18 years and older including national ranking

| Year | Number of adult suicides | Suicide death rate (per 100,000) | Rank among 50 states (50 is lowest rate) |
|---|---|---|---|
| 2015 | 742 | 23.4 | 13 |
| 2016 | 744 | 23.1 | 15 |
| 2017 | 794 | 24.3 | 15 |
| 2018 | 805 | 24.3 | 14 |
| 2019 | 886 | 26.4 | 7 |
| 2020 | 808 | 23.9 | 12 tied with another state |
| 2021 | 872 | 25.8 | 11 |
| 2022 | 860 | 25.3 | 14 |
| 2023 | 868 | 25.5 | 11 |

Source: WONDER

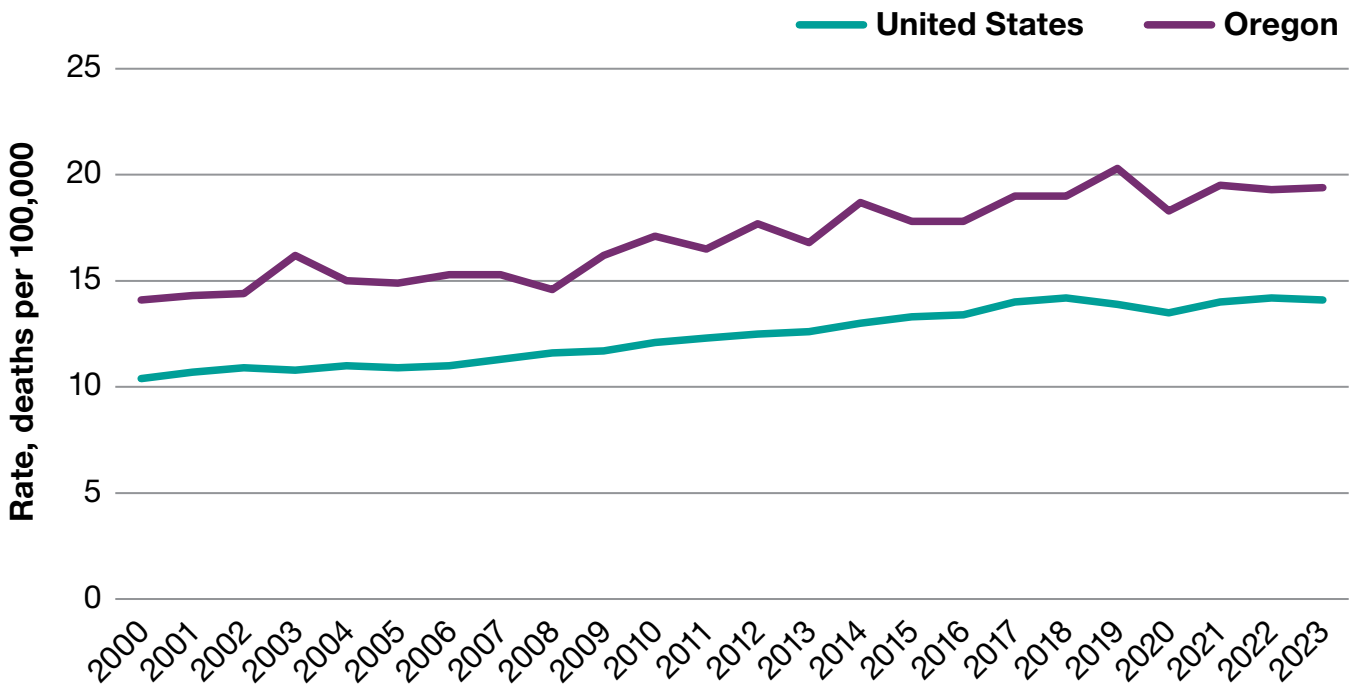
### Table 1a. Oregon suicide deaths and age-adjusted rates by year including national ranking

| Year | Number of suicides | Suicide death rate (per 100,000) | Rank among 50 states (50 is lowest rate) |
|---|---|---|---|
| 2015 | 762 | 17.8 | 13 |
| 2016 | 772 | 17.8 | 16 |
| 2017 | 825 | 19 | 15 |
| 2018 | 844 | 19 | 17 |
| 2019 | 906 | 20.4 | 9 tied with another state |
| 2020 | 833 | 18.3 | 13 |
| 2021 | 889 | 19.5 | 15 tied with other two states |
| 2022 | 883 | 19.3 | 14 |
| 2023 | 888 | 19.4 | 13 |

Source: WONDER

OHA will continue to track suicide deaths and rates to identify increasing and decreasing trends as new finalized data becomes available. Information on Oregon youth suicide data trends can be found in the 2024 Youth Suicide Intervention and Prevention Annual Report.

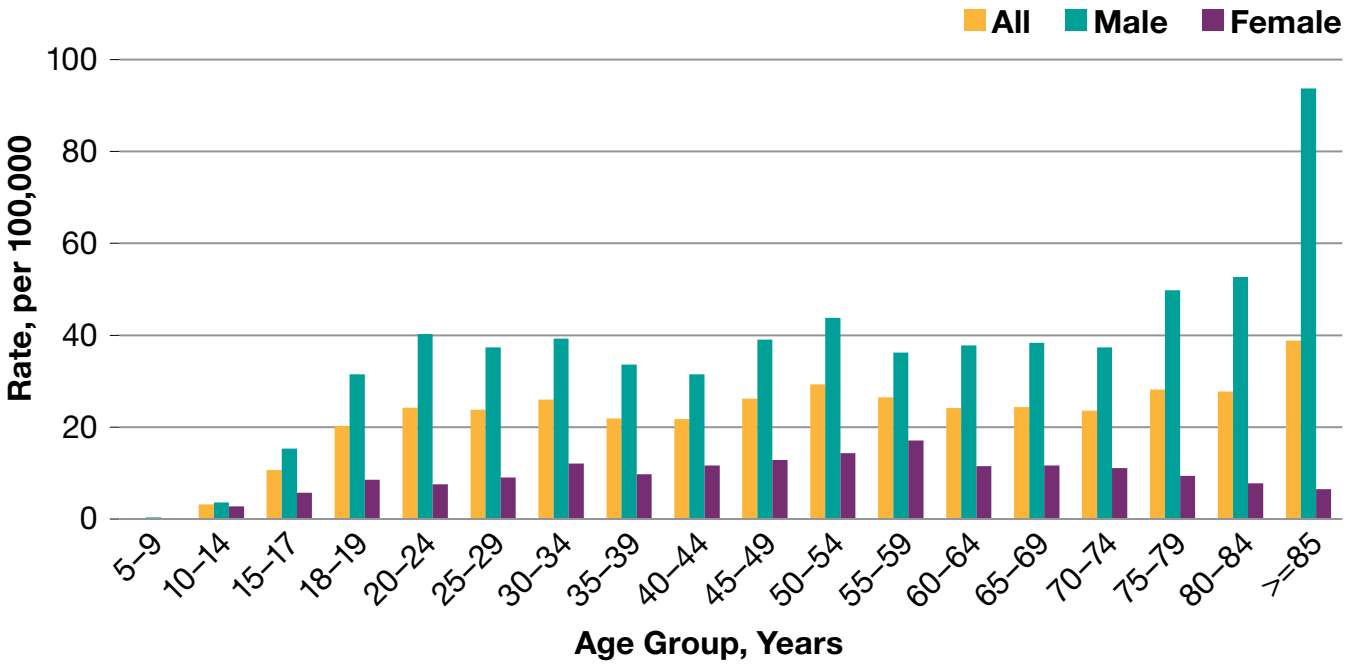
**Figure 1. The age-adjusted rate of suicide, United States versus Oregon, 2000–2023**




Source: WONDER

- Males across the lifespan had higher suicide rates than females. (Figure 2)
- Among adults, suicide rates tend to increase in adults 45–59 and 75 and older. There is a dramatic increase in male adults aged 85 and older. (Figure 2)
- From 2018-2022, the Oregon Violent Death Reporting System (ORVDRS) identified 59 suicides among transgender adults ages 18 and older. An additional 32 suicides were identified among adults who identified as lesbian, gay, bisexual or had a sexual orientation other than straight or heterosexual. These recorded deaths accounted for 10.5 percent of Oregon adult suicides between 2018 and 2022. This is likely an undercount of LGBTQIA2S+ adults who died by suicide due to existing data collection methods. Oregon House Bill 3159, passed in 2021, requires OHA to build data collection systems to collect sexual orientation and gender identity (SOGI). Learn more about these efforts on the OHA website.

## Figure 2. Age-specific rate of suicide, Oregon 2019–2023




Source: OPHAT

## Common circumstances for suicide

Table 2 highlights common circumstances surrounding suicide deaths for adults. This information can inform prevention and intervention activities. Some of these circumstances vary by binary sex and age subcategories. Between 2018 and 2022, the most common circumstances in Oregon for adults include:

- Diagnosed mental health problems
- History of expressed suicidal thoughts or plan
- Current depressed mood, and
- Current treatment for mental health or substance use problem

### Table 2. Circumstances surrounding suicide incidents, by age group and sex, 2018–2022

| Circumstances | Aged 18–24 | | | Aged 25–54 | | | Aged >= 55 | | |
|---|---|---|---|---|---|---|---|---|---|
| | All sexes (n=439 | Male (n=367) | Females (n=72) | All sexes (n=2,154) | Male (n=1,655) | Females (n=495) | All sexes (n=1,720) | Male (n=1,312) | Females (n=408) |
| Diagnosed mental disorder, % of total suicides | 49.0 | 43.9 | 75.0 | 52.7 | 48.0 | 68.3 | 46.4 | 40.9 | 64.2 |
| Alcohol problem, % of total suicides | 12.3 | 13.4 | 6.9 | 23.3 | 23.8 | 21.4 | 17.3 | 17.9 | 15.2 |
| Non-alcohol substance use problem, % of total suicides | 20.5 | 20.4 | 20.8 | 24.2 | 24.8 | 22.4 | 6.6 | 6.9 | 5.6 |
| Current depressed mood, % of total suicides | 31.2 | 30.2 | 36.1 | 28.0 | 28.0 | 28.3 | 30.8 | 30.5 | 31.6 |
| Current treatment for mental health / substance use problem, % of total suicides | 23.0 | 19.9 | 38.9 | 26.3 | 23.9 | 34.5 | 22.9 | 18.7 | 36.5 |
| Recently disclosed intent to die by suicide, % of total suicides | 18.7 | 18.8 | 18.1 | 21.5 | 21.6 | 21.4 | 17.6 | 17.6 | 17.4 |

## Table 2. Circumstances surrounding suicide incidents, by age group and sex, 2018–2022, cont.

| Circumstances | Aged 18–24 | | | Aged 25–54 | | | Aged >= 55 | | |
|---|---|---|---|---|---|---|---|---|---|
| | All sexes (n=439 | Male (n=367) | Females (n=72) | All sexes (n=2,154) | Male (n=1,655) | Females (n=495) | All sexes (n=1,720) | Male (n=1,312) | Females (n=408) |
| History of suicide attempt, % of total suicides | 25.5 | 21.0 | 48.6 | 26.0 | 22.4 | 37.2 | 14.4 | 11.1 | 25.2 |
| Left a suicide note, % of total suicides | 33.7 | 31.9 | 43.1 | 29.2 | 27.1 | 35.6 | 34.4 | 32.4 | 40.7 |
| History of expressed suicidal thought or plan, % of total suicides | 48.1 | 46.3 | 56.9 | 45.8 | 44.7 | 49.1 | 40.9 | 40.9 | 40.7 |
| Intimate partner problem, % of total suicides | 28.5 | 27.5 | 33.3 | 33.7 | 34.2 | 31.9 | 13.2 | 14.5 | 9.1 |
| Family stressor(s), % of total suicides | 8.0 | 7.9 | 8.3 | 6.1 | 5.7 | 7.3 | 4.5 | 3.8 | 6.9 |
| Recent criminal / non-criminal legal problem, % of total suicides | 5.5 | 6.5 | 0.0 | 12.0 | 13.1 | 8.3 | 4.6 | 5.5 | 1.7 |
| Financial / job problem, % of total suicides | 6.2 | 7.1 | 1.4 | 12.8 | 13.2 | 10.9 | 9.4 | 10.1 | 7.4 |
| Physical health problem, % of total suicides | 1.6 | 1.6 | 1.4 | 6.5 | 6.0 | 8.3 | 39.5 | 42.5 | 30.1 |
| Death of family member or friend within past five years, % of total suicides | 4.1 | 4.9 | 0.0 | 3.3 | 3.4 | 3.0 | 6.9 | 7.2 | 6.1 |
| Suicide of family member or friend within past five years, % of total suicides | 2.1 | 1.6 | 4.2 | 1.7 | 1.6 | 1.8 | 1.3 | 0.9 | 2.5 |

## Table 2. Circumstances surrounding suicide incidents, by age group and sex, 2018–2022, cont.

| Circumstances | Aged 18–24 | | | Aged 25–54 | | | Aged >= 55 | | |
|---|---|---|---|---|---|---|---|---|---|
| | All sexes (n=439 | Male (n=367) | Females (n=72) | All sexes (n=2,154) | Male (n=1,655) | Females (n=495) | All sexes (n=1,720) | Male (n=1,312) | Females (n=408) |
| School problem, % of total suicides | 1.8 | 1.9 | 1.4 | 0.2 | 0.1 | 0.6 | 0.0 | 0.0 | 0.0 |
| Experienced a crisis within two weeks, % of total suicides | 17.3 | 15.5 | 26.4 | 22.1 | 23.5 | 17.4 | 16.8 | 17.5 | 14.5 |
| Crisis related to problem with intimate partner, % of total suicides | 10.9 | 9.0 | 20.8 | 12.2 | 12.7 | 10.5 | 4.3 | 4.6 | 3.4 |
| Crisis related to physical health problems, % of total suicides | 0.0 | 0.0 | 0.0 | 0.4 | 0.5 | 0.2 | 4.8 | 5.2 | 3.7 |
| Crisis related to recent criminal / civil legal problem, % of total suicides | 1.6 | 1.9 | 0.0 | 3.9 | 4.5 | 2.0 | 1.5 | 2.0 | 0.0 |
| Crisis related to family stressor(s), % of total suicides | 2.3 | 2.2 | 2.8 | 1.0 | 0.9 | 1.4 | 1.0 | 1.1 | 1.0 |
| Crisis related to financial / job problem, % of total suicides | 0.9 | 1.1 | 0.0 | 2.1 | 2.4 | 1.4 | 1.3 | 1.3 | 1.2 |
| Crisis related to eviction, % of total suicides | 0.7 | 0.5 | 1.4 | 1.4 | 1.5 | 0.8 | 1.6 | 1.5 | 1.7 |
| Suspected alcohol use prior to incident | 22.3 | 23.2 | 18.1 | 29.3 | 30.3 | 26.5 | 18.5 | 18.4 | 19.1 |

Sources: ORVDRS

There were 868 suicides among Oregon adults aged 18 and older. As described in Table 3, most suicide deaths occurred among:

- Males (77.3 percent)
- Non-Hispanic white persons (82.4 percent), and
- Persons 25 to 54 (49 percent).

In 2023, 136 veteran suicides occurred. This accounted for approximately 16.1 percent of all adult suicide deaths that year. In 2023, the most common method of suicide deaths among adults included:

- Firearms (55.5 percent)
- Suffocation or hanging (22.0 percent), and
- Poisoning (15.1 percent).

### Table 3. Characteristics of adult suicides, Oregon 2023

| | | Deaths* | % of total |
|---|---|---|---|
| Age | 18 -24 | 79 | 9.3 |
| | 25-54 | 415 | 49.0 |
| | 55+ | 353 | 41.7 |
| Sex | Male | 655 | 77.3 |
| | Female | 192 | 22.7 |
| Race/Ethnicity** | White NH (Non-Hispanic) | 698 | 82.4 |
| | African American NH | 19 | 2.2 |
| | American Indian or Alaska Native NH | 12 | 1.4 |
| | Asian NH | 16 | 1.9 |
| | Pacific Islander NH | 5 | 0.6 |
| | More than one race NH | 22 | 2.6 |
| | Hispanic, all races | 64 | 7.6 |
| Veteran status** | Veteran | 136 | 16.1 |
| | Non-Veteran | 698 | 82.4 |
| Mechanism of death | Firearms | 470 | 55.5 |
| | Hanging or suffocation | 186 | 22.0 |
| | Poisoning | 128 | 15.1 |
| | Other | 63 | 7.4 |

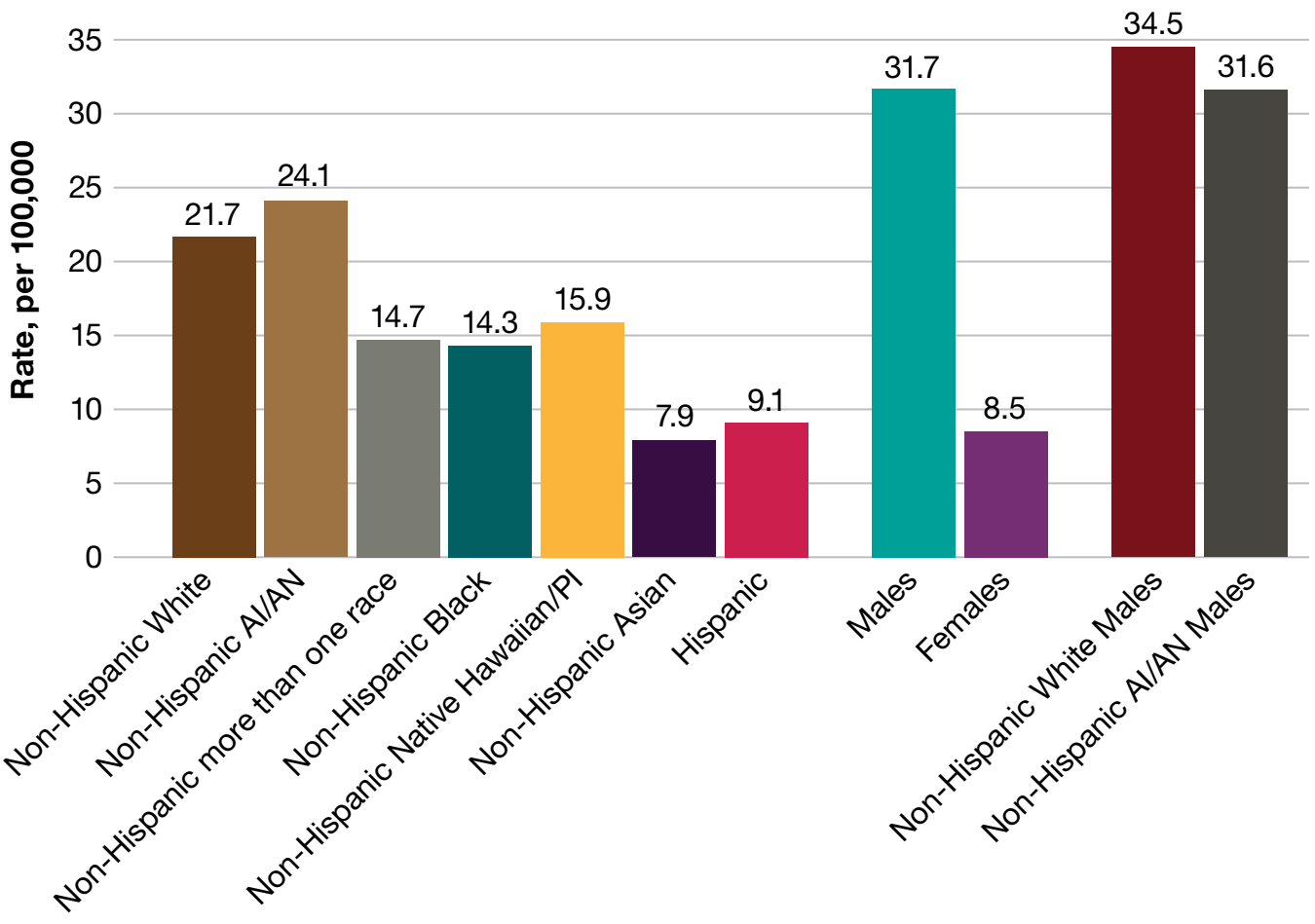
Sources: Oregon Violent Death Reporting System

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

** some deaths don't have information on race/ethnicty or veteran status. Therefore, sum of % will not be equal to 100%.

There are racial disparities in the data. For an in depth exploration of root causes, issues of equity and disparities refer to pages 28–29 of the ASIPP. Between 2019 and 2023, non-Hispanic American Indian and Alaska Native persons had the highest rate of suicide (24.1 per 100,000). When looking at non-Hispanic American Indian and Alaska Native males, the suicide rate jumps to 31.6 per 100,000. This was followed by non-Hispanic white persons (21.7 per 100,000). Non-Hispanic Native Hawaiian and Pacific Islander persons have the next highest rate of suicide followed by non-Hispanic persons with more than one race (15.9 and 14.7 per 100,000, respectively). This was followed by Non-Hispanic Black persons (14.3 per 100,000), Hispanic persons (9.1 per 100,000) and Non-Hispanic Asian persons (7.9 per 100,000). Non-Hispanic white males had the highest rate of suicide at 34.5 per 100,000.

## Numbers and percentages of suicides across all ages by race, gender and ethnicity, Oregon 2019–2023




Source: OPHAT

In 2023, when looking at percent of population by race and ethnicity, Native Indian/Alaska Native non-Hispanic adult suicide deaths accounted for 1.4% of total deaths, however they made up 1.1% of the Oregon population showing a disparity in deaths. Black non-Hispanic suicide deaths made up 2.2% of suicide deaths but only 2% of the population. Non-Hispanic white made up 82% of suicide deaths in 2023, however only made up 75.9% of the 2023 population reflecting a disparity for this community.

### Table 4. Adult (aged 18 and older) suicide numbers and percentages compared to percentage of 2023 Oregon population, 2023

| | 2023 | | 2023 population |
|---|---|---|---|
| **Race or ethnicity** | **Deaths** | **% of total** | **% of population** |
| American Indian or Alaska Native NH | 12 | 1.4 | 1.1 |
| Asian NH | 17 | 2 | 5.1 |
| Black NH | 19 | 2.2 | 2 |
| Hispanic* | 66 | 7.6 | 12.6 |
| Native Hawaiian or Pacific Islander NH | 3 | 0.3 | 0.4 |
| Two or More Races NH | 24 | 2.8 | 2.8 |
| White NH | 713 | 82 | 75.9 |
| Non-White, includes Hispanic, all races | 141 | 16.2 | 24.1 |

Sources: OPHAT

* Includes any race

The suicide death method among adults varies by male or female. Table 5 shows the mechanism of injury among suicide deaths by age group and sex in Oregon between 2018 and 2022. Among males 18-24, firearm suicide is the leading cause of death (62 percent). This is followed by hanging or suffocation (22 percent). Among females 18-24, hanging or suffocation is the leading cause of death (39 percent). This is followed by poisoning (26 percent) and firearm (22 percent). Among 25 to 54-year-olds, males died primarily by firearm (48 percent) or suffocation (34 percent). Among females aged 25 to 54 years old, 35 percent died by firearm, and 31 percent through suffocation. Those were followed by poisoning at 27 percent. Among adults aged 55 and older, males died overwhelmingly by firearm (72 percent). Among females aged 55 and older, 37 percent died by firearm followed by hanging or suffocation (35 percent).

## Table 5. Mechanism of injury among suicide deaths by age group and sex, Oregon, 2018–2022

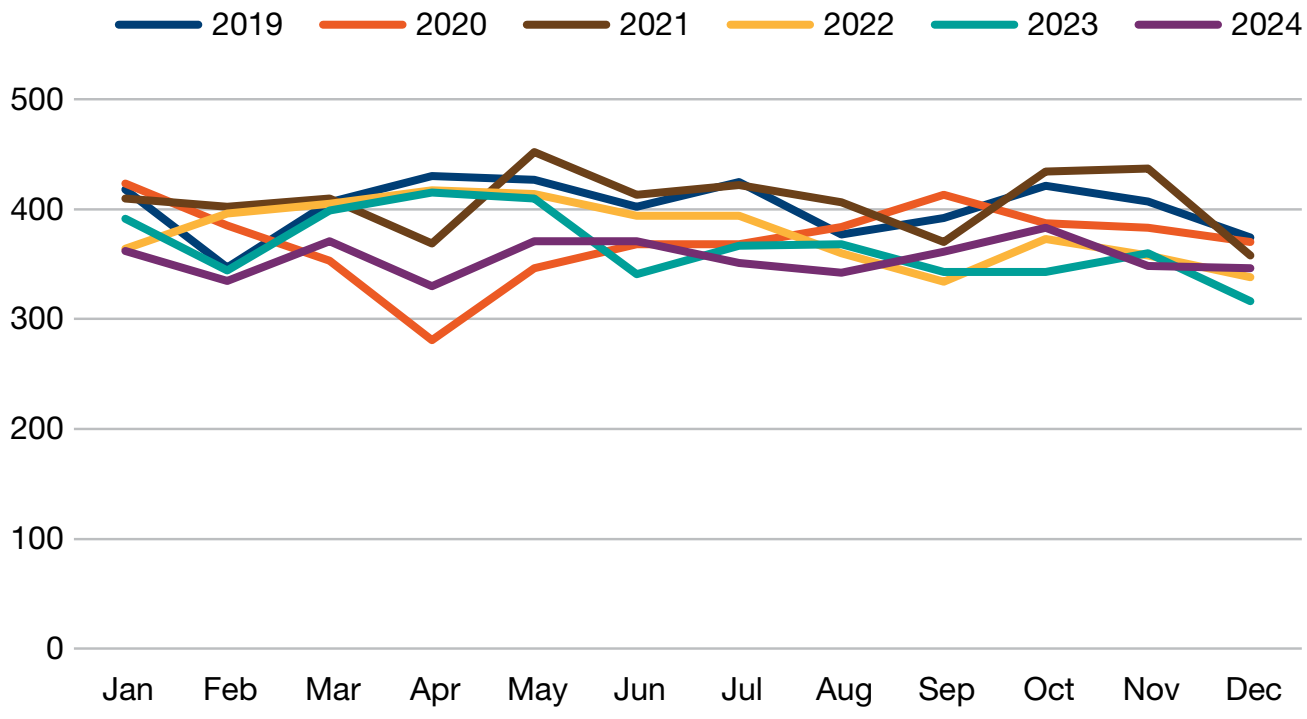
| Age group | Mechanism of injury | All | | Males | | Females | |
|---|---|---|---|---|---|---|---|
| | | Percent | Count | Percent | Count | Percent | Count |
| 18–24 years | Firearm | 55% | 243 | 62% | 227 | 22% | 16 |
| | Hanging or suffocation | 25% | 110 | 22% | 82 | 39% | 28 |
| | Poisoning | 9% | 39 | 5% | 20 | 26% | 19 |
| | Fall | 5% | 21 | 5% | 17 | 6% | 4 |
| | Motor vehicle or train | 3% | 11 | 2% | 9 | 3% | 2 |
| | Sharp instrument | 1% | 6 | 1% | 4 | 3% | 2 |
| | Other or unknown | 2% | 9 | 2% | 8 | 1% | 1 |
| | **Total** | **100%** | **439** | **100%** | **367** | **100%** | **72** |
| 25–54 years | Firearm | 45% | 966 | 48% | 794 | 35% | 171 |
| | Hanging or suffocation | 33% | 709 | 34% | 557 | 31% | 151 |
| | Poisoning | 13% | 271 | 8% | 136 | 27% | 134 |
| | Fall | 3% | 66 | 3% | 51 | 3% | 15 |
| | Motor vehicle or train | 2% | 48 | 2% | 39 | 2% | 9 |
| | Sharp instrument | 2% | 49 | 2% | 41 | 2% | 8 |
| | Other or unknown | 2% | 45 | 2% | 37 | 1% | 7 |
| | **Total** | **100%** | **2154** | **100%** | **1655** | **100%** | **495** |
| 55+ | Firearm | 64% | 1099 | 72% | 950 | 37% | 149 |
| | Hanging or suffocation | 16% | 268 | 15% | 191 | 19% | 77 |
| | Poisoning | 14% | 237 | 7% | 95 | 35% | 142 |
| | Fall | 2% | 37 | 2% | 21 | 4% | 16 |
| | Motor vehicle or train | 1% | 16 | 1% | 12 | 1% | 4 |
| | Sharp instrument | 2% | 30 | 2% | 22 | 2% | 8 |
| | Other or unknown | 2% | 33 | 2% | 21 | 3% | 12 |
| | **Total** | **100%** | **1720** | **100%** | **1312** | **100%** | **408** |

Sources: ORVDRS

2024 data is available for the number of suicide-related visits to emergency departments (EDs) and urgent care centers (UCCs) for adults ages 18 and older. This data is similar in 2024 to previous years. However, some differences in visits by age grouping are noted below. Historically, more females than males present to EDs and UCCs for suicide-related visits. In 2024, across adults ages 18 and older, females represented 53.7 percent of visits compared to 46.3 percent of visits by males.

The number of suicide-related visits to EDs and UCCs for adults ages 18 to 24 in 2024 (4,271) is slightly lower than in 2022 or 2023 (4,547 and 4,397, respectively. (Figure 4)

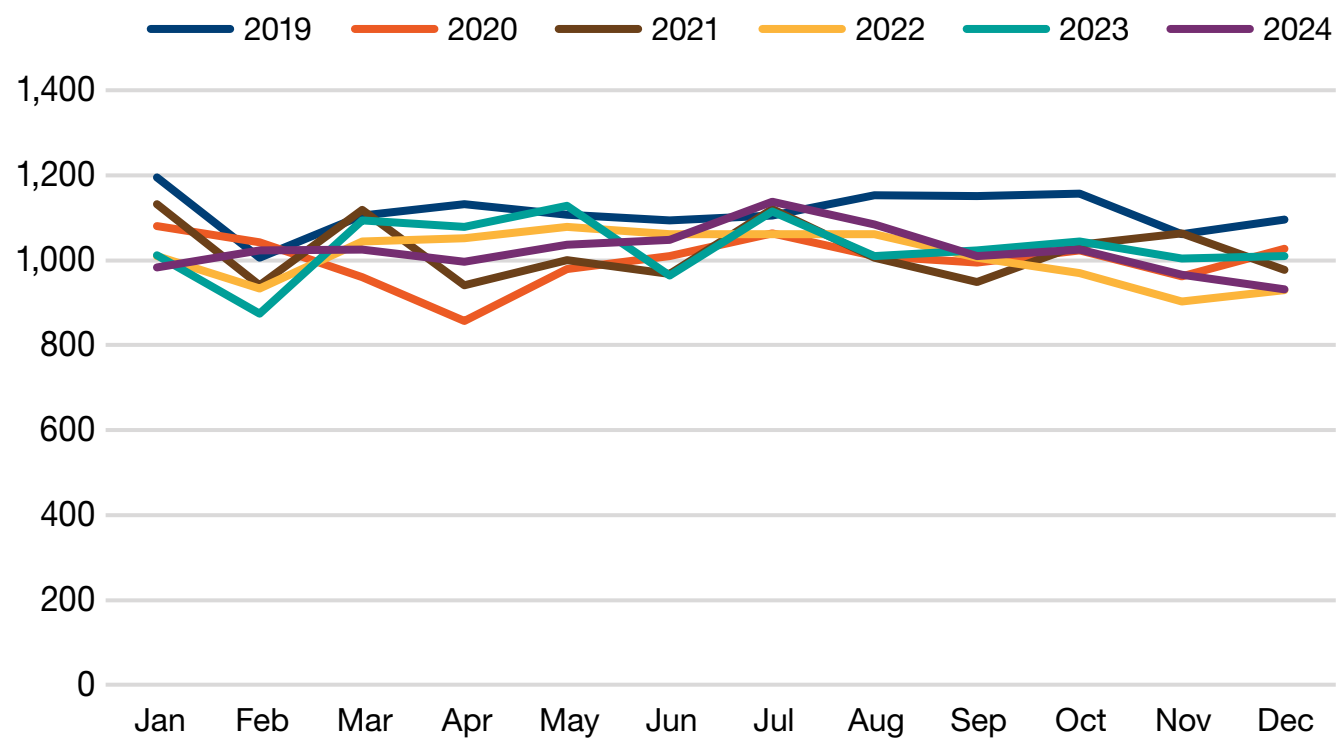
**Figure 4. Suicide-related visits to emergency departments and urgent care centers, 18–24, Oregon**




Source: ESSENCE

The number of suicide-related visits to EDs and UCCs for adults ages 25 to 54 in 2024 (12,268) is slightly lower than in 2023 (12,360). (Figure 5)

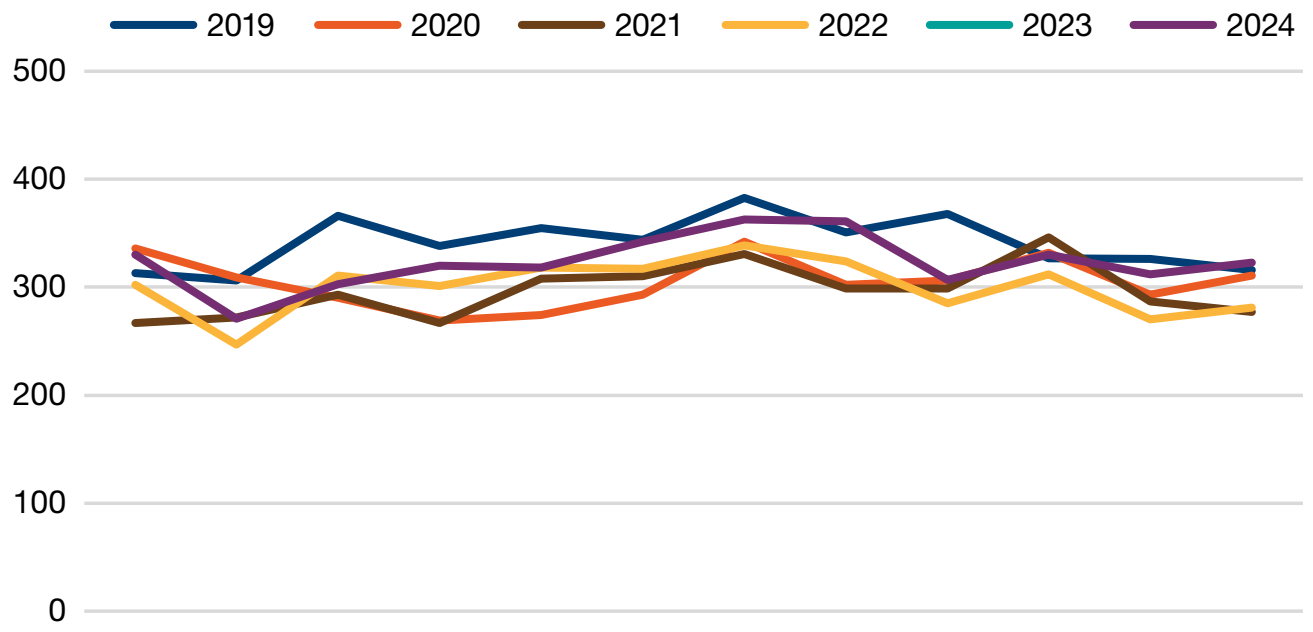
## Figure 5: Suicide-related visits to emergency departments and urgent care centers, 25–54, Oregon




Source: ESSENCE

The number of suicide-related visits to EDs and UCCs for adults ages 55 and older in 2024 (3,843) is slightly lower than in 2023 (3,896). (Figure 6)

**Figure 6: Suicide-related visits to emergency departments and urgent care centers, 55 and older, Oregon**




Source: ESSENCE

## Veteran data

OHA identified 136 veterans who died by suicide (including Oregon and non-Oregon residents) in 2023. These veterans represent 16.1 percent of all adult suicides (ages 18 and older). (Table 3) A veteran, as defined here, was someone who was ever a member of the U.S. Armed Forces. This does not include National Guard.

The suicide rate for veterans is significantly higher than the Oregon suicide rate (51 per 100,000 and 25.5 per 100,000, respectively) in 2023 (including Oregon and non-Oregon residents who died by suicide in Oregon). OHA displays veterans' Department of Defense age grouping counts and rates for better reliability. (Table 6) Suicide rates are highest in veterans aged 75+ (75.8 per 100,000) followed by veterans aged 18-34 (48.4 per 100,000). Most veteran suicide deaths are male (128 deaths in 2023, as compared to 8 deaths in females). From 2019-2023, 730 male veterans died for a suicide rate of 57.1, compared to 35 female veterans for a suicide rate of 26.4.

### Table 6. Oregon Veteran Suicide Numbers and Rates,* 2018-2023

| Year | Total 18+ | | 18-34 | | 35-54 | | 55-74 | | 75+ | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| **2018** | 170 | 55.5 | 15 | 61.8 | 32 | 45 | 71 | 52.3 | 52 | 69.3 |
| **2019** | 158 | 52.5 | 22 | 92.2 | 25 | 35.9 | 61 | 46.3 | 50 | 66.4 |
| **2020** | 161 | 54.5 | 13 | 55.5 | 40 | 58.5 | 64 | 50.2 | 44 | 57.9 |
| **2021** | 146 | 52.6 | 16 | 69.3 | 29 | 44.5 | 54 | 46.3 | 47 | 64.9 |
| **2022** | 164 | 60.3 | 18 | 78.3 | 33 | 51.7 | 48 | 44.2 | 65 | 84.9 |
| **2023** | 136 | 51.0 | 11 | 48.4 | 27 | 43.15 | 39 | 37.7 | 59 | 75.8 |

Source: ORVDRS and National Center for Veterans Analysis and Statistics.

* Only those who were injured and died in Oregon (including Oregon and non-Oregon residents) are included.

## Suicide-related county-level data

In 2023, 5,819 adults aged 18 and older, compared to 5,881 in 2022, were admitted to the emergency department or hospital related to a suicide attempt, suicide ideation or self-harm. COVID-19 had a significant effect on emergency department and hospital admissions. There was a substantial drop in non-COVID-19 emergency department and hospitalization visits in 2020 and 2021. Consider trending data cautiously, as these are still lower than 2018 and 2019.

### Table 7. Emergency Department and Hospitalization Admission Numbers for Suicide Attempt, Suicide Ideation or Self-Harm among people aged 18 and older by county of residence, Oregon 2023

| County | Ages 18–24 | | Age 25 and older | |
|---|---|---|---|---|
| | Count | % of total | Count | % of total |
| Baker | * | * | * | * |
| Benton | 28 | 1.7 | 67 | 1.6 |
| Clackamas | 132 | 8.1 | 323 | 7.7 |
| Clatsop | 24 | 1.5 | 60 | 1.4 |
| Columbia | * | * | 39 | 0.9 |
| Coos | 26 | 1.6 | 68 | 1.6 |
| Crook | * | * | 22 | 0.5 |
| Curry | * | * | 29 | 0.7 |
| Deschutes | 60 | 3.7 | 157 | 3.7 |
| Douglas | 35 | 2.2 | 73 | 1.7 |

## Table 7: Emergency Department and Hospitalization Admission Numbers for Suicide Attempt, Suicide Ideation or Self-Harm among people aged 18 and older by county of residence, Oregon 2023 (cont.)

| County | Ages 18–24 | | Age 25 and older | |
|---|---|---|---|---|
| | Count | % of total | Count | % of total |
| Gilliam | * | * | * | * |
| Grant | * | * | * | * |
| Harney | * | * | * | * |
| Hood River | * | * | 26 | 0.6 |
| Jackson | 64 | 3.9 | 236 | 5.6 |
| Jefferson | 21 | 1.3 | 47 | 1.1 |
| Josephine | 16 | 1.0 | 87 | 2.1 |
| Klamath | 48 | 3.0 | 83 | 2.0 |
| Lake | * | * | * | * |
| Lane | 203 | 12.5 | 465 | 11.1 |
| Lincoln | 14 | 0.9 | 59 | 1.4 |
| Linn | 61 | 3.8 | 188 | 4.5 |
| Malheur | * | * | 25 | 0.6 |
| Marion | 157 | 9.7 | 409 | 9.7 |
| Morrow | * | * | * | * |
| Multnomah | 320 | 19.7 | 892 | 21.2 |
| Polk | 42 | 2.6 | 85 | 2.0 |
| Sherman | 0 | 0.0 | * | * |
| Tillamook | * | * | 40 | 1.0 |
| Umatilla | 25 | 1.5 | 64 | 1.5 |
| Union | 12 | 0.7 | 25 | 0.6 |
| Wallowa | * | * | * | * |
| Wasco | 11 | 0.7 | 26 | 0.6 |
| Washington | 208 | 12.8 | 441 | 10.5 |
| Wheeler | 0 | 0.0 | 0 | 0.0 |
| Yamhill | 55 | 3.4 | 123 | 2.9 |

Source: HAO and HPA-OHA

* Range between 1–9; Counts less than 10 and not 0 are not reported to protect individual identity.

Table 8 shows the number of suicide deaths among adults 18 and older by county in 2023. There are geographic disparities in the data. Between 2019-2023 rural and remote (frontier) counties had higher rates of suicide (25.6 per 100,000 and 24.4 per 100,000, respectively) than the state suicide rate (19.4 per 100,000). Conversely, urban counties had a lower suicide rate (17.7 per 100,000) compared to the state suicide rate.

### Table 8. Number of suicides among people aged 18 years and older by county, Oregon 2023

| County | Ages 18–24 | | Age 25 and older | |
|---|---|---|---|---|
| | Death count | % of total | Death count | % of total |
| Baker | 0 | 0.0 | 2 | 0.3 |
| Benton | 1 | 1.2 | 24 | 3.0 |
| Clackamas | 8 | 9.8 | 68 | 8.6 |
| Clatsop | 0 | 0.0 | 8 | 1.0 |
| Columbia | 1 | 1.2 | 10 | 1.3 |
| Coos | 1 | 1.2 | 14 | 1.8 |
| Crook | 0 | 0.0 | 7 | 0.9 |
| Curry | 0 | 0.0 | 6 | 0.8 |
| Deschutes | 5 | 6.1 | 36 | 4.6 |
| Douglas | 5 | 6.1 | 31 | 3.9 |
| Gilliam | 0 | 0.0 | 2 | 0.3 |
| Grant | 0 | 0.0 | 1 | 0.1 |
| Harney | 0 | 0.0 | 2 | 0.3 |
| Hood River | 0 | 0.0 | 4 | 0.5 |
| Jackson | 1 | 1.2 | 50 | 6.3 |
| Jefferson | 1 | 1.2 | 3 | 0.4 |
| Josephine | 4 | 4.9 | 29 | 3.7 |
| Klamath | 2 | 2.4 | 26 | 3.3 |
| Lake | 0 | 0.0 | 2 | 0.3 |
| Lane | 8 | 9.8 | 76 | 9.6 |
| Lincoln | 0 | 0.0 | 12 | 1.5 |
| Linn | 2 | 2.4 | 27 | 3.4 |
| Malheur | 1 | 1.2 | 10 | 1.3 |
| Marion | 9 | 11.0 | 51 | 6.5 |

**Table 8: Number of suicides among people aged 18 years and older by county, Oregon 2023 (cont.)**

| County | Ages 18–24 | | Age 25 and older | |
|---|---|---|---|---|
| | Death count | % of total | Death count | % of total |
| Morrow | 0 | 0.0 | 2 | 0.3 |
| Multnomah | 17 | 20.7 | 140 | 17.8 |
| Polk | 1 | 1.2 | 10 | 1.3 |
| Sherman | 0 | 0.0 | 1 | 0.1 |
| Tillamook | 2 | 2.4 | 12 | 1.5 |
| Umatilla | 2 | 2.4 | 13 | 1.6 |
| Union | 1 | 1.2 | 5 | 0.6 |
| Wallowa | 0 | 0.0 | 1 | 0.1 |
| Wasco | 1 | 1.2 | 8 | 1.0 |
| Washington | 9 | 11.0 | 74 | 9.4 |
| Wheeler | 0 | 0.0 | 0 | 0.0 |
| Yamhill | 0 | 0.0 | 21 | 2.7 |

Source: OPHAT

## Data sources and limitations of data used for suicide surveillance

Death and suicide-related injury data has a delay in reporting due to data collection and processing both at the state and national level. Suicide-related data sources have different time delays in reporting. For example, the most recent year of finalized death data is 2023. For suicide-related visits to EDs and UCCs the report contains 2024 finalized data. The OHA Injury and Violence Prevention Program Data Glossary reviews information on datasets used in this report including timelines to release finalized data. OHA recently released the Injury and Violence Prevention Program Dashboard Overview. This is an overview of dashboards maintained by the OHA Injury and Violence Prevention Program, plus other OHA Public Health Division dashboards relevant to suicide prevention and broader injury prevention work. Suicide is one of the leading causes of death for the general population in Oregon. Suicide prevention is one of OHA's top priority issues.

Suicide is a complex behavior and is associated with many factors, including:

- Mental health
- Substance use
- Physical health
- Relationships
- Life events
- Isolation
- Social connectivity
- Other environmental and societal conditions
- Adverse childhood experiences, and
- Lack of access to mental and behavioral health services.

Oregon uses various existing administrative data sets, surveys and active surveillance efforts to monitor and track suicide and some risk and protective factors that may lead to or prevent suicide. However, these data sources may fall short in other areas of interest. Standard administrative data used to track outcomes (such as death certificates, hospitalizations or ED 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)
- Other 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 adult who died by suicide:

- Previous admissions or treatment for depression or suicidality
- Primary spoken language
- Disability status
- Depression-related intervention services in the past 12 months, and
- Previous attempts, emergency department visits or hospitalizations in the last 12 months.

Gathering missing data would require more resources, position authority and planning. It would involve many steps, including:

- Linking several large administrative data sets
- In-person case interviews
- Requirements for law enforcement agencies and health care providers to release each person's information
- Personnel for data entry and database management, and
- Requirements for hospitals to report more data types and specific reporting criteria

## Considerations for hospital and emergency department public health data sets to track suicide, self-harm and suicide ideations

Hospital and emergency department (ED) discharge data is available for 2018 on from the Hospital Association of Oregon and analyzed by OHA. Emergency department and hospitalization administrative data sets typically capture population data for all admissions. However, tracking public health trends is not their primary function. For example, administrative data sets do not capture all deaths or suicide attempts within Oregon. Not everyone in Oregon has access to an ED, and people with suicide ideation may forgo medical assistance. Many may never be admitted to the emergency department or hospital before death. Still, they do capture all diagnosed self-harm, suicide ideation and suicide attempt admissions. The data are limited on factors that may have led the person to suicide, such as untreated depression or life stressors.

The International Classification of Diseases, 10th Revision (ICD-10) added code R45.88 in October 2022 related to self-harm, suicide attempt and suicide ideation. Code R45.88 has been added to differentiate self-harm without suicide ideation (e.g., self-cutting as a coping mechanism) from self-harm with suicide intent. This code will be important to track, particularly related to youth suicide prevention as overall counts, especially among youth, will increase with R45.88 being added. OHA is currently analyzing use of R45.88 to understand how it is being used in hospital and ED settings and interpreting data for program implications.

## Considerations for active public health tracking

The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) provides real-time data from:

- All non-federal hospital emergency departments (EDs), and
- Select urgent care centers (UCC) across Oregon.

These data allow public health agencies and hospitals to track what happens in emergency departments across Oregon before, during and after a public health emergency. The International Society For Disease Surveillance's (ISDS's) Syndrome Definition (SD) Subcommittee , with input from the CDC Division of Violence Prevention, created the suicide-related query that provides data for this report . It includes ED and UCC visits for self-harm, suicide ideation and suicide attempts. Significant limitations of these data include the following:

- They do not distinguish suicide attempts from other forms of self-harm.
- Data from EDs and UCC visits fluctuate as they get and update information.
- Not everyone in Oregon can access an ED or UCC.
- People with suicidal ideations may go without medical help.

## Considerations for death certificate data

The Center for Health Statistics (CHS) at the Oregon Public Health Division (PHD) collects death certificate data. The data have been traditionally used for public health surveillance. The data provide detailed demographics and general mechanism of injury information. As well as health outcomes and geographical information. However, the data:

- Do not tell the story behind deaths, such as why the people die by suicide, and
- Do not include what may have led persons to suicide, such as untreated depression or life stressors

## Considerations for Oregon Violent Death Reporting System (ORVDRS) data

ORVDRS data link deaths to medical examiner and law enforcement reports to examine individual risk. ORVDRS data provide a more complete picture, including:

- Detailed demographics
- Mechanism of death
- Facts surrounding suicide incidents, and
- Associated suicide risk factors.

However, there is a lack of standard questionnaires and investigations on deaths in Oregon. This means data collection and reporting are not always consistent. ORVDRS data does not always include certain data elements — for example, LGBTQIA2S+ status among people who died by suicide. The data rely on witnesses and contacts of a person who died by suicide. So, incident information is not always complete. Therefore, ORVDRS data may underestimate some circumstances or risk factors.

# Appendix 1. Suicide rates among adults aged 18 years and older by state, U.S. 2023

| State | Deaths | Crude Rate |
|---|---|---|
| Alaska | 196 | 35.1 |
| Montana | 297 | 33.1 |
| Wyoming | 148 | 32.6 |
| Idaho | 426 | 28.4 |
| New Mexico | 468 | 28.1 |
| Oklahoma | 859 | 27.8 |
| Utah | 682 | 27.4 |
| Colorado | 1256 | 26.9 |
| Nevada | 669 | 26.7 |
| Arkansas | 608 | 25.7 |
| Oregon | 868 | 25.5 |
| South Dakota | 176 | 25.2 |
| Arizona | 1457 | 24.9 |
| Kansas | 547 | 24.4 |
| West Virginia | 340 | 24 |
| Maine | 270 | 23.5 |
| Missouri | 1106 | 22.9 |
| Vermont | 121 | 22.7 |
| Kentucky | 783 | 22.3 |
| Tennessee | 1232 | 22.2 |
| Indiana | 1146 | 21.7 |
| North Dakota | 130 | 21.7 |
| Alabama | 824 | 20.7 |
| Washington | 1245 | 20.2 |
| Louisiana | 698 | 19.9 |
| Mississippi | 440 | 19.5 |
| Florida | 3541 | 19.4 |
| Iowa | 478 | 19.3 |

| State | Deaths | Crude Rate |
|---|---|---|
| Wisconsin | 890 | 19.1 |
| Georgia | 1615 | 19 |
| South Carolina | 799 | 18.9 |
| Ohio | 1732 | 18.8 |
| New Hampshire | 216 | 18.8 |
| Pennsylvania | 1939 | 18.8 |
| Hawaii | 214 | 18.7 |
| Michigan | 1474 | 18.6 |
| Texas | 4211 | 18.4 |
| North Carolina | 1540 | 18.1 |
| Nebraska | 268 | 17.9 |
| Virginia | 1207 | 17.7 |
| Minnesota | 772 | 17.4 |
| Delaware | 140 | 17.1 |
| Illinois | 1526 | 15.5 |
| California | 4060 | 13.3 |
| Rhode Island | 108 | 12.1 |
| Maryland | 583 | 12.1 |
| Connecticut | 350 | 12.1 |
| Massachusetts | 650 | 11.5 |
| New York | 1673 | 10.7 |
| New Jersey | 693 | 9.5 |
| District of Columbia | 40 | 7.2 |

Rates are deaths per 100,000.

Source: CDC WONDER.

# Appendix 2. Numbers of suicides among adults aged 18 and older by race or ethnicity and year, Oregon 2018–2023

| Race or ethnicity | 2018 | | 2019 | | 2020 | | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Deaths | % of total deaths | Deaths | % of total deaths | Deaths | % of total deaths | Deaths | % of total deaths | Deaths | % of total deaths | Deaths | % of total deaths |
| American Indian/Alaska Native NH | 9 | 1 | 11 | 1 | 7 | 1 | 11 | 1.5 | 16 | 2 | 12 | 1.4 |
| Asian NH | 15 | 2 | 19 | 2 | 13 | 1.5 | 13 | 1.5 | 20 | 2.5 | 17 | 2.0 |
| Black NH | 8 | 1 | 10 | 1 | 7 | 1 | 15 | 1.5 | 12 | 1.5 | 19 | 2.2 |
| Hispanic, all races | 31 | 4 | 52 | 6 | 48 | 6 | 40 | 4.5 | 49 | 5.5 | 66 | 7.6 |
| Pacific Islander NH | 1 | <1 | 4 | 0.5 | 2 | <1 | 1 | <1 | 4 | 0.5 | 3 | 0.3 |
| Two or More Races NH | 9 | 1 | 18 | 2 | 18 | 2 | 20 | 2.5 | 14 | 1.5 | 24 | 2.8 |
| White NH (% of total) | 730 | 90.5 | 771 | 87 | 711 | 88 | 768 | 87.5 | 730 | 85.5 | 713 | 82.0 |
| **Total** | **805** | | **888** | | **810** | | **876** | | **855** | | **870** | |
| Total Non-White, includes Hispanic all races | 73 | 9.1 | 114 | 12.8 | 95 | 11.7 | 100 | 11.4 | 115 | 13.5 | 141 | 16.2 |

Source: OPHAT

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Behavioral Health Division

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