

2025

Adult Suicide Intervention and Prevention Plan

Second Year Progress Report



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Introduction letter

Dear people of Oregon:

First, I want to acknowledge the trauma and tragedy involved in death by suicide and its potential long-term ripple impact in our families, workplaces, schools, places of worship and communities. While suicide may impact specific communities differently, it remains a persistent cause of death in all communities.

In most instances suicide is preventable. The Adult Suicide Intervention and Prevention Plan (ASIPP), published in 2023, and new culturally infused Oregon Suicide Prevention Framework serves as our adult suicide prevention, intervention and postvention roadmap. The new framework embeds preferred languages and cultural values, practices, beliefs, behaviors, and research into suicide prevention efforts. Diverse identities are embraced and equity is the upmost priority.

This report highlights adult suicide prevention work that OHA and partners have accomplished this past year (2025) and details the newest data available (2024).

At OHA, we're making progress through support from federal grants, held in the Public Health Division, including Centers for Disease Control (CDC) and Substance Abuse and Mental Health Services Administration (SAMHSA). The CDC Comprehensive Suicide Prevention Grant (CSP) prioritizes adult populations that are disproportionately affected by suicide which includes older adults and veterans living in rural areas.

OHA does not do this work alone and is fortunate to have hundreds of dedicated, talented partners across the state who serve as suicide prevention trainers, advocates, community members and champions around the state. Together, we conduct suicide prevention and postvention trainings, distribute community mini grants, provide free safe firearm storage and medication lock boxes, organize upstream alcohol prevention activities, and provide group sessions of Programs to Encourage Active, Rewarding Lives (PEARLS) which reduces depression in older Adults.

Although this work is movement toward reducing suicide rates in our adult population, we know there is more to be done. This will require focused and sustained efforts, including dedicated state funding for adult suicide prevention programming. It will also require using an approach to suicide prevention that honors cultural differences such as preferred languages, cultural values, practices, beliefs, and behaviors.

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 strategies (2025) as well as updated CDC data (2024) on adult suicide deaths in Oregon.

The data in the report shows:

- Adult suicide deaths (aged 18 years and older) in Oregon increased between 2023 and 2024. In 2024, 913 Oregonians, ages 18 years and older, lost their lives to suicide, the 9th highest adult rate in the nation. Preliminary 2025 suicide deaths appear to be lower than 2024 deaths.*
- In 2024, 941 Oregonians died by suicide (20.0 per 100,000) compared to 888 deaths (19.4 per 100,000) in 2023.
- Oregon saw an increase in 2024 while the national suicide rate saw a slight decrease.
- The increased rate in 2024 appears to be driven by an increase in suicides among adults aged 55 and older. Older adult suicides increased by 18 percent between 2023 and 2024. Preliminary 2025 suicide deaths for older adults appear to be more similar to the number of 2023 suicide deaths.
- The suicide death rate is highest among men throughout the lifespan. The highest is among older men, reaching a rate of 103.6 per 100,000 for men ages 85+.
- The suicide death rate for women increases with age until age 59. The highest rate for women is between ages 55–59 (16.9 per 100,000). But it declines with age thereafter.
- In 2024, Veteran suicide rates (55.8 per 100,000) continue to be significantly higher than non-veteran rates.
- Between 2020 and 2024, non-Hispanic American Indian and Alaska Native persons had the highest rate of suicide (23.8 per 100,000). When looking at non-Hispanic American Indian and Alaska Native men, the suicide rate jumps to 33.1 per 100,000.

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 this work.

* Data for 2025 will not be official until late spring 2027. This is when Centers for Disease Control and Prevention (CDC) releases finalized data.

The Oregon Suicide Prevention Framework has been culturally infused in alignment with the ASIPP, the [Youth Suicide Intervention and Prevention Plan](#) (YSIPP), and the broader OHA health equity goal. This change impacts the reporting process because strategies have changed since the [2023–2027 Adult Suicide Intervention and Prevention Plan](#) (ASIPP) was published. There are now [133 ASIPP strategies and initiatives](#) which is an increase from the ASIPP 2023 publication which had 92 initiatives. An example of a new initiative includes “3.3.2.1 OHA will support culturally and linguistically responsive approaches to services that address diverse cultural conceptualizations of suicide, including body work, movement work, cultural healing practices, sleep therapy, tribal based practices, and other evidence informed treatments for reducing suicidality.” All strategies can be found at ASIPP Year Two Smartsheet Tracker.

The strategies and initiatives include:

- Strategies and initiatives from the ASIPP published in 2023
- Federal grant strategies and initiatives
- Culturally infused strategies
- Across the lifespan work shared by the YSIPP and ASIPP.

The report details progress made through the following:

- The Oregon Health Authority (OHA)
- OHA’s contractors
- Community partners
- Adult-serving state agency partners

Ideally, an evaluation team and an advisory committee would have been in place before other work. State funding has yet to come for all ASIPP work. However, some strategies were funded by federal grants and braiding of other OHA funding sources.

Oregon Suicide Prevention Framework

The [OHA Public Health Division 2025 State Health Assessment](#) states, “The Institutional discrimination and racism have contributed to Oregon’s communities of color and Tribal communities to experience poorer health outcomes, including related to mental health and suicide. Historical disenfranchisement through genocide, cultural disconnection and pressure to assimilate has resulted in American Indian/Alaska Native peoples having high rates of suicide”.

Keeping in line with the OHA goal to end health inequities by 2030 and aligning the ASIPP with the recently published [Youth Suicide Intervention and Prevention Plan \(YSIPP\) 2026–2030](#), the [Oregon Suicide Prevention Framework](#) was culturally infused and was updated for this year two report. This new culturally infused framework will be used in the upcoming ASIPP 2027–2032 publication and will be used from this point forward in annual reports and when referencing ASIPP.

The [ASIPP 2023–2027](#) attempted to avoid a one-size-fits-all approach, but did not go far enough to consider ways in which culture influences suicide prevention. For example, when the ASIPP 2023–2027 was being developed, 4.2% of partners self-identified as AI/AN. However there was no formal tribal consultation or involvement. This will be rectified in the 2028–2032 ASIPP.

What is cultural infusion?

OHA relied on the [Cultural Theory and Model of Suicide](#),* which shows that culture:

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

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

* Chu, J. P., Goldblum, P., Floyd, R., & Bongar, B. (2010). The cultural theory and model of suicide. *Applied and Preventive Psychology*, 14, 25–40. <https://doi.org/10.1016/j.appsy.2011.11.001>

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

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

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

Following the in-depth learning series, The OHA suicide prevention team reviewed the previous Oregon Suicide Prevention Framework line-by-line to culturally infuse the pillars, goals and pathways resulting in the revised [Oregon Suicide Prevention Framework](#). The Framework guides the Youth Suicide Intervention and Prevention Plan and the Adult Suicide Intervention and Prevention Plan. Thinking about culture across the framework expanded strategies for all youth and adults.

A few examples in the ASIPP include:

Original Framework	Culturally Infused Framework
Voice of lived experience – Positive Connections: Build active relationships through outreach with organizations of all types led by and working with Black, Indigenous, and People of Color to become fully embedded in the community.	1.1.4.1 Build active relationships through outreach with organizations that serve diverse communities such as persons of color, tribal, LGBTQ+, SMVF, rural communities, older adults and others. Include voices of lived experience in all advisories and meetings.
Postvention Services: OHA will support Connect: Postvention training by providing low or no-cost access to Train-the-Trainer events, statewide coordination for local training needs, evaluation support and limited course support.	Increase culturally responsive postvention services across Oregon with a focus on Service Members Veterans and their Families (SMVF).

Following this in-depth review, CCPA, on behalf of OHA, sought community input including surveys, focus groups, and round tables. After incorporating community feedback and input, a scan for promising practices was conducted by the University of Oregon Suicide Prevention Lab to see what else we may have missed in new work. For more information on the development and cultural infusion of this Framework, review the [YSIPP 2026-2030, pages 8-17](#).

New 2026 Oregon Suicide Prevention Framework

The chart below shows the strategies in the [ASIPP Year Two Smartsheet Tracker](#). Each strategy has a four-part numbering system, with initiatives tucked under strategies with five- and six-part numbers:

1 = Pillars

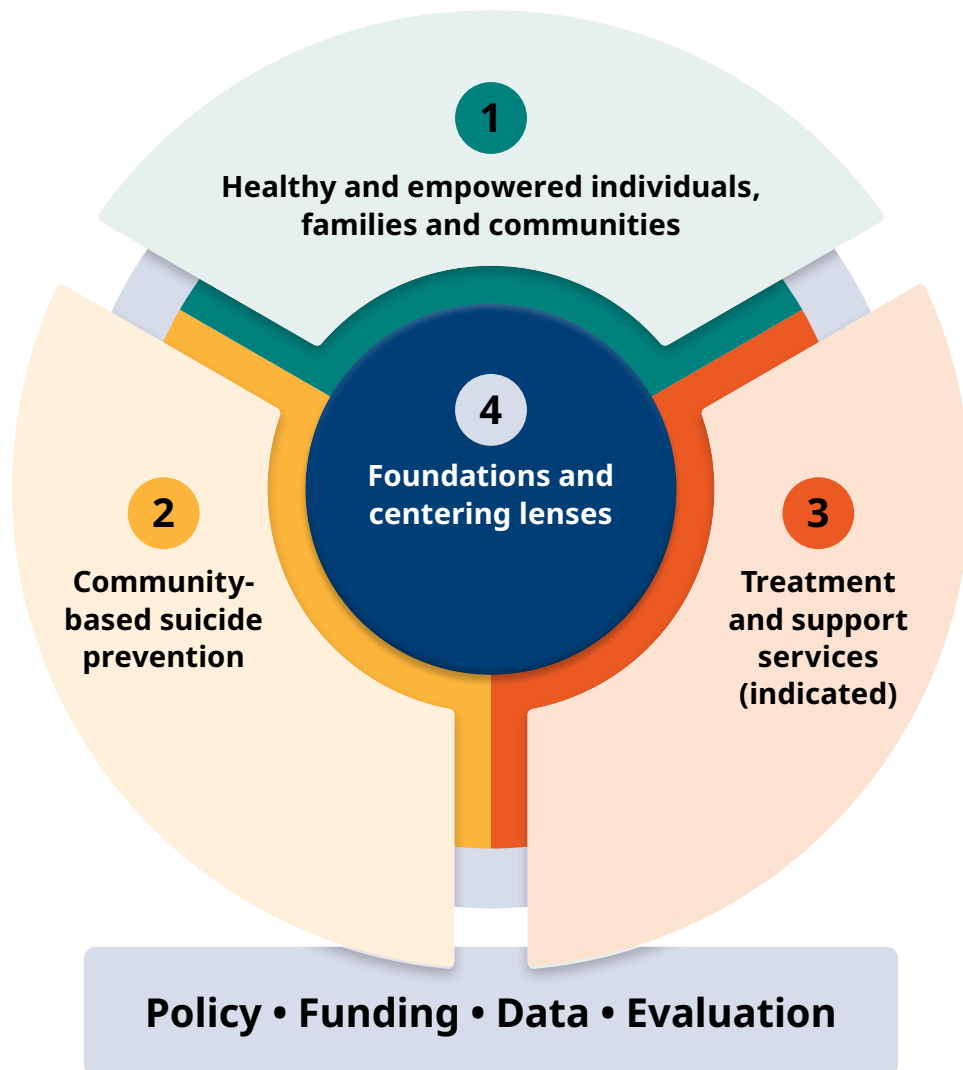
1.1 = Goals

1.1.1 = Pathways

1.1.1.1 = Strategies

1.1.1.1.1 and 1.1.1.1.1.1 = Initiatives

Oregon Suicide Prevention Framework



Click on the individual pillars to learn more.

Adult suicide prevention funding

There is one dedicated position for this work, the Adult Suicide Prevention Coordinator, which is funded through a successful POP in 2019, held in the Child Family and Behavioral Health unit.

In addition to the dedicated position, several “across the lifespan” suicide prevention strategies are funded by the 2019 CFBH POP. These are detailed in the [ASIPP Year Two Smartsheet Tracker](#).

Some ASIPP strategies 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 are detailed in the next section – “Progress Report”.

Progress report on ASIPP 2024–2025 strategies

The new culturally infused strategies and initiatives proposed are listed in the [ASIPP Year Two Smartsheet Tracker](#). These initiatives include many original initiatives from the ASIPP 2023–2027 publication that have been modified to include cultural infusion and across-the-lifespan initiatives from the YSIPP 2026–2030. Grant funding helped to move some ASIPP initiatives forward. However, many strategies that were projected to be completed were not implemented due to lack of funding. These strategies include efforts such as creating an evaluation plan and establishing an advisory committee. The CDC–CSP grant, along with other federal grants, were able to provide limited funding that enabled some of the ASIPP to progress including:

SAMHSA Garrett Lee Smith Memorial Act (Oregon GLS)

OHA received a new round of GLS grant funding beginning September 30th, 2024. Oregon receives \$735,000 a year through this grant mechanism. Currently, this funding supports suicide prevention capacity grants in select Oregon counties and through both the Oregon Department of Human Services (ODHS) and Oregon Youth Authority (OYA, serving adults aged 18–24). It also supports community and clinical training to reduce suicides of adults aged 18–24 years old.

SAMHSA Zero Suicide in Health Systems Grant

OHA received \$700,000 a year from September 2020 through August 2025. This grant supported 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. OHA was able to continue momentum on health system Zero Suicide efforts with one-time Behavioral Health Division monies that are providing mini-grants to eight health systems through June 2026. SAMHSA has released a new funding opportunity for an additional cohort of this grant that OHA plans to apply for.

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.
- 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. Per CDC, the grant aligns with the CDC's [Suicide Prevention Resource to Action](#) guide that outlines seven strategies based on the best available evidence for suicide prevention. The guide includes approaches to advance each strategy. The goal is to reduce suicide attempts and deaths in rural and remote 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 and remote areas. Attention is paid specifically toward older adults and service members, veterans and their families (SMVF). Through this grant, OHA has sought to:

- Enhance partnerships – 31 partners are involved in the CSP grant including dedicated contractors, external partners, organizations working in rural and remote areas, other state agencies, Tribal organizations and OHA internal partners. An advisory is held quarterly with an average of 23 participants in attendance. Grant team meetings are held bi-weekly.
- Work between OHA's Suicide Prevention Program and Excessive Alcohol Use Prevention Program on several activities given the identified strong relationship between alcohol and suicide-related outcomes:
 - Enhanced partnership and infrastructure between OHA suicide and alcohol programs. Programs have worked to get information on the connection between alcohol and suicide-related outcomes to local Alcohol and other Drug Prevention and Education Program (ADPEP) grantees.
 - OHA created [Alcohol Outlet Density maps](#) that went live October 30, 2024. Several studies have suggested that reduced alcohol outlet density can reduce alcohol-involved suicide. The map is being promoted in partner meetings and presentations.

- OHA's Excessive Alcohol Use Prevention webpage contains links to all alcohol related information, data and resources that currently exist across OHA Public Health Division programs. The Chronic Disease Data Portal provides data on alcohol consumption by various socioeconomic variables as well as other alcohol data. The chronic disease dashboards were also updated to include an "excessive alcohol use" button for non-alcohol risk factors or causes of death.
- OHA's Rethink the Drink campaign website links and citations were updated in Fall 2025. Rethink the Drink continues to be featured in multiple media outlets regularly.
- Communication and Dissemination - A suicide prevention, intervention and postvention trainings article was published in 4 Oregon medical board newsletters for a combined reach of approximately 56,000 healthcare professionals. Following the dissemination, there was an increase in the number of healthcare professionals who completed the Addressing Firearm Safety with Patients at Risk of Suicide course focused on key elements of rural culture that impact conversations and suicide safer care practices with firearm owners living in rural areas.
- Suicide prevention trainings – Trainings are offered through the CSP grant including Applied Suicide Intervention and Skills Training (ASIST), Oregon Community CALM Conversations on Lethal Means, Oregon Counseling on Access to Lethal Means, and Addressing Firearm Safety with Patients at Risk of Suicide.
- Suicide Postvention – The Service Members, Veterans and their Families (SMVF) Connect postvention curriculum was completed in July 2025 including workbooks and slides. A train-the-trainer event was held in August of 2025 with 11 participants completing the training. Several SMVF Connect Postvention trainings took place in rural Oregon.
- Lethal means related work:
 - Secure storage devices, including Large and XXL gun lock boxes and storage cases with keyed pad locks (for other lethal means), have been distributed to Older Adult Behavioral Health Specialists across 26 counties to distribute directly to older adults or provide to partnering organizations to distribute when they support an older adult at risk of suicide.
 - Extreme Risk Protection Orders – Oregon's ERPO law went into effect on January 1, 2018. There is increasing evidence that ERPO laws can reduce firearm suicides. Through the CSP grant, OHA is working to understand perceptions and barriers. Oregon Health and Sciences University's (OHSU) Gun Violence Prevention Research Center has been contracted to implement a series of interviews including key informant (judges, law enforcement,

attorneys, judicial clerks, prevention specialists), civil petitioners and respondents. The first two (key informant and civil petitioners) are complete and the reports can be found on the [OHSU Gun Violence Prevention Research Center Resources page](#).

- [Safe Life Oregon](#) – modeled after the national [Armory Project](#), the Oregon Firearm Safety Coalition has been contracted to create an Oregon Armory Project webpage. This webpage will provide an array of information on ways to store firearms safely including Federal Firearm Licensee (FFL) that are willing to store them on their premises. The website will also contain Oregon-specific firearm laws, secure firearm storage maps, suicide prevention resources, and tools for creating time and distance strategies. An Oregon Armory Summit was held in February of 2026 with 19 participants present that included FFL's, counties and state agencies. The website is projected to go live in the early fall of 2026.
- [Program to Encourage Active and Rewarding Lives \(PEARLS\)](#) – this is a psychoeducational program that educates older adults about depression and helps them develop the skills they need for self-sufficiency and more active lives. The program takes place in six to eight sessions and is held in a group setting. The Older Adult Behavioral Health Specialists throughout the state have been trained as PEARLS “coaches” and hold sessions in community settings where older adults are likely to congregate. Settings have included senior centers, libraries, Tribal Health Centers, and assisted living communities, among others. In October of 2025, PEARLS began being offered virtually using Zoom.
- Rural Older Adult Mini grants – between 2023 and 2025, a total of 27 low barrier, small (up to \$15,000) mini grants were awarded to rural organizations with the goal of reducing loneliness and increasing connection among older adults and veterans living in rural areas. There were a series of three cohorts, with participation in 32 of the 36 Oregon counties. Some of the projects included: equine activities, gardening, music and art therapies, meal education and prep, ‘World Cafe’ style events on aging, death and memory, and wellness programs. Yellowhawk Tribal Health Center programming included Elders Garden Guild, Elders movie matinee, Horse Medicine Elders group, weaving and crafting, music performances Age/Memory/Death Cafes and a grief loss support group.

For greater detail, the CSP grant strategies have been included as a part of the ASIPP strategies and can be found in the [ASIPP Year Two Smartsheet Tracker](#).

Data section

This report contains program updates for 2025 and final suicide death data from 2024. Suicide numbers, rates and rankings change from year to year. The best way to study the data is by tracking trends long-term. Oregon’s suicide rates across all ages have fluctuated over the past 5 years with a significant decrease between 2019 and 2020 followed by stable rates between 2021 and 2023. Oregon saw an increase in the suicide rates between 2023 (19.4 per 100,000) and 2024 (20 per 100,000). In 2024, 941 individuals died by suicide in Oregon with 913 people being 18 years of age or older (Table 1. and 1a.).

Oregon’s suicide rate for adults was the 9th highest in the nation in 2024. (Table 1) Overall, adult suicide deaths and rates increased from 2015 to 2024. Oregon suicide rates continue to be higher than the United States average.

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

Year	Number of 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
2024	913	26.5	9

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 two other states)
2022	883	19.3	14
2023	888	19.4	13
2024	941	20	9

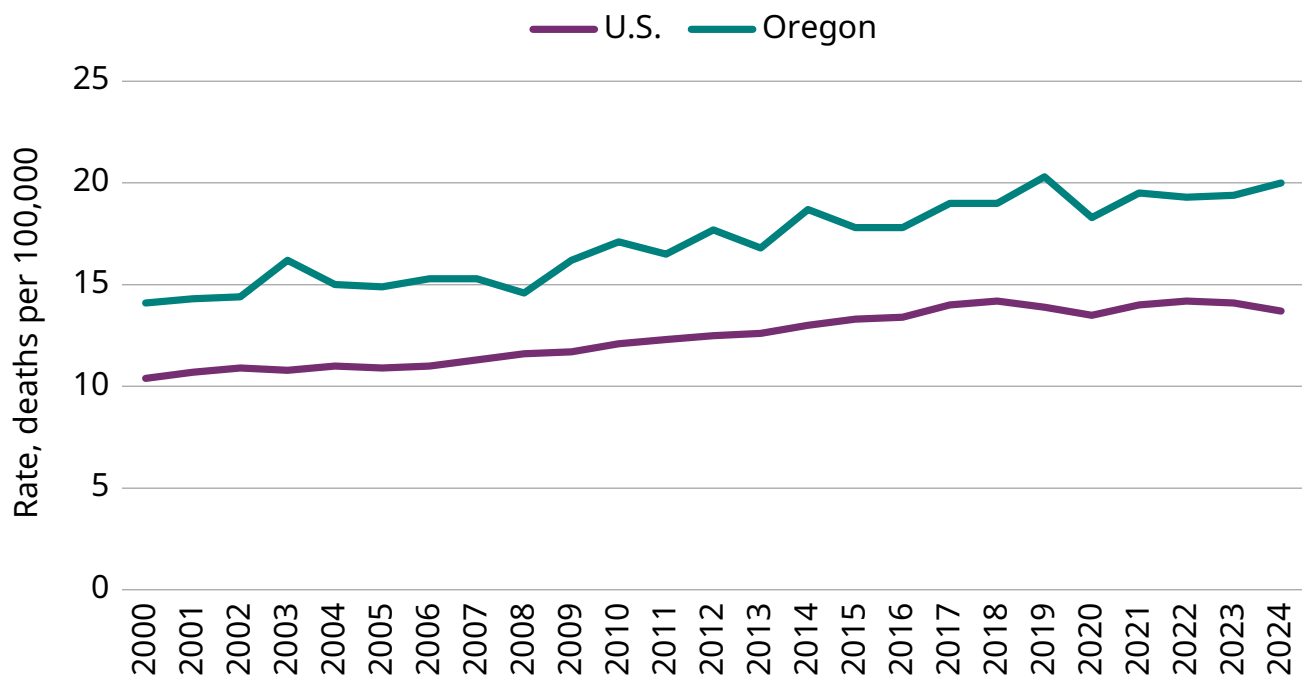
Source: WONDER

Data are for Oregon residents ages 18 and older, unless otherwise specified. It focuses on Oregon adults who:

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

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 [2025 Youth Suicide Intervention and Prevention Annual Report](#).

Figure 1: Age-adjusted rate of suicide, U.S. vs Oregon, 2000–2024

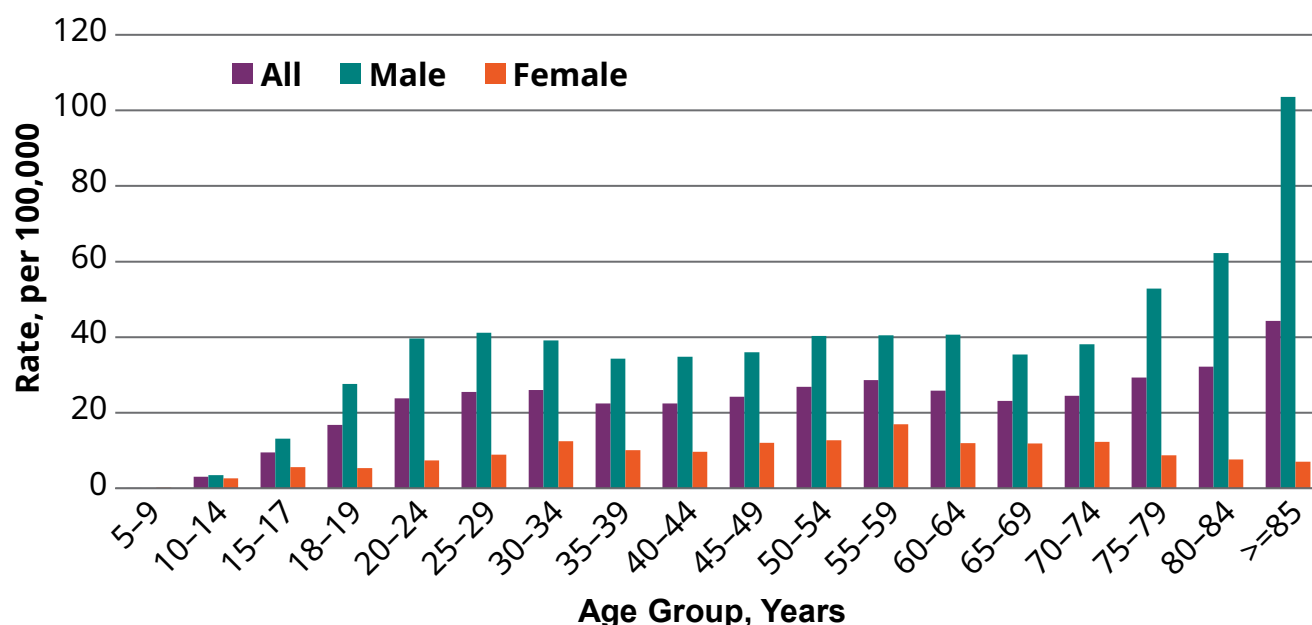


Source: WONDER

According to 2024 Oregon suicide death data:

- Men across the lifespan had higher suicide rates than women. (Figure 2)
- Among adults, suicide rates tend to increase in adults 45–59 and 75 and older. There is a dramatic increase in men aged 85 and older. (Figure 2)
- From 2019–2023, the Oregon Violent Death Reporting System (ORVDRS) identified 67 suicides among transgender adults ages 18 and older. Forty-six 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 2.4 percent of Oregon adult suicides between 2019 and 2023. 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](#).
- Between 2020 and 2024, non-Hispanic American Indian and Alaska Native persons had the highest rate of suicide (23.8 per 100,000). When looking at non-Hispanic American Indian and Alaska Native men, the suicide rate jumps to 33.1 per 100,000.

Figure 2: Age-specific rate of suicide, Oregon 2020–2024



Source: WONDER

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 2019 and 2023, the most common circumstances in Oregon for adults include:

Aged 18 to 24:

- Diagnosed mental health condition
- History of expressing suicidal thought or plan
- Intimate partner problem
- Current depressed mood
- Suspected alcohol use prior to incident

Aged 25-54:

- Diagnosed mental health condition
- History of expressed suicidal thought or plan
- Intimate partner problem
- Suspected alcohol use prior to incident
- History of suicide attempt

Aged 55 and older:

- Diagnosed mental health condition
- History of expressed suicidal thought or plan
- Physical health problems
- Current depressed mood
- Current treatment for mental health or substance use problem

Table 2. Circumstances surrounding suicide incidents, by age group and sex, Oregon, 2019–2023

Circumstances	Aged 18–24			Aged 25–54			Aged ≥ 55		
	All sexes (n=439)	Males (n=366)	Females (n=67)	All sexes (n=2,197)	Males (n=1,708)	Females (n=486)	All sexes (n=1,757)	Males (n=1,340)	Females (n=417)
Diagnosed mental disorder, % of total suicides	52	48.4	71.6	54.8	50.7	69.1	46.2	41	62.8
Alcohol problem, % of total suicides	12.7	13.9	6	23.3	24.2	19.8	17	17.6	15.1
Non-alcohol substance use problem, % of total suicides	17.8	18	16.4	26.6	27.6	23.3	7.3	7.7	6.2
Current depressed mood, % of total suicides	28.4	28.1	29.9	26.5	26.7	25.9	29.2	29.3	29
Current treatment for mental health / substance use problem, % of total suicides	22.9	20.5	35.8	26.1	24.2	33.1	20.5	16.5	33.6
Recently disclosed intent to die by suicide, % of total suicides	18	18.9	13.4	21.3	21.1	22	16.4	16.9	14.9
History of suicide attempt, % of total suicides	24.5	19.7	50.7	27.4	23.7	39.9	13.7	10.6	23.5
Left a suicide note, % of total suicides	33.5	31.7	43.3	28.4	26.4	35.2	35	33.1	41.2
History of expressed suicidal thought or plan, % of total suicides	49.7	48.1	58.2	46.7	45.4	51	41.7	41.1	43.4

Table 2. Circumstances surrounding suicide incidents, by age group and sex, Oregon, 2019–2023 (continued)

Circumstances	Aged 18–24			Aged 25–54			Aged ≥ 55		
	All sexes (n=439)	Males (n=366)	Females (n=67)	All sexes (n=2,197)	Males (n=1,708)	Females (n=486)	All sexes (n=1,757)	Males (n=1,340)	Females (n=417)
Intimate partner problem, % of total suicides	29.8	29	34.3	33.1	33.4	31.9	12.9	13.9	9.6
Family stressor(s), % of total suicides	7.2	7.7	4.5	5.5	5.5	5.3	4.7	3.8	7.4
Recent criminal / non-criminal legal problem, % of total suicides	5.8	6.8	0	11	12	7.4	4.4	5.3	1.4
Financial / job problem, % of total suicides	4.8	5.5	1.5	12.2	12.6	10.9	9.6	10.1	7.9
Physical health problem, % of total suicides	1.8	1.9	1.5	5.6	5.3	7	37.8	40.1	30.5
Death of family member or friend within past five years, % of total suicides	3.7	4.4	0	3.6	3.5	4.1	7.5	7.6	7.2
Suicide of family member or friend within past five years, % of total suicides	2.3	2.2	3	1.5	1.6	1	1.2	0.7	2.6
School problem, % of total suicides	1.4	1.1	3	0.1	0.1	0.2	0	0	0
Experienced a crisis within two weeks, % of total suicides	17.1	16.4	20.9	22.8	24.1	18.5	16.4	16.6	15.6
Crisis related to problem with intimate partner, % of total suicides	10.4	9	17.9	12.9	13.2	12.1	4.8	5.2	3.6
Crisis related to physical health problems, % of total suicides	0.2	0.3	0	0.4	0.4	0.2	3.5	3.4	3.8

Table 2. Circumstances surrounding suicide incidents, by age group and sex, Oregon, 2019–2023 (continued)

Circumstances	Aged 18–24			Aged 25–54			Aged ≥ 55		
	All sexes (n=439)	Males (n=366)	Females (n=67)	All sexes (n=2,197)	Males (n=1,708)	Females (n=486)	All sexes (n=1,757)	Males (n=1,340)	Females (n=417)
Crisis related to recent criminal / civil legal problem, % of total suicides	2.8	3.3	0	4	4.6	1.9	1.5	2	0
Crisis related to family stressor(s), % of total suicides	1.8	1.9	1.5	1	1.1	0.6	1.1	1	1.4
Crisis related to financial / job problem, % of total suicides	1.2	1.4	0	2.2	2.3	1.9	1.4	1.4	1.2
Crisis related to eviction, % of total suicides	0.2	0.3	0	1	1.2	0.6	1.6	1.3	2.4
Suspected alcohol use prior to incident	24.9	26	19.4	28.9	29.9	25.7	19.3	19.1	19.9

Source: ORVDRS

There were 913 suicides among Oregon adults aged 18 and older. As described in Table 3, most suicide deaths occurred among:

- Men (78.2 percent)
- Non-Hispanic white persons (83.9 percent), and
- Persons 55 and older (46.4 percent).

In 2024, the most common method of suicide deaths among adults included:

- Firearms (56.5 percent)
- Suffocation or hanging (19.2 percent), and
- Poisoning (14.8 percent).

Table 3. Characteristics of adult suicides, Oregon 2024

		Deaths*	% of total†
Age	18–24	73	8.2
	25–54	406	45.4
	55+	415	46.4
Sex	Male	699	78.2
	Female	195	21.8
Race/Ethnicity	White NH (Non-Hispanic)	750	83.9
	African American NH	15	1.7
	American Indian or Alaska Native NH	9	1.0
	Asian NH	15	1.7
	Native Hawaiian/Pacific Islander NH	3	0.3
	More than one race NH	21	2.3
	Hispanic, all races	68	7.6
Veteran status	Veteran	146	16.3
	Non-Veteran	740	82.8
Mechanism of death	Firearms	505	56.5
	Hanging or suffocation	172	19.2
	Poisoning	132	14.8
	Other	66	7.4

Sources: Oregon Violent Death Reporting System

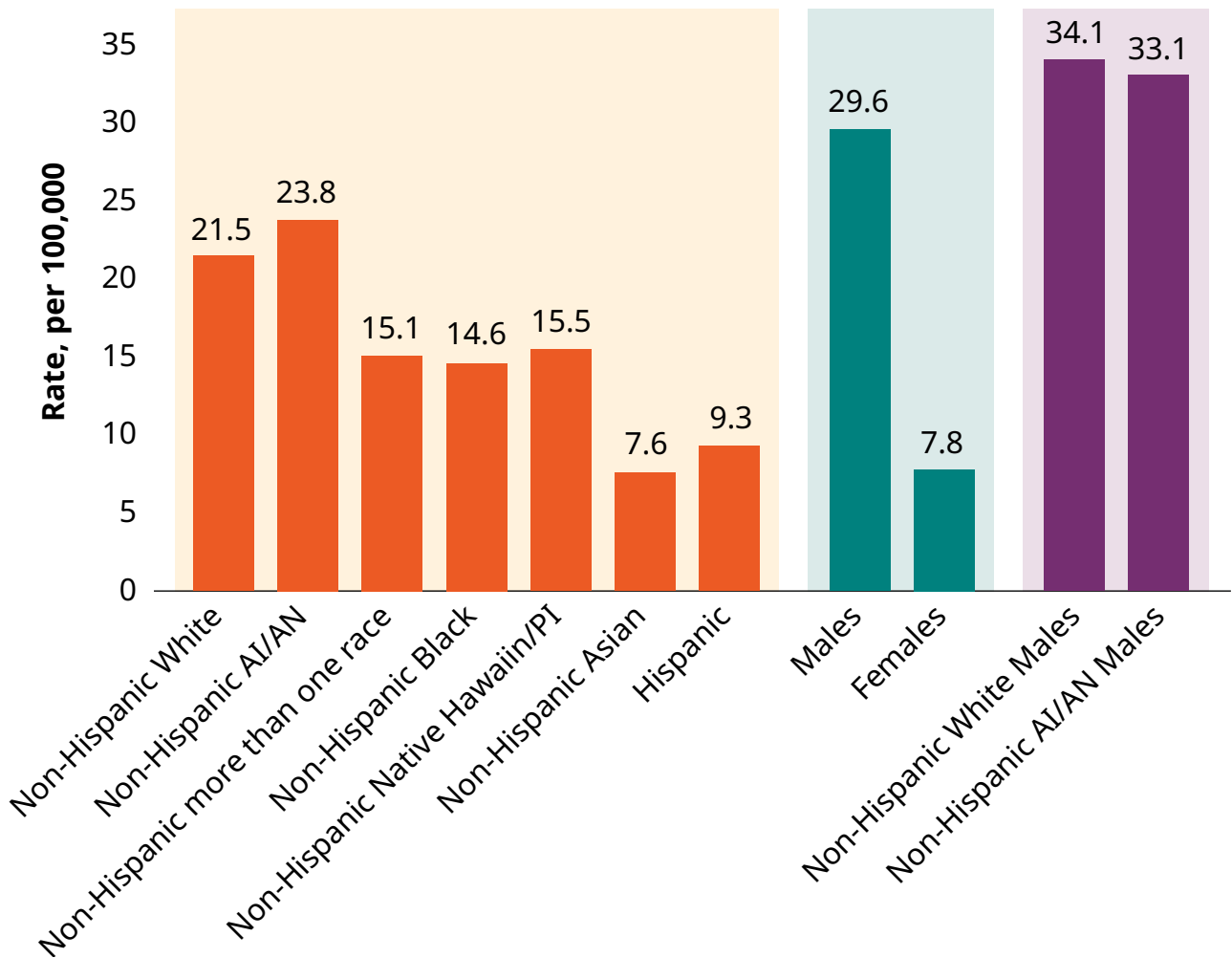
* Nineteen out-of-state deaths are not included because their death certificate information is not accessible.

† Some deaths don't have information on race/ethnicity 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, and issues of equity and disparities refer to pages 28–29 of the [ASIPP 2023-2027](#). Between 2020 and 2024, non-Hispanic American Indian and Alaska Native persons had the highest rate of suicide (23.8 per 100,000). When looking at non-Hispanic American Indian and Alaska Native men, the suicide rate jumps to 33.1 per 100,000. This was followed by non-Hispanic white persons (21.5 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 (15.5 and 15.1 per 100,000, respectively). This was followed by Non-Hispanic Black persons (14.6 per 100,000), Hispanic persons (9.3 per 100,000) and Non-Hispanic Asian persons (7.6 per 100,000). Non-Hispanic white men had the highest rate of suicide at 34.1 per 100,000.

Figure 3. Age-adjusted suicide rate by race, ethnicity and sex, Oregon, 2020–2024



Source: OPHAT

In 2024, Non-Hispanic white persons made up 84% of suicide deaths, however only made up 74.9% of the 2024 population reflecting a disparity for this community. (Table 4)

Table 4. Adults (aged 18 and older) suicide numbers and percentages compared to percentage of 2024 Oregon population, 2024

Race/Ethnicity	2024		2024 population
	Deaths	% of total	% of population
American Indian/Alaska Native NH	11	1.2	1.1
Asian NH	15	1.6	5.4
Black NH	15	1.6	2.1
Hispanic*	65	7.1	12.5
Native Hawaiian/Pacific Islander NH	6	0.7	0.6
Two or More Races NH	25	2.7	4.5
White NH	763	84.0	74.9
Non-White, includes Hispanic all races	137	15.0	26.1
Total	913[†]	NA	

Sources: OPHAT

* Includes any race

† Includes 13 deaths with unknown race/ethnicity

The suicide death mechanism among adults varies by men and women. Firearm is the leading cause of death across all age groups. Table 5 shows the mechanism of injury among suicide deaths by age group and sex in Oregon between 2019 and 2023. Among men 18–24, firearm suicide is the leading cause of death (62 percent). This is followed by hanging or suffocation (22 percent).

Among women 18–24, hanging or suffocation is the leading cause of death (37 percent). This is followed by poisoning and firearm, both at 76 percent. Among 25 to 54-year-olds, men died primarily by firearm (49 percent) or suffocation (33 percent). Among women aged 25 to 54 years old, 34 percent died by firearm, and 30 percent by hanging or suffocation. Twenty-nine percent of women aged 25 to 54 years old died by poisoning. Among adults aged 55 and older, men died overwhelmingly by firearm (74 percent). Among women aged 55 and older, 36 percent died by firearm followed by poisoning (37 percent).

Table 5. Mechanism of injury among suicide deaths by age group and sex, Oregon, 2019–2023

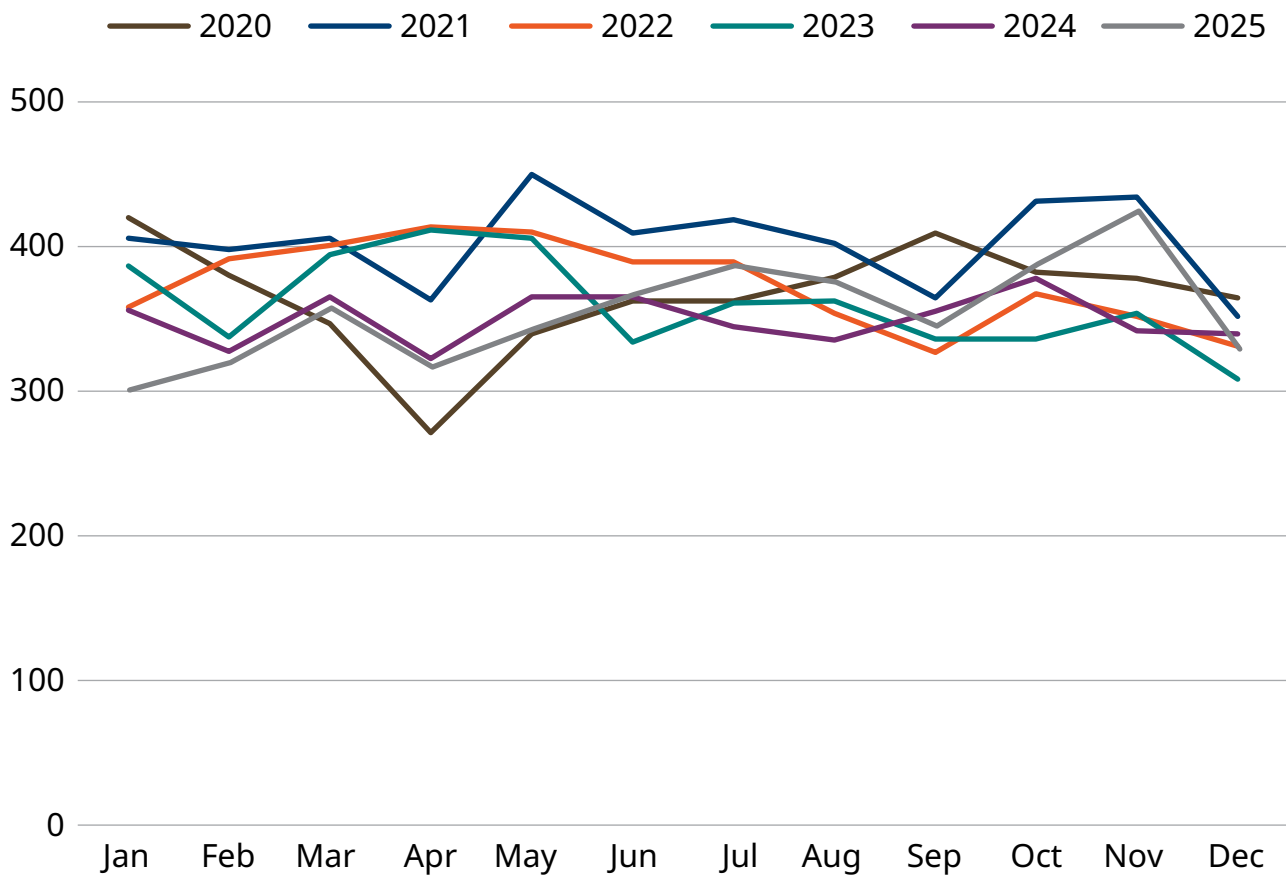
Age group	Mechanism of injury	All		Males		Females	
		Percent	Count	Percent	Count	Percent	Count
18–24	Firearm	57%	246	62%	228	27%	18
	Hanging/suffocation	24%	104	22%	79	37%	25
	Poisoning	8%	36	5%	18	27%	18
	Fall	6%	25	6%	22	4%	3
	Motor Vehicle/Train	1%	7	2%	7	0%	0
	Sharp instrument	2%	8	1%	6	3%	2
	*Other/Unknown	2%	7	1%	6	2%	1
	Total	100%	433	100%	366	100%	67
25–54 years	Firearm	46%	1003	49%	836	34%	166
	Hanging/suffocation	32%	704	33%	561	30%	143
	Poisoning	13%	275	8%	132	29%	142
	Fall	3%	72	3%	57	3%	15
	Motor Vehicle/Train	2%	48	2%	40	2%	8
	Sharp instrument	2%	50	2%	44	1%	6
	*Other/Unknown	2%	40	2%	34	1%	5
	Total	100%	2192	100%	1704	100%	485
55+	Firearm	65%	1135	74%	984	36%	151
	Hanging/suffocation	15%	260	14%	186	18%	74
	Poisoning	14%	250	7%	95	37%	155
	Fall	2%	33	1%	19	3%	14
	Motor Vehicle/Train	1%	13	1%	10	1%	3
	Sharp instrument	2%	30	2%	24	1%	6
	*Other/Unknown	2%	33	1%	20	4%	13
	Total	100%	1754	100%	1338	100%	416

Sources: ORVDRS

2025 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 2025 to previous years. However, some differences in visits by age grouping are noted below. Historically, more women than men present to EDs and UCCs for suicide-related visits. In 2025, across adults ages 18 and older, women represented 53.2 percent of visits compared to 46.8 percent of visits by men.

The number of suicide-related visits to EDs and UCCs for adults ages 18 to 24 in 2025 (4,333) is similar than in 2024 or 2023 (4,271 and 4,397, respectively). (Figure 4)

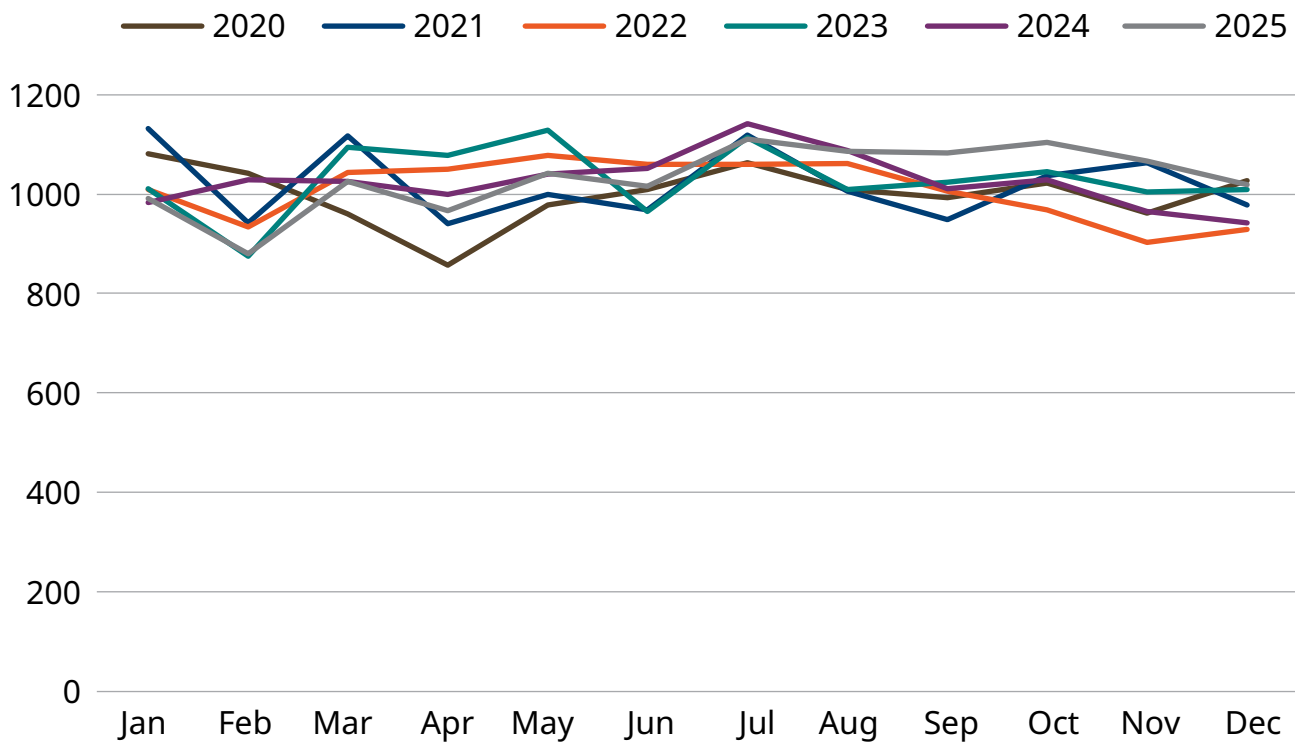
Figure 4. Suicide-related visits to emergency departments and urgent care centers, 18–24, Oregon



Source: ESSENCE

The number of suicide-related visits to EDs and UCCs for adults ages 25 to 54 in 2025 (12,394) is slightly higher than in 2024 (12,268). (Figure 5)

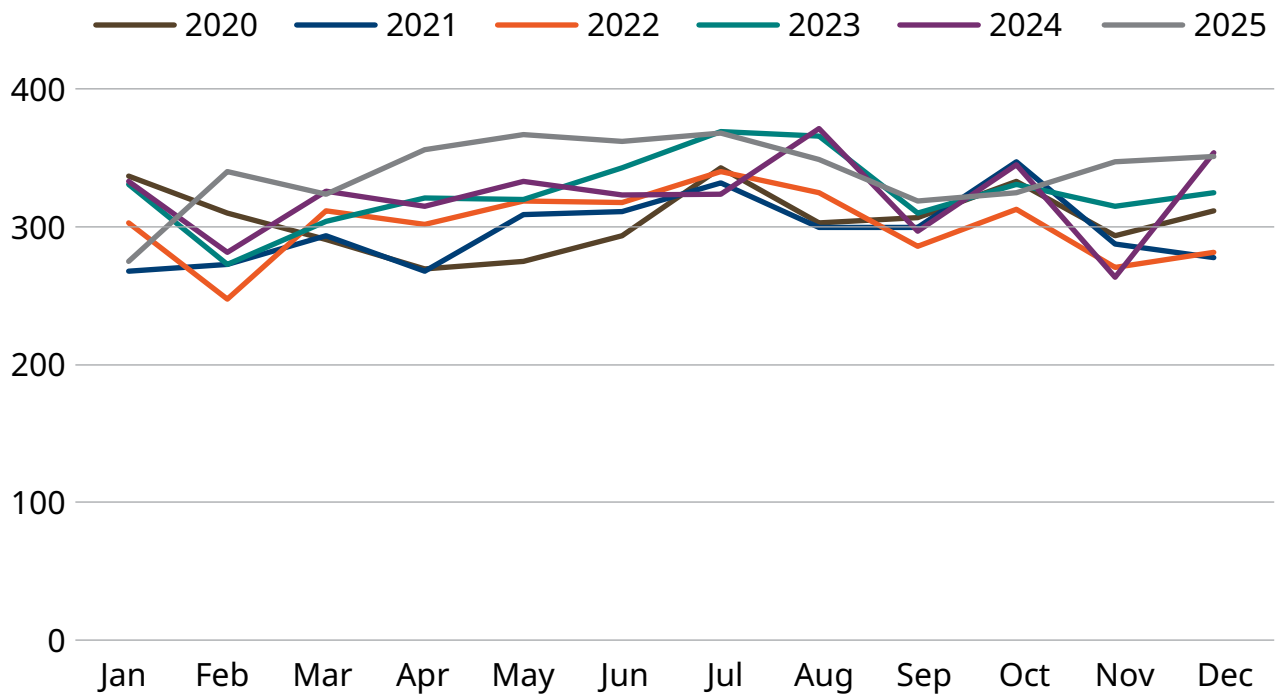
Figure 5. Suicide-related visits to emergency departments and urgent care centers, 25–54, Oregon



Source: ESSENCE

The number of suicide-related visits to EDs and UCCs for adults ages 55 and older in 2025 (4,071) is higher than in 2024 (3,843). (Figure 6)

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



Source: ESSENCE

Veteran data

OHA identified 146 veterans who died by suicide (including Oregon and non-Oregon residents) in 2024. This accounted for 16.3 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 (55.8 per 100,000 and 20 per 100,000, respectively) in 2024 (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+ (78.7 per 100,000) followed by veterans aged 18-34 (53.4 per 100,000). Most veteran suicide deaths are men (140 deaths in 2024, as compared to 6 deaths by women). From 2020-2024, 720 male veterans died at a suicide rate of 58 per 100,000 while 33 female veterans for a suicide rate of 25.1.

Table 6. Oregon veteran suicide numbers and rates,* 2018–2024

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
2024	146	55.8	12	53.4	26	42.4	47	46.8	61	78.7

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 2024, 5,728 adults aged 18 and older, compared to 5,819 in 2023, were admitted to the emergency department or hospital related to a suicide attempt, suicide ideation or self-harm.

Table 7. Emergency Department and hospitalization admission numbers for suicide attempt, suicide ideation, or self-harm among among people aged 18 years and older by county of residence, Oregon 2024

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
Gilliam	*	*	*	*

Table 7. Emergency Department and hospitalization admission numbers for suicide attempt, suicide ideation, or self-harm among people aged 18 years and older by county of residence, Oregon 2024 (continued)

County	Ages 18–24		Age 25 and Older	
	Count	% of total	Count	% of total
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 2024. There are geographic disparities in the data. Between 2020-2024 rural and remote (frontier) counties had higher rates of suicide (27.3 per 100,000 and 27.2 per 100,000, respectively) than the state suicide rate (20 per 100,000). Conversely, urban counties had a lower suicide rate (19 per 100,000) compared to the state suicide rate.

Table 8. Number of suicides among people aged 18 years and older by county, Oregon 2024

County	Ages 18–24		Age 25 and Older	
	Death Count	% of Total	Death Count	% of Total
Baker	0	0	9	1.1
Benton	0	0	15	1.8
Clackamas	5	6.8	66	7.9
Clatsop	0	0	15	1.8
Columbia	0	0	14	1.7
Coos	2	2.7	24	2.9
Crook	2	2.7	4	0.5
Curry	0	0	11	1.3
Deschutes	5	6.8	36	4.3
Douglas	2	2.7	23	2.7
Gilliam	0	0	0	0
Grant	0	0	3	0.4
Harney	0	0	4	0.5
Hood River	0	0	5	0.6
Jackson	8	11	56	6.7
Jefferson	1	1.4	0	0
Josephine	2	2.7	27	3.2
Klamath	1	1.4	19	2.3
Lake	0	0	6	0.7
Lane	7	9.6	100	11.9
Lincoln	0	0	17	2
Linn	5	6.8	21	2.5
Malheur	0	0	5	0.6
Marion	3	4.1	62	7.4
Morrow	0	0	3	0.4
Multnomah	19	26	136	16.2

Table 8. Number of suicides among people aged 18 years and older by county, Oregon 2024 (continued)

County	Ages 18–24		Age 25 and Older	
	Death Count	% of Total	Death Count	% of Total
Polk	0	0	13	1.5
Sherman	0	0	1	0.1
Tillamook	0	0	6	0.7
Umatilla	0	0	10	1.2
Union	2	2.7	10	1.2
Wallowa	0	0	1	0.1
Wasco	1	1.4	3	0.4
Washington	7	9.6	89	10.6
Wheeler	0	0	1	0.1
Yamhill	1	1.4	25	3
Frontier	0	0.0	33	3.9
Rural	14	19.2	213	25.4
Urban	59	80.8	594	70.7

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 2024. For suicide-related visits to EDs and UCCs the report contains 2025 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. The [OHA Injury and Violence Prevention Program Dashboard Overview](#) provides information on publicly available data dashboards, including suicide data. 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 2024 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 to 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 is important to track, particularly related to youth suicide prevention as overall counts, especially among youth, and 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 leave the ED or UCC without receiving 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 provides 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 person dies 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 provides 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.

Oregon, along with all 50 U.S. states, the District of Columbia and Puerto Rico submits violence death, including suicide, decedent data to the CDC's [National Violent Death Reporting System \(NVDRS\)](#). NVDRS pools more than 600 unique data elements from multiple sources into an anonymous database. In February 2025, CDC removed the transgender data element from the NVDRS database. OHA is capturing transgender data of decedents outside of the NVDRS database starting at this time to ensure Oregon continues to have this important data point for 2023 finalized data moving forward. There were 16 decedents identified as transgender in 2023. OHA is committed to collecting this data outside of the NVDRS data reporting system to inform suicide prevention, intervention and postvention efforts focused on the transgender and gender nonconforming community.

Appendix 1. Suicide rates among adults aged 18 years and older by state, U.S. 2024

State	Deaths	Crude Rate
Alaska	222	29.7
Wyoming	169	27.8
Montana	320	26.8
New Mexico	532	24.6
South Dakota	198	21.9
Idaho	437	21.2
Oklahoma	868	20.9
Colorado	1313	20.8
Oregon	941	20
Nevada	676	19.6
Utah	665	19.5
Maine	285	19.2
North Dakota	145	19.2
Arkansas	592	19
Arizona	1516	18.9
Kansas	527	17.9
Kentucky	844	17.9
Missouri	1152	17.8
Iowa	548	17.1
Indiana	1175	16.8
New Hampshire	248	16.4
Tennessee	1229	16.4

Suicide rates among adults aged 18 years and older by state, U.S. 2024 (continued)

State	Deaths	Crude Rate
West Virginia	303	16.4
South Carolina	904	16
Alabama	837	15.9
Ohio	1856	15.2
Mississippi	450	15.1
Nebraska	297	14.9
Wisconsin	920	14.8
Vermont	105	14.7
Washington	1221	14.5
Georgia	1648	14.3
Texas	4490	14.2
Louisiana	654	14.1
North Carolina	1620	14.1
Florida	3633	13.9
Hawaii	200	13.7
Michigan	1448	13.7
Minnesota	818	13.7
Pennsylvania	1845	13.3
Virginia	1196	12.9
Delaware	125	11.8
Illinois	1426	10.8
Connecticut	394	10
Maryland	630	9.7
California	4022	9.6
Rhode Island	105	8.9

Suicide rates among adults aged 18 years and older by state, U.S. 2024
(continued)

State	Deaths	Crude Rate
Massachusetts	648	8.3
New York	1701	8.1
New Jersey	682	6.7
District of Columbia	44	5.7

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 2019–2024

Race/ethnicity	2019		2020		2021		2022		2023		2024	
	Death	% of total deaths	Death	% of total deaths	Death	% of total deaths	Death	% of total deaths	Death	% of total deaths	Death	% of total deaths
American Indian/Alaska Native NH	11	1	7	1	11	1.5	16	2	12	1.4	11	1.2
Asian NH	19	2	13	1.5	13	1.5	20	2.5	17	2.0	15	1.6
Black NH	10	1	7	1	15	1.5	12	1.5	19	2.2	15	1.6
Hispanic, all races	52	6	48	6	40	4.5	49	5.5	66	7.6	65	7.1
Pacific Islander NH	4	0.5	2	<1	1	<1	4	0.5	3	0.3	6	0.7
Two or More Races NH	18	2	18	2	20	2.5	14	1.5	24	2.8	25	2.7
White NH (% of total)	771	87	711	88	768	87.5	730	85.5	713	82.0	763	84.0
Total	888		810		876		855		870		913	
Total Non-White, includes Hispanic all races	114	12.8	95	11.7	100	11.4	115	13.5	141	16.2	137	15.0

State Health Assessment

Institutional discrimination and racism have contributed to Oregon's communities of color and Tribal communities to experience poorer health outcomes, including related to mental health and suicide. Historical disenfranchisement through genocide, cultural disconnection and pressure to assimilate has resulted in American Indian/Alaska Native peoples having high rates of suicide.

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