

2014-2015

# >> Youth Suicide Annual Report



Oregon  
Health  
Authority  
Health Systems Division

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# Executive summary

ORS 418.704 requires preparation of an Oregon Youth Suicide Intervention and Prevention Plan in 2015, with updates a minimum of every five years. The enabling legislation enacted in 2014 (HB 4124) also requires that an annual report be submitted to the Legislature. HB 4124 established a position of youth suicide intervention and prevention coordinator in the Oregon Health Authority Health Systems Division (formerly Addictions and Mental Health), to help stakeholders prepare the plan and submit the annual reports.

Starting on December 1, 2014, the coordinator worked with staff in the Health Systems Division and Public Health Division and groups of diverse stakeholders to write the plan. Approximately 100 subject matter experts were recruited from across disciplines, including youth and families, and from all geographic areas for a steering committee and seven work groups to prepare the plan between March and November 2015.

Modeled after the National Strategy for Suicide Prevention, the state's document addresses key priorities and best practice interventions for suicide prevention and customizes national approaches for use in Oregon.

The plan includes approximately 80 action items under four general themes: Healthy and empowered individuals, families and communities; Clinical and community preventive services; Treatment and support services; and Surveillance, research and evaluation. Below are example action items under each category:

## Healthy and empowered individuals, families and communities

- Develop an Oregon Alliance to Prevent Suicide of public and private partners to establish priorities and a public policy agenda to guide implementation of the plan over five years, including recommendations for providing suicide risk assessment and crisis counseling as essential health benefits.
- Develop materials to promote mental health literacy and system understanding among parents and youth.
- Establish a work group involving youth to prepare a plan for use of social media.

## Clinical and community preventive services

- Supplement trauma-informed care with suicide prevention strategies.
- Analyze suicide risk assessments used in medical and behavioral health care settings and disseminate best practice assessment tools.
- Train medical and behavioral health providers in assessing, managing and treating individuals at risk for suicide or self-harm.

- Expand the Oregon Pediatric Society’s trainings for primary care physicians on depression and substance use screening.
- Disseminate best practice guidelines on recommended activities after a suicide (postvention) to schools and a wide range of community members, and provide technical assistance to those communities/individuals.
- Establish information-sharing protocols at the local and state levels in forming postvention activities (2015 SB 561).

## Treatment and support services

- Establish programs to follow up with youth and families after release from emergency departments to ensure safety and warm handoffs to outpatient care.
- Provide discharge planning at release from emergency departments.
- Develop guidelines on use of peer and family supports in suicide intervention and treatment.
- Collaborate to identify ways stakeholders can implement laws pertaining to confidentiality of information (including HIPAA and 2015 HB2948) to promote information-sharing across systems (physical and mental health, substance use treatment and schools) and with families and families of choice.
- Encourage integration of behavioral health and primary care.

## Surveillance, research and evaluation

- Establish an OHA Evaluation Committee to identify measures and sources of data to gauge progress on suicide prevention and intervention initiatives and monitor implementation of the plan.
- Compare Oregon’s youth suicide rates with other states ranked the highest and lowest for youth suicide.

Also included are action items related to a grant-funded suicide prevention project administered by the Public Health Division that is currently underway. Through congressional funding to Oregon from the Garrett Lee Smith Memorial Act, the Caring Connections Initiative builds on existing public/private partnerships and health system transformation efforts on youth suicide prevention in Oregon.

Copies of the full plan are available online at: [www.tinyurl.com/hr94228](http://www.tinyurl.com/hr94228)

For information about the plan or to obtain a hard copy, email Ann D. Kirkwood, Suicide Intervention Coordinator, at [ann.d.kirkwood@state.or.us](mailto:ann.d.kirkwood@state.or.us) or call 503-947-5540.

# Background

Suicide is the second leading cause of death among 10–24-year-olds in Oregon. In 2012–2013, the Oregon youth suicide rate of 11 per 100,000 population of that age group ranked 14th highest among all U.S. states. Over the past 10 years, Oregon consistently has been ranked among the top states for youth suicide and the rate has been increasing since 2011.

In 2014, the Legislature passed HB 4124 to address the rising trend of youth suicide in Oregon by mandating a new five-year Youth Suicide Intervention and Prevention Plan and augmenting state suicide prevention efforts by hiring a youth suicide intervention and prevention coordinator assigned to Oregon Health Authority programs dealing with mental health and substance use (Health Systems Division).

## State Suicide Intervention and Prevention Plan

Section 2 of HB 4124 refers to the Youth Suicide Intervention and Prevention Plan required under ORS 418.704 to be updated at a minimum of every five years. Starting work on December 1, 2014, the coordinator collaborated with staff in the Health Systems Division (formerly Addictions and Mental Health) and Public Health Division to facilitate groups of geographically diverse stakeholders to write the plan. Planning for the participatory process and recruitment of subject matter experts occurred in December 2014–February 2015. Approximately 100 subject matter experts were recruited for a steering committee and seven work groups to prepare the plan over 18 meetings between March and November 2015.

Stakeholders volunteering for the planning process included representatives from:

- Coordinated care organizations (CCOs) and private insurers;
- Behavioral health and primary care providers;
- Health systems and hospitals;
- Prevention specialists;
- Youth with behavioral health conditions and their parents;
- Oregon Department of Education and local schools;
- Lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals;
- Tribal members, African Americans and Latinos;

- Oregon Department of Veterans Affairs, the Oregon Air and Army National Guard, and the U.S. Department of Veterans Affairs;
- Oregon Department of Human Services Child Welfare;
- Oregon Youth Authority; and
- Suicide loss survivors (those who have lost a loved one to suicide) and attempt survivors (those who have lived experience with serious suicidal ideation or suicidal behaviors).

Modeled after the National Strategy for Suicide Prevention, the state's document addresses key priorities and best practice interventions and customizes national approaches for practical implementation in Oregon. The plan was scheduled for publication in January 2016.

# House Bill 4124, Section 2

## Section 2

**Below are listed the legislatively mandated sections of the plan. They are followed by a bulleted list of sample action items included in the plan.**

### Section 2 (1):

**Recommendations for access to mental health intervention, treatment and supports for depressed and suicidal youth.**

- Programs to follow up with youth and families after release from emergency departments to ensure safety and warm handoffs to outpatient care.
- Provision of discharge planning at release from emergency departments.
- Development of materials to promote mental health literacy and system understanding among parents and youth.
- Development of guidelines by the Children's System Advisory Committee concerning use of peer and family supports in suicide intervention and treatment.

### Section 2 (2):

**Recommendations to improve access to care and supports, including affordability, timeliness, cultural appropriateness and availability of qualified providers.**

- Development of an Oregon Alliance to Prevent Suicide to establish priorities and a public policy agenda to guide implementation of the plan over five years, including recommendations for provision of suicide risk assessment and crisis counseling as essential health benefits.
- Supplementing trauma-informed care with suicide prevention strategies.

### Section 2 (3):

**Recommendations including best practices to identify and intervene with youth who are depressed, suicidal or at risk of self-injury.**

- An analysis of risk assessments used in medical and behavioral health care settings and dissemination of best practices.

- Training for medical and behavioral health providers in assessing, managing and treating individuals at risk for suicide or self-harm.
- Expanding the Oregon Pediatric Society’s trainings for primary care physicians on depression and substance use screening.

## Section 2 (4):

### **Recommendations for collaborations among schools, school-based health clinics and CCOs for school-based programs.**

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

## Section 2 (5):

### **Recommendations related to use of social media for intervention and revention of youth suicide and self-inflicted injury.**

- Establishment of a work group involving youth to prepare a plan for use of social media. (Already underway by Youth M.O.V.E. Oregon, Lines For Life and Reachout.com.)

## Section 2 (6):

### **Recommendations to respond to schools and communities following completed youth suicides.**

- Dissemination of best practice guidelines on activities after a suicide (postvention) to schools and a wide range of community members, and provision of technical assistance to those communities/individuals.
- Establishment of information-sharing protocols at the local and state levels in forming postvention activities (2015 SB 561).

## Section 2 (7–8):

### **An analysis of intervention and prevention strategies used by states with the five lowest suicide rates.**

- A comparison of Oregon’s youth suicide rates with other states ranked the highest and lowest for youth suicide.



**Also included are action items related to a grant-funded suicide prevention project administered by the Public Health Division.** Through congressional funding to Oregon from the Garrett Lee Smith Memorial Act, the Caring Connections Initiative is building on existing public/private partnerships and health system transformation efforts to implement and sustain youth suicide prevention through gatekeeper education; training of clinical service providers to assess, manage and treat youth at risk for suicide; and to improve continuity of care, among other activities.

# House Bill 4124, Section 1

## Section 1

**The following section reviews requirements of Section 1 of the legislation.**

**Section 1 (2)(a): A suicide intervention and prevention coordinator has been hired.**

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

In developing the plan, outreach included efforts to collaborate with:

- Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth;
- Military members, veterans and their families;
- African Americans;
- Latinos;
- Tribes and programs that serve Native Americans;
- Department of Human Services Child Welfare programs;
- Foster parents;
- Oregon Youth Authority for justice-involved youth;
- Youth with behavioral health disorders; and
- Youth and young adults through the Youth M.O.V.E. program.

Youth M.O.V.E. also conducted focus groups to inform the plan.

The Children's System Advisory Committee (CSAC) also designated parents, providers and youth to serve on all work groups. Collaboration with the involved groups in developing the plan has afforded the suicide intervention and prevention coordinator with diverse partners from high-risk groups for implementation of the plan in 2016 and beyond.

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

The steering committee and work groups discussed barriers to access to services and identified key action items to address these challenges.

These included:

- Improving discharge and safety planning for youth in emergency or inpatient care;
- Welfare checks with youth and families within 48 hours after being seen for suicidal ideation or an attempt;
- Training for behavioral and physical health providers in conducting timely best practice suicide risk assessments, intervention and treatments;
- Determining the length of time between emergency department release and the initiation of outpatient therapies after assessments;
- Establishing guidelines for use of peer and family support for at-risk youth; and
- Creation of an Oregon Alliance to Prevent Suicide to develop a policy agenda, including addressing access to care.

## Section 1 (2)(d): Technical assistance

Section 1 (2)(d) requires the suicide intervention coordinator to provide technical assistance to state and local partners. Since November 2014, the coordinator has provided technical assistance on best practice response to suicides to communities across the state. Additional technical assistance was provided to behavioral health staff and providers, suicide prevention advocates and prevention specialists, parents, youth organizations, state programs, adults living with mental illnesses, attempt survivor support group leaders and through the Youth Suicide Prevention Listserv moderated by the Public Health Division, among others.

# House Bill 4124, Section 3

## Section 3

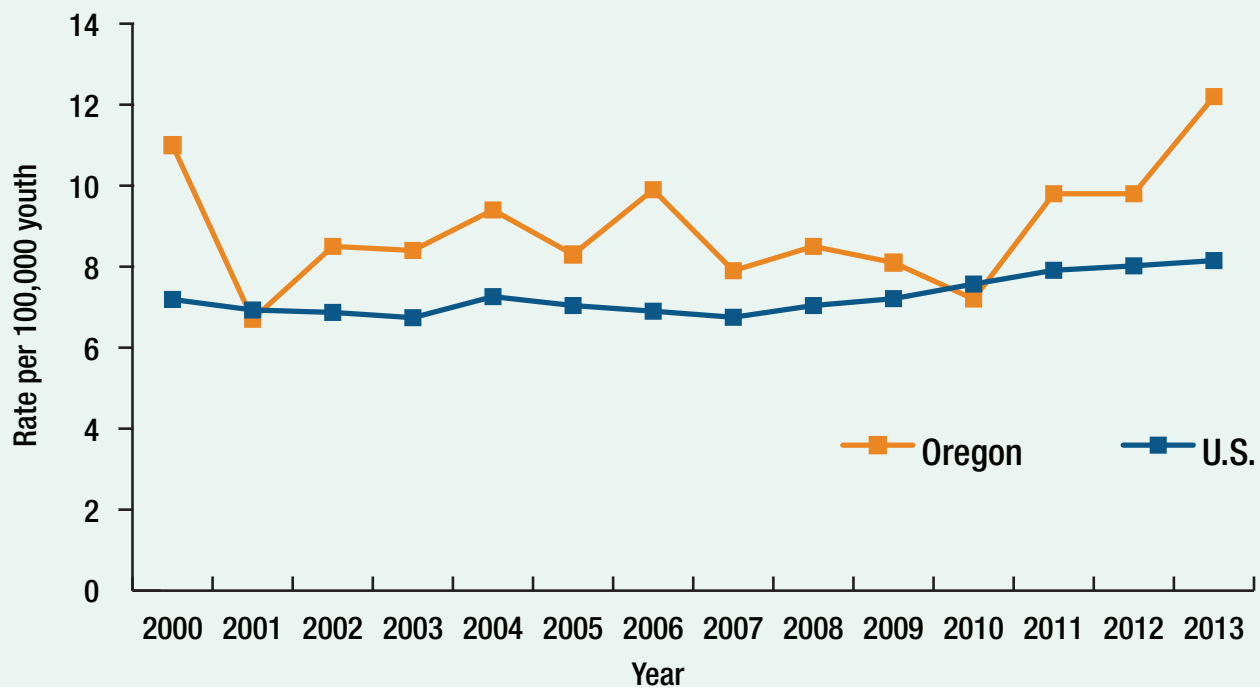
### Review data and prepare an annual report to the Legislature.

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

### Basic facts(1,2)

- Suicide is the second leading cause of death among youth aged 10 to 24 years in Oregon.
- Overall, Oregon suicide rates were higher than the U.S. rates in the past decade; and Oregon suicide rates rose after 2011 (Figure 1).

Figure 1: Suicide rates among youth aged 10–24 years, U.S. and Oregon, 2000–2013



Source: CDC WISQARS

- From 2012 to 2013, Oregon youth suicide rate of 11.0 per 100,000 ranked the 14th among all U.S. states.
- Male youth were four times more likely to die by suicide than female youth.
- Suicide rates increased with age. The rate increased from approximately 1.0 per 100,000 among youth aged 10 to 14 years to 16.0 per 100,000 among youth aged 20 to 24 years.
- Suicide rate among male veterans was more than four times higher than non-veteran males.

### Common risk factors (Table 1, page 13):

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

### In 2014 (Table 2, page 14 and Table 4, page 16):

- Ninety suicides occurred among Oregon youth aged 10 to 24 years.
- The majority of suicides occurred among males (77%), White (86%) and those aged 20–24 years (57%). Twenty-six of them were middle school students and high school students.
- Firearms, suffocation (hanging) and poisoning are the most frequently observed mechanisms of injury in suicide deaths. Firearms alone were accounted for more than 50% of deaths.
- Among 23 adolescent suicides aged 10 to 17 years, 19 deaths were reviewed by county child fatality review teams.<sup>(3)</sup> Of 19 adolescent suicides, eight cases (42%) had received a mental health service before suicide, seven were receiving mental health service and three were taking psychiatric medication at the time of death.

**Table 1: Common circumstances surrounding suicide incidents by sex, among youth ages 10–24 years, Oregon, 2002–2012**

Circumstance	Males (N=532)		Females (N=119)		All (N=651)	
<b>Mental health status</b>	<b>Count</b>	<b>%</b>	<b>Count</b>	<b>%</b>	<b>Count</b>	<b>%</b>
Mentioned mental health problems*	348	65	88	74	436	67
Diagnosed mental disorder	171	32	66	55	237	36
Problem with alcohol	83	16	14	12	97	15
Problem with other substance	83	16	24	20	107	16
Current depressed mood	210	39	54	45	264	41
Current treatment for mental health problem†	127	24	55	46	182	28
<b>Interpersonal relationship problems</b>	<b>Count</b>	<b>%</b>	<b>Count</b>	<b>%</b>	<b>Count</b>	<b>%</b>
Broken up with boy/girlfriend, Intimate partner problem	185	35	47	39	232	36
Suicide of family member or friend within past five years	14	3	3	3	17	3
Family stressor(s)‡	66	32	27	49	93	36
History of abuse as a child‡	2	1	8	15	10	4
<b>Life stressors</b>	<b>Count</b>	<b>%</b>	<b>Count</b>	<b>%</b>	<b>Count</b>	<b>%</b>
A crisis in the past two weeks	207	39	45	38	252	39
Recent criminal legal problem	79	15	3	3	82	13
School problem	44	8	11	9	55	8
<b>Suicidal behaviors</b>	<b>Count</b>	<b>%</b>	<b>Count</b>	<b>%</b>	<b>Count</b>	<b>%</b>
Disclosed intent to die by suicide	199	37	44	37	243	37
Left a suicide note	157	30	46	39	203	31
History of suicide attempt	95	18	48	40	143	22

Source: Oregon Violent Death Reporting System.

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

† Include treatment for problems with alcohol and/or other substance.

‡ Data were not collected before 2009.

## Of 19 adolescent suicides:

- One child had a prior suicide attempt and two had history of self-mutilation. Five children had talked about suicide and three had made a suicide threat before suicide.
- Four had a history of substance abuse and three had been victims of child maltreatment (two experience with physical abuse, two with emotional abuse and one with sexual abuse). One child had a foster care history.
- The most reported personal crises before suicide were breakup with boyfriend/girlfriend (n=5), parents' divorce/separation (n=2), family discord (n=2), bullying as victim (n=2) and drug/alcohol use (n=2). No case was reported due to a problem of sexual orientation.

**Table 2: The characteristics of youth suicides among youth ages 10–24 years, Oregon 2014**

	Deaths	% of total
<b>Age</b>		
10–14	7	8%
15–19	32	36%
20–24	51	57%
<b>Sex</b>		
Male	69	77%
Female	21	23%
<b>Race/ethnicity</b>		
White	77	86%
African American	0	0%
Am. Indian/Native Alaskan	1	1%
Asian/Pacific Islander	3	3%
Multirace	1	1%
Other/unknown	6	7%
Hispanic	9	10%
<b>Student status</b>		
Middle school	5	6%
High school	21	23%
<b>Mechanism of death</b>		
Firearm	48	53%
Hanging/suffocation	30	33%
Poisoning	6	7%
Other	6	7%
<b>Other</b>		
Veteran	4	4%

Source: Oregon Violent Death Reporting System.

## Table 3: Suicide rates among youth aged 10–24 years by state, U.S. 2012–2013

Rates are deaths per 100,000.

State	Deaths	Crude Rate
1. Alaska	82	25.36
2. Wyoming	45	19.23
3. North Dakota	58	18.5
4. South Dakota	63	18.28
5. Montana	67	16.84
6. Idaho	107	15.48
7. New Mexico	129	14.79
8. Colorado	283	13.4
9. Utah	182	12.88
10. Oklahoma	205	12.76
11. Arkansas	141	11.64
12. Kansas	143	11.57
13. Maine	53	11.07
<b>14. Oregon</b>	<b>166</b>	<b>10.99</b>
15. Kentucky	189	10.73
16. Hawaii	56	10.49
17. Washington	279	10.18
18. Arizona	282	10.17
19. Iowa	130	10.16
20. West Virginia	68	9.82
21. Missouri	240	9.79
22. Michigan	395	9.55
23. Vermont	24	9.53
24. Wisconsin	215	9.3
25. Indiana	254	9.16
26. Indiana	254	9.16

State	Deaths	Crude Rate
27. Minnesota	196	9.13
28. Nebraska	68	8.76
29. Pennsylvania	433	8.61
30. South Carolina	163	8.41
31. Tennessee	213	8.17
32. Nevada	89	8.1
33. Virginia	267	8.07
34. Ohio	377	8.05
35. Alabama	159	7.99
36. Louisiana	152	7.87
37. Texas	901	7.79
38. New Hampshire	39	7.51
39. North Carolina	299	7.46
40. Florida	535	7.39
41. Mississippi	92	7.15
42. Georgia	300	7.03
43. Maryland	162	6.91
44. Illinois	340	6.42
45. Massachusetts	164	6.12
46. California	918	5.64
47. District of Columbia	13	5.31
48. New Jersey	181	5.25
49. New York	406	5.18
50. Connecticut	70	4.85
51. Rhode Island	15	3.41

Source: CDC WISQARS

### Suicide attempts(4)

- Each year, more than 500 Oregon youth aged 10 to 24 years were hospitalized for the self-inflicted injury/attempted suicide. There were 566 hospitalizations (75.2 per 100,000) in 2014 (Table 4, page 16).
- More than 90% of the self-inflicted injury hospitalizations were attributable to poisoning, followed by cutting/piercing, fall and firearms.
- In contrast to suicide, females were far more likely to be hospitalized for suicide attempt than males.



**Table 4: Numbers of self-harm hospitalizations and suicides among youth 10–24 years by county, Oregon, 2014**

County	Hospitalizations		Deaths	
	Count	% of total	Count	% of total
Baker	2	0.4	1	1.1
Benton	8	1.4	3	3.3
Clackamas	54	9.5	3	3.3
Clatsop	2	0.4	1	1.1
Columbia	19	3.4	3	3.3
Coos	10	1.8	4	4.4
Crook	3	0.5	0	0.0
Curry	3	0.5	0	0.0
Deschutes	27	4.8	6	6.7
Douglas	13	2.3	1	1.1
Gilliam	0	0.0	0	0.0
Grant	0	0.0	0	0.0
Harney	3	0.5	0	0.0
Hood River	3	0.5	0	0.0
Jackson	28	4.9	6	6.7
Jefferson	3	0.5	1	1.1
Josephine	11	1.9	0	0.0
Klamath	7	1.2	5	5.6
Lake	3	0.5	0	0.0
Lane	57	10.1	8	8.9
Lincoln	2	0.4	2	2.2
Linn	18	3.2	2	2.2
Malheur	0	0.0	2	2.2
Marion	39	6.9	6	6.7
Morrow	0	0.0	0	0.0
Multnomah	135	23.9	19	21.1
Polk	11	1.9	2	2.2
Sherman	0	0.0	0	0.0
Tillamook	4	0.7	0	0.0
Umatilla	3	0.5	1	1.1
Union	1	0.2	1	1.1
Wallowa	1	0.2	0	0.0
Wasco	3	0.5	0	0.0
Washington	76	13.4	10	11.1
Wheeler	1	0.2	0	0.0
Yamhill	16	2.8	3	3.3
<b>State totals</b>	<b>566</b>	<b>N/A</b>	<b>90</b>	<b>N/A</b>

Source: Oregon Hospital Discharge Index

## Suicidal ideation(5,6)

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

# Limitations of data used for suicide surveillance

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

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

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

Expediting surveillance capacity to create rapid response and information for policy makers is a growing interest and priority as outlined in Senate Bill 561 (2015). OHA's Health Systems Division is collaborating with local mental health authorities and other stakeholders to implement SB 561. It should be noted that current legal restrictions and

confidentiality protections in the Health Insurance Portability and Accountability Act (HIPAA) limit Oregon Health Authority’s ability to obtain information and disseminate it. To deliver actionable data in relatively quick time frames, it will be necessary for the state to examine legal considerations, privacy needs of families and youth, and the “need to know” identifiable information about youth and families struggling with suicidal behavior and suicide completion.

# References

1. Oregon Public Health Division, Oregon Violent Death Reporting System. Suicides in Oregon: Trends and Associated Factors, 2003–2012.
2. The CDC WISQARS.
3. Oregon State Child Fatality Review Team. Child Death in Oregon: 2014.
4. Oregon Public Health Division, Injury and Violence Prevention Program. Injury in Oregon, 2013 injury data report.
5. Oregon Health Authority, Addictions and Mental Health Division. 2014 Student Wellness Survey.
6. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance - United States, 2013.



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