Oregon Health Authority

RESOURCE GUIDE

2022

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Summary, interpretation guide, and links to the various data sources that Oregon Health Authority uses to report on suicide in Oregon. Click here to access the data glossary

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OHA's monthly summary of suicide-related data including death, emergency department and urgent care center, Oregon Poison Center and suicide hotline call data. The most recent update can be found here. Anyone can sign-up to receive the report directly by email here.

Safe Messaging Guidelines and Crisis Supports 25

Safe messaging guidelines and crisis lines and supports. Refer to OHA's March 2022 press release for additional data insights and resources. Note that the 988 Suicide & Crisis Lifeline, launched in July 2022, has replaced the National Suicide Prevention Lifeline.

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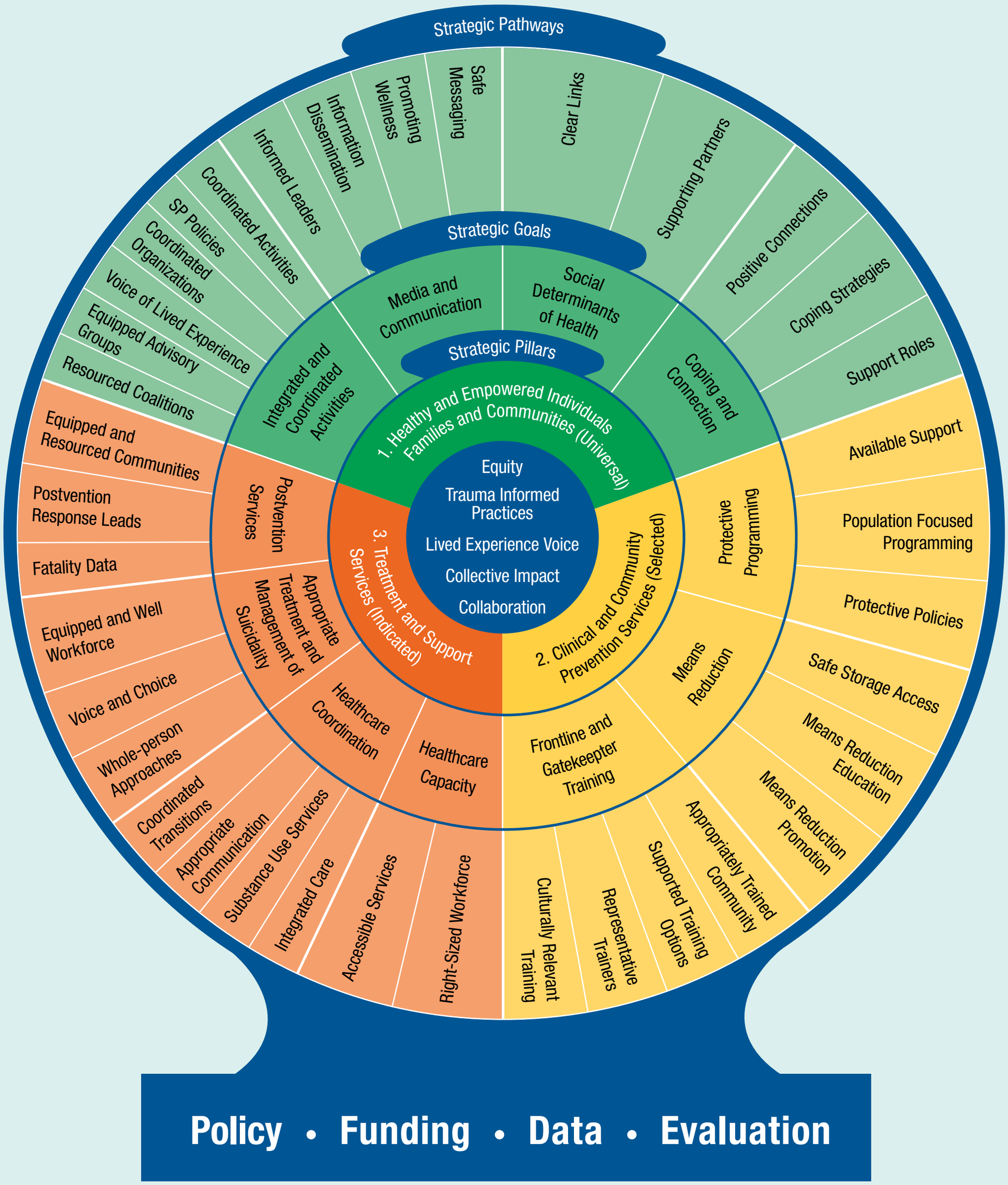
Oregon Suicide Prevention Framework



To view an interactive document of the Oregon Suicide Prevention Framework including Strategic Pathway definitions, visit: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3636b.pdf

PUBLIC HEALTH DIVISION
HEALTH SYSTEMS DIVISION
Suicide Prevention Team

Oregon Health Authority

OHA 3636B-2 (07/2022)

Oregon Suicide Prevention Framework
1. Healthy & Empowered Individuals, Families and Communities: These goals and pathways seek to reduce suicide risk by promoting wellbeing and creating supportive communities for all Oregonians. Other terms you might recognize here are "universal", “primary prevention” and “upstream prevention” or “tier 1 strategies.”
1.1 Integrated & Coordinated Activities
1.1.1 “Coordinated Activities” Youth suicide prevention programming is coordinated between tribes, state, county, and local leaders to maximize reach & ensure equitable access for all Oregonians.
1.1.2 "SP Policies" Organizations and agencies have suicide prevention policies for clients and staff that are known and utilized.
1.1.3 "Coordinated Organizations" Organizations and agencies are coordinated and understand their role in suicide prevention.
1.1.4 "Voice of Lived Experience" People with lived experience have meaningful voice in Oregon's suicide prevention, including programming decisions and links to key leaders.
1.1.5 "Equipped Advisories" Advisory groups are well supported, equipped, and function efficiently to make meaningful change.
1.1.6 "Resourced Coalitions" Regional Suicide Prevention Coalitions are informed and resourced to address their local needs and priorities.
1.2 Media & Communications
1.2.1 "Safe Messaging" All Oregonians receive safe messaging about suicide and self-injury.
1.2.2 "Promoting Wellness" Organizations and agencies routinely and strategically promote wellness, emotional strength, mutual aid examples, and protective factors.
1.2.3 "Information Dissemination" Suicide prevention programming, information and resources are widely advertised and centrally located on one website. Information is kept up-to-date.
1.2.4 "Informed Leaders" Key decision-makers are kept well informed & up-to-date about suicide activity and prevention efforts (i.e. legislators, Oregon Health Authority leaders, Oregon Department of Education leaders, county commissioners).
1.3 Social Determinants of Health
1.3.1 "Clear Links" The link between economic factors and risk of suicide is highlighted outside of typical suicide prevention work.
1.3.2 "Supporting Partners" Suicide prevention advocates and experts support the work of those decreasing disparities and inequities.
1.4 Coping & Connection
1.4.1 "Positive Connections" All Oregonians have access to meaningful places and spaces to experience positive connection & promote mutual aid.
1.4.2 "Coping Strategies" All Oregonians understand and have access to what helps them to cope with hardship as an individual and within their community including culturally specific strategies.
1.4.3 "Support Roles" People, family and caregivers understand and feel equipped to fulfill their role and understand their important impact on suicidality.
2. Clinical & Community Prevention Services: These goals and pathways seek to reduce suicide by focusing on strategic locations, groups, and sectors to promote wellbeing, to help navigate challenges, to decrease risk, and to recognize warning signs early. Other terms you might recognize here are "selected", “prevention”, “primary intervention” or “tier 2 strategies”.
2.1 Frontline & Gatekeeper Training
2.1.1 "Appropriately Trained Community" - Oregonians receive the appropriate level of training for suicide prevention (basic awareness, enhanced, and/or advanced) and are retrained appropriately.
2.1.2 "Supported Training Options" - Suicide prevention frontline and gatekeeper training is widely available at low or no cost for Oregon communities.
2.1.3 "Representative Trainers" - The trainer pool in Oregon for suicide prevention programming represents the cultural and linguistic diversity of the communities in which they train.
2.1.4 "Culturally Relevant Training" - Suicide prevention programming is regularly evaluated and updated to ensure equity, cultural relevance and responsiveness, and linguistic needs are addressed.

2.2 Means Reduction

2.2.1 "Safe Storage Access" - All Oregonians experiencing a behavioral health crisis have access to safe storage for medicine and firearms.

2.2.2 "Means Reduction Education" - Oregon communities are equipped with means reduction strategies and resources.

2.2.3 "Means Reduction Promotion" - Means reduction practices are promoted regularly in Oregon and are linked to suicide prevention.

2.3 Protective Programming

2.3.1 "Available Support" - Oregonians who need immediate support or crisis intervention have access to it.

2.3.2 "Population Focused Programming" - People within populations at greater risk for suicide have access to positive and protective programming in their community.

2.3.3 "Protective Policies" - Organizations and agencies have policies and procedures that increase protection against suicide risk (including passive risk, active risk, and crisis intervention) and those policies are implemented.

3. Treatment and Support Services: These goals and pathways seek to reduce suicide by focusing services and policies for those who experience suicidality or have been impacted by suicide loss. Other terms you might recognize include "indicated", "Tier 3 strategies", or "intervention".

3.1 Healthcare Coordination

3.1.1 "Coordinated Transitions" - All Oregonians who access healthcare for behavioral health crises or suicidal ideation receive coordinated care in transitions between levels of care.

3.1.2 "Appropriate Communication" There is formal communication between healthcare providers, behavioral healthcare providers and social and family supports (including schools for youth).

3.1.3 "Substance Use Services" - Substance Use Disorder and Mental Health services are integrated when possible and coordinated when not fully integrated.

3.1.4 "Integrated Care" - Oregonians will receive integrated care between primary care and behavioral healthcare (including school-based care for youth).

3.2 Healthcare Capacity

3.2.1 "Accessible Services" - Oregonians can access the appropriate services on the continuum of behavioral healthcare at the right time for the right amount of time, regardless of health insurance.

3.2.2 "Right Sized Workforce" - There is adequate behavioral healthcare workforce to meet the need.

3.3. Appropriate Treatment & Management of Suicidality

3.3.1 "Equipped and Well Workforce" - The behavioral healthcare workforce is well-equipped to help Oregonians with suicidality (including understanding variations of risk and protective factors and current risk and protective conditions).

3.3.2 "Voice and Choice" - Oregonians have voice and choice in treatment.

3.3.3 "Whole-person Approaches" - Whole-person approaches are used to enhance treatment for suicide and to increase effectiveness of management of long term symptoms.

3.4 Postvention Services

3.4.1 "Equipped & Resourced Communities" - Oregon communities are equipped to proved trauma informed postvention care for those impacted by a suicide death.

3.4.2 "Postvention Response Leads" - Postvention Response Leads (PRLs) (and teams) are supported and equipped to fulfill their legislative mandates.

3.4.3 "Fatality Data" -Suicide fatality data is gathered, analyzed, and used for future system improvements and prevention efforts.

4. Foundations and Centering Lenses: These are the "how" we agree to do this work together.

4.1 Data and Research

4.2 Evaluation

4.3 Policy Needs/Gaps

4.4 Funding Needs

4.5 Equity

4.6 Trauma Informed Practices

4.7 Lived Experience Voice

4.8 Collective Impact

Youth Suicide Intervention and Prevention Plan (YSIPP) 2021-2025

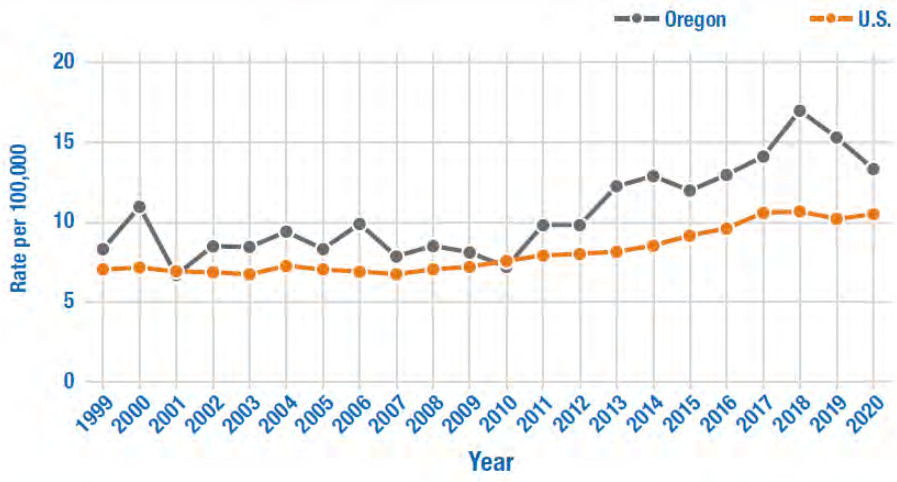
Since 2011, suicide rates have been rising nationwide for youth 10 to 24 years of age.

Oregon's rate continues to exceed the national rate, as shown in this chart.

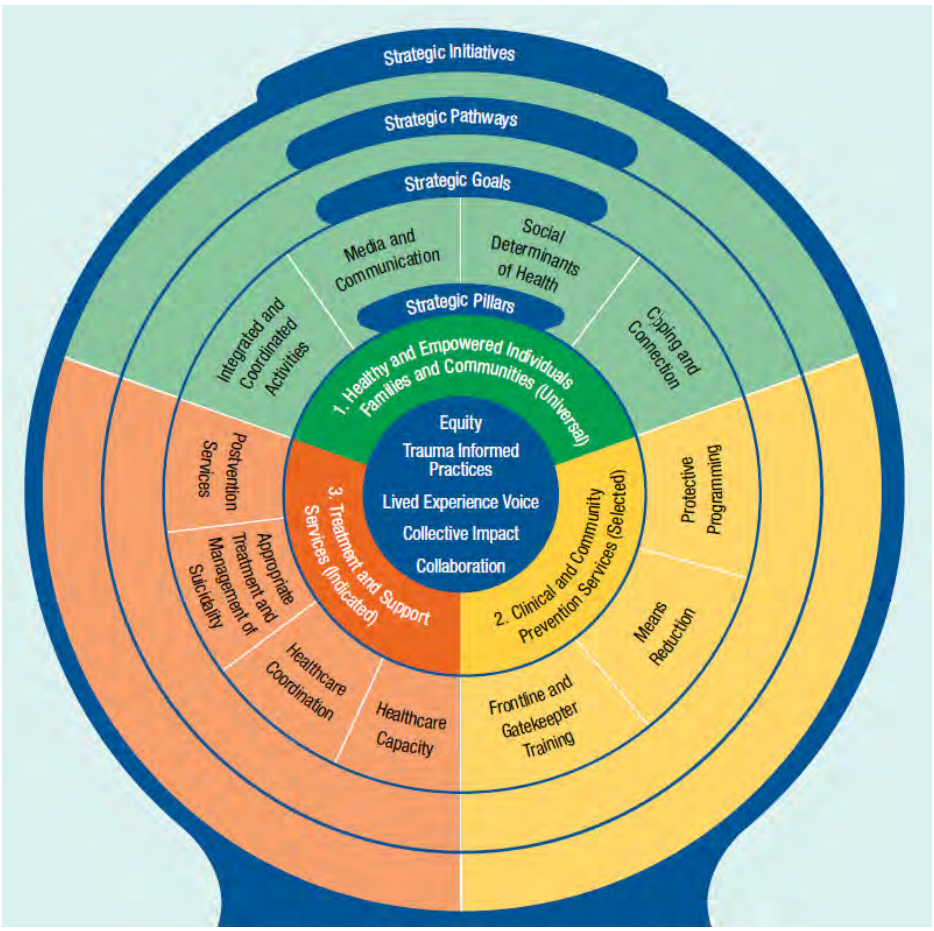
While still above the national rate, Oregon's youth suicide rate has decreased since 2018. Based on preliminary data, OHA anticipates an additional decrease in 2021.

Since 2016, the YSIPP has outlined strategies to decrease youth suicide.

Figure 1. Suicide rates among youth age 10–24 in the United States and Oregon, 1999–2020



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



Oregon Suicide Prevention Framework and the YSIPP

The Oregon Suicide Prevention Framework was developed in alignment with the CDC's Technical Package for Suicdie Prevention and the National Strategy for Suicide Prevention, along extensive feedback from community partners and experts in Oregon. Embedded within the Oregon Suicide Prevention framework, the YSIPP outlines the goals, pathways and initiatives that OHA and suicide prevention partners have identified as being the most important areas of focus.

The Oregon Alliance to Prevent Suicide[i] monitors implementation of the plan, chooses Alliance-related priority initiatives of focus each year and advises OHA regarding statewide priorities for suicide prevention.

Progress on the YSIPP

Updates on the current year's priority initiatives are here. Each fall, OHA's Suicide Prevention team, the Alliance, and other key partners assess progress on the YSIPP initiatives and choose activities to start, stop and continue for the following year.

OHA has completed many activities to support the 117 priority initiatives for 2021 and 2022. Highlights of the activities include:

- Big River programming support: Strengthening access statewide to high quality suicide prevention, intervention and postvention training opportunities, including training in treatment of suicide ideation for providers. The current map of suicide prevention Big River programming includes twelve available supported training options.
- Free access to K-2 suicide prevention curriculum to support schools
- An Oregon specific Counseling on Access to Lethal Means training option
- Distribution of thousands of medication lock boxes and firearm safes to promote safe storage
- Oregon's launch of the 988 Crisis and Suicide Lifeline
- Support for local postvention (after a suicide loss) response efforts across the state

Oregon's priorities moving forward

- The YSIPP has been implemented without full funding since 2016. The suicide prevention team submitted a funding request for the 2023-2025 biennium through a Policy Option Package that would fully fund the YSIPP and launch the work of the Adult Suicide Intervention and Prevention Plan (ASIPP).
- Focus on equity through community-driven suicide prevention efforts
- Strengthen culturally and linguistically responsive training options, treatment and services, and designate representative providers and trainers
- Strengthen youth and young adult voice to guide policy and programs

Funding

Before July 1, 2019: $1.75 million funded OHA's efforts. $1 million was one-time funding through the Budget Note for House Bill 5201 (2018), which funded the Sources of Strength, Rapid Response and safe online spaces programs, and an evaluation by the University of Oregon, of Oregon's YSIPP implementation. As of July 1, 2019: Funding increased by $6.3 million allocated in the legislatively approved budget for the 2019-2021 and 2021-2023 biennia.

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[i] The Oregon Alliance to Prevent Suicide is a cross system, statewide group administered by the Association of Oregon Community Mental Health Programs with funding from the Oregon Health Authority

Youth Suicide Intervention and Prevention Plan Annual Report







To read the full 2021 YSIPP Report go to:

https://www.oregon.gov/oha/HSD/BH-Child-Family/Pages/Youth-Suicide-Prevention.aspx

Oregon Health Authority

PUBLIC HEALTH DIVISION
HEALTH SYSTEMS DIVISION

Executive summary

Oregon made significant progress in 2021 in youth suicide prevention. This progress included:

- Developing a suicide prevention framework (pg 4)
- Publishing an updated five year plan for youth suicide prevention, and
- Starting the work outlined in the YSIPP 21–22 initiatives.

Preliminary data in Oregon indicate the following:

- For youth age 17 and under, suicide numbers decreased in 2021 compared to 2020.
- For youth age 18–24, suicide numbers in 2021 were similar to 2020.
- Suicide numbers decreased overall for youth age 24 and under in 2021 compared to 2020.

This is the first time since 2001 that Oregon has had a three year decrease in youth suicide fatalities (24 and under). While this is positive news, it is important to note that some counties in Oregon did not see this overall decrease in youth suicide in 2021 and Oregon remains above the national average for youth suicide rates. This good news is also wrapped in the context of big challenges for so many in Oregon. There is so much more to do to create safety for our children and young people. The suicide prevention team at OHA and our partners across the state will remain earnestly focused on this work.

In 2019, the legislature invested in dedicated funding for youth suicide prevention activities. This is called "Big River" programming. These activities launched throughout 2020 and continued to grow in 2021, despite the challenges COVID-19 presented. Big River programming is offered statewide. It includes a statewide coordinator for each Big River program and support for train-the-trainer events. This combination allows for locally-delivered suicide prevention programs with robust human and funding support from the state. Of course, these activities cannot thrive without being delivered by local communities. This report includes a summary of the progress Big River programming achieved in 2021.

Training and programing are only one piece of Oregon's suicide prevention strategy. OHA's suicide prevention coordinators have worked closely with the evaluation team at University of Oregon and the advocates who serve on the Oregon Alliance to Prevent Suicide to develop a framework for suicide prevention. This framework outlines the work that Oregon needs to do over the next five years to continue in the direction we have started. It includes centering equity and the voices of those with lived experience. It includes being grounded in good policy, informed by rich data and evaluation, and delivering services in a trauma-informed and culturally-responsive way. This report outlines progress on the YSIPP 21–22 priority initiatives as well as several data sets.

Youth Suicide Prevention Programing Available at low or no cost

Click on any logo for more information

MHFA – Mental Health First Aid

QPR – Question, Persuade, Refer

ASIST – Applied Suicide Intervention Skills Training

Youth SAVE – Youth Suicide Assessment in Virtual Environments

988 – Call or text 988 for crisis support 24/7

CALM – Counseling on Access to Lethal Means

Advanced Skills

CAMS – Collaborative Assessment and Management of Suicidality

DBT – Dialectical Behavioral Therapy

AMSR – Assessment and Management of Suicide Risk

CBT – Cognitive Behavioral Therapy

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Oregon Health Authority

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OHA 3548 (09/2022)

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Suicide Prevention within Oregon Schools

Youth Suicide Prevention

Youth suicide is a persistent problem nationwide. In Oregon, the rate of youth suicide deaths increased steadily from 2011 to 2018. Oregon experienced a two-year decrease in youth suicide in 2019 and 2020 and, based on preliminary data, OHA anticipates an additional decrease in 2021. Despite this promising decrease, Oregon ranks above the national average for youth suicide. Collaborative, innovative work is being done to create a state that is safer against suicide for young people in Oregon.

Every school district is required to adopt a comprehensive policy on student suicide prevention, intervention, and postvention before the 2020school year (Senate Bill 52 (2019), "Adi's Act"). According to Oregon Department of Education (ODE), all 197 school districts have self-reported compliance with this requirement. There remains a significant gap between the number of school districts reporting having Adi's Act plans and the number which have plans posted to their website.

Comprehensive suicide prevention in schools must include:

- Intentional **prevention** (focus on wellness, equity, coping skills, supportive culture-building, normalizing and encouraging help-seeking);
- **Curriculum** to teach developmentally appropriate suicide prevention for all students;
- Consistent and effective **intervention training for all staff** (knowledge of warning signs and how to refer students in crisis);
- **Mental health support** readily available to students;
- Informed and careful **postvention** (response after a suicide death); and
- **Collaboration** with local mental health programs.

OHA Collaboration to Support Adi's Act

School Suicide Prevention and Wellness program[1]	A partnership with ODE, OHA, and Lines for Life, the program provides hands-on support to help schools, districts, and educational service districts (ESDs) create and sustain suicide prevention plans. ▶ Regional specialists provide technical assistance, connection to resources, and access to funding to support plan development and implementation. ▶ As of May 2021, over 125 school districts or buildings in 30 of Oregon's 36 counties have received support through the program.
Research and Evaluation Efforts	Several research and evaluation projects are happening in Oregon to help inform the work of Adi's Act to address: ▶ What are districts including in their Adi's Act plans? ▶ What does implementation of district plans look like at the school building level? ▶ What supports do districts need to implement Adi's Act plans?

[1] To reach the regional student suicide prevention and wellness specialist in your area visit www.oregonyouthline.org/sspw/

Suicide Prevention Training programs	Since 2019 school year, OHA makes programs available to schools at low or no cost to help meet prevention, intervention, and postvention program requirements: ▶ Sources of Strength; Question, Persuade, Refer (QPR); Mental Health First Aid; Applied Suicide Intervention Skills Training (ASIST); and Connect Postvention. In 2021, OHA added trainings for mental health providers (including school counselors): ▶ Collaborative Assessment and Management of Suicidality (CAMS) and ▶ Youth Suicide Assessment in Virtual Environments (Youth SAVE).

Effective protective factors against youth suicide

Youth suicide prevention is grounded in local communities that care. Every Oregonian can be a part of creating a safe Oregon. The protective factors below are elements that have been proven effective in protecting youth from suicide:

- Connection to a kind, caring, trusted adult
- Support from family members (including non-biological family) and community
- Feelings of belonging, purpose, hopefulness
- Coping and problem-solving skills
- Access to effective physical and mental health care
- Stability in housing, income, and employment

What priorities is OHA focusing on?

With increased funding for youth suicide prevention in 2019, OHA continues work toward the following priorities:

- Creating equitable statewide access to suicide prevention, intervention and postvention programs and services supported by OHA. Click here for current programming.
- Supporting school districts and ESDs in adopting and growing comprehensive policies and plans for student suicide prevention, intervention, and postvention.
- Increasing support and funding for priority populations.
- Using reliable data and evaluation to guide and inform suicide prevention.

What else needs to be done?

Looking ahead to 2022-2023 school year, OHA will focus on:

- Achieving equitable statewide access to suicide prevention, intervention and postvention programs and services supported by OHA;
- Increasing the number of school districts with Adi's Act plans posted to school district websites, allowing OHA to monitor implementation and improve comprehensive plans for student suicide prevention, intervention, and postvention;
- Continued increase in support and funding for priority and historically excluded populations;
- Improved use of reliable data and evaluation to guide and inform suicide prevention; and
- Increased supports and programming for the 18 years and older population transitioning from high school to postsecondary education.

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Injury and Violence Prevention Program (IVPP) Data Glossary

This is an overview of data that the Injury & Violence Prevention Program uses. Please contact us at IVPP.General@odhsoha.oregon.gov. We will connect you with the person who can best answer your specific questions.

Medication Prescribing

Prescription Drug Monitoring Program (PDMP)

Pharmacies report prescriptions filled for drugs such as pain or anxiety medications through an electronic database known as the PDMP. Providers use the program's data to collaborate with other prescribers to reduce the risk of dangerous drug combinations and to make sure their patients are not getting similar medication from other providers before they prescribe it. Information is available by state, county, and age. It has been published since 2016 and takes three months to become available. PDMP data are updated quarterly.

Emergency Medical Services (EMS)

Oregon EMS Information System (OR-EMSIS)

Licensed transporting EMS and EMS/Fire agencies are required to report pre-hospital care information for patients. For example, on a call to a transportation-related accident, information on seat belt and helmet use is collected. This information is available by state and county. It has been available since 2016 and takes three months to become available.

Urgent Care Centers, Emergency Department and Hospital Stays

Health care information is available from two sources:

- ESSENCE data (emergency department and urgent care centers)
- Administrative discharge data (emergency department and hospital stays)

ESSENCE: Electronic Surveillance System for the Early Notification of Community-Based Epidemics

Emergency departments and participating urgent care centers in Oregon share de-identified information on visits to monitor health-related activity, such as suicide attempts and non-fatal overdose. This information is shared with OHA several times a day so that public health officials can alert staff if a higher-than-expected number of visits occur. Statewide information has been available since 2018. A suicide attempt report and overdose report are published monthly. Approved local public health ESSENCE users can get data daily for their counties.

Administrative Discharge Data: Oregon Association of Hospitals and Health Systems

Discharge data include hospital and emergency department (ED) information. Hospitals and EDs report data to OAHHS on visits and stays **when** there is a charge for services. This information includes diagnosis, medical care received, and demographic information (e.g., age, sex, race, and ethnicity). Hospital and ED discharge data **do not** overlap. If a patient goes to an ED first and then is admitted to the hospital, their information will appear in the hospital discharge data only.

Hospital discharge data include information for hospital visits that were at least 24 hours long. This information **does not** include outpatient and ED visits. This information has been available since 2000. The diagnoses classifications changed in October 2015, so information after this cannot be compared directly to data from earlier years. It takes six months for data to become available. For example, information about discharges in July 2021 would be available in January 2022. Hospital discharge data will start being published online by the end of 2021.

Emergency Department discharge data include information for ED admissions. This information has been available since 2018. It takes six months for data to become available. For example, information about discharges in July 2021 would be available in January 2022. Emergency department discharge data will start being published online by the end of 2021.

What's the difference between ESSENCE and administrative discharge data?

ESSENCE data describe ED and urgent care visits (with or without charges for service) but **do not** include information on hospital stays. Discharge data describe ED visits and hospital stays (only when there is a charge for services) but **do not** include information on urgent care center visits.

Both ESSENCE and discharge data have ED visit information, but the number of visits reported in ESSENCE will not match the number of visits reported in discharge data since each of these sources collect and report data differently. This means that the number of ED visits from discharge data cannot be compared to ESSENCE data.

Instead compare each source to itself over time*, "What was the number of ED visits for traumatic brain injuries from discharge data in 2017 compared to number from discharge data in 2018?"* Both sources can be used to describe general trends, "*Both ESSENCE and discharge data show an increase in the number of ED visits for traumatic brain injuries over the last six months."*

Death/Mortality

Death data are available from three sources:

- Center for Health Statistics
- Oregon Violent Death Reporting System
- State Unintentional Drug Overdose Reporting System

Center for Health Statistics (CHS)

Death certificates are registered with CHS. Death certificates are completed and signed by a physician, physician assistant, nurse practitioner, or medical examiner. The data are reported in two ways: "resident deaths," which include the deaths of all Oregon residents, even if the death happened out of state; and "occurrence deaths," which include all deaths that happened in the state, including those who died here but were not Oregon residents. Information is available by state, county, age, race, ethnicity, and sex. Oregon began statewide registration of deaths in 1903. This preliminary information is updated monthly. This information is finalized 10 to 11 months after the calendar year. For example, data from 2020 will be finalized by November 2021.

Oregon Violent Death Reporting System (ORVDRS)
ORVDRS staff gather, review, and link data from death certificates, medical examiner reports, law enforcement reports, and lab (toxicology) reports. Complex, national guidelines are used to translate this data into information that provides a more complete picture of violent deaths. Violent deaths include suicides, homicides, deaths of undetermined intent, legal interventions, and unintentional firearm injury deaths. As a result, questions like the following can be answered: "*Was this random violence? Was the victim a bystander? Did the victim use a weapon? Was this a hate crime? Was there drug involvement?* Because information comes from several sources, it takes longer than other death data to become available. Demographic information such as age, sex, race, and ethnicity is available. This information has been available since 2003 and is updated yearly. The data take about 16 months to become available. For example, data from 2020 will be available after April 2022.

The State Unintentional Drug Overdose Reporting System (SUDORS)
SUDORS staff gather, review, and link data from death certificates, medical examiner reports, and lab (toxicology) reports. Complex rules are used to translate this data into information that provides a more complete picture of each overdose death. As a result, questions like the following can be answered: *"How many overdose deaths involved more than one substance, happened in front of a bystander, or involved people with a history of substance misuse/treatment?"* Because information is taken from several sources, it takes longer than other overdose death data to become available. Demographic information such as age, sex, race, and ethnicity is available. This information has been available since July 2019. The first annual report will be published by Fall 2021. The data take six months to become available. For example, information on overdose deaths from July to December 2020 will be available after June 2021.

What's the difference between CHS, ORDVRS, and SUDORS data?

The number and rates of deaths from these three sources will be different from one another because data are collected and defined differently. Each of these sources have strengths and one is not "better" than the others. Which data are used needs to be based on what questions are to be answered. For example, if **descriptions** about deaths are needed, ORVDRS and SUDORS data should be used. If the data are needed **as soon as possible**, then preliminary CHS data may be more helpful.

The most important thing is to **not** compare data from one source to another. Instead, compare each source to itself over time*, "How many suicides occurred in 2017 compared to 2018 based on CHS data?"* You **can** use multiple sources of information to describe **general** trends, *"Both CHS data and ORVDRS data show an increase in the number of suicides between 2017 and 2018."*

Questions? Please contact us at IVPP.General@odhsoha.oregon.gov. We will connect you with the person who can best answer your specific questions.

PUBLIC HEALTH DIVISION

Suicide-related Public Health Surveillance Update
Sept 16th, 2022

Data Sources

Oregon Violent Death Reporting System (ORVDRS) suicide deaths.

Emergency department (ED) and urgent care center (UCC) suicide-related visits.

Lines for Life suicide hotline call data.

Summary of Findings

Counts

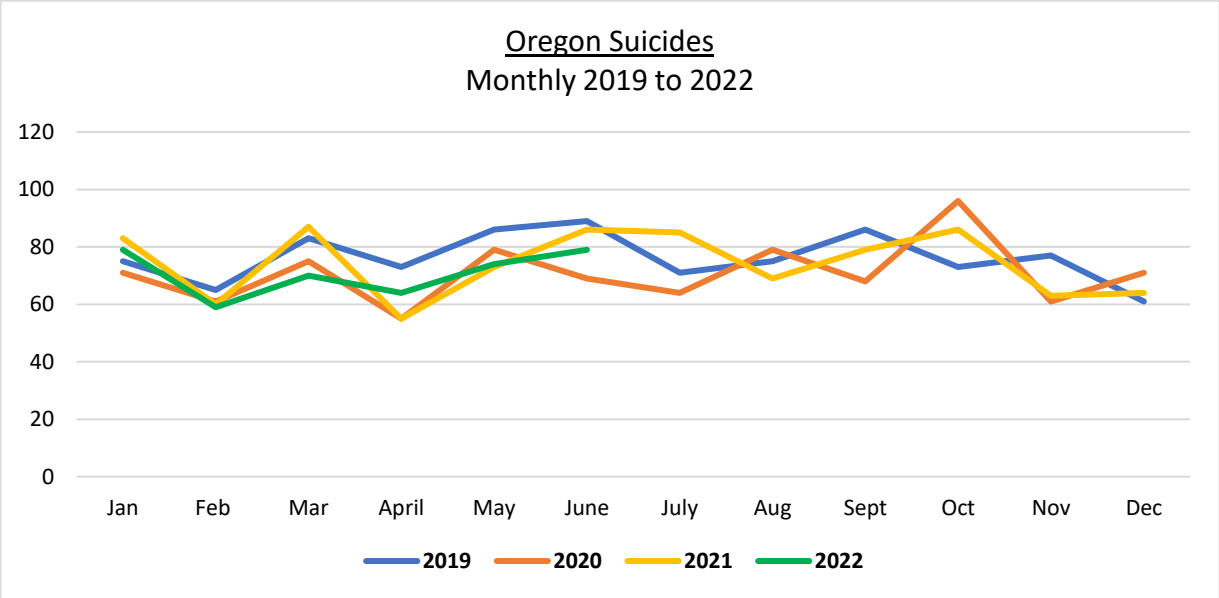
- Suicide deaths in 2022 are similar to 2021. Mortality data is still being processed and numbers for recent months may change.
- Suicide-related visits to EDs and UCCs in the first two quarters of 2022 are similar to 2019.
- Suicide-related visits to EDs and UCCs for youths ages 18 and under in the first quarter of 2022 were higher than previous years, but started to recede in the second quarter.
- Oregon Lines for Life call volume is influenced by many factors such as willingness to seek assistance, visibility of the lifeline phone number, or high-profile suicides of celebrities or community members. Calls have increased annually since 2016. Calls in 2021 align with this trend. No increases beyond the variation expected have been identified.

Percentages

- The percent of suicide-related visits to emergency departments and urgent care centers in 2022 is slightly lower than previous years.

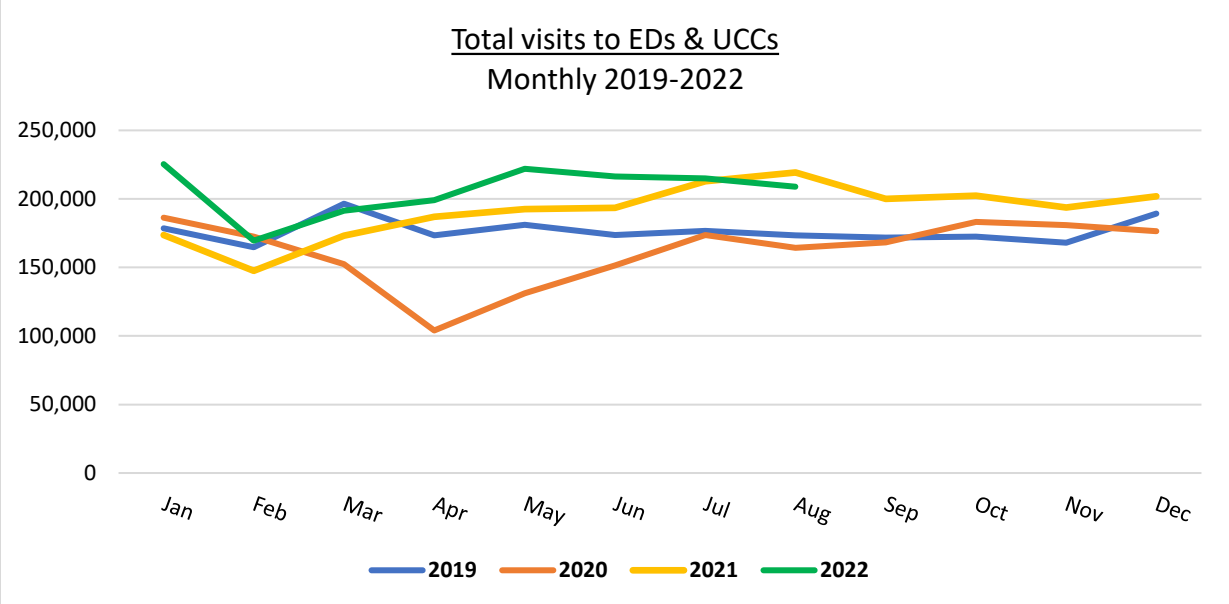
Details of Findings: ORVDRS suicide deaths

Suicide deaths in 2022 are similar to 2021. Mortality data is still being processed and numbers for recent months may change.

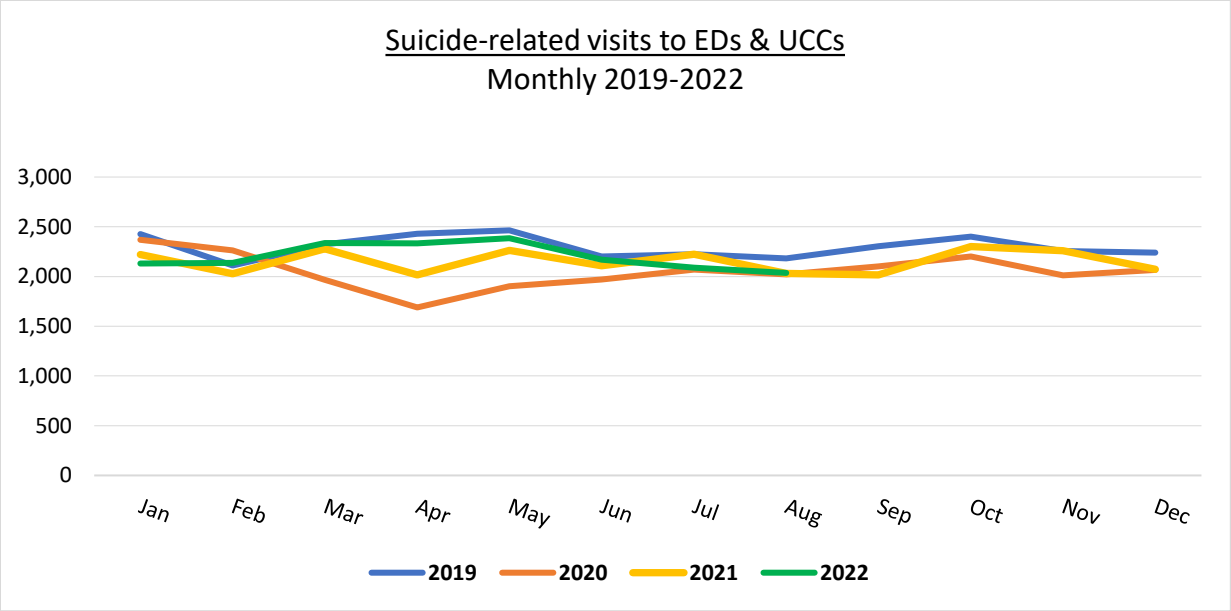


Details of Findings: EDs and UCCs

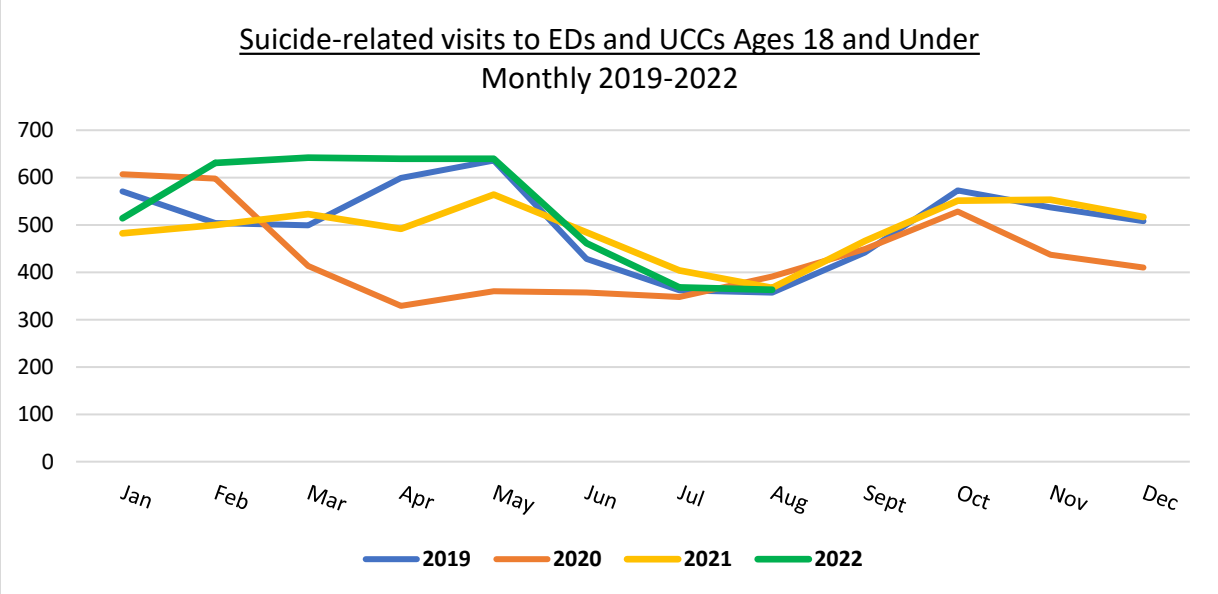
Total visits for all health concerns to EDs and UCCs in 2022 are higher than previous years.



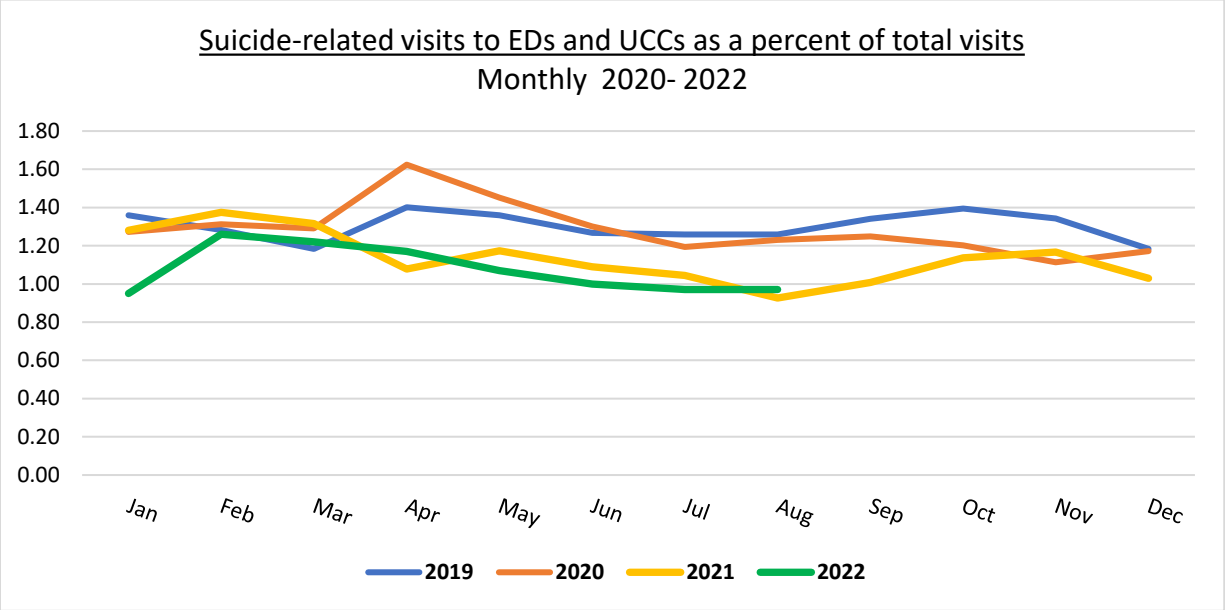
Suicide-related visits to EDs and UCCs in 2022 are similar to 2019.



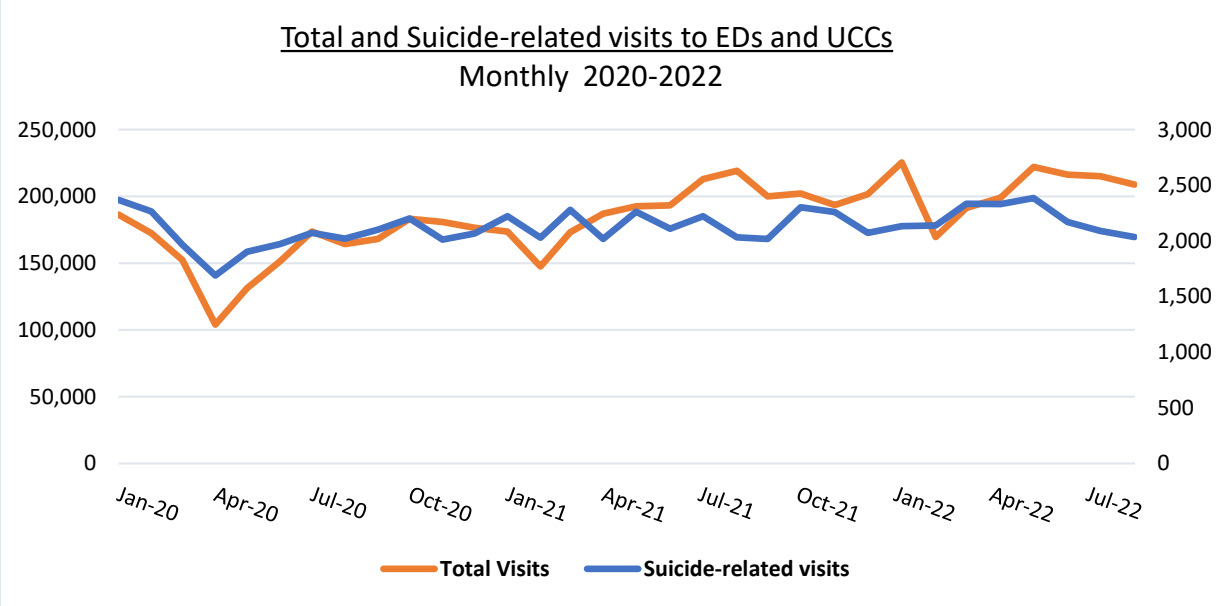
Suicide-related visits to EDs and UCCs for youths ages 18 and under in the first quarter of 2022 were higher than previous years, but started to decrease in the second quarter.



The percent of suicide-related visits to emergency departments and urgent care centers in 2022 is slightly lower than previous years.

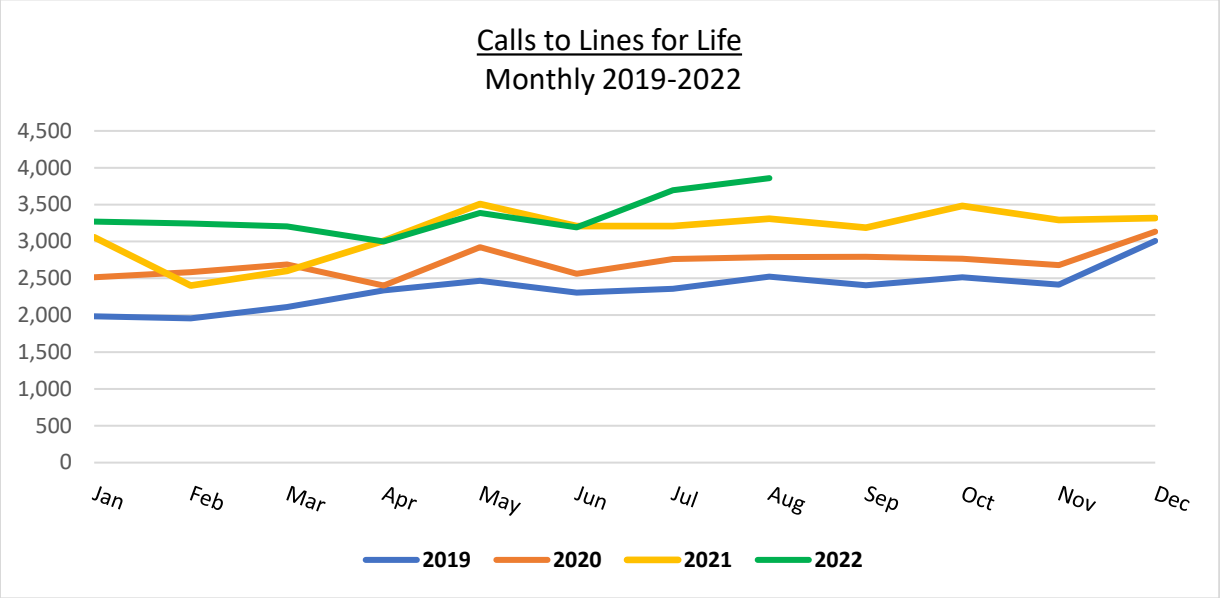


Total and suicide-related visits to EDs and UCCs presented side by side show a sharp decrease in total visits and a smaller decrease in suicide-related visits during March and April of 2020 when shelter in place orders were announced.



Details of Findings: Lines for Life Calls

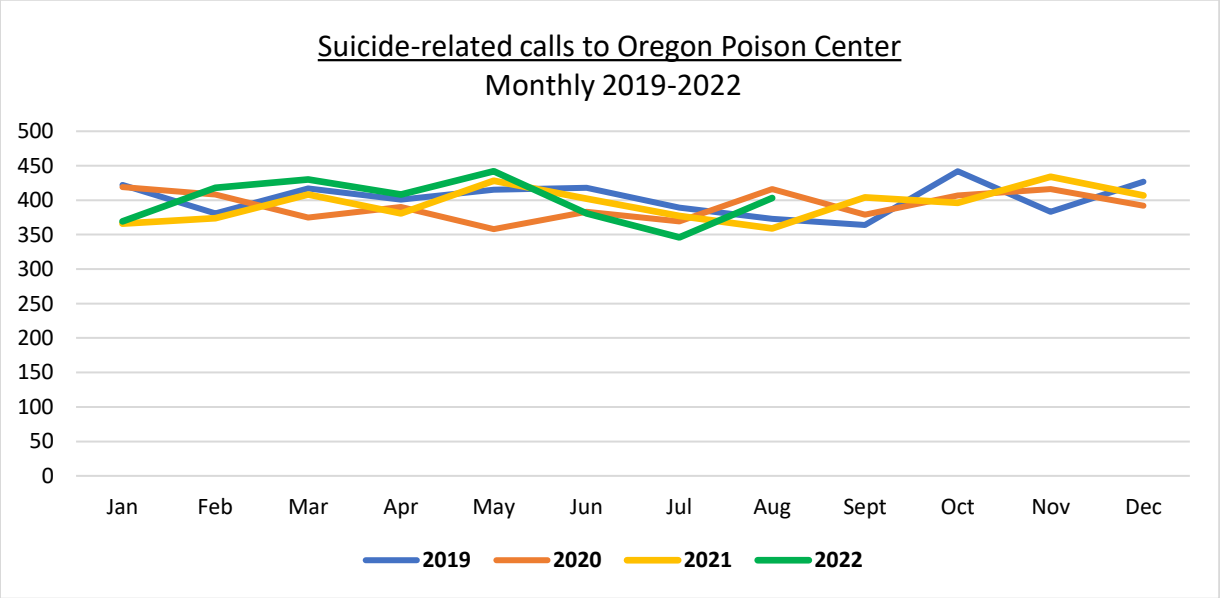
Lines for Life call volume is influenced by many factors such as willingness to seek assistance, visibility of the lifeline phone number, or high-profile suicides of celebrities or community members. Calls have increased annually since 2016. Calls in 2021 align with this trend. No increases beyond the variation expected have been identified.



Details of Findings Oregon Poison Center (OPC) Calls

Total calls:

Suicide related calls to OPC in of 2022 are similar to previous years.



Methods/ Data Sources

Oregon Violent Death Reporting System (ORVDRS) includes combined and abstracted data from medical examiners, death certificates, and law enforcement.

Emergency Departments (EDs) and Urgent Care Centers (UCCs)
The Oregon Health Authority (OHA) queried Oregon Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) for suicide-related visits to Emergency Departments (EDs) and Urgent Care Centers (UCCs) using the self-harm and suicide-related visits query developed by the International Society for Disease Surveillance (ISDS) Syndrome Definition Committee with input from the Centers for Disease Control and Prevention, Division of Violence Prevention.

Lines for Life
Lines for Life is the Oregon affiliate of the National Suicide Prevention Lifeline and receives calls to 1-800-273-8255 that originate from Oregon area codes. Lines for Life provides crisis intervention services for drug addiction, suicidal ideations, and other mental health issues. Call data for 2019 and 2020 were supplied to OHA by Lines for Life.

Strengths

To assess suicide-related visits to EDs and UCCs, OHA used the query developed by the International Society for Disease Surveillance (ISDS) Syndrome Definition Committee.

OHA evaluated 6,112 visits from January 1 through March 22, 2020 to determine the positive predictive value of this query. To be considered a true positive, a visit must contain a minimum of two suicide-related terms: chief complaint and discharge diagnosis. OHA further evaluated visits with non-suicide chief complaints using triage notes, when available. The positive predictive value of this query for this period is 98.6%.

Considerations & Limitations

Data derived from emergency department and urgent care center visits are still being received/updated and minor fluctuation is anticipated.

Not all people in Oregon have access to an emergency department or urgent care center. People with suicidal ideations may forgo medical assistance.

Classification of suicide deaths may be delayed by required pathology.

Oregon ESSENCE
OREGON HEALTH AUTHORITY
Public Health Division
Oregon.ESSENCE@dhsoha.state.or.us
healthoregon.org/essence

Injury and Violence Prevention
OREGON HEALTH AUTHORITY
Public Health Division
IVPP.General@dhsoha.state.or.us
healthoregon.org/suicideprevention

Safe Messaging Around Suicide

In the event that your agency receives inquiries about suicides from the public or from the media, or whenever it is necessary to communicate information about a suicide to staff, safe messaging guidelines are included below. Please share these as appropriate.

Research shows that the language and content of communications about suicide play an important role in prevention. Thoughtful communication about suicide can change perceptions, dispel myths and emphasize the complexities of the issue. Framing communication about suicide in messages of hope and recovery and that include helpful resources can result in help-seeking by those who may be at risk of suicide. Recommendations on safe communication about suicide include:

- Always include crisis lines and resources in your communication such as the 988 Suicide & Crisis Lifeline (Call, text or chat 988), other national crisis lines and Oregon county crisis lines.
- Describe suicide as a public health issue: Provide accurate information about suicide facts and suicide prevention efforts. Including stories of hope, healing and recovery may reduce the risk of contagion.
- Use appropriate language: Certain phrases and words can further stigmatize suicide, spread myths and undermine suicide prevention objectives such as "committed suicide" or referring to suicide as "successful, "unsuccessful" or a "failed attempt." Instead use "died by suicide or "killed him/herself/themselves."
- Keep information shared about the location of the suicide general whenever possible and do not include details on the method of suicide. Keep information about the person general.
- Describe warning signs, risk factors and protective factors that give the suicide context as opposed to oversimplifying or speculating on the reason for the suicide.
- Ask an Expert: Interview suicide prevention or mental health experts to ensure

that you're sharing factual information about suicide and mental illness.

More information on safe messaging and examples can be found through:

- Recommendations on Reporting on Suicide
- National Action Alliance for Suicide Prevention's Framework for Successful Messaging

Resources for Staff and Clients

Oregonians are experiencing high levels of stress and mental distress due to compounding traumas including the COVID-19 pandemic, social isolation, and wildfires. Beyond these current stressors, suicide remains a public health issue in Oregon and the United States. In 2019, suicide was the eight leading cause of death for Oregonians and the second leading cause of death of youth ages 10-24. Health care organizations have a unique opportunity to help prevent suicide by identifying patients at risk of suicide and following the recommended standard of care to support these individuals. Please review the following guidance:

Actions requested:

- **Review** risk factors and warning signs of potential suicide risk.
- **Ask** patients and clients about suicide directly, "Are you thinking about killing yourself?" or "Sometimes when someone is feeling the way you are, they consider suicide. Are you thinking about suicide?"
- **Assess** suicide risk using an evidence-based suicide risk assessment tool. As well as using a standard risk assessment, assess for the emotional impact of COVID-19 and if there is an increased suicide risk. Examples that can escalate risk include:
  - » Increase social isolation,
  - » Social conflict of sheltering together,
  - » Increased financial concerns or worry about health or vulnerability in self, friends and family,
  - » Decreased social support,
  - » Increased anxiety and fear, and

» Disruptions of routines and support.

- **Complete** a safety plan during the same visit if concerned about suicidal thoughts or actions. One possible template is available here. The safety plan includes arranging for removal of firearms or medications from the home temporarily, identifying a 24/7 telephone crisis lines such as the National Suicide Prevention Lifeline, and empowering the person at risk to identify internal coping strategies.
- **Identify** protective factors to emphasize including reasons for living such as family, hope for the future, children, cultural and spiritual connections/ supports. Reach out to positive connections with friends, family and others. Connectedness is a key protective factor against suicide.
- **Engage** the patient in treatment with a behavioral health professional, if possible, with one who has training in suicide.
- **Follow-up** with the patient (by phone, text, e-mail or face-to-face) to check-in on them and see if they have been able to make a follow-up appointment with a behavioral health professional.

Additional information:

- Hospital, primary care, and mental health providers, first responders and other healthcare professionals experience intense, sometimes stressful situations at work. In an unprecedented crisis, natural disaster or public health emergency, healthcare providers may be at risk of suicide. The Healthcare Provider Mental Health and Crisis Support webpage offers helplines, ready-to-use tools, webinars and other resources to support physical and mental health.
- Children and adolescents often react to stressful events differently than adults. Caregivers and providers can help children by staying calm and reassuring them. Talk to children about what is happening in a way they can understand. Keep it simple and appropriate for the child's age. Encourage them to share their concerns; ask questions.
- A sharp increase in firearm purchases during the pandemic indicates there may be a large number of new firearm owners who have had less access than usual to safety education.

- The combination of stressors and risk factors means health care and social service providers, as well as Oregonians, must increase our vigilance about suicide risk.

Resources for Providers:

- National Action Alliance to Prevent Suicide: Recommended Standard Care for People with Suicide Risk: Includes Recommendations by Primary Care, Outpatient Behavioral Health Care, Emergency Department and Behavioral Inpatient Care settings.
- Oregon Psychiatric Access Line Kids and Adults (OPAL-K and OPAL-A): Provides free, same-day, Monday – Friday, child and adult psychiatric phone consultation to primary care providers in Oregon (registration is required).

Resources for Clients and Community:

- Crisis Services by Oregon County
- Crisis helplines including the 988 Suicide & Crisis Lifeline (Call, text or chat 988); En español: 988 . Deaf & hard of hearing access: Dial 711 then 988 or chat.
- YouthLine (For teen-to-teen support). Call 977-968-8491 or text teen2teen to 839863 (peer support available 4-10pm PST)
- The Veteran Crisis Line (Call 988 and then press "1" or text 838255) and the Military Helpline (Call 1-888-457-4838 anytime; text MIL1 to 839863 Monday – Friday from 2-6pm PST)
- Crisis Text Line: Text OREGON to 741741