

## >> Prevent deaths from suicide

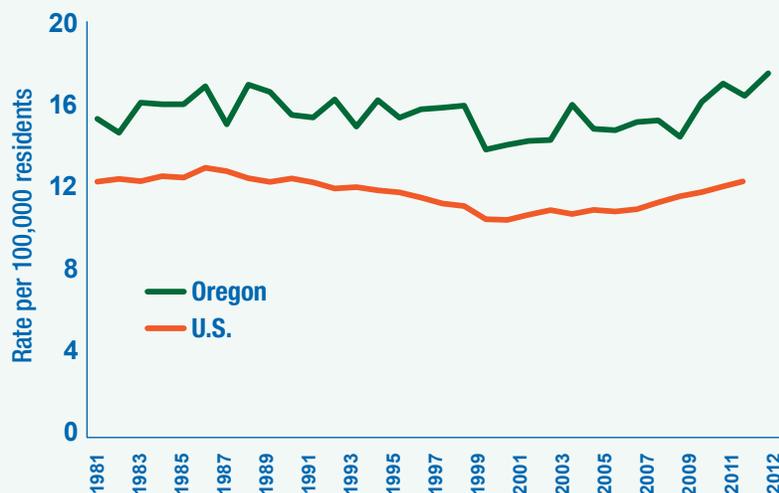


Suicide is among the leading causes of death in Oregon, and is a major public health issue nationally. There are more than 650 suicides in Oregon each year and more than 2,100 hospitalizations due to suicide attempts.<sup>1</sup>

Individuals that attempt suicide, when not fatal, can have lasting health problems that may include brain damage, organ failure, depression and other mental health problems. Suicide also affects survivors and communities. Suicide and other self-inflicted injuries result in an estimated \$41.2 billion in combined medical and work loss costs in the United States annually.<sup>2</sup>

Suicide rates in Oregon have been consistently higher than the U.S. for the past 30 years. Both nationally and in Oregon, rates of suicide have steadily increased since 2000. Suicide is one of the five leading causes of death for people in Oregon aged 10–54 years.<sup>3</sup>

### Suicide, Oregon and U.S., 1981–2012



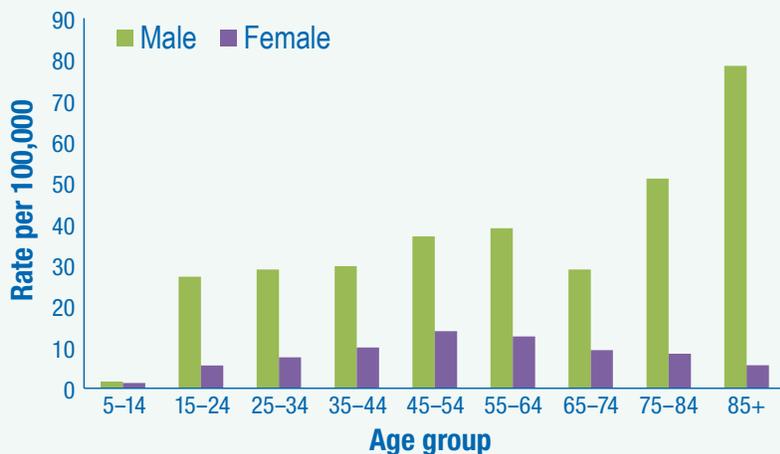
Notes: The national suicide mortality data for 2012 were not available at this time.  
Source: CDC's WISNARS and Oregon Violent Death Reporting System

Disparities exist among racial/ethnic groups in Oregon. In 2012, the age-adjusted rate of deaths from suicide was highest among Hispanic and non-Hispanic Whites (18.6 per 100,000). Age-adjusted rates were lowest among Hispanics (5.6 per 100,000) and non-Hispanic Asians (6.3 per 100,000).<sup>4</sup> The overall suicide rate in Oregon was 17.6 per 100,000.

Gender and age disparities also exist. Rates of suicide are higher among men than women. Nationally, although men are four times more likely to die from suicide than women, women

attempt suicide three times more often than men and have higher rates of hospitalizations due to suicide attempts. Rates of suicide increase with age. Among men in Oregon, rates more than double between males 55–64 years of age and those 85 years of age and older.<sup>1</sup>

### Suicide crude mortality rate/100,000 by age group and sex, 2010



Source: Death certificate data

Suicide is a serious health problem among Oregon veterans. From 2008–2012, veterans made up 8.7% of Oregon’s population, but accounted for 23% of suicide deaths.<sup>5</sup> The overall number of suicide deaths among veterans has remained steady since 2001, but the rate of suicide among veterans has increased from 40.1 per 100,000 in 2001 to 48.3 per 100,000 in 2012.

### Strategies to prevent deaths from suicide

To prevent deaths from suicide, Oregon must employ evidence-based interventions across

sectors, including health care, education and the community, and at all levels from the individual to societal. Suicide prevention strategies must reduce the risk factors for suicide, and increase factors that promote resilience.

Oregon’s strategy to prevent deaths from suicide include upstream, protective interventions to improve well-being in childhood and to ensure adequate resources exist to help individuals and families in need.

## Priorities, strategies and measures

### Priority targets

#### Rate of suicide

**Target: 16.0 per 100,000**

**Baseline: 17.6 per 100,000 (2012)**

**Data source: Death certificate data**

#### Suicide attempts among eighth graders

**Target: 7.0%**

**Baseline: 7.9% (2013)**

**Data source: Oregon Healthy Teens Survey**

#### Emergency department visits for suicide attempts

**Target: Pending**

**Baseline: Unknown developmental measure (2015)**

**Data source: To be determined**

### Population interventions

#### **Strategy 1: Promote use of the National Suicide Prevention Lifeline**

Justification: The National Strategy for Suicide Prevention (2012) states there is a particular need to increase awareness of the role of crisis lines and other local crisis services in providing services and support to individuals in crisis.<sup>6</sup>

##### Measure 1.1: Number of callers to the National Suicide Prevention Lifeline

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: National Suicide Prevention Lifeline data

##### Measure 1.2: Percentage of people who receive telephone follow up after treatment for a suicide attempt

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: To be determined

### **Strategy 2: Ensure communities implement an array of services and programs to promote safe and nurturing environments**

Justification: Communities can promote safe and nurturing environments by making available a spectrum of services and programs to community members, including those for positive youth development, positive parenting and nurse family partnerships. The services and programs available should meet the needs of the community.

Measure 2.1: Percentage of adolescents who meet Positive Youth Development benchmark<sup>7</sup>

Target: Eighth grade males and females: 70%; 11th grade males and females: 75%

Baseline: Eighth grade females: 58%

Eighth grade males: 64%

11th grade females: 64%

11th grade males: 68% (2013)

Data source: Oregon Healthy Teens Survey

Measure 2.2: Percentage of youth reporting depressed mood

Target: Eighth grade females: 20%, eighth grade males: 10%; 11th grade females: 20%; 11th grade males: 10%

Baseline: Eighth grade females: 35%

Eighth grade males: 16%

11th grade females: 34%

11th grade males: 20% (2013)

Data source: Oregon Healthy Teens Survey

Measure 2.3: Percentage of eighth graders who have seriously considered attempting suicide in the past 12 months

Target: 14.5%

Baseline: 16.1% (2013)

Data source: Oregon Healthy Teens Survey

## Health equity interventions

### **Strategy 1: Reduce the disparity of suicide among veterans**

Justification: From 2008–2012, veterans made up 8.7% of Oregon’s population, but accounted for 23% of suicide deaths.

Measure 1.1: Increase identification, referrals, treatment and follow up for veterans at risk for suicide

Target: Pending

Baseline: Unknown, developmental data (2015)

Data source: To be determined

### Health system interventions

#### **Strategy 1: Create incentives for private and public health plans and health care providers to prevent deaths from suicide**

Justification: Incentive measures and alternative payment methodologies ensure health plans and health care providers are working on a common set of priority areas designed to improve care and access, eliminate disparities and contain health care costs. The measures currently focus on public health plans, but measures will be expanded to include private insurers as data become available.

Measure 1.1: Number of public health plans that receive an incentive or shared savings payment for suicide prevention

Target: 16 CCOs, PEBB and OEBC carriers

Baseline: 0 CCOs, PEBB and OEBC unknown (2015)

Data source: OHA Metrics and Scoring, PEBB and OEBC contracts

Measure 1.2: Number of public health plans that incorporate suicide prevention in alternative payment methodologies for contracted providers

Target: 16 CCOs, PEBB and OEBC carriers

Baseline: Unknown, developmental measure (2015)

Data source: CCO Transformation Plans, PEBB and OEBC contracts

#### **Strategy 2: Establish universal screening for individuals at risk of suicide**

Justification: Early intervention and linkages to care result in a reduction in suicide attempts

Measure 2.1: Rate of patients identified for suicide risk

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: To be determined

Measure 2.2: Rate of patients identified at risk who are referred for treatment

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: To be determined

Measure 2.3: Rate of follow up for patients screened at risk for suicide and referred for treatment

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: To be determined

Measure 2.4: Rate of follow up for patients after leaving emergency department or discharged from psychiatric inpatient unit

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: To be determined

### **Strategy 3: Reduce access to lethal means of suicide**

Justification: Restricting access to lethal means for suicidal people prevents death. Reducing access to lethal means that are commonly used has been shown to decrease suicide rates by as much as 30–50% in other countries.

Measure 3.1: Number of counseling encounters to reduce access to lethal means by health care providers (physical, mental and behavioral health) to persons/families at risk of suicide

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: Program evaluation data

### **Strategy 4: Ensure training for health professionals is available to address suicide risk**

Justification: Many people who attempt suicide have had recent contact with a health care or behavioral health professional. Training ensures these professionals have the skills and resources to assess individuals for suicide risk and refer to care.

Measure 4.1: Number of private and public health plans, clinics and hospitals that require training for health care workers to identify suicide risk, refer to care, treat and follow up with patients at risk

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: Program evaluation data

Measure 4.2: Number of physical, mental and behavioral health care professionals trained to identify suicide risk, refer to care, treat and follow up with patients at risk

Target: Pending

Baseline: Unknown, developmental measure (2015)

Data source: To be determined

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<sup>1</sup> Oregon Health Authority, Public Health Division, Injury & Violence Prevention Program. Oregon Injury Prevention Plan 2011–2015 2012. Retrieved from: <https://public.health.oregon.gov/DiseasesConditions/Injury-FatalityData/Documents/OregonInjuryPreventionPlan.pdf>.

<sup>2</sup> Centers for Disease Control and Prevention, Injury Prevention & Control: Division of Violence Prevention. Suicide Prevention. 2015. Retrieved from: [www.cdc.gov/violenceprevention/suicide/](http://www.cdc.gov/violenceprevention/suicide/).

<sup>3</sup> Oregon Health Authority, Public Health Division. Oregon State Health Profile. Suicide. 2014. Retrieved from: <https://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/suicide.pdf>.

<sup>4</sup> Oregon Health Authority, Public Health Division. Oregon Violent Death Reporting System, 2009–11. 2014. Retrieved from: <https://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/suicideRE.pdf>.

<sup>5</sup> Oregon Health Authority, Public Health Division. Oregon Violent Death Reporting System. Suicide Among Oregon Veterans. 2014. Retrieved from: <https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/suicide-among-oregon-veterans2008through2012.pdf>.

<sup>6</sup> U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. National Strategy for Suicide Prevention: Goals and Objectives for Action. 2012. Available at: [www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/).

<sup>7</sup> Positive youth development (PYD) provides a holistic view of the physical, psychological and social supports for healthy youth development, and is strongly associated with behaviors that promote physical and emotional health, as well as academic achievement. The PYD benchmark is a composite measure of physical, mental and emotional health status, and protective individual environmental factors drawn from PYD theory.