Clackamas County

Suicide Fatality Review Annual Report

2022

CLACKAMAS COUNTY

MEDICAL EXAMINER
CLACKAMAS COUNTY OREGON

Table of Contents

Background

Suicide is a priority health issue in Clackamas County. The Blueprint for A Healthy Clackamas (2017 – 2020), the County's Community Health Improvement Plan (CHIP) identified this key health need. In 2021, Clackamas County's age adjusted rate of suicide of 15.9 (Oregon Health Authority, 2017) was the highest in the tri-county region and higher than the national rate at that time of 14.0. (Oregon Health Authority, 2017).

Developed in 2021 and with the intent of reviewing as many suicides as possible, the Clackamas County Suicide Fatality Review Committee (SFR) was created to better evaluate the circumstances leading to and causing suicides to improve community and service systems and to take action to prevent suicide. The committee consists of a multidisciplinary group of professionals and community members with lived experience. The SFR functions as a sub-committee of the Clackamas County Coalition to Prevent Suicide which began in 2018.

The objectives of the Clackamas County Suicide Fatality Review are to:

- Identify specific barriers and systems issues involved with suicide deaths
- Identify risk factors and trends in suicide deaths for future prevention/intervention efforts as well as looking at the enhancement of potential protective factors
- Develop strategies for increased communication and coordination of delivery of services to survivors of suicide loss.

Confidentiality and Privacy

An integral part of the SFR process is obtaining consent from next of kin. To protect the rights of the deceased and after waiting an appropriate amount of time after the death, permission from the legal next of kin is requested to review their family member's death by sending a formal letter with a release of information request, following-up with phone calls if necessary. The SFR committee only reviews those cases in which a release of information has been signed by the legal next of kin.

At the beginning of their service on the committee, and each year thereafter, all SFR members will sign a confidentiality agreement. Additionally, members are asked to sign another confidentiality agreement before every SFR meeting.

Committee Structure

The SFR formed in late 2021 and spent several months onboarding and training committee members on the SFR purpose and process. No cases were reviewed in 2021. In 2022, the SFR met virtually three times and reviewed a total of five cases.

SFR membership includes:

- Clackamas County Disaster Management, Office of the Medical Examiner
- Oregon State Medical Examiner's Office
- Clackamas County Health Centers
- Clackamas County Behavioral Health
- Clackamas County Social Services
- Clackamas County Public Health
- Clackamas County District Attorney's office
- Portland VA Health Care System
- Providence Willamette Falls Hospital Medical Center
- Kaiser Northwest Permanente
- Clackamas American Medical Response (AMR)
- Clackamas County Sheriff's Office
- Oregon City Police Department
- Lake Oswego & West Linn Police Departments
- State of Oregon Department of Human Services Departments and Programs
- Suicide Attempt Survivors
- Suicide Loss Survivors

Methods

The Chief Medicolegal Death Investigator contacted the next of kin from 135 deaths that occurred in 2020 or 2021 and received authorization to review 17 (12.6%). The SFR committee reviewed 5 of these cases in 2022.

During each fatality review, SFR committee members took notes on the events leading up to the individual's death as well as any life circumstances or experiences deemed relevant to the manner of death. Committee members were given the option of taking notes in a grid format that was intended to help members organize their thoughts; the grid employed the codes that would eventually be used in the final analysis (figure 1). These notes were then coded by a Clackamas County Public Health epidemiologist using a set of pre-identified codes that were selected based on secondary research in suicidality and suicide prevention, mirroring Washington County Public Health Division's SFR methodologies. The data were analyzed using Nvivo QSR International qualitative data analysis software with the purpose of identifying variables of greater or lesser influence as well as patterns among the decedents.

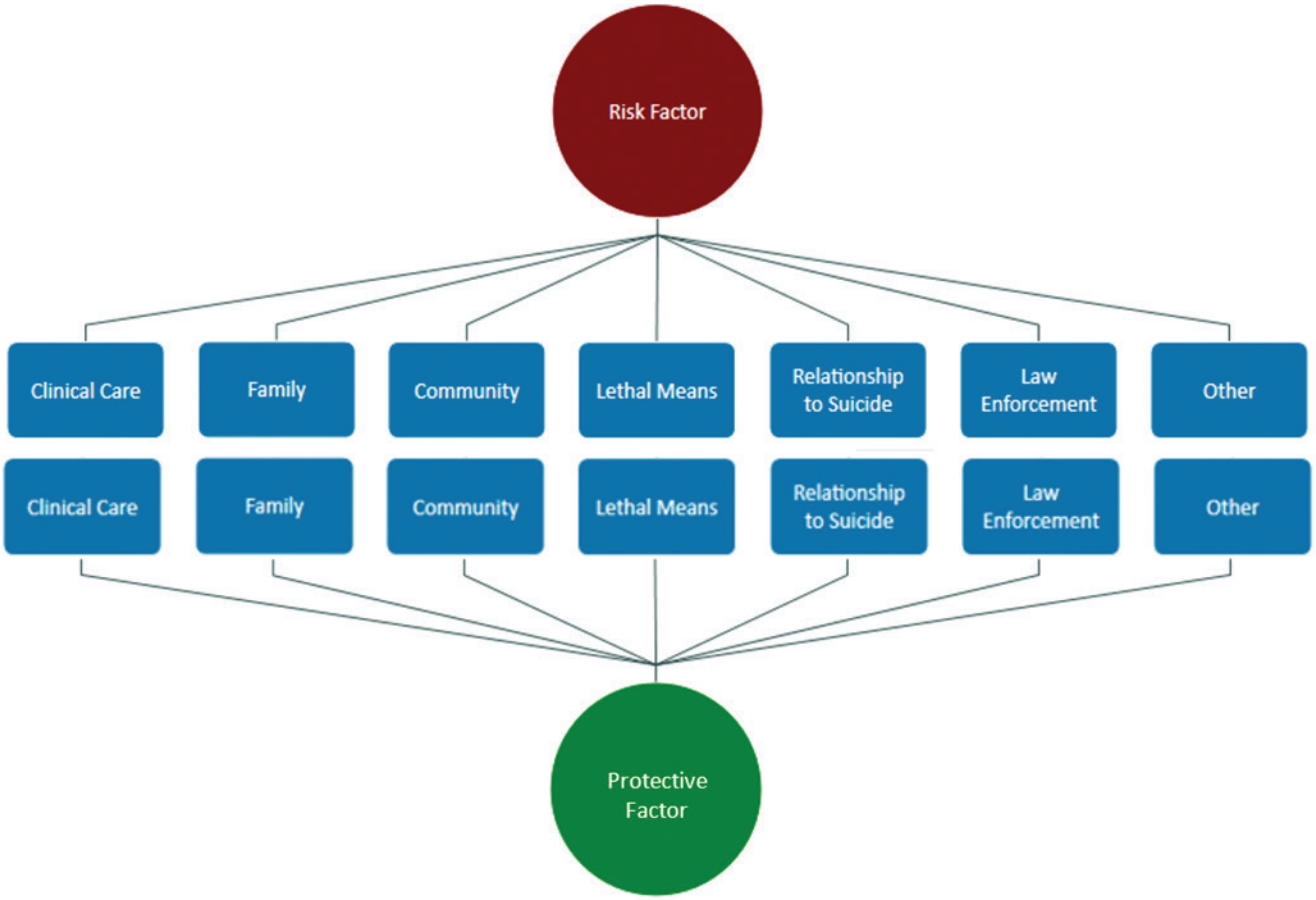
Figure 1

Case Number Date:

	Protective Factors	Risk Factors	Notes on System Improvement
Clinical Care			
Lethal Means			
Community			
Family			
Problem Solving Skills			
Law Enforcement			
Other			

SFR committee members' notes were categorized under one of two parent codes: risk factor or protective factor. From there, findings were subcategorized using a set of child codes under each parent code: clinical care, family, community, lethal means, relationship to suicide, law enforcement, and other (figure 2). (Note: while the grid that committee members took notes in included a category called "problem solving skills," this category was dropped for the final analysis due to it not being relevant or used. It was replaced with the code "relationship to suicide," which encapsulates a theme that appeared in all notes.) Any mention of a life event, experience, or fact related to the individual's death was categorized using one of the child codes and corresponding parent code. For example, if the SFR committee member stated that the decedent had access to a firearm, that statement would receive the child code of "lethal means" under the parent code of "risk factor."

Figure 2



This dichotomous method of coding creates a structure that allows for commonalities and patterns to emerge even though each case the committee examined is unique. By classifying the events and circumstances leading up to each person's death as being either potential protective factors or risk factors, public health can better detect and mitigate societal and health system pain points that may contribute to a death by suicide. This information can also assist with identifying any assets that may help prevent excess death, with the goal of bolstering those assets through public health programs and messaging.

There are some shortcomings to this coding method. It requires making some judgements based off the information available, which can impart bias. However, offering the grid format to committee members to take notes in helped control for some of this bias by dispersing categorization of life events across many people. This coding method also does not allow for the existence of gray areas or nuances, which can provide valuable details. As such, this analysis is meant to be paired with narrative findings to offer a more complete understanding of events.

Definitions of Codes

- **Risk factors:** characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. In this case, the outcome is death by suicide[3]
- **Protective factors:** characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events[3]
- **Clinical care:** a decedent's interactions with the medical and behavioral health care system as well as any diagnoses and prescriptions
- **Family:** a decedent's relationships with family members and pets
- **Community:** a decedent's relationships with friends, hobbies, church groups, employment, or any other areas in which personal connection is fostered
- **Lethal means:** a decedent's access to or relationship with items that could act as a mechanism to die by suicide. Examples include: firearms, pills, motor vehicles
- **Relationship to suicide:** a decedent's personal or family history of suicidal ideation, suicide attempts, or death by suicide
- **Law enforcement:** a decedent's relationship to or involvement with police or the legal system
- **Other:** any experience, asset, deficit, or variable that may have acted as a risk factor or protective factor surrounding suicide that does not fit clearly in the aforementioned categories

High Level Overview

- There were about 1.5 times as many mentions of suicide risk factors (118) as protective factors (80)
- The category of clinical care received the most mentions as both a risk and protective factor, followed by family, and then community (figure 3)
  - 42% of the risk factors mentioned were related to clinical care while only 28% of protective factors were related to clinical care
  - Family as a protective factor was almost the same percentage as clinical care as a protective factor
  - Family and community were not weighted as heavily as risk factors as they were protective factors
  - The remaining child codes (law enforcement, relationship to suicide, lethal means, and other) are proportionally similar between risk factor and protective factor

Figure 3

Clinical Care

Risk Factors

- 5/5 decedents expressed distress or dread over having to manage a debilitating mental or physical illness for what was perceived as the rest of their lives, including exhaustion over having to navigate the healthcare system
  - 1/5 decedents expressed this phenomenon with regards to caring for a child with medical needs
- 3/5 decedents expressed having difficulty either adjusting to new medications or stopping/starting medications for mental health diagnoses
- 3/5 decedents had known mental health diagnoses such as depression, schizophrenia, or post-traumatic stress disorder
- 2/5 decedents mentioned lacking peer support

Protective Factors

- 2/5 decedents were known to be actively engaged with comprehensive mental health services at the time of their deaths
- 2/5 decedents were known to be actively engaged with a primary care provider at the time of their deaths
- 1/5 decedents were known to have a safety plan in place with their family

Family

Risk Factors

- 3/5 decedents were separated from some or all immediate family (spouse/children) due to various factors including divorce, break-up, deployment, custody, and estrangement
- 2/5 decedents experienced difficulty and stress surrounding childcare – either routine or medically specific childcare

Protective Factors

- There were more mentions of family-related protective factors than there were mentions of family-related risk factors. This is not the case with any of the other codes
- While many types of familial relationships were identified as assets, 4/5 decedents had supportive siblings
- 3/5 decedents had a partner or spouse and 2/5 had a dog

Community

Risk Factors

- 3/5 decedents recently transitioned away from working for various reasons such as retirement, quitting to care for children, or layoff
- 5/5 decedents died during the COVID-19 pandemic and a time of social upheaval surrounding Black Lives Matter in the Portland area

Protective Factors

- 3/5 decedents were known to have had good relationships with their neighbors
- Overall, only 4 types of relationships or activities that could be considered a community-related protective factor were mentioned: having a good relationship with a neighbor, being employed or in school, participating in sports, and being linked to a faith-based community

Lethal Means

Risk Factors

- 4/5 decedents died by firearm
- Access to a firearm was the most mentioned lethal means risk factor

Protective Factors

- The mention of firearms being purchased years prior to the death and therefore not an impulsive acquisition was mentioned several times as a protective factor
- Family taking away car keys, locking up medications, and removing firearms were identified as protective factors

Relationship to Suicide

Risk Factors

- 2/5 previously attempted suicide
- 1/5 had known family history of suicide
- 2/5 had known history of suicidal ideation

Protective Factors

- 0/5 had no relationship to death by suicide, suicidal ideation, or suicide attempts personally or via a family member

Law Enforcement

Risk Factors

- 2/5 decedents had a history of law enforcement encounters including a DUI and other unknown arrests
- 1/5 decedents had known ideation of suicide by police officer

Protective Factors

- The only protective factor mentioned was a lack of interaction with law enforcement, which occurred in 3/5 decedents

Other

Risk Factors

- Some risk factors mentioned by the committee but that did not result in a pattern across several decedents were: housing insecurity, living rurally, post-partum psychosis, and gender dysphoria

Protective Factors

- Some uncategorized protective factors mentioned were being very physically active and having a project or hobby such as sailing or fixing cars

System Recommendations Made

Information collected during the death review process is compiled into the annual report and shared with the larger Suicide Prevention Coalition of Clackamas County. This information will help to direct the Coalition's areas of focus in a variety of areas.

SFR committee recommendations will or have already led to system improvements in the community such as:

- Increase awareness about the intersectionality of suicide risk and chronic pain or illness among medical providers such as dentists, chiropractors, ophthalmologists, and others.
- Increase awareness about the risk of suicide for individuals that experience chronic pain or illness and access to lethal means such as firearms or medications.
- Provide educational materials and resources with each issued concealed handgun license.
- Caregivers for persons experiencing chronic illness or pain will be trained to better understand common signs and symptoms of someone who might be emotionally struggling, what to do about it and where in the community help is available.

Advancements for Suicide Fatality Review

The SFR committee made several improvements to our process such as creating forms that were fillable and editing existing forms to make them more accessible to committee members. To help ensure all pertinent information on each death review is obtained, organizations and individuals that represent lived experience will be added to the SFR committee as is appropriate.

Summary

The SFR's first year of reviewing cases in 2022 provided system level change recommendations that were turned into action and a diverse and devoted committee membership resulting in increased community partnerships. As Clackamas County moves towards its vision of zero suicides, this committee will help guide the way.

Authorship and Acknowledgments

Clackamas County would like to thank the members of our Suicide Fatality Review committee:

- Cathy Phelps, Chief Medicolegal Death Investigator, Clackamas County Medical Examiner's Office
- Dr. Rebecca Millius, Deputy State Medical Examiner, State of Oregon
- Tracy Goodrich, Administrative Specialist, Clackamas County Medical Examiner's Office
- Joan Schweizer Hoff, Lived Experience Member
- Elizabeth Chantelle Volk, Lived Experience Member
- Jackie Ryan, Specialty Mental Health Practice Director, Kaiser Northwest Permanente
- Visjna Brooks, Manager of Care Management, Providence Milwaukie Hospital & Providence Willamette Falls Medical Center
- Dr. Martha Carlson, Suicide Prevention Program Manager, Portland VA
- Tina Beeler, Clackamas American Medical Response (AMR)
- Scott Healy, Senior Deputy District Attorney, Clackamas County District Attorney's Office
- Joan Radonich, Administrative Specialist, Clackamas County District Attorney's Office
- Jesse Ashby, Undersheriff, Clackamas County Sheriff's Office
- Valentina Muggia, Behavioral Health Specialist, Oregon City Police Department
- Amber Hambrick, Behavioral Health Specialist, Lake Oswego & West Linn Police Departments
- June Vining, Executive Director, Trauma Intervention Program (TIP)
- Kevin Long, Child Welfare Program Manager, State of Oregon, Department of Human Services Departments and Programs
- Navaz Behramkamdin, Mental Health Specialist III, Clackamas MHC, Clackamas County Behavioral Health Division
- Egan Danehy, Behavioral Health Program Manager, Clackamas County Health Centers Division
- Kati Tilton, Human Services Manager, Clackamas County Social Services Division

This report was authored by:

- Molly Mew, MPH, Population Epidemiologist
- Galli Murray, LCSW, Suicide Prevention Coordinator

Contact:

Galli Murray, LCSW
Suicide Prevention Coordinator
Public Health Division
Clackamas County Health, Housing and Human Services Department
gallimur@clackamas.us

Sources

1. Clackamas County Medical Examiner's Office; Clackamas County Public Health Division Data and Performance Unit
2. Repp, Kimberly K. PhD, MPH; Hawes, Eva MPH, CHES; Rees, Kathleen J. MSPH; Lovato, Charles AAS; Knapp, Adam BA; Stauffenberg, Michele MD. Evaluation of a Novel Medicolegal Death Investigator–Based Suicide Surveillance System to the National Violent Death Reporting System. The American Journal of Forensic Medicine and Pathology 40(3):227-231, September 2019.
3. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence Based Practices Resource Center. Risk and Protective Factors (accessed February 2023).
4. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Service Members, Veterans, and their Families Technical Assistance Center (SMVFTA); U.S Department of Veterans Affairs. Promising Practices for Suicide Mortality Review Committees Toolkit, December 2022. (accessed February 2023).