Clackamas County

Suicide Fatality Review Annual Report

2023

CLACKAMAS COUNTY

MEDICAL EXAMINER
CLACKAMAS COUNTY OREGON

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Background

Suicide remains a common, and yet largely preventable, cause of death and continues to be a priority health issue in Clackamas County. Suicide ranks 12th in our community as a leading cause of death. In comparison, influenza and pneumonia rank 13th and homicide ranks 21st in our county. Research suggests that up to 135 people can be impacted by one death by suicide, causing a substantial and long-lasting ripple effect into our community.

The Blueprint for A Healthy Clackamas (2020-2023), the County's Community Health Improvement Plan (CHIP), has continued to identify suicide prevention as a key health need. In 2021 (the most updated data available at the time of this writing), Clackamas County's rate of suicide was the highest in the tri-county region and higher than the national rate.

Developed in 2021 and with the intent of reviewing as many suicides as possible, the Clackamas County Suicide Fatality Review (SFR) Committee 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.

This report includes an annual, high-level brief analysis of the cases from the 2023 review period in addition to a robust analysis of all 11 cases reviewed by the SFR since its formation.

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
- 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
- Kaiser Permanente
- Clackamas County Sheriff's Office
- Oregon City Police Department
- State of Oregon Dept. of Human Services Depts. and Programs
- Suicide Attempt Survivors
- Suicide Loss Survivors

Methods

For the 2023 review year, the Chief Medicolegal Death Investigator contacted the next of kin from 17 deaths and received authorization to review four (24%). In 2023, the SFR met virtually two times and reviewed six cases (four from consent letters received in 2023 and two from letters received 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 Clackamas County Public Health epidemiologists 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. Coded notes from the five cases in the 2022 Suicide Fatality Review were appended to this year's review of six additional cases for a more robust analysis of 11 cases. 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 (persons who have died).

Case Number: Date:

	Protective Factors	Risk Factors	Notes on System Improvement
Clinical Care			
Lethal Means			
Community			
Family			
Relationship to Suicide			
Law Enforcement			
Other			

Figure 1

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). 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."

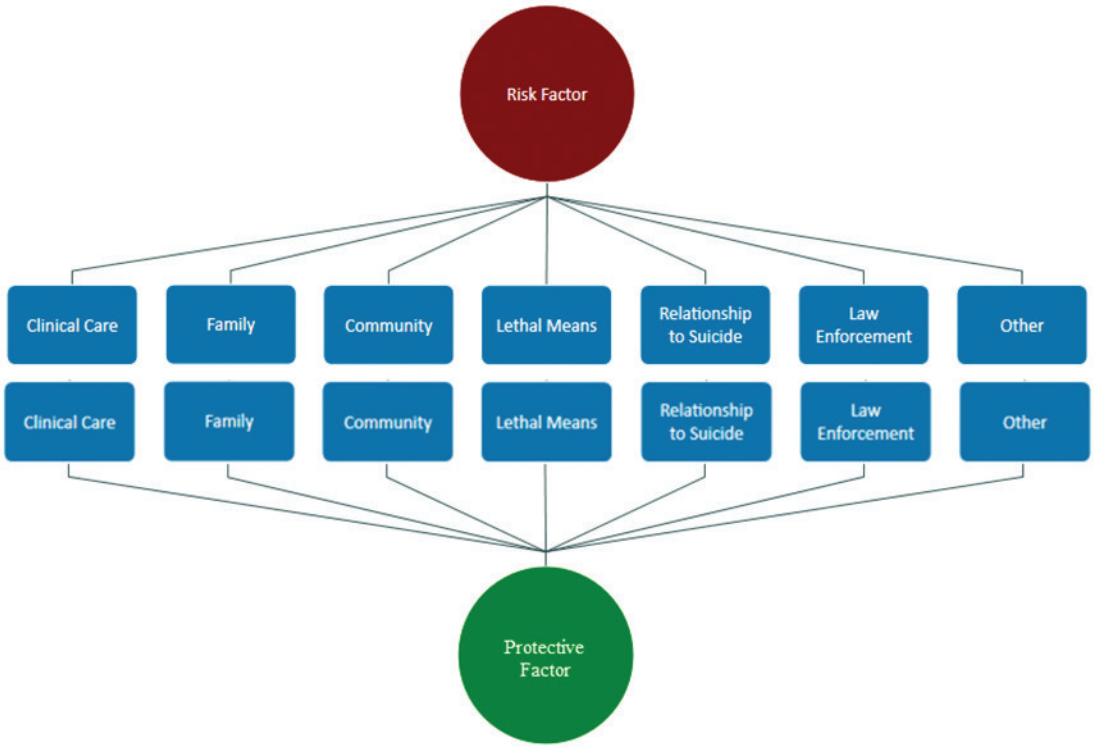

Figure 2

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 for taking notes helped control 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, and 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.

2023 Analysis Summary

Notes from the six cases reviewed in 2023 were also analyzed independently to summarize patterns in risk and protective factors identified during this review year. The six decedents died between 2020 and 2023. Nearly three times as many risk factors (179) were mentioned compared to protective factors (68). Clinical care was mentioned the most as both a suicide risk and protective factor, followed by family and community (figure 3), which is reflective of the 2022-2023 analysis.

Four out of six cases were reported to have had one or more mental health disorders. Additionally, four out of six were known to have a substance or alcohol use disorder. The majority of decedents had a history of suicidal ideation or threats (five of six) and prior suicide attempts (four of six). Common protective clinical factors identified were recent engagement in mental health care (five of six) and medical care (three of six).

Feelings of lacking social support from peers (four of six) or familial relationships (five of six) were frequently mentioned. However, all six cases were noted to be engaged with some family around the time of their deaths. Three decedents had experienced recent job loss or substantial job stress. Two were known to be employed or were seeking employment.

Five decedents had mentions of prior arrests or interactions with law enforcement. Of the four decedents who died by firearm, two were known to have used a firearm not registered to them. Other uncategorized factors mentioned by the committee but did not result in patterns included marijuana use, running away as an adolescent, and showing aggression towards others.

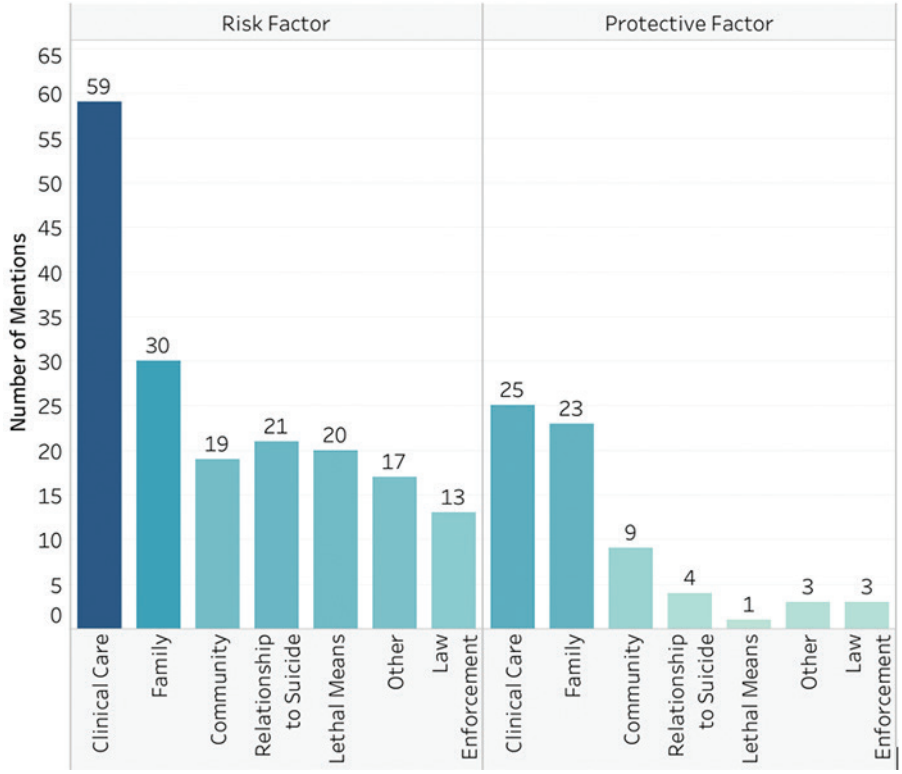

Figure 3

2022 – 2023 Analysis Summary

High Level Overview

- There were nearly twice as many mentions of suicide risk factors (285) as protective factors (146).
- Clinical care had the most mentions as both risk and protective factors, followed by family, then community (figure 4).
  - 37% of risk factors mentioned were related to clinical care compared to 32% of protective factors.
  - Family mentions were proportionally higher among protective factors (30%) compared to risk factors (15%).
  - The proportion of community mentions were slightly higher among protective factors (15%) than risk factors (11%).
  - Collectively, the remaining child codes (lethal means, relationship to suicide, law enforcement, and other) accounted for 37% of risk factor mentions compared to only 23% of protective factor mentions.

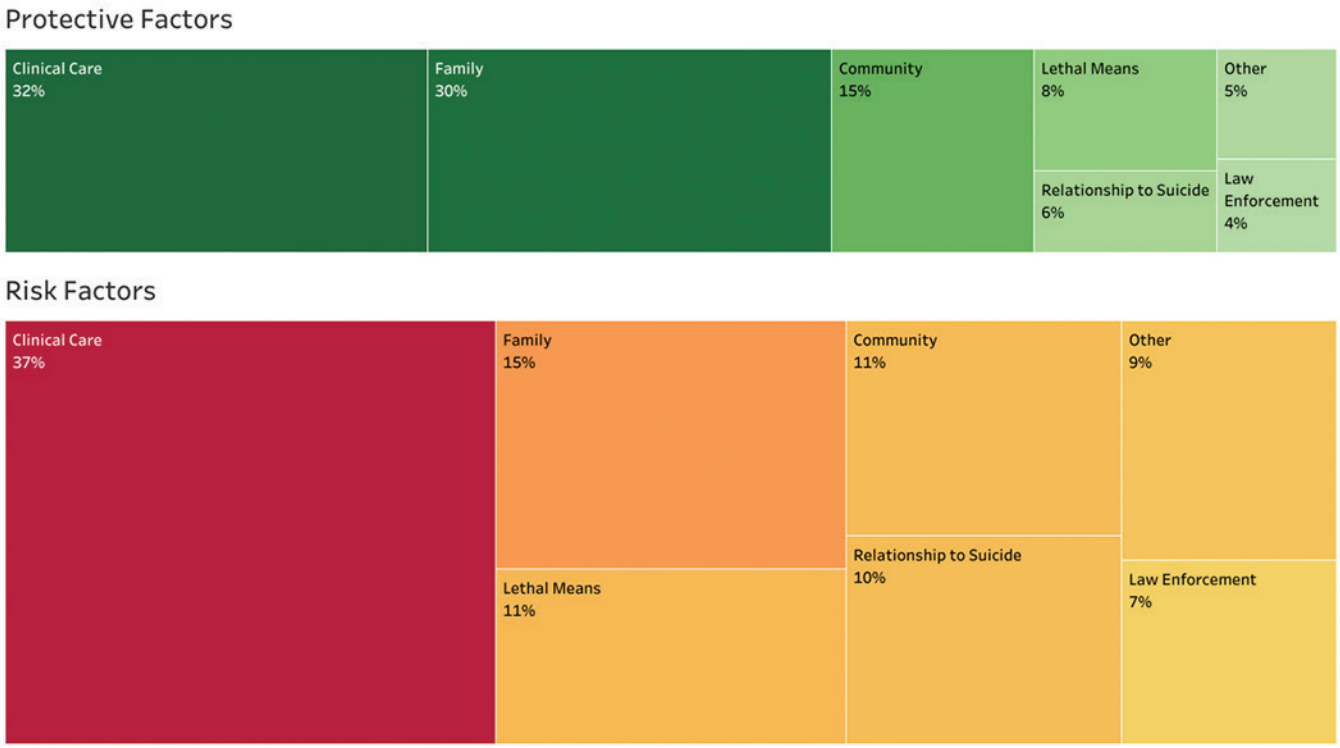

Figure 4

Clinical Care

- Risk Factors
  - 8/11 decedents had known mental health diagnoses such as depression, anxiety, and schizophrenia.
  - 6/11 decedents were having difficulty obtaining medication, having difficulty complying with medication regimens, or had a recent change in medication for a mental health disorder.
  - 6/11 decedents had known substance use or alcohol use disorders.
  - 5/11 decedents had no recent medical or mental health care, were having trouble navigating the healthcare system, or had no health insurance.
  - 4/11 decedents were affected by a chronic medical condition or pain.
- Protective Factors
  - 7/11 decedents were recently engaged in medical care.
  - 7/11 decedents were recently engaged in mental health care.
  - 5/11 decedents were compliant with current prescriptions for a mental health disorder.

Family

- Risk Factors
  - 8/11 decedents lacked support or were estranged from family members.
  - 3/11 decedents were divorced or separated from a long-term partner.
  - 2/11 decedents expressed feeling stressed about relying on family as caretakers.
  - 2/11 decedents had known family history of mental health disorders.
- Protective Factors
  - 11/11 decedents had support from one or more family members.
  - 4/11 decedents had a supportive spouse or partner.
  - 2/11 decedents had a dog.

Community

- Risk Factors
  - 6/11 decedents were not working (due to job loss or retirement) or had expressed job stress.
  - 5/11 decedents reported feeling isolated, lived alone or in an isolated area, or lacked social supports.
  - All decedents in this report died during the COVID-19 pandemic.
- Protective Factors
  - 3/11 decedents had mentions of engaging with friends or neighbors.

- 2/11 decedents were religious or engaged with a faith-based community.
- 2/11 decedents were known to be employed or in school.

Lethal Means

- Risk Factors
  - 8/11 decedents died by firearm.
    - 3/8 decedents who died by firearm had purchased or obtained the firearm by other means recently.
    - 2/8 decedents who died by firearm did not have the firearm registered to them.
    - 2/8 decedents who died by firearm had mentions of the firearm not being in a locked, secured location.
  - 2/11 decedents died by overdose of pills.
- Protective Factors
  - 3/8 decedents who died by firearm had not obtained the firearm recently.
  - Family taking away car keys, locking up medications, and removing firearms were identified as protective factors.

Relationship to Suicide

- Risk Factors
  - 8/11 decedents had expressed suicidal ideation.
  - 5/11 decedents had previously attempted suicide.
- Protective Factors
  - 2/11 decedents had no known prior suicide attempts.

Law Enforcement

- Risk Factors
  - 8/11 decedents had prior interactions with law enforcement including police officer holds (POH) or arrests.
- Protective Factors
  - 3/11 decedents had no known interactions with law enforcement.

Other

- Risk Factors
  - Some uncategorized risk factors mentioned by the committee but that did not result in a pattern across several decedents were: housing insecurity, age (both young adult and advanced age), marijuana use, and recent homelessness.

- Protective Factors
  - Some uncategorized protective factors mentioned by the committee but did not result in a pattern across several decedents were: housing security, active lifestyle, having hobbies, and having other financial means.

Acknowledgements

To the families who have entrusted the Clackamas County Suicide Fatality Review Committee to review the details of their loved one's case, we are incredibly grateful. It is with your permission that we are able to identify risk factors and make recommendations for county wide system improvements as a step toward preventing future suicides.

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