2023

FRANKLIN COUNTY
Suicide
Prevention
COALITION

FRANKLIN COUNTY SUICIDE REPORT

This report was compiled by the Franklin County Suicide Prevention Coalition Data and Research Action Team

MHA Mental Health America of Ohio

ADAMH
ALCOHOL, DRUG AND MENTAL HEALTH BOARD OF FRANKLIN COUNTY

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INTRODUCTION

The Franklin County Suicide Prevention Coalition (FCSPC) bridges Central Ohio organizations together to enhance the overall efficacy of collective suicide prevention efforts. It works to increase communication, coordination, and collaboration efforts to prevent suicide and bring hope and support to those affected by suicide. Its foci include decreasing stigma, increasing awareness of available support, increasing suicide prevention education, and improving suicide data quality. The FCSPC is hosted by Mental Health America of Ohio (MHAOhio) and funded by the Alcohol, Drug, and Mental Health Board of Franklin County (ADAMH). The FCSPC is one of the few suicide prevention coalitions in the nation with fully-dedicated staff positions.

The FCSPC's Data and Research Action Team leads the work to increase access and utilization of suicide data to inform suicide prevention efforts in Franklin County. The FCSPC extends its gratitude to all the organizations and individuals who collaborated in developing this county-wide report, including: ADAMH, Center for Community Solutions, Columbus Public Health, the Franklin County Coroner's Office, Franklin County Public Health, MHAOhio, Netcare Access, and The Ohio State University.

The objective of this report is to provide community agencies, policy leaders, and general community members access to a single resource of compiled suicide data from local, state, and national agencies in order to better inform suicide prevention efforts. This report also aims to identify data gaps and provide recommendations to address these gaps, as well as encourage readers and organizations to learn how they can be part of the local collaborative movement to help prevent suicide in the Franklin County community.

FRANKLIN COUNTY Suicide Prevention COALITION
Hosted by Mental Health America of Ohio

ADAMH
ALCOHOL, DRUG AND MENTAL HEALTH BOARD OF FRANKLIN COUNTY

Franklin County Public Health

FRANKLIN COUNTY CORONER'S OFFICE

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

WHERE AND HOW TO GET HELP

988 is the new three-digit dialing code for the Suicide & Crisis Lifeline, formally known as the National Suicide Prevention Lifeline. When people call, text, or chat 988, they will connect with trained counselors who will listen, provide support, and connect them to resources, if necessary. Counselors provide support for both individuals in a crisis and individuals concerned about someone else. 988 includes the Veterans Crisis Line and is available in Spanish.

The Crisis Textline can be reached by texting HOME to 741741. People will reach a trained volunteer Crisis Counselor who will actively listen and may suggest referrals. This 24/7 service is free and available in Spanish.

Central Ohio Crisis Hotlines & Support

Nationwide Children's Hospital offers mental health and substance abuse crisis services to youth who are 17 years old or younger. The Franklin County Youth Crisis Line is available 24/7 and can be reached at (614) 722-1800.

Netcare Access offers mental health and substance abuse crisis intervention and assessment services for adults. Call 614-276-CARE (2273) or visit their website.

North Central Mental Health Services offers a 24-hour Suicide Prevention Hotline. Community members can speak with trained volunteers at 614-221-5445. Volunteers also offer assistance for individuals who may be concerned about someone else. The 24-hour Teen Hotline offers peer counseling and can be reached at 614-294-330. The 24-hour Senior Hotline can be reached at (614) 294-3309.

National Hotlines

The Trevor Project provides information and support to LGBTQ young people. It is confidential, free, and available 24/7. Reach a trained counselor by calling 1-866-488-7386 or texting START to 678-678.

Trans Lifeline is a peer support phone service run by trans people for trans and questioning peers. The hotline is available in Spanish and can be reached at (887) 565-8860.

Safe Call Now is a confidential 24-hour crisis referral service for all public safety employees, emergency personnel, and their family members nationwide. Call (206) 459-3020.

Loss Survivor Resources

LOSS Community Services provides grief support for those bereaved by suicide, including support groups and a loss survivor companion program.

North Central Mental Health Services provides a Survivors of Suicide Support Group for persons who have lost a loved one to suicide. The group meets monthly; call (614) 395-0727 or email sps@ncmhs.org for more information.

Ohio Health Hospice offers a variety of grief support groups, grief programs and services for schools, information and referral services. For information, call (614) 566-5377.

Syntero offers a Military Survivor Support Group for families and friends who have lost a loved service member to suicide, combat, or an accident while on duty. Call Syntero at 614-889-5722 ext. 133 to learn more.

Finding Local Providers

The Alcohol, Drug and Mental Health Board of Franklin County offers a directory of more than 30 community-based mental health and addiction services, and individuals can search for specific types of programs using helpful filters.

Mental Health America of Ohio's Get Connected Program links callers with a mental health professional who provides assistance with navigating the mental health care system in Central Ohio. Call or text (614) 242-4357 or email connect@mhaohio.org.

RESPONSIBLE REPORTING ON SUICIDE IN THE MEDIA

Suicide contagion occurs when exposure to a death by suicide, in the local community or the news or social media, results in an increase in suicidal behavior in others. Research into the impact of media stories about suicide points to a link between media depictions of suicide (real or fictional) or media reporting on suicide deaths and a subsequent increase in deaths by suicide.[1] Suicide contagion is responsible for up to 5% of all deaths by suicide.[2]

In one well-studied case, the Netflix series "13 Reasons Why" depicted the death by suicide of a high school student who left behind audio tapes for each person she felt had influenced her to end her life, explaining to each their role in her decision. The release of the series was associated with a significant increase in U.S. monthly suicide rates among youth ages 10 to 17 years.[3] Especially problematic in the case of a series like "13 Reasons" is the practice of releasing an entire season of a show at once, making possible binge watching and an intensifying of exposure to contagion in vulnerable viewers.

Reporting on high-profile celebrity deaths by suicide can also saturate the media due to the high level of public interest in these deaths, similarly intensifying contagion exposure. In addition, people identify with celebrities and can feel personally close to them, increasing the impact of a celebrity death.

Responsible reporting on suicide deaths can reduce the risk of suicide contagion, provide crisis resources for those at risk, and convey positive public health messaging around suicide. A consensus has emerged around guidelines for best practices in responsible reporting on suicide, readily available online from a number of organizations as toolkits and tip sheets. One such list of recommendations from ReportingOnSuicide.org is included below.

According to the Pew Research Center, more than 80% of Americans get news from digital devices.[4] The internet's immediacy and competition among media providers for eyes on content make vital the need not only for news reporters to ensure the accuracy of their reporting, but also to make their best effort to follow guidelines for responsible reporting on suicide.

Unlike a print newspaper article or broadcast news story, an online article can link to other web sites, including resources for suicide prevention but also to sites with content that runs counter to best-practice recommendations. In addition to ensuring that their own content conforms to best practices for reporting on suicide, media creators should also vet any web pages they link to from within their reporting, to control as much of the message as they can. However, despite the best efforts of responsible media creators, news reporting is no longer the sole purview of journalists writing for print, broadcast, or mainstream Internet venues. Social media enables the social construction of news through mixing mainstream and alternative media with first-person reports, second-hand accounts, opinion, video, and images. The resulting content may not preserve the framing or accuracy of the original report or, in the case of suicide reporting, the prevention resources from the original report.

Young people are among the heaviest media consumers, and they can be particularly vulnerable to harmful messaging both in the news and through their interactions with social media. The American Association of Suicidology provides a tip sheet for parents, caregivers, and providers on helping youth who may be exposed to potentially harmful content. It is recommended that parents, caregivers, and pediatricians familiarize themselves with social media trends and ask youth about how social media impacts their daily lives.

Media Resources

A tip sheet on best practices and recommendations for reporting on suicide is available at ReportingOnSuicide.org

The American Association of Suicidology offers suicide reporting recommendations for journalists on word choice and appropriate framing for stories on suicide.

FRANKLIN COUNTY FAST FACTS

- There were over 24,000 years of potential life lost due to suicide among Franklin County residents from 2016 to 2020.
- In 2020, firearms were used in half (49%) of suicide deaths. While males were more likely to die by firearm from 2016-2020, females were more likely to die by drug overdose.
- In 2020, residents ages 45-54 years and 75 years and older had the highest suicide rates.
- From 2016 to 2020, the suicide rate of those ages 15-24 years more than doubled.
- From 2016 to 2020, the suicide rate among non-Hispanic Black residents increased by 75%.
- From 2016 to 2020, younger non-Hispanic Black residents were more likely to die by suicide than older non-Hispanic Black residents. Oppositely, older non-Hispanic White residents were more likely to die by suicide than younger non-Hispanic White residents.
- In 2020, the overall age-adjusted suicide rate per 100,000 population in Franklin County (10.9) was lower than in Ohio (13.8) and the US (13.5).

HOW TO HELP SOMEONE CONSIDERING SUICIDE

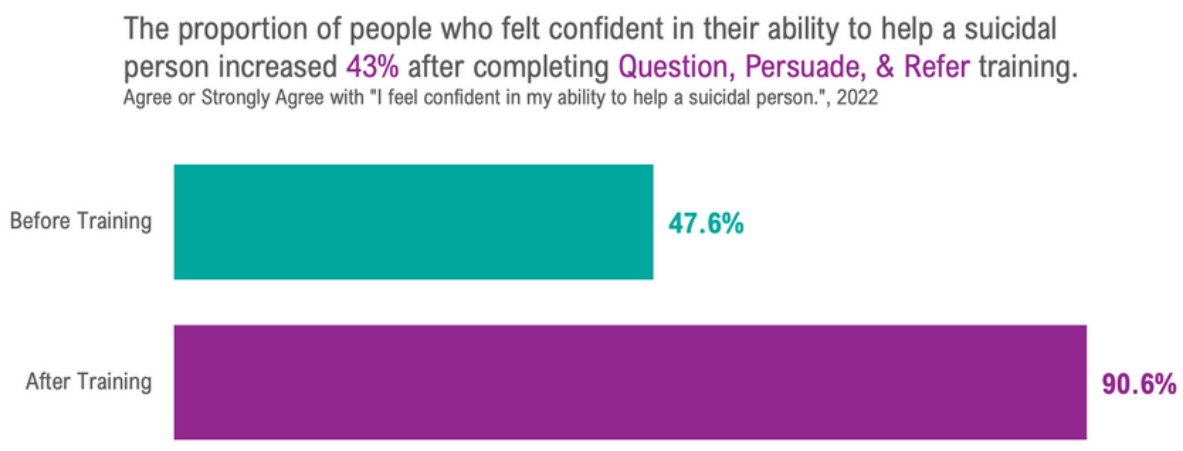
Every individual and every organization can play a role in suicide prevention. Stigma perceived with suicide is prevalent and has a negative impact on those who are struggling with their mental health. Stigma discourages individuals from seeking mental health support. Because of this, it is essential to promote suicide prevention conversations and decrease stigma.

In 2020, the FCSPC administered a Community Readiness Assessment to measure Franklin County's readiness to implement a comprehensive approach to suicide prevention. On a scale of 1 to 9, with 9 being the highest level of readiness, Franklin County received a score of 3.5, falling within the stage of vague awareness. The results indicate that residents are unlikely to discuss suicide and are more likely to access resources in response to a crisis, as opposed to proactively.[5]

To address these barriers, the FCSPC partners with local organizations to coordinate evidence-based suicide prevention training for Franklin County organizations and groups. This includes the evidence-based Question, Persuade, and Refer training which teaches individuals how to identify and respond to someone showing warning signs of suicide as well as how to refer an individual to support services. Franklin County organizations and groups can request this 60 to 90 minute training through the FCSPC's website.

In 2022, 91% of individuals who became certified in QPR through the FCSPC, and completed the pre- and post- surveys, reported feeling confident in their ability to help a suicidal person (Figure 1).

Figure 1: Question, Persuade, & Refer Training Results



Ask the Question: “Are you considering suicide?”

It is important to remember that discussing suicide with individuals will not push them to take their own life. If you suspect that someone may be contemplating suicide, do not wait to ask the question. When asking someone if they have been thinking about suicide, try to ask directly and withhold personal judgment. The following is an example:

- “Sometimes, when people feel overwhelmed, they might start thinking about suicide. Have you thought about suicide?”

Listen

Asking someone if they are considering suicide creates a safe space for them to disclose what they are struggling with. It is important to listen without judgment and to give individuals the chance to speak without being interrupted. Use active listening skills to let the individual know that you are listening and that you care.

Refer to Support Services

Encourage the individual to speak with a mental health professional about what they are experiencing. If it is safe, you may offer to stay with the individual while you help connect them with support services.

Follow Up

If your relationship allows, check back in with the individual. Let them know that you are thinking of them. This is also a good opportunity to ensure they are receiving the assistance they need.

To request a suicide prevention training for your Franklin County organization or group, visit the Franklin County Suicide Prevention Coalition's website.

FRANKLIN COUNTY SUICIDE FATALITY REVIEW

Unique Opportunities for Prevention in the Coroner's Office

The idea of prevention within a Coroner's or Medical Examiner's (ME) Office is not a new topic. There have been several studies that highlight this idea throughout the years. Some of those studies include:

1) embedding social workers into a Coroner's/ME's Office to work with survivors of violent deaths with a focus on preventing associated PTSD and depression

2) conducting fatality reviews to develop recommendations on prevention and harm reduction

3) embedding epidemiologists and statisticians to evaluate data which is used to identify emerging trends

The Franklin County Forensic Science Center, Office of the Coroner has been working to incorporate all three of the above examples. Although the Franklin County Coroner's Office does not have social workers on staff, the Coroner's Office works with outside agencies such as LOSS Community Services and Netcare Access to aid with community grief. The Franklin County Coroner's Office also presents on many different fatality reviews and works with a statistician that was granted to the Coroner's Office by the Centers for Disease Control and Prevention (CDC) to evaluate fatality data within Franklin County.

Turning Postvention into Prevention

In July of 2021, Tony Coder, the Executive Director of the Ohio Suicide Prevention Foundation and former Franklin County Coroner Dr. Anahi Ortiz shared a passion for suicide prevention and worked together to create the nation's first Suicide Investigations and Postvention Specialist position based in a Coroner's/ME's office. Their willingness to create such a unique position has truly changed the way suicide is approached in Franklin County.

Traditionally, a Coroner's Office is more in the realm of postvention as they work with the deceased. The implementation of the Suicide Specialist and the Suicide Fatality Review has transformed Franklin County's approach to suicide fatalities from reactive to proactive.

The Suicide Investigations and Postvention Specialist attends the scene of suicide fatalities within Franklin County and completes a full psychosocial investigation to determine the life experiences and suicide related stressors that the decedent was exposed to that may have led to the decedent's decision to take their own life. The information obtained through this unique investigation allows for the Coroner's Office to identify trends that have gone unnoticed in the past. These data-informed and community-engaged approaches allow suicide prevention stakeholders to have a better understanding of the issues our community is faced with when it comes to mental health and suicide.

Suicide is a complex issue that cannot be addressed alone. The Suicide Fatality Review was developed to create partnerships within the community that may not have been formed otherwise. The agencies that attend the reviews work to apply recommendations to their daily operations. With agency-to-agency information sharing and the ongoing implementation of the fatality review recommendations, a united front will be created to address the issues that are prevalent in our community.

Franklin County Suicide Fatality Review

The purpose of the Franklin County Suicide Fatality Review (SFR) is to decrease the incidence of preventable suicide deaths by promoting cooperation, collaboration, and communication between all groups, professions, and agencies engaged in suicide prevention, education, and treatment efforts.

The SFR is a closed review that is backed by House Bill 110 134th General Assembly, Section 3701.0411, which grants agencies the ability to share appropriate information. The SFR is composed of various mandated and non-mandated agencies. The mandated agencies for the review include the Chief of Police or County Sheriff, a public health official, the executive director of ADAMH, and a physician authorized to practice medicine. If the individuals that hold these titles within the community cannot attend the review, they must designate someone to attend the review to represent their agency.

In addition to the mandated agencies, a non-mandated agency is permitted to attend the review when they can provide beneficial discussion and present recommendations for certain at-risk populations.

An example of a non-mandated agency would be the Franklin County Office of Aging which attended the Suicide Fatality Review when the review covered the 65+ community. The Franklin County Office of Aging was able to provide knowledge on the resources that are available for older adults in Franklin County.

The Franklin County Suicide Fatality Review takes place quarterly and during the review a suicide death that occurred in Franklin County is presented in detail. The presentation covers the individual's demographics, social dynamics, religion, education/employment, substance use history, physical and mental health history, COVID-19 experiences, criminal history, suicide stressors, and suicidal ideation history.

After the case is presented, the floor is opened for a collaborative discussion about the case and recommendations are made to help prevent a similar situation from happening again.

Agencies that attend the review are expected to apply the information and implement recommendations into their daily operations. They are also expected to share the information to educate additional agencies and individuals on best practices that were developed to reduce suicide rates in Franklin County.

Recommendations

Since the implementation of the Suicide Specialist in July of 2021, there have been over 200 psychosocial interviews completed with individuals who have lost loved ones to suicide. After review of those interviews, there has been numerous commonalities identified within the life experiences of individuals who died by suicide in Franklin County. This section highlights those commonalities and recommendations that were discussed by the review team.

Most Common Recommendations

1. Increase education
2. Increase resource follow through
3. Increase resource connection
4. Decrease stigma and increase awareness of resources

Increase Education

The first commonality would be the overall lack of education related to mental health and suicide. The fatality review team believes the lack of education at an individual level stems from the stigma attached to suicide. People are not comfortable with talking about it or researching the topic. More education could give individuals more confidence when navigating a conversation about mental health and suicide with their loved ones, which could lead to earlier detection.

Continued promotion of programs such as Question, Persuade, and Refer (QPR) and Mental Health First Aid will help individuals guide their at-risk loved ones to the appropriate resources. Many individuals are fearful about what to say to someone who is struggling with suicidal ideation. People do not have to say the right thing, they just have to say something. Simply put, having these difficult conversations can save someone's life.

Depression and suicidal ideation present differently in different people. Being overwhelmed may be the only way it is presenting. Understanding that suicidal thoughts can happen within anyone, no matter their life experiences, allows for better detection. A "stereotypical" suicide decedent does not exist. Having a stereotype in mind can be dangerous as atypical warning signs may be missed. Having flexibility in the way we question at-risk individuals is important.

When someone is asked if they are "depressed", they might hesitate to answer accurately due to fear of being negatively labeled. Instead of using strong terms like "depressed," the individual could be asked if they are feeling "stressed," "tired," or "bogged down." Asking questions in different ways could help to increase the number of people who are identified as at-risk and connected to support services.

Most of the families that participated in the psychosocial interviews reported that their loved one was compliant with their mental health medication at the time of their death and believed that the medication should have changed their loved one's mindset. Individuals who struggle with mental health complications and the family members that support them should understand the importance of pairing therapy with medication. Therapy provides education on healthy coping strategies to improve quality of life.

Treatment for mental health and suicide needs to be normalized. Numerous family members were shocked by their loved one's fatal self-injury incident because they believed the individual was mentally healthy at the time of the incident.

For an individual experiencing suicidal ideation, a sudden burst of euphoria can increase risk due to increased energy to act on suicidal thoughts. It is critical for at-risk individuals to have a safety plan which provides techniques for de-escalation and increases the likelihood of intervention during highly stressful times.

Mental health professionals, peer specialists, and first responders can request safety plan training through the FCSPC's website. In addition to addressing lack of education at the individual level, it is also recommended to increase education at the treatment and community levels.

Schools, universities, treatment facilities, and employers are all examples of entities that could increase education. If one student is experiencing mental illness and suicidal ideation, it is likely that additional students are experiencing similar situations. With this idea in mind, there may be opportunities for public health officials to partner with local schools and universities to provide more awareness and outreach.

For example, anxiety rates are increasing among high school and college seniors. This type of data can support schools with obtaining additional resources for their students during these times. Improvements are being made in this area, such as monthly meetings between the Suicide Specialist with student life offices and other counseling officials to discuss trends and innovative ways to address mental health at the university level.

Treatment facilities and other resource agencies may struggle with best practices regarding determining mental health complications with certain at-risk populations (i.e., 65+ population).

Self-screening or self-assessments may not be the best way to identify suicide risk. This particularly applies to individuals who may unwilling to admit that they need help and may not answer accurately.

More research is needed to identify best practices so family doctors and other treatment facilities can intervene appropriately.

Increase Resource Follow Through

Most families interviewed for psychosocial history reported that their loved one had a recent hospitalization within six months of their fatal self-injury incident. Family believed that their loved one was screened for mental health complications but was ultimately discharged with a list of mental health facilities.

Sufficient follow through must be provided to ensure that an individual receives the proper assistance. Lack of follow through was also evident with individuals who had a criminal history and have been incarcerated as both a juvenile and an adult. There have been scenarios where individuals do not receive the continuous care that could have saved their life because the mental health history that was indicated in one system was not indicated in the next.

It is evident that Franklin County is working hard to locate at-risk populations and implement early intervention. However, for many suicide deaths, the individual had resources but the agencies working with the individual did not know about each other, complicating wrap around care. Creating partnerships can increase access to resources due to the possibility of sharing expenses. For example, Franklin County now has community agencies working with local jails to connect individuals who are incarcerated with resources once they are released with a hope to promote a continued path of success.

Increase Resource Connection

Franklin County has numerous resources that are available to individuals who are struggling with mental health and suicidal ideation, but there are challenges with resource connection for those in highest need. There are many suicide cases in Franklin County where the decedent and decedent's family were not aware of the resources that were available to them.

Language barriers and cultural differences are common reasons that someone may be unaware of available resources. The FCSPC has identified refugees and immigrants as a target population due to increased suicide risk and decreased access to care.

The FCSPC has been meeting with cultural community leaders to learn about best practices to help their community. Through partnership with local organizations, the FCSPC developed a series of multilingual suicide prevention videos which are available on their website. In addition to the FCSPC's work, The Franklin County Forensic Science Center, Office of the Coroner has created multilingual information material to better serve the diverse community of Franklin County.

Decrease Stigma and Increase Awareness of Resources

The review team identified stigma as a risk factor for suicide within the Franklin County community and recommends large-scale messaging to normalize treatment and increase awareness of resources. Information about warning signs and resources should be available in highly visible places throughout the year. This includes using culturally appropriate language for Franklin County's diverse communities.

Reaching different populations through their preferred form of communication is vital. Examples include providing messaging through places of worship, television, newspaper, radio, and social media. The review team believes that providing appropriate and diverse messaging could help lift the stigma surrounding mental health and suicide.

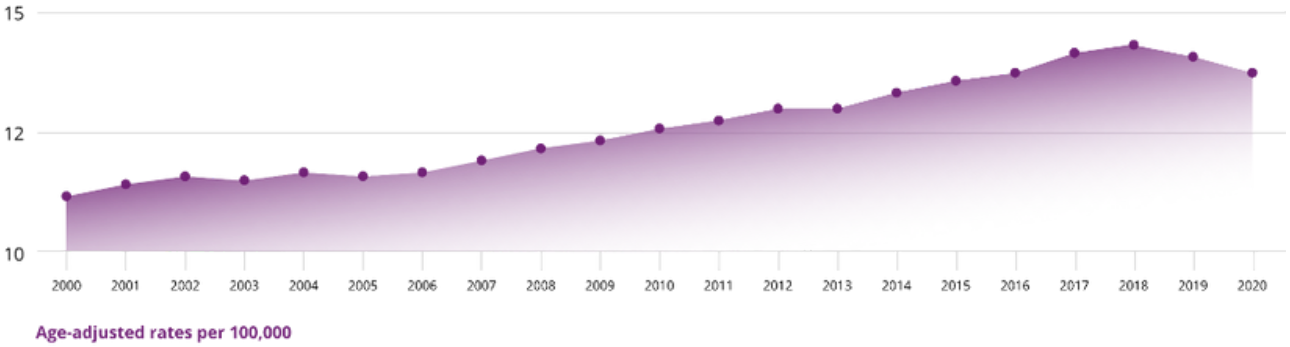
Appropriate and safe messaging related to mental health and suicide is critical. Individuals who find themselves in a position where they must present suicide related information to the public need to be diligent when researching the topic to ensure safe reporting. Safe messaging recommendations and resources are available in Responsible Reporting on Suicide in the Media.

*** The Franklin County Suicide Fatality Review is led by Suicide Investigations and Postvention Specialist, Dallas Allen. The recommendations mentioned in this section are recorded by the Suicide Specialist and were compiled through collaborative discussion with the rest of the SFR team in accordance with Ohio House Bill 110, Section 3701.0411: Suicide Fatality Review.*

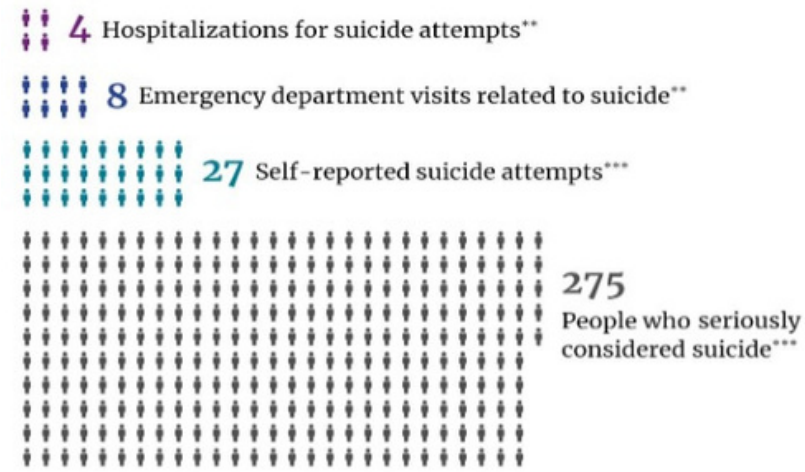
UNITED STATES DATA ON SUICIDE

In the United States, suicide is a leading cause of death with 45,979 deaths in 2020.[9] Between 2000-2018, suicide rates increased in the United States by 30% and declined in 2019 and 2020 (Figure 1). In 2020, suicide was the second leading cause of death for people ages 10-14 and 25-34 years. [9]

Individuals ages 85 and older experience the highest rate of suicide, followed by people ages 25-34 and 75-84.[10] In the US, non-Hispanic American Indian/Alaska Native and non-Hispanic White populations, as well as veteran populations, experienced the highest rates of suicide. Firearms are used in more than 50% of suicides.[10] Males die by suicide at more than four times the rate of females (22 per 100,000 and 5.5 per 100,00 respectively).[10]



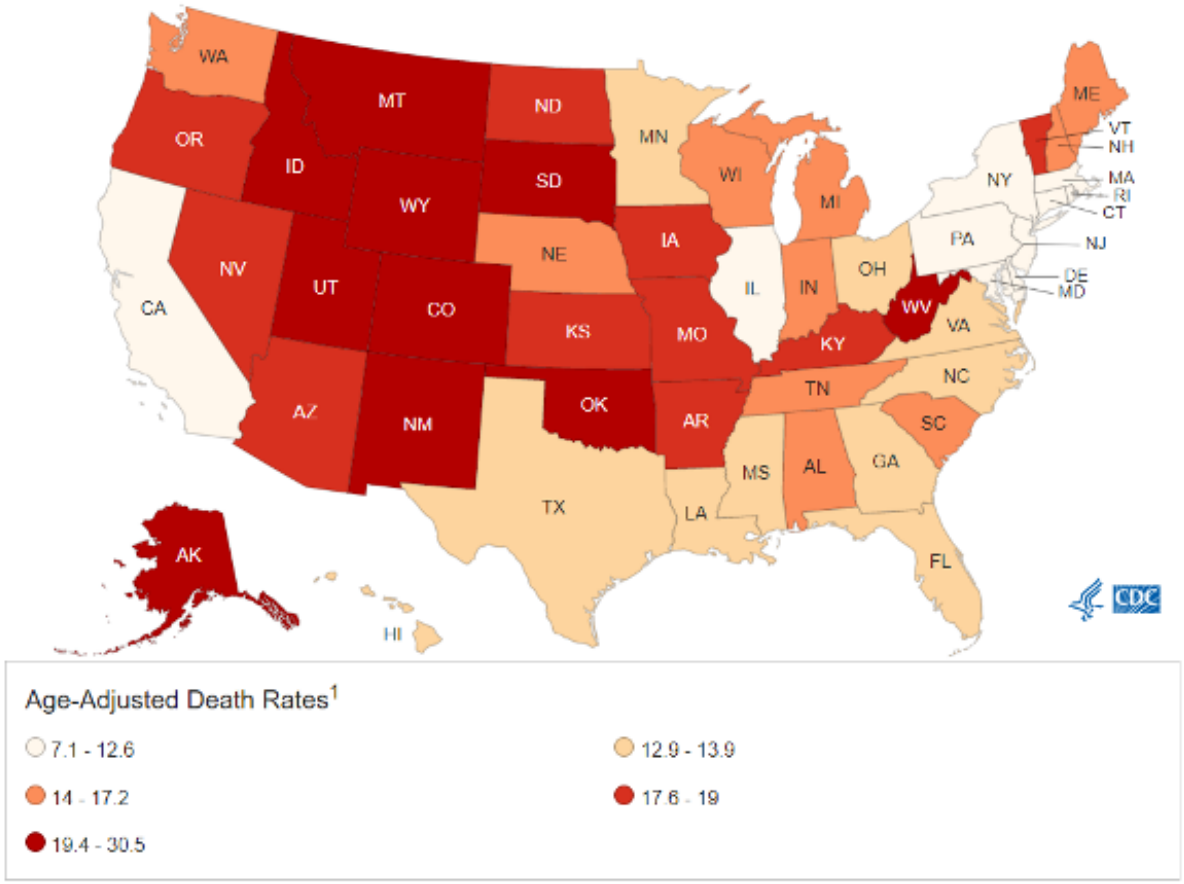
The CDC provides estimates for how many emergency department (ED) visits, attempts, and serious considerations are made for every one suicide death (Figure 2).[10] In 2020, 12.2 million US adults seriously thought about suicide and 1.2 million adults attempted suicide. Young people who identify with the LGBTQ+ community experience higher rates of suicidal thoughts and behavior when compared to peers who identify as heterosexual.[9] For every suicide death, there are[10]:



More information on suicide data and statistics, disparities, risk and protective factors, and comparison by state can be found on the CDC's website:

OHIO DATA ON SUICIDE

In 2020, 1,644 Ohioans died by suicide (13.8 per 100,000 residents).[10] Figure 3 shows the comparison of each US State with darker orange indicating a higher rate of suicide and lighter orange indicating a lower rate of suicide.



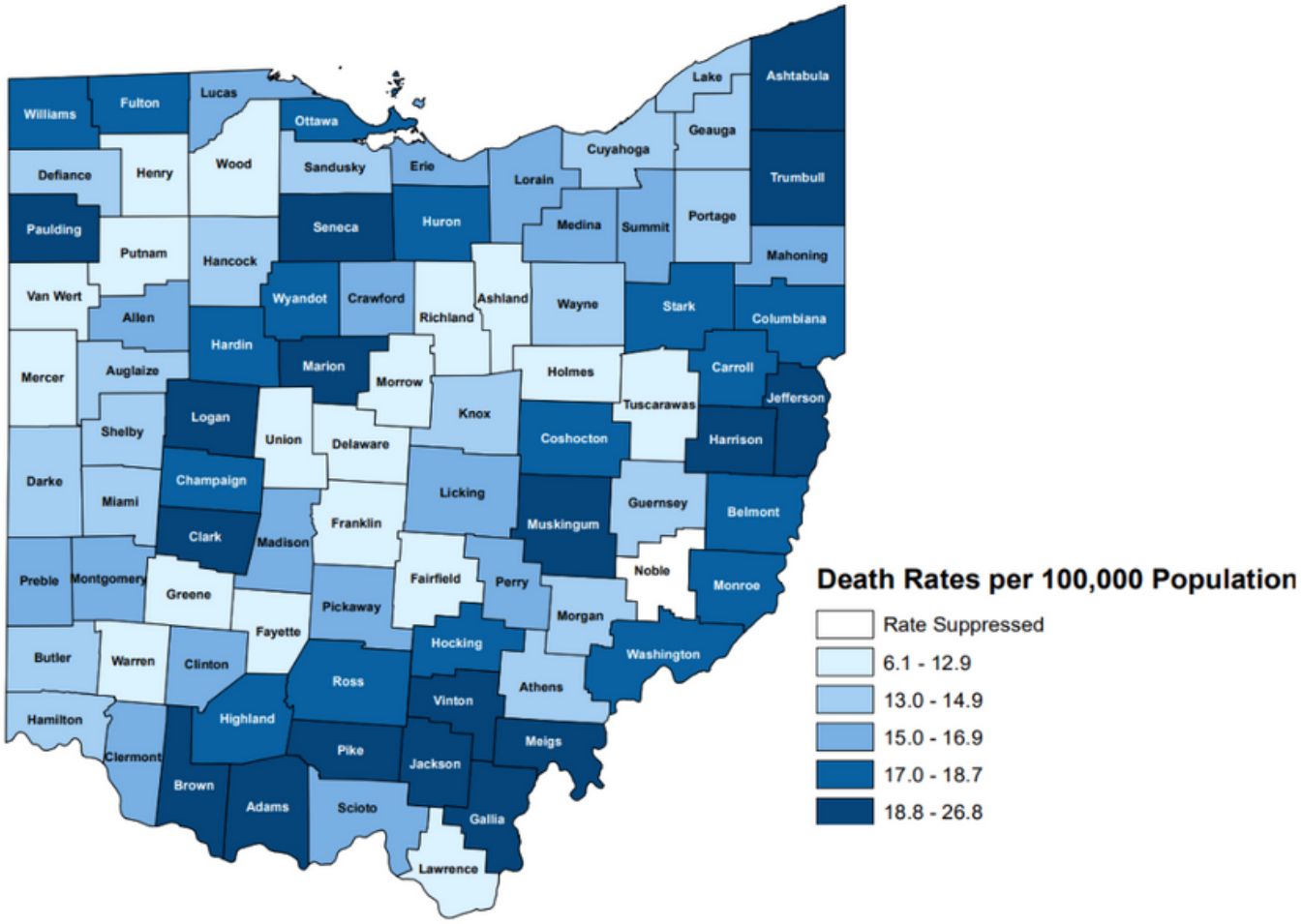
Similar to US trends, Ohio saw an increase in suicides between 2014-2018 and a decrease from 2019-2020. The 2020 total was the lowest since 2014. Although an overall decrease was observed between 2019-2020, the rate of suicide increased among non-Hispanic Black males and females during this time. Also similar to the US trends, firearms were the leading mechanism of suicide. This trend was observed in both males (60% of total) and females (32% of total, closely followed by suffocation at 29% of total). Males also account for the majority of suicides in Ohio, making up 81% of the total deaths.[11]Ohioans ages 25-44 years had the highest rate of suicide.

The Ohio Department of Health (ODH) reports Ohioans ages 75+ had the highest rate of death by suicide when compared to other age groups (41.7 per 100,000). This trend is similar to the national trend where older adults experience the highest rates of death.[10]

When considering 2016-2020 deaths by county of residence, Gallia County (South Eastern Ohio) has the highest suicide rate at 26.8 deaths per 100,000. Holmes County (Mid-Eastern Ohio) has the lowest rate at 6.1 per 100,000. [11] Franklin County (Central Ohio) had a rate of 11.7 per 100,000 residents, putting Franklin County in the lowest quintile.

ODH found 16 of the 17 counties with the highest rate of suicide were rural, a majority of those being found in the Appalachian region.

Average Age-Adjusted Rate of Suicide Deaths by County of Residence, Ohio, 2016–2020



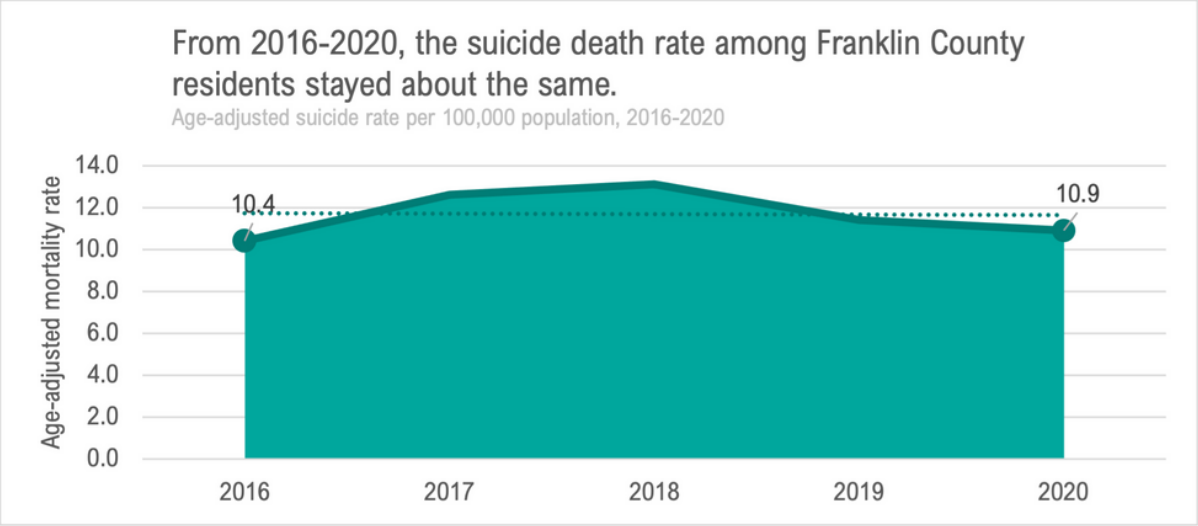
Specific county totals, rates, and information about trends can be found on the Ohio Department of Health website

FRANKLIN COUNTY DATA ON SUICIDE

Suicide Mortality

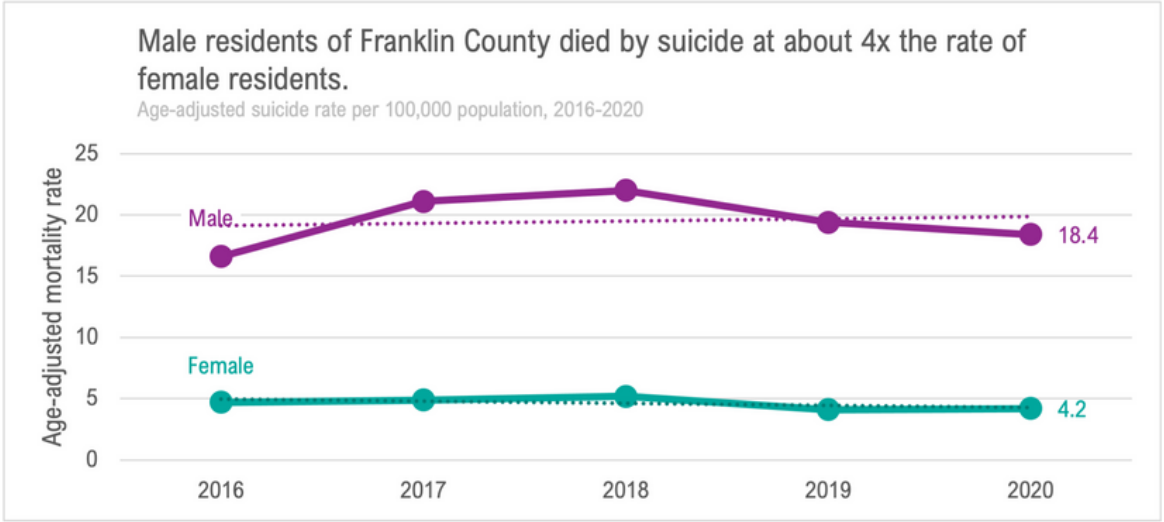
From 2016 to 2020, suicide was the 12th leading cause of death overall and the third leading cause of death among children ages 12 to 19 years. In 2020 alone, suicide was still the third leading cause of death among children of the same ages.

In 2020, the overall age-adjusted suicide rate per 100,000 population in Franklin County (10.9) was lower than in Ohio (13.8) and the US (13.5). Preliminary data for 2021 shows a 13% increase from 10.9 to 12.3 in the overall age-adjusted suicide rate per 100,000 population from 2020.



Sex

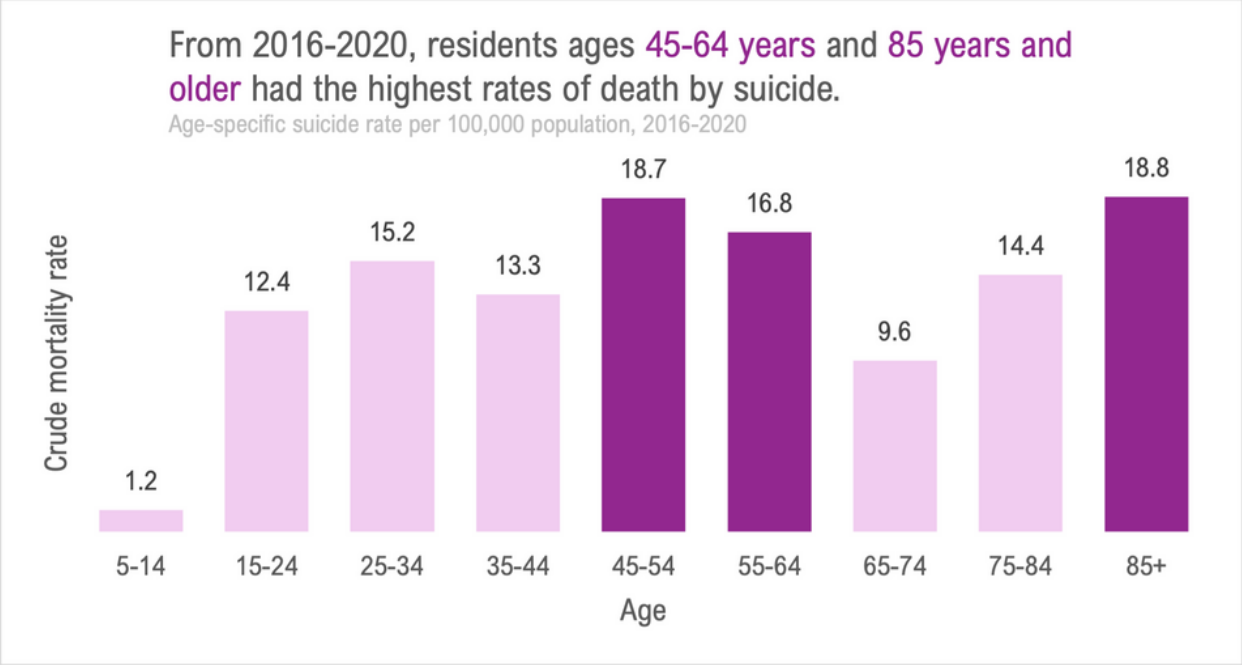
In 2020, males and females died by suicide at an age-adjusted rate of 18.4 and 4.2, respectively. This means that male residents of Franklin County died by suicide at an age-adjusted rate 4.4 times higher than female residents.

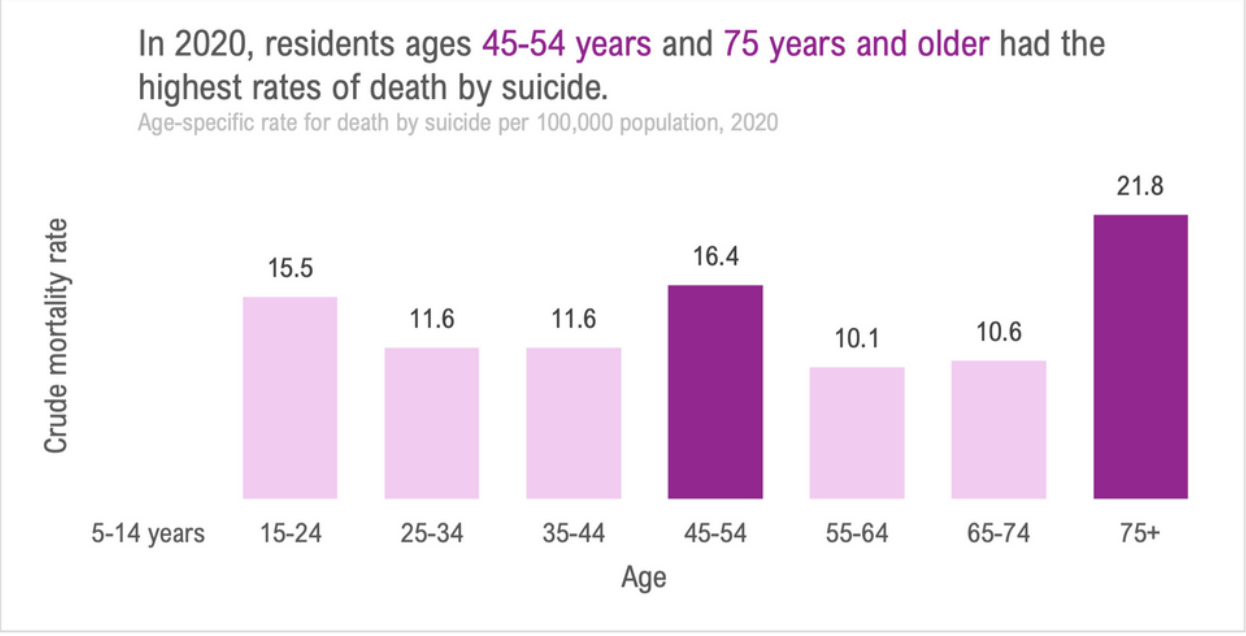


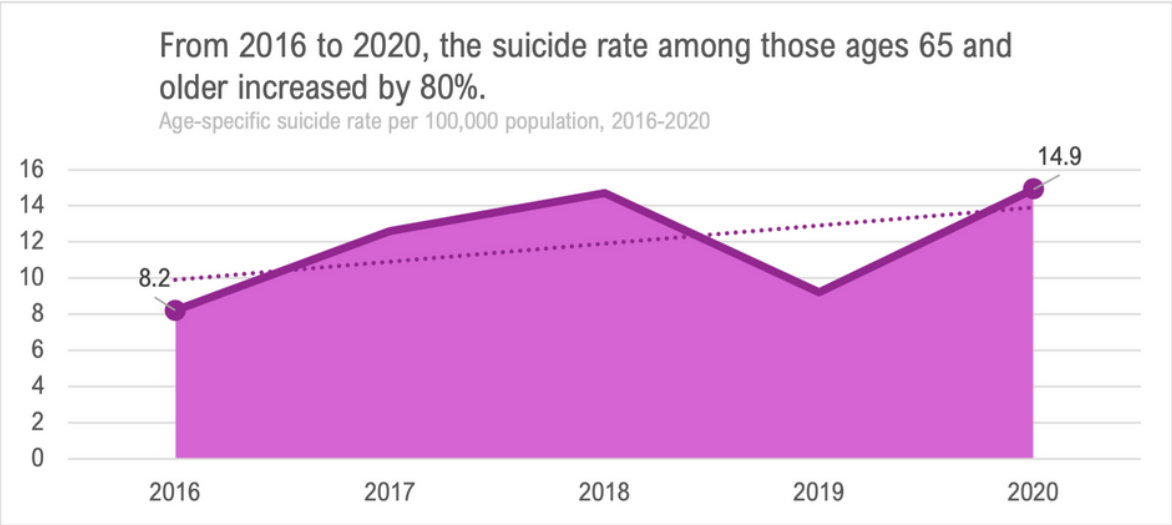
Age Group

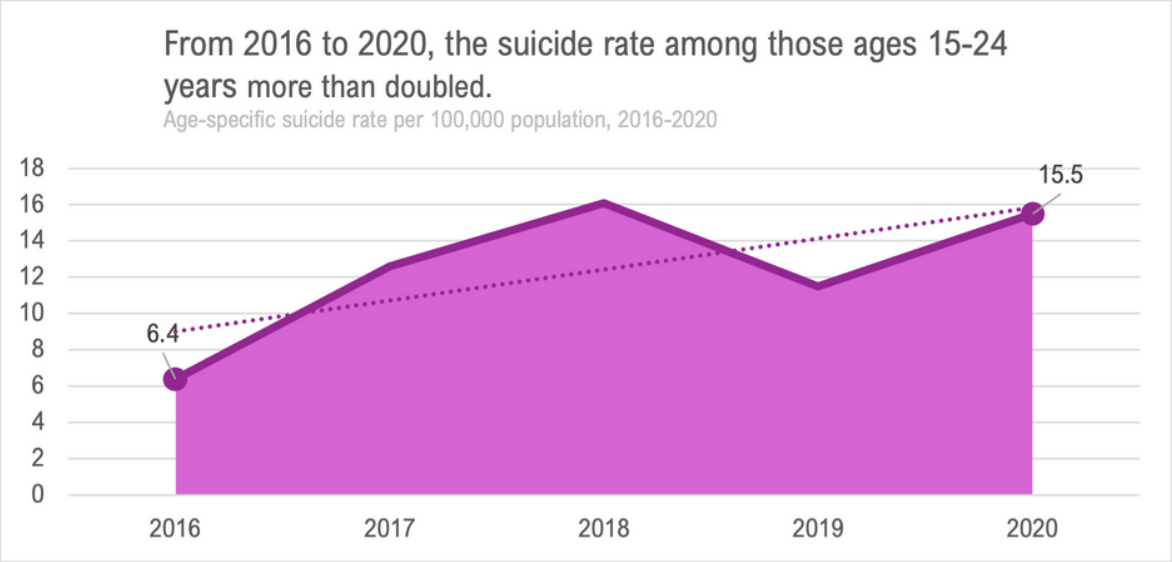
From 2016 to 2020, Franklin County residents ages 45-64 years and 85 years and older had the highest rates of death by suicide compared to other age groups. In 2020, residents ages 45-54 and 75 years and older had the highest suicide rate. The suicide rate among residents 85 years and older was much higher than any other group.

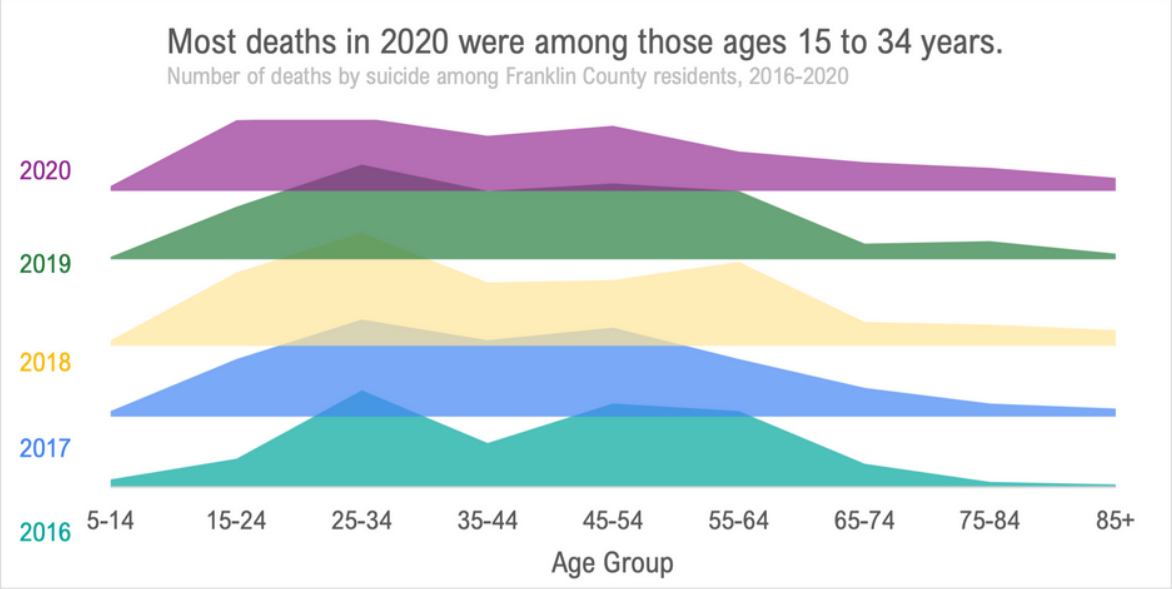
- From 2016 to 2020, the suicide rate among residents ages 65 years and older increased from 8.2 to 14.9 deaths per 100,000 residents.
- From 2016 to 2020, the suicide rate among residents ages 15-24 years increased from 6.4 to 15.5 deaths per 100,000 residents.







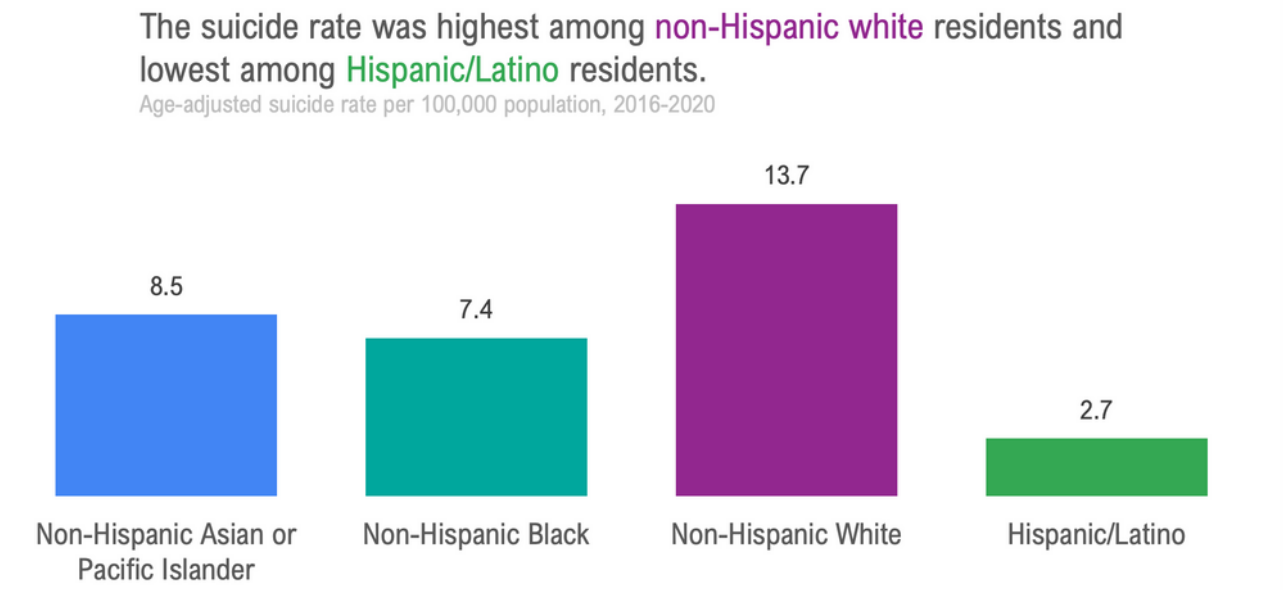


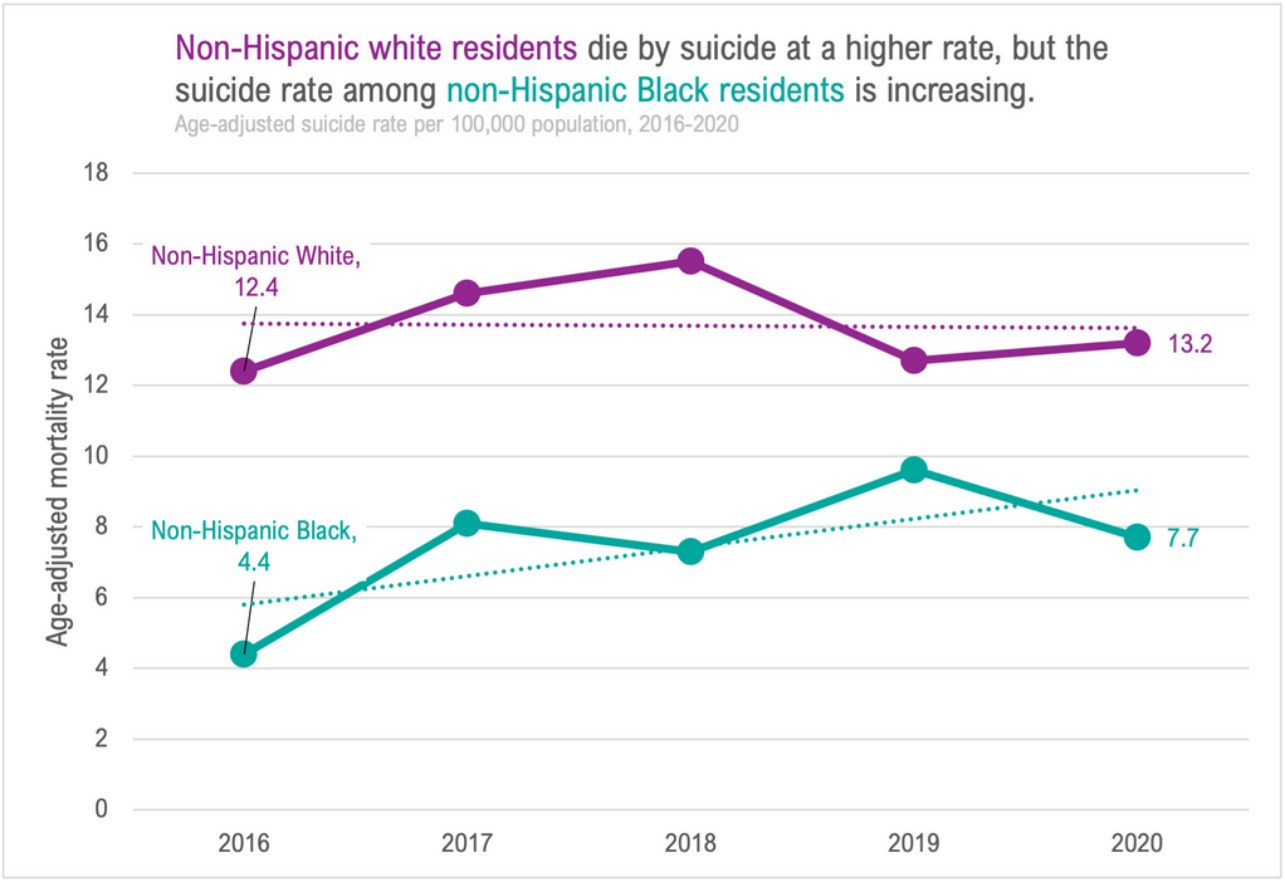


In the ridge plot above, the higher the ridge, the greater the number of people in that group who died by suicide.

Race/Ethnicity

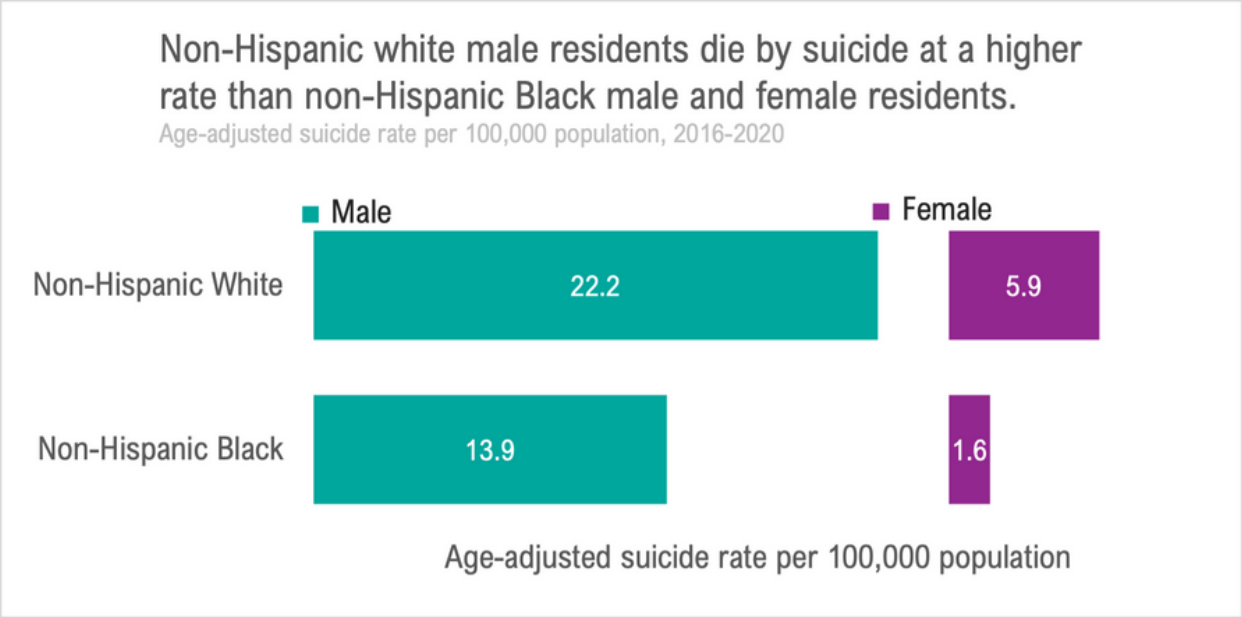
From 2016 to 2020, the age-adjusted suicide rate per 100,000 residents was highest among non-Hispanic White residents and lowest among Hispanic/Latino residents. While non-Hispanic White residents die by suicide at a higher rate overall, the suicide rate for non-Hispanic Black residents increased by 75% from 2016 to 2020.





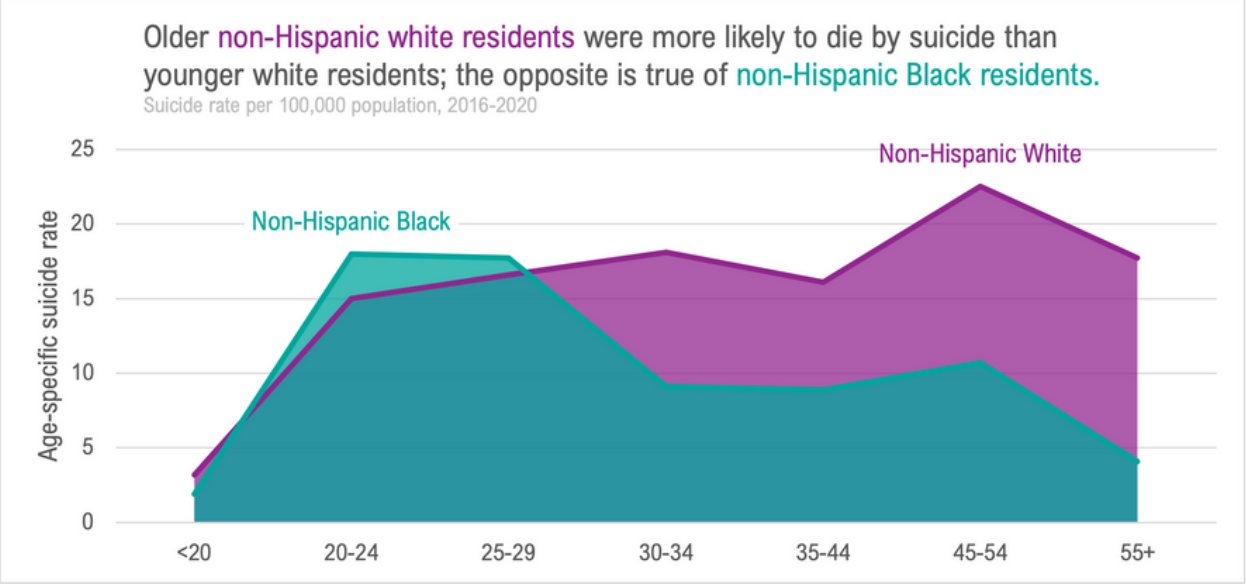
Race/Ethnicity & Sex

When comparing age-adjusted suicide rates by race/ethnicity and sex from 2016 to 2020, non-Hispanic White male residents died by suicide at a higher rate than non-Hispanic Black male residents and all female residents. Non-Hispanic White female residents died at a higher rate than non-Hispanic Black female residents.



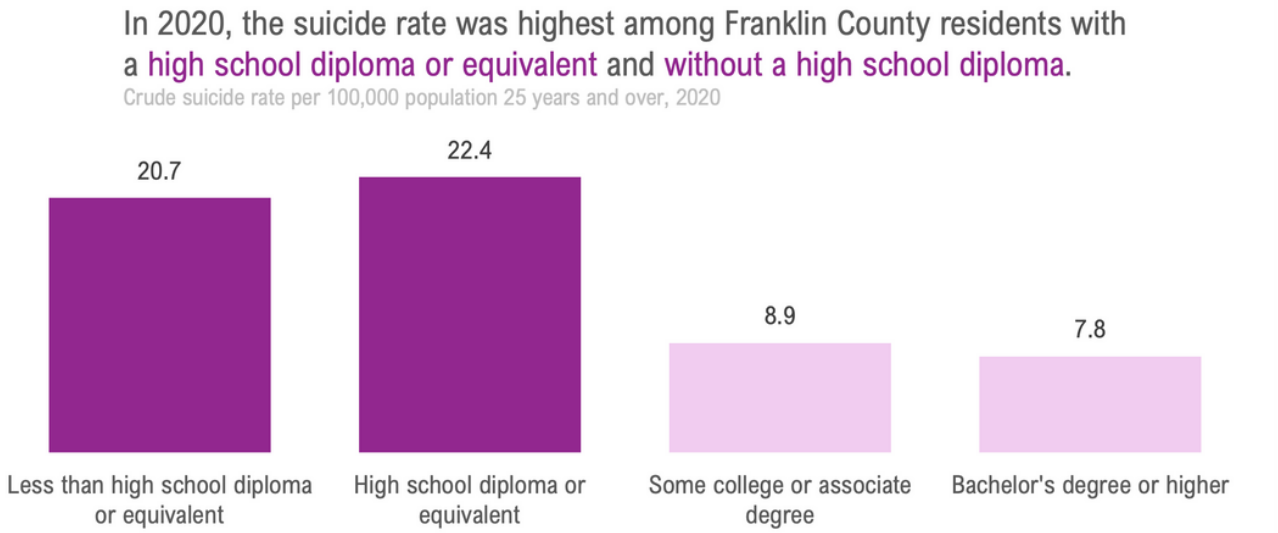
Race/Ethnicity & Age

From 2016 to 2020, older non-Hispanic White residents were more likely to die by suicide than younger non-Hispanic White residents. During the same period, younger non-Hispanic Black residents were more likely to die by suicide than older non-Hispanic Black residents.



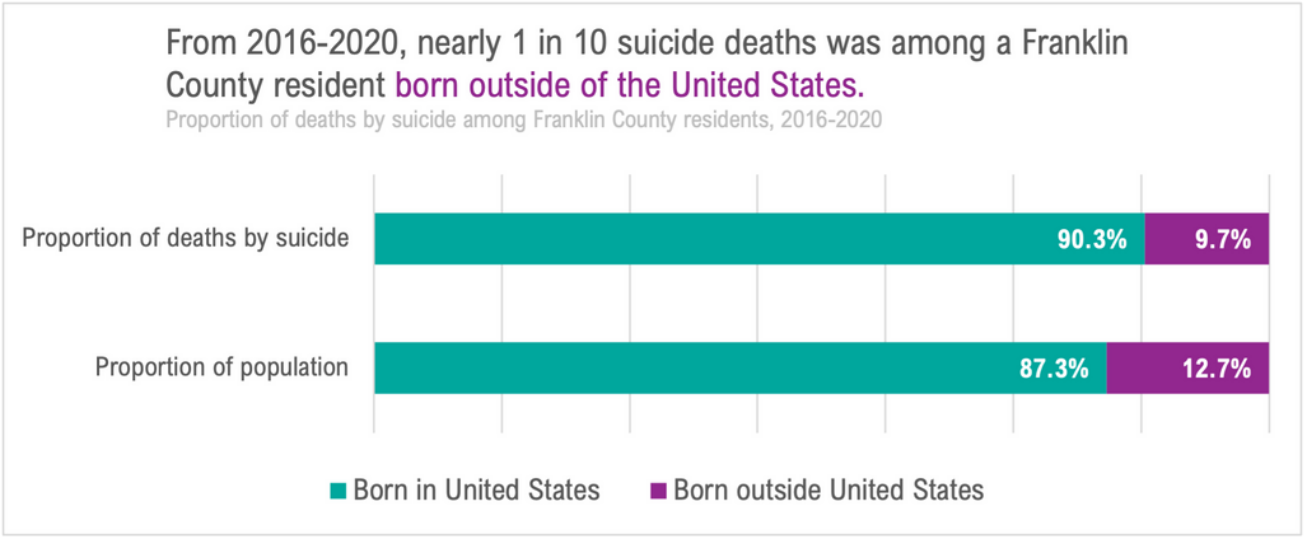
Education

In 2020, the crude suicide rate was highest among Franklin County residents with a high school diploma or equivalent and without a high school diploma compared to those with some college education or higher. Other areas have shown similar trends by education.[1,2]



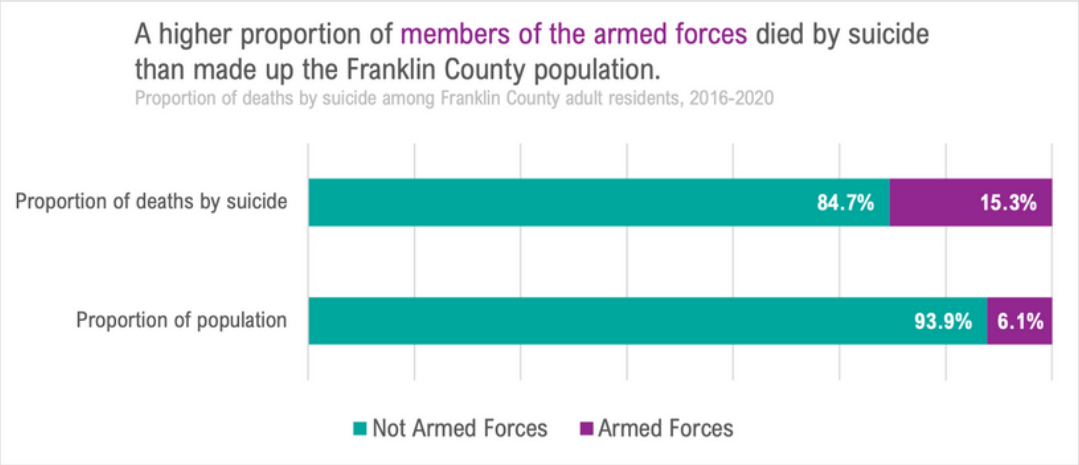
Place of Birth

From 2016 to 2020, 9.7% of suicide deaths were among Franklin County residents born outside of the United States. During the same period, residents born outside of the United States made up 12.7% of the Franklin County population.



Armed Forces

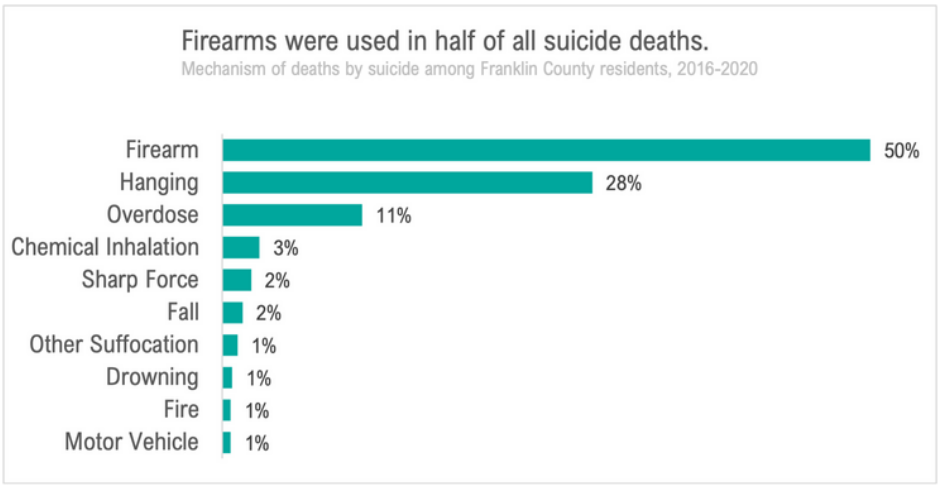
Veterans and members of the armed forces are at higher risk of dying by suicide. From 2016 to 2020, 15.3% of adult suicides were among members of the armed forces despite making up only 6.1% of Franklin County's adult population.

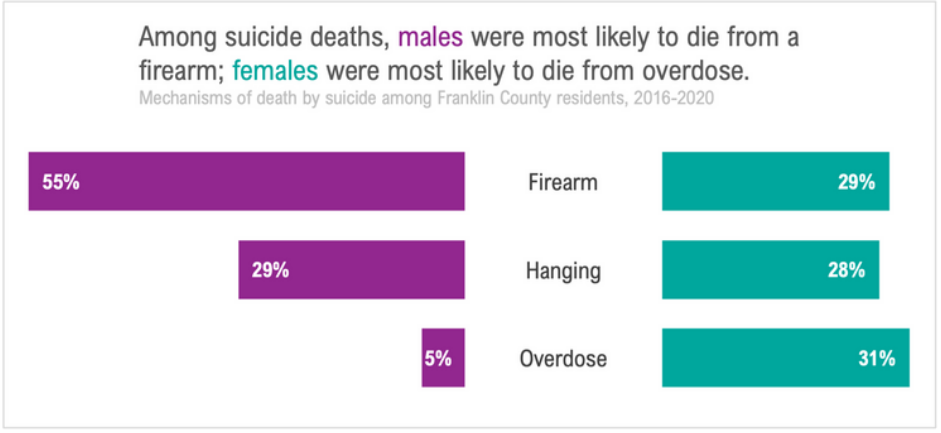


* Population proportion reflects veterans while the armed forces proportion may include veterans and current armed forces members at the time of their death

Mechanisms

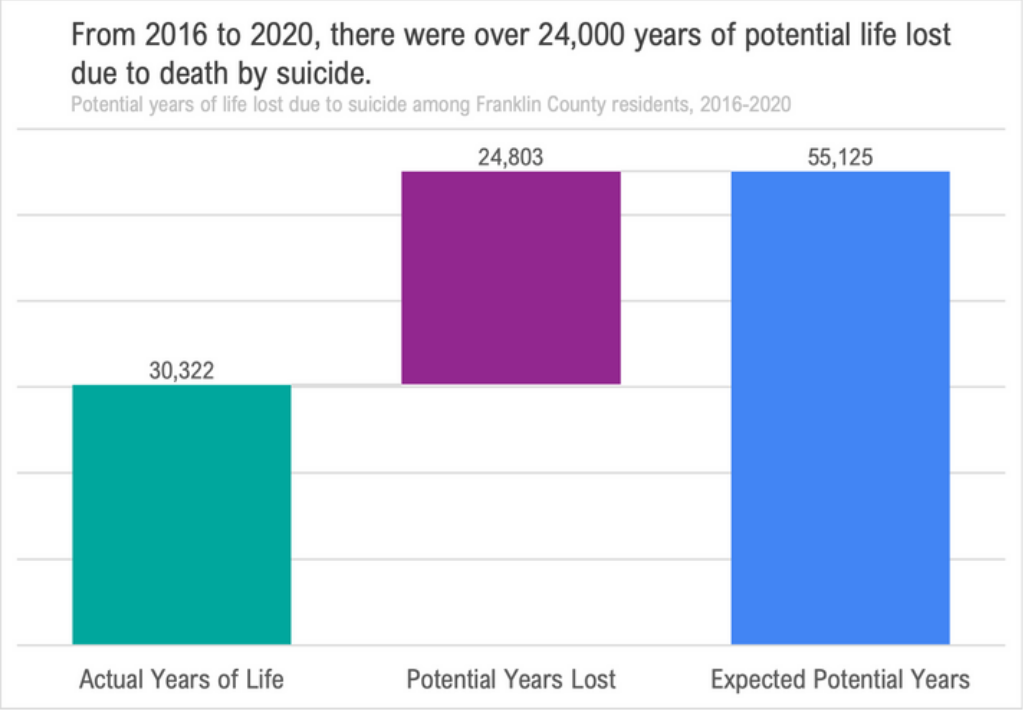
From 2016 to 2020, firearms were used in half of all suicide deaths among Franklin County residents. This trend persisted each year, with firearm deaths accounting for 47% to 53% of suicide deaths depending on the year. Hanging and drug overdose were the next most common mechanism for suicide. While males were most likely to die from a firearm, females were most likely to die from drug overdose.





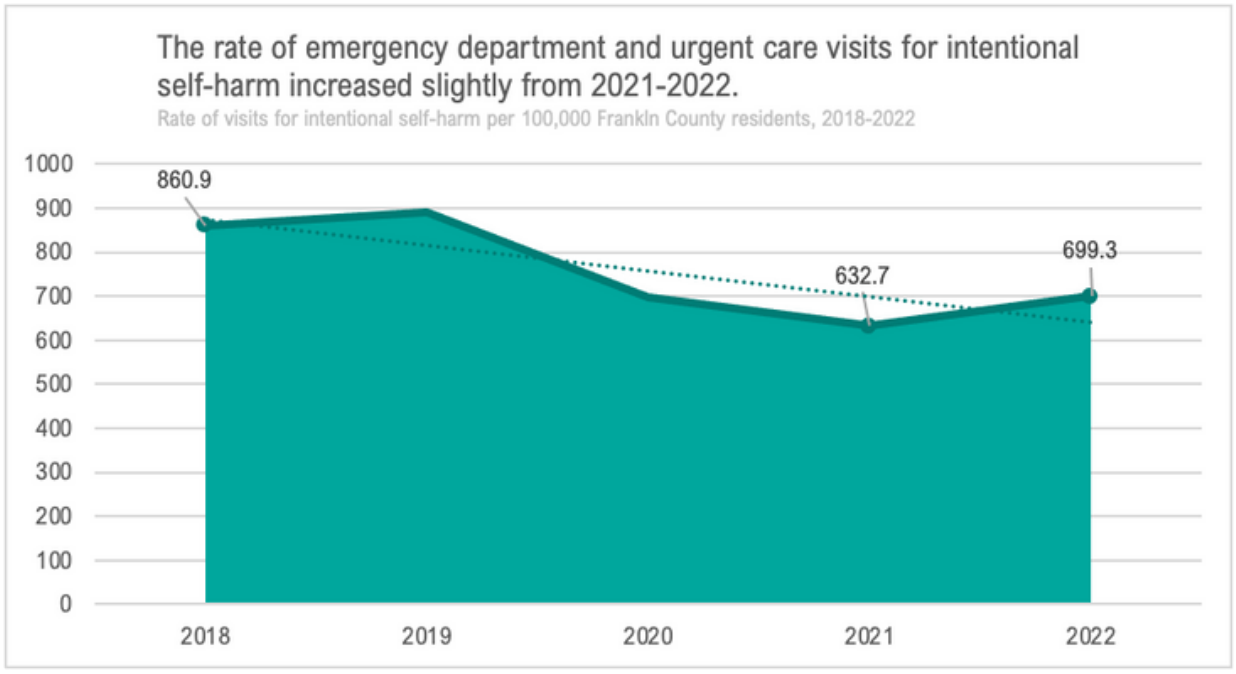
Years of Potential Life Lost

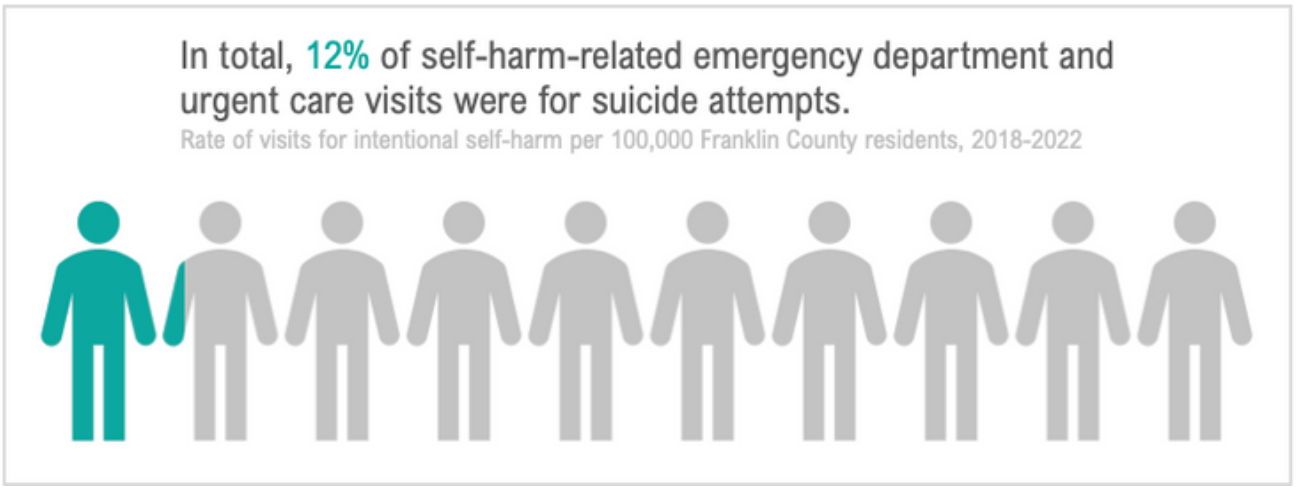
From 2016 to 2020, there were 24,803 years of potential life lost due to death by suicide. In other words, if everyone who died by suicide had actually lived to at least 75 years, then they would have lived a combined additional 24,803 years.



Self-Harm-Related Emergency Department & Urgent Care Visits

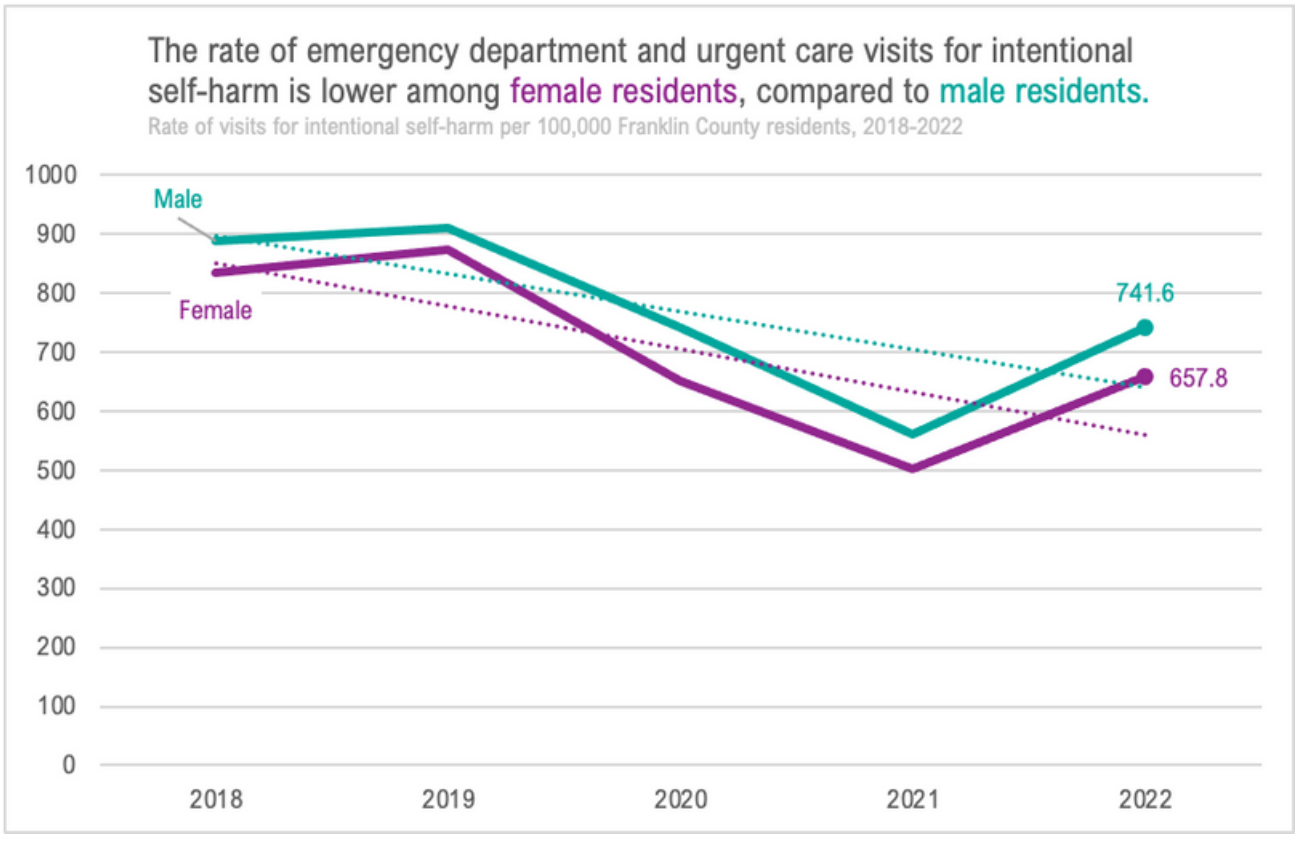
From 2018 to 2022, Franklin County emergency departments and urgent cares reported 49,842 suicide-related visits for self-harm, suicidal ideation, and suicide attempt. From 2018 to 2022, the rate of emergency department and urgent care visits for intentional self-harm and suicide decreased overall. In total, 12% of self-harm-related emergency department and urgent care visits were for suicide attempts.





Sex

From 2016 to 2020, the rate of emergency department and urgent care visits for intentional self-harm decreased for both male and female residents. While the rate of emergency department and urgent care visits for intentional self-harm is lower among female residents compared to male residents, there is a smaller difference than when comparing suicide deaths between males and females. Additional information regarding self-harm classification is available in Methods.



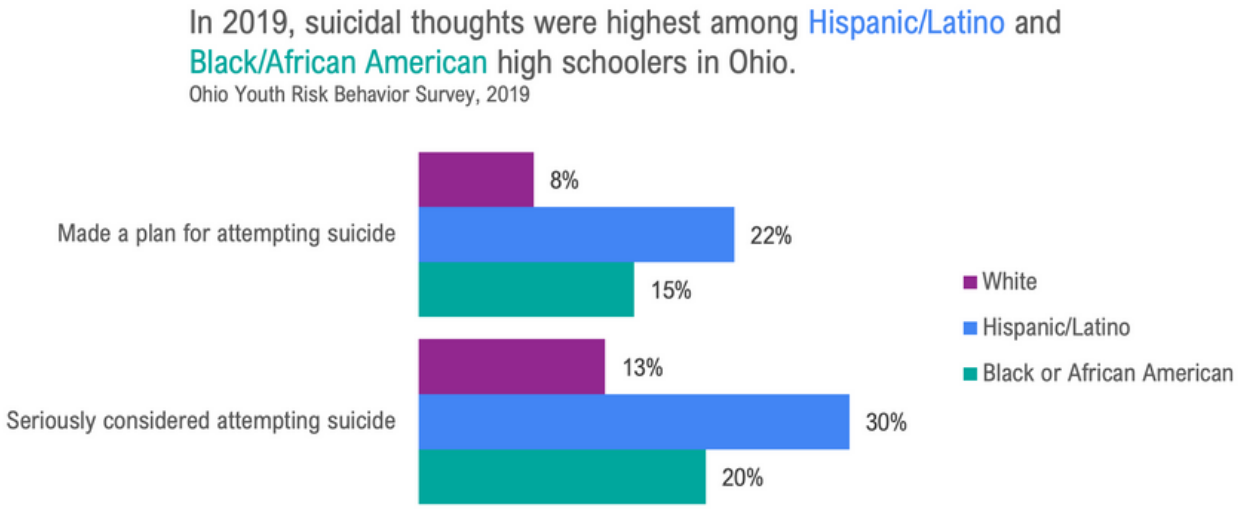
SURVEY DATA

In 2020, 23.0% of Franklin County adults reported having been diagnosed with depression. This is higher than in the US, where the prevalence of depression is 18.4%.[12]

- During 2018 to 2020, 5.6% of all Franklin County adults had serious thoughts of suicide in the past year. Comparatively, 13.9% of Franklin County adults ages 18-25 years had serious thoughts of suicide in the past year*.[13]

- In 2019, 15.0% of Ohio high schoolers and 15.0% of Ohio middle schoolers had seriously considered attempting suicide in the past year. Among high schoolers, 30.0% of Hispanic/Latino students and 20.0% of Black or African American students had seriously considered suicide compared to 13.0% of White students.

- In 2019, 10.0% of Ohio high schoolers and 12.0% of Ohio middle schoolers had made a plan for how they would attempt suicide in the past year. Among high schoolers, 22.0% of Hispanic/Latino students, 15.0% of Black or African American students, and 8.0% of White students had made a plan in the past year for how they would attempt suicide.



* Substate estimates from the 2018-2020 National Survey for Drug Use and Health (NSDUH) are no longer available due to methodological concerns with combining 2020 data with data from 2018 and 2019. Click here for more information from the Substance Abuse and Mental Health Services Administration (SAMHSA).

CONCLUSIONS & DATA RECOMMENDATIONS

- While the rate of deaths by suicide stayed relatively stable from 2016 to 2020, preliminary data from 2021 shows an increase in the suicide death rate. Furthermore, certain groups have displayed changes over the past 5 years, with suicide rates increasing among:
  - Non-Hispanic Black residents, residents ages 15 to 24 years, and residents over the age of 65.
  - Males continue to be disproportionately impacted by suicide death when compared to females, despite more similar rates of self-harm-related acute care interactions.
  - Members of the armed forces are overrepresented in suicide deaths.
  - Over the 5-year period, firearms were involved in half of suicide deaths.

- Franklin County is limited in assessing the suicide rate among refugee and immigrant populations. However, research shows refugees and undocumented immigrants often experience mental health and substance use issues at an increased rate compared to individuals born and raised in the United States.[14] ADAMH's 2020 Community Needs Assessment identified Bhutanese refugees and Somali immigrants to be at particularly high risk for depression and post-traumatic stress disorder. **The FCSPC recommends the expansion of suicide and proxy data on local refugee and immigrant communities to inform suicide prevention programming.** Proxy data, or an indirect measure of an outcome where direct measures are unavailable, may include information on both risk and protective factors, which may differ across communities.

- While there are community concerns of a rising trend in suicidal ideation among Franklin County youth, Franklin County lacks consistent, reliable, and representative data measuring mental health, suicide ideation, and suicide attempts among youth. **The FCSPC recommends that all Franklin County school districts consider implementing the Ohio Healthy Youth Environment Survey (OHYES!).** The OHYES! measures these indicators in addition to risk and protective factors, such as Adverse Childhood Experiences (ACEs), substance use, bullying, support from adults, etc. The free, web-based survey is voluntary and can be completed in 20 minutes.

- While national data related to suicide risk among the LGBTQ+ community is limited, research has shown that people who identify as sexual minorities have higher rates of suicide attempts compared to heterosexual people.[13] One survey showed that 23.4% of lesbian, gay, or bisexual high school students attempted suicide in the prior 12 months compared to 6.4% of heterosexual students.[15] **The FCSPC recommends investing in obtaining quantitative and/or qualitative data related to mental health and suicide within the LGBTQ+ community in Franklin County.** This will assess any disparities, better allocate resources, and guide investment in prevention strategies.

- While acute care interaction data from ODH is currently utilized for general counts of suicide for self-harm, suicidal ideation, and suicide attempts, these data do not include reliable demographics or additional details related to stay or treatment. **The FCSPC recommends the establishment of a continued agreement with Franklin County area hospitals to obtain hospital discharge records, as is practiced in other states.** These hospital discharge data would allow public health practitioners to better estimate the scope of suicide's impact in Franklin County outside of suicide deaths, including the presence of potential risk and protective factors in readmissions, disparities in suicide-related hospital utilization, and more.

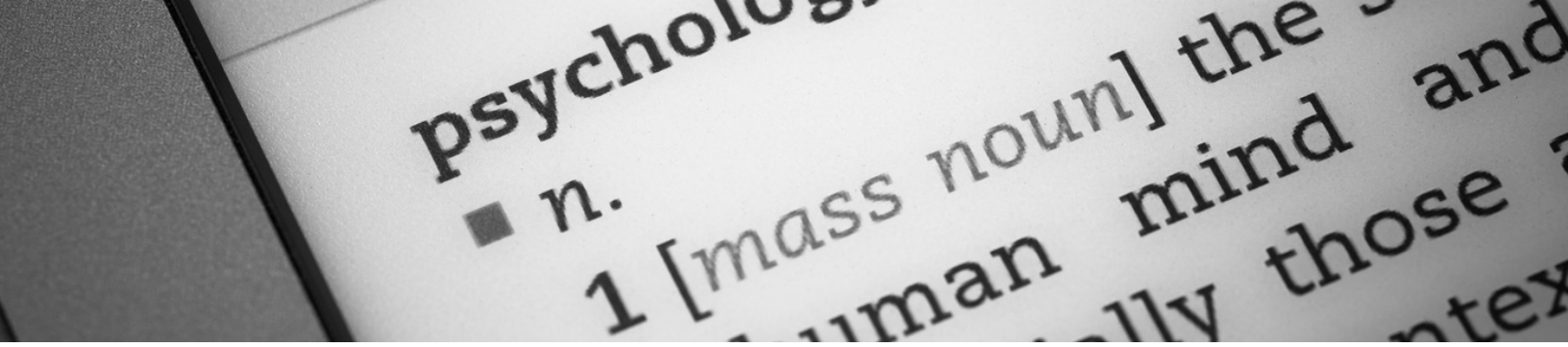
- Race and ethnicity categories utilized by health departments, hospitals, and other organizations that align with US Census Bureau categories are useful for linking other census data and comparing populations across geographies but are not useful for uncovering suicide trends by race/ethnicity among smaller, more specific communities. For example, FCSPC partner organizations have received requests to investigate suicide trends among the Bhutanese community in Franklin County but have limited opportunities to complete this request due to limited racial/ethnic data. **The FCSPC recommends the investigation of alternative racial/ethnic categories to be used in data collection to allow for more comprehensive investigations of suicide trends within racial/ethnic subgroups in Franklin County.** More detailed racial/ethnic categories will allow for more comprehensive investigations of suicide trends by race/ethnicity when numbers are large enough that data privacy does not become a barrier. If possible, subgroup data could be aggregated and reported in public reports. If numbers are too small to maintain data privacy and/or stability, then aggregated subgroup data could still be utilized in the Franklin County Suicide Fatality Review and other internal case investigations.

METHODS

Mortality data were provided by ODH and are derived from Ohio Certificates of Death. ODH specifically disclaims responsibility for any analyses, interpretations or conclusions. Intentional self-harm (suicide) deaths were determined by ICD 10 codes U03, X60-X84, and Y87.0. Deaths include individuals living in Franklin County at the time of their death. Mortality rates based on counts less than 10 were suppressed. Age-adjusted, age-specific, and crude mortality rates per 100,000 population were calculated in ODHs Secure Ohio Public Health Information Warehouse using population files from the National Center for Health Statistics for all metrics besides death rates by education group. Crude mortality rates by education group were calculated using 2021 single-year United States Census Bureau American Community Survey (ACS) estimates for Franklin County residents over the age of 25 years. Leading causes of death were determined using summed death counts. Deaths where the mechanism of suicide was redacted were excluded from calculations and interpretations related to mechanism of death. 2021 mortality estimates were still preliminary as of April 11, 2023.

Self-harm-related acute care interactions (ACIs) include all hospital and urgent care visits classified as intentional opioid overdose (explicit), intentional opioid overdose (suggestive), self harm, suicidal ideation, and/or suicide attempt by Ohio facilities participating in EpiCenter, a syndromic surveillance system developed by Health Monitoring Systems. ODH specifically disclaims responsibility for any analyses, interpretations or conclusions. Numbers are subject to change as updates are made within the hospital medical records and within the EpiCenter system. Classifications are made utilizing chief complaints, diagnosis codes, and medical notes. Patients were classified by area of residence, meaning Franklin County residents seen in facilities outside of Franklin County were included. Patients seen in Franklin County facilities but living outside of Franklin County were excluded. For yearly ACI rates, single-year ACS population estimates were utilized for all years except for 2020. For 2020 ACI rates, the midpoint population between ACS single-year 2019 and ACS single-year 2021 were utilized instead of ACS 5-year 2020 population estimates.

Analyses were completed by the Epidemiology & Data Section within Franklin County Public Health's Division of Health Systems & Planning.



DEFINITIONS

- **Actual Years of Life:** The age of an individual when they lost their life.
- **Acute Care Interaction:** A specific level of care where the individual receives short-term treatment for severe symptoms due to an underlying illness or disease.
- **Age-Adjusted:** The statistical process used to compare different age ranges on a specified health outcome.
- **Expected Potential Years:** The average life expectancy of an individual.
- **Morbidity:** The occurrence of illness or disease that leads to the presence of suicidal thoughts or ideations.
- **Morbidity Rates:** Data on the presence of disease or illness that lead to suicidal thoughts or ideations in a specified population.
- **Mortality:** A term used to describe a death.
- **Mortality Rate:** Data on the occurrence of death due to a specific illness or disease.
- **Protective Factors:** Individual, relational, communal, and societal characteristics that decrease the likelihood of a negative outcome.
- **Risk Factors:** Individual, relational, communal, and societal characteristics that increase the likelihood of a negative outcome.
- **Suicidal Ideation:** Actions or organized thoughts/preoccupation around death and suicide. An expansion from Suicidal Thoughts to now include self-harm actions.
- **Suicidal Thoughts:** Intrusive thought patterns or passive reoccurring thoughts around death or planning ways of ending one's own life (no actions).
- **Suicide:** The act of willingly and voluntarily taking one's own life through lethal actions with the intent of dying.
- **Suicide Attempt:** The act of engaging in lethal behaviors with the intent and purpose of ending one's own life.
- **Warning Signs:** Early signs an individual may display to show that there is a potential for negative outcomes or dangerous behaviors.
- **Years of Potential Life Lost (YPLL):** A calculation to determine the years an individual lost due to their death based on a standard age of life. (Life expectancy age – Age of death = YPLL)

APPENDIX

Table 1. Suicide Mortality by Demographic Group, 2016-2020

	Death Count	Age-Adjusted Rate
Franklin County Residents	779	11.7
Sex		
Male	621	19.5
Female	158	4.6
Race/Ethnicity		
Non-Hispanic white	611	13.7
Non-Hispanic Asian or Pacific Islander	33	7.4
Non-Hispanic Black	116	8.5
Hispanic/Latino	11	2.7
Race/Ethnicity by Sex		
Non-Hispanic white male	478	22.2
Non-Hispanic Black male	103	13.9
Non-Hispanic white female	133	5.9
Non-Hispanic Black female	13	1.6

Table 1. Suicide Mortality by Demographic Group, 2016-2020, continued

	Death Count	Crude Rate
Age Group		
5 to 14 years	10	1.2
15 to 24 years	108	12.4
25 to 34 years	181	15.2
35 to 44 years	117	13.3
45 to 54 years	145	18.7
55 to 64 years	124	16.8
65 to 74 years	46	9.6
75 to 84 years	31	14.4
85+ years	17	18.8
	Death Count	**Percentage of Total**
Educational Attainment (all residents)		
8th grade or less	22	2.8%
9th through 12th grade (no diploma)	92	11.9%
High school diploma or equivalent	303	39.2%
Some college, no degree	145	18.8%

Table 1. Suicide Mortality by Demographic Group, 2016-2020, continued

Associate degree	49	6.3%
Bachelor's degree	111	14.4%
Graduate degree	50	6.5%
Place of Birth		
Born inside United States	688	90.3%
Born outside United States	74	9.7%
Armed Forces (adults)		
No	633	84.7%
Yes	114	15.3%

Table 2. Suicide Mortality by Demographic Group, 2020

	Death Count	Age-Adjusted Rate
Franklin County Residents	143	10.9
Sex		
Male	113	18.4
Female	30	4.2
Race/Ethnicity		
Non-Hispanic white	114	13.2
Non-Hispanic Black	24	7.7
	Death Count	**Crude Rate**
Educational Attainment (residents 25+ years)		
Less than high school diploma or equivalent	15	20.7
High school diploma or equivalent	47	22.4
Some college or associate degree	21	8.9
Bachelor's degree or higher	29	7.8

Table 2. Suicide Mortality by Demographic Group, 2020 continued

Age Group		
5 to 14 years	*	*
15 to 24 years	27	15.5
25 to 34 years	28	11.6
35 to 44 years	21	11.6
45 to 54 years	25	16.4
55 to 64 years	15	10.1
65 to 74 years	11	10.6
75+ years	14	21.8

* Number of suicide deaths too small to share

Table 3. Emergency Department & Urgent Care Visits for Self-Harm, 2018-2022

	Visit Count	Percentage of Total
Franklin County Residents	49842	100.0%
Sex		
Male	24781	49.7%
Female	23707	47.6%
Classification		
Self Harm	49832	100.0%
Suicidal Ideation	46440	93.2%
Suicide Attempt	6135	12.3%
Intentional Opioid Overdose*	137	0.3%

* Intentional overdoses caused by substances other than opioids may be captured in the data under the additional categories, but are not distinguished as a separate classification

Table 4. Emergency Department & Urgent Care Visits for Self-Harm, 2022

	Visit Count	Crude Rate
Franklin County Residents	9265	699.3
Sex		
Male	4824	741.6
Female	4436	657.8

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