MONTANA DOESN’T NEED MORE SUICIDE: SAY “NO” TO THE OREGON EXPERIENCE

By Margaret Dore, Esq., MBA
October 12, 2016

Since the passage of Oregon’s law allowing physician-assisted suicide, other suicides in Oregon have steadily increased. This is consistent with a suicide contagion in which the legalization of physician-assisted suicides has encouraged other suicides. In Oregon, the financial and emotional impacts of suicide on family members and the broader community are devastating and long-lasting.¹

A. Suicide is Contagious

It is well known that suicide is contagious. A famous example is Marilyn Monroe.² Her widely reported suicide was followed by “a spate of suicides.”³

With the understanding that suicide is contagious, groups such as the National Institute of Mental Health and the World Health Organization have developed guidelines for the responsible reporting of suicide, to prevent contagion. Key points include that the risk of additional suicides increases:

[W]hen the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.⁴

B. Physician-Assisted Suicide in Oregon

In Oregon, prominent cases of physician-assisted suicide include Lovelle Svarth and Brittany Maynard.

Lovelle Svarth died in 2007.³ The Oregonian, which is Oregon’s largest paper, violated

¹ Shen X., Millet L., Suicides in Oregon: Trends and Associated Factors. 2003-2012, Oregon Health Authority, Portland Oregon, p.3, Executive Summary. (Excerpts attached hereto at A-56 to A-58)


³ Id., page 1.


the recommended guidelines for the responsible reporting of suicide by explicitly describing her suicide method and by employing “dramatic/graphic images.” Indeed, visitors to the paper’s website were invited “to hear and see when Lovelle swallowed the fatal dose.” There are still photos of her online, lying in bed, dying.

Brittany Maynard reportedly died from physician-assisted suicide in Oregon, on November 1, 2014. Contrary to the recommended guidelines, there was “repeated/extensive coverage” in multiple media, worldwide. This coverage is ongoing, especially in Colorado, where her image is now being used to promote a pending ballot initiative (Prop. 106).

C. The Young Man Wanted to Die Like Brittany Maynard

A month after Ms. Maynard’s death, Dr. Will Johnston was presented with a twenty year old patient during an emergency appointment. The young man, who had been brought in by his mother, was physically healthy, but had been acting oddly and talking about death.

Dr. Johnston asked the young man if he had a plan. The young man said "yes," that he had watched a video about Ms. Maynard. He said that he was very impressed with her and that he identified with her and that he thought it was a good idea for him to die like her. He also told Dr. Johnston that after watching the video he had been surfing the internet looking for suicide drugs. Dr. Johnston’s declaration states:

He was actively suicidal and agreed to go to the hospital, where he stayed for five weeks until it was determined that he was

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6 Id.
7 Id.
8 The worldwide coverage of Ms. Maynard in multiple media started with an exclusive cover story in People Magazine. A copy of the cover is attached hereto at A-64. Other media included TV, radio, print, web and social media.
10 Id.
11 Id.
12 Id.
13 Id.
14 Id.
sufficiently safe from self-harm to go home.\textsuperscript{15}

The young man had wanted to die like Brittany Maynard.

D. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide

Oregon government reports show the following positive correlation between the legalization of physician-assisted suicide and an increase in other suicides. Per the reports:

Oregon legalized physician-assisted suicide “in late 1997.”\textsuperscript{16}

By 2000, Oregon’s conventional suicide rate was “increasing significantly.”\textsuperscript{17}

By 2007, Oregon's conventional suicide rate was 35% above the national average.\textsuperscript{18}

By 2010, Oregon's conventional suicide rate was 41% above the national average.\textsuperscript{19}

By 2012, Oregon's conventional suicide rate was 42% above the national average.\textsuperscript{20}

E. The Financial and Emotional Cost of Suicide in Oregon

Oregon’s most recent report, for 2012, describes the cost of suicide as “enormous.”

The report states:

\textsuperscript{15} Id.

\textsuperscript{16} Oregon Death with Dignity report, attached hereto at A-35.


\textsuperscript{18} Suicides in Oregon: Trend and Risk Factors, issued September 2010 (data through 2007). (Excerpts attached hereto at A-68 to A-70).


Suicide is the second leading cause of death among Oregonians aged 15 to 34 year, and the eighth leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 201[2] alone, self-inflicted injury hospitalization charges in Oregon exceeded $54 million; and the estimate of total lifetime cost of suicide in Oregon was over $677 million. The loss to families and communities broadens the impact of each death.21

F. The Significance for Montana

In Montana, the law on assisted suicide is governed by the Montana Supreme Court decision, Baxter v. State, 354 Mont. 234 (2009). Baxter gives doctors who assist a patient’s suicide a potential defense to criminal prosecution. Baxter does not legalize assisted suicide by giving doctors or anyone else immunity from criminal and civil liability. Under Baxter, a doctor cannot be assured that a suicide will qualify for the defense.

Some assisted suicide proponents nonetheless claim that Baxter has legalized assisted suicide in Montana. More importantly, some doctors are assisting suicides in Montana.

Montana already has a higher suicide rate than Oregon.22 If Baxter is not overturned and/or the law clarified that assisted suicide is not legal, the suicide problem in Montana will only get worse. Montana does not need the Oregon experience.

21 Id., attached at A-57.
22 CDC Centers For Disease Control and Prevention, Age Adjusted Suicide Rates by State, US, 2012. (Attached hereto at A-71)
Introduction
Oregon’s Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by the Oregon Public Health Division as of January 27, 2016. More information on the reporting process, required forms, and annual reports is available at: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2015

Participation Summary and Trends
During 2015, 218 people received prescriptions for lethal medications under the provisions of the Oregon DWDA, compared to 155 during 2014 (Figure 1, above). As of January 27, 2016, the Oregon Public Health Division had received reports of 132 people who had died during 2015 from ingesting the medications prescribed under DWDA.

Since the law was passed in 1997, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications. From 1998 through 2013, the number of prescriptions written annually increased at an average of 12.1%; however, during 2014 and...
Executive Summary

Suicide is one of Oregon’s most persistent public health problems. Suicide is the second leading cause of death among Oregonians aged 15 to 34 years, and the eighth leading cause of death among all Oregonians in 2012. The financial and emotional impacts of suicide on family members and the broader community are devastating and long-lasting. This report provides the most current suicide statistics in Oregon. We analyzed mortality data from 1981 to 2012 and Oregon Violent Death Reporting System (ORVDRS) data from 2003 to 2012. This report presents findings of suicide trends and associated factors in Oregon. These data can inform prevention programs, policy, and planning.

Key Findings

In 2012, the age-adjusted suicide rate among Oregonians was 17.7 per 100,000, 42 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among adolescents aged 10 through 17 years has increased since 2011 after decreasing from 1990 to 2010.

Suicide rates among adults aged 45 to 64 years rose more than 50 percent from 18.1 per 100,000 in 2000 to 28.7 per 100,000 in 2012; the rate increased more among females than among males.

Suicide rates among males aged 65 years and older decreased approximately 18 percent from nearly 50 per 100,000 in 2000 to 42 per 100,000 in 2012.

From 2003 to 2012:

Males were 3.6 times more likely to die by suicide than females. The highest suicide rate occurred among males aged 85 years and older (72.4 per 100,000). Non-Hispanic white males had the highest suicide rate among all racial/ethnic groups (27.1 per 100,000).

Approximately 25 percent of suicides occurred among veterans. Male veterans had almost twice the suicide rate than non-veteran males (45.5 vs. 29.0 per 100,000). Veteran suicide victims were reported to have more physical health problems than non-veteran males.

Psychological, behavioral, and health problems co-occur and are known to increase suicide risk. Approximately 70 percent of suicide victims had a diagnosed mental disorder, alcohol and/or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, fewer than one third of male victims, and fewer than 60 percent of female victims, were receiving treatment for mental health problems at the time of death.

Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 showed that approximately 15 percent of teens and four percent of adults aged 18 years and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year.  

In 2012, 717 Oregonians died by suicide and more than 2,100 hospitalizations were due to suicide attempts. Suicide is the second leading cause of death among Oregonians aged 15 to 34 years, and the eighth leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 2013 alone, self-inflicted injury hospitalization charges in Oregon exceeded $54 million, and the estimate of total lifetime cost of suicide in Oregon was over $677 million. The loss to families and communities broadens the impact of each death.

“Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors”. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2012, and 2003 to 2012 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and associated factors in Oregon.

Methods, data sources and limitations

Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths on death certificates.

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Suicide was considered with code of X60-84 and Y87.0. Deaths relating to the Death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.

Mortality data from 1981 to 2012 are from Web-based Injury Statistics Query and Reporting System (WISQARS) of the Centers of Disease Control and Prevention. This system contains information from death certificates filed in state vital statistics offices.

The ORVDRS is a statewide, active surveillance system that collects detailed information on all homicides, suicides, deaths of undetermined intent, deaths resulting from legal intervention, and deaths related to unintentional firearm injuries. ORVDRS obtains data from Oregon medical examiners, local police agencies, death certificates, and the Homicide Incident Tracking System. All available data are reviewed, coded, and stored in the National Violent Death Reporting System. Details regarding NVDRS procedures and coding are available at http://www.cdc.gov/ncipc/profiles/nvdrspublications.htm.

Rates were calculated according to death counts and bridged-race postcensal estimates released by the National Center for Health Statistics (NCHS). The populations of 2007 and 2008, which were at the mid-point of the period from 2003 to 2012, were used to calculate rates. The age-adjusted rate was adjusted to the 2000 standard million. Because of limited death counts in some categories, some rates might not be statistically reliable or stable; use caution with regard to those categories with fewer than 20 deaths.

A three-year moving average of age-specific suicide death rates was computed to smooth fluctuations from one year to another. The trend in rates was tested by using Poisson regression analysis. P<0.05 is considered significant.

When comparing rates, 95 percent confidence intervals were calculated. If the 95 percent confidence intervals do not overlap, then the difference is considered to be statistically significant at the 0.05-level. A Chi-square test was used to test the difference in proportion (percentage) for the studied groups.

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The Science Behind Suicide Contagion
Margot Sanger-Katz @sangerkatz  AUG. 13, 2014

When Marilyn Monroe died in August 1962, with the cause listed as probable suicide, the nation reacted. In the months afterward, there was extensive news coverage, widespread sorrow and a spate of suicides. According to one study, the suicide rate in the United States jumped by 12 percent compared with the same months in the previous year.

Mental illness is not a communicable disease, but there’s a strong body of evidence that suicide is still contagious. Publicity surrounding a suicide has been repeatedly and definitively linked to a subsequent increase in suicide, especially among young people. Analysis suggests that at least 5 percent of youth suicides are influenced by contagion.

People who kill themselves are already vulnerable, but publicity around another suicide appears to make a difference as they are considering their options. The evidence suggests that suicide “outbreaks” and “clusters” are real phenomena; one death can set off others. There’s a particularly strong effect from celebrity suicides.

“Suicide contagion is real, which is why I’m concerned about it,” said Madelyn Gould, a professor of Epidemiology in Psychiatry at Columbia University, who has studied suicide contagion extensively.

She’s particularly concerned this week, after the high-profile death of the comedian and actor Robin Williams.
Recommendations for Reporting on Suicide

Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking.

Download the PDF (http://www.nimh.nih.gov/health/topics/suicide-prevention/PDF-recommendations-for-reporting-on-suicide_136457.pdf) (2 pages)

Important Points for Covering Suicide

More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.

- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.

Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

This table is scrollable by touch on mobile devices.

**Instead of This:**
- Big or sensationalistic headlines, or prominent placement (e.g., "Kurt Cobain Used Shotgun to Commit Suicide").
- Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.
- Describing recent suicides as an "epidemic," "skyrocketing," or other strong terms.
- Describing a suicide as inexplicable or "without warning."
- "John Doe left a suicide note saying...".
- Investigating and reporting on suicide similar to reporting on crimes.
- Quoting/interviewing police or first responders about the causes of suicide.
- Referring to suicide as "successful," "unsuccessful" or a "failed attempt."

**Do This:**
- Inform the audience without sensationalizing the suicide and minimize prominence (e.g., "Kurt Cobain Dead at 27").
- Use school/work or family photo; include hotline logo or local crisis phone numbers.
- Carefully investigate the most recent CDC data and use non-sensational words like "rise" or "higher."
- Most, but not all, people who die by suicide exhibit warning signs. Include the "Warning Signs" and "What to Do" sidebar (from p. 2) in your article if possible.
- "A note from the deceased was found and is being reviewed by the medical examiner."
- Report on suicide as a public health issue.
- Seek advice from suicide prevention experts.
- Describe as "died by suicide" or "completed" or "killed him/herself."

Suicide Contagion or "Copycat Suicide" occurs when one or more suicides are reported in a way that contributes to another suicide.
Lovelle Svart, 1945 - 2007

Ed Madrid, The Oregonian By Ed Madrid, The Oregonian
on September 28, 2007 at 10:51 PM, updated October 05, 2007 at 12:43 PM

Lovelle's Diaries: Click here to view the entire Living to the End series

Lovelle's Last Hours: Click here to watch Lovelle's final diary entry and to hear and see when Lovelle swallowed the fatal dose

Lovelle Svart, who shared through online videos the struggle and choices of her final months, ended her life today by taking a drug overdose prescribed at her request under Oregon's Death With Dignity Act. She was 62 and had lived with lung cancer for nearly five years.

Lovelle Svart

She died quietly in her mother’s apartment in the assisted-living center where they both live. Her family and a few close friends gathered beforehand for storytelling, music, life-celebration and private goodbyes.

A few minutes after 5 p.m., while sitting up in bed with 10 family members and close friends gathered around her, she swallowed the lethal dose.

"I'm peaceful," she said. "It stopped raining, and the sun's out. And I've had so much love today."

She then eased into a lying position and fell into a coma. She died at 10:42 pm.

Lovelle chronicled through videos her request for a doctor's prescription to end her life, her receipt of the drug and her personal debate about whether to use it.

She also shared with readers the day-to-day experience of living with a serious, progressive illness - including "this joy." With humor and compassion, she spoke out on a range of topics from grief and pain to polka dancing and filling out a will. She talked openly about her love-hate relationship with tobacco (she had smoked since age 19), her sense of time slipping away and the difficult balance between welcoming visitors and keeping time and space for herself.

Her goal, she said, was to spur a franker discussion of death and dying, and hundreds of people responded in writing, many addressing her directly as Lovelle, as if they had become friends.

Lovelle was born in Portland on Jan. 31, 1945. She was due on Valentine's Day but arrived two weeks early, on her parents' third wedding anniversary. Her father was aboard a U.S. Navy ship in the Pacific, and her mother decided that their newborn daughter's name had to be something about love.

Her life, she was the first to acknowledge, included "my share of mistakes and rough patches, along with the high points." Two marriages ended in divorce. She dropped out of college in the early 1960s. She abused alcohol in her 30s, until she finally sought treatment and stopped drinking altogether at age 40.
Lovelle, in bed, dying, printed 10/9/16
Lovelie in bed, dying - printed 10/9/16
Inside Terminally Ill Brittany Maynard’s Decision to Die

483
SHARES

Brittany Maynard

My Decision to Die

Why Brittany Maynard, 29, plans to end her life in less than 5 weeks

A TERMINAL CANCER PATIENT'S CONTROVERSIAL CHOICE

Mr. & Mrs. Clooney

Inside Their Life as Newlyweds PLUS Amal's Congenial Style!

Guest Editor DREW BARRYMORE

2014 Fall Beauty Guide

A Beloved TV Dad’s SHOCKING SCANDAL

Mayim Bialik Can’t Name a Kardashian — and That’s Just Fine

RHONY’s Carole Radziwill Reveals Why She’s Not Surprised Former Beau George Clooney Got Married

Suspect Arrested in Pregnant Food Network Star Contestant’s Murder

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BEFORE THE LEGISLATURE OF THE
STATE OF CALIFORNIA

In Re SB 128

DECLARATION OF WILLARD
JOHNSTON, MD

I, Williard Johnston, declare the following under penalty of perjury.

1. I am a family practice doctor in Vancouver, BC, Canada, where I have had my own practice since 1985.

2. In the first week of December 2014, a mother brought in her twenty year old son for an emergency appointment. She had told me that he had been acting oddly and talking about death.

3. During the appointment, I asked the young man if he had a plan. He said "yes" that he had watched Ms. Maynard's video, that he was very impressed and identified with her and that he thought it was a good idea for him to die like her. He also told me that after watching the video he had been surfing the internet looking for ways to obtain suicide drugs.
4. He was actively suicidal and agreed to go to the hospital, where he stayed for five weeks until it was determined that he was sufficiently safe from self-harm to go home.

I certify under penalty of perjury under the laws of the British Columbia, Canada, that the foregoing is true and correct.

SIGNED AND DATED this 24 day of May, 2015, at Vancouver BC, Canada.

Williard Johnston, MD
Date: Sept. 9, 2010

Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk; 503-602-8027, cell; christine.l.stone@state.or.us

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon’s suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000.

After decreasing in the 1990s, suicide rates have been increasing significantly since 2000, according to a new report, “Suicides in Oregon: Trends and Risk Factors,” from Oregon Public Health. The report also details recommendations to prevent the number of suicides in Oregon.

“Suicide is one of the most persistent yet preventable public health problems. It is the leading cause of death from injuries – more than even from car crashes. Each year 550 people in Oregon die from suicide and 1,800 people are hospitalized for non-fatal attempts,” said Lisa Millet, MPH, principal investigator, and manager of the Injury Prevention and Epidemiology Section, Oregon Public Health.

There are likely many reasons for the state’s rising suicide rate, according to Millet. The single most identifiable risk factor associated with suicide is depression. Many people can manage their depression; however, stress and crisis can overwhelm their ability to cope successfully.

Stresses such as from job loss, loss of home, loss of family and friends, life transitions and also the stress veterans can experience returning home from deployment – all increase the likelihood of suicide among those who are already at risk.

“Many people often keep their depression a secret for fear of discrimination. Unfortunately, families, communities, businesses, schools and other institutions often discriminate against people with depression or other mental illness. These people will continue to die needlessly unless they have support and effective community-based mental health care,” said Millet.

The report also included the following findings:

- There was a marked increase in suicides among middle-aged women. The number of women between 45 and 64 years of age who died from suicide rose 55 percent between 2000 and 2006 — from 8.2 per 100,000 to 12.8 per 100,000 respectively.
Suicides in Oregon
Trends and Risk Factors

Oregon Violent Death Reporting System
Injury and Violence Prevention Program
Office of Disease Prevention and Epidemiology

[DHS | Independent. Healthy. Safe.]

Executive Summary

Suicide is one of Oregon’s most persistent yet largely preventable public health problems. Suicide is the leading cause of injury death—there are more deaths due to suicide in Oregon than due to car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all Oregonians. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data of Oregon Violent Death Reporting System (ORVDRS). This report presents main findings of suicide trends and risk factors in Oregon.

Key Findings

In 2007, the age-adjusted suicide rate among Oregonians of 15.2 per 100,000 was 35 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among women ages 45-64 rose 55 percent from 8.2 per 100,000 in 2000 to 12.8 per 100,000 in 2007.

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (78.4 per 100,000). White males had the highest coefficient rate among all races/ethnicity (25.6 per 100,000). Firearms were the dominant mechanism of suicide among men (62%).

Approximately 27 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (45.7 vs. 27.4 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.

Over 70 percent of suicide victims had a diagnosed mental disorder, alcohol and/or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and just about half of female victims were receiving treatment for mental health problems at the time of death.

Investigators suspect that 30 percent of suicide victims had used alcohol in the hours preceding their death.

The number of suicides in each month varies. But there was not a clear seasonal pattern.
Introduction

Suicide is an important public health problem in Oregon. Each year there are more than 350 Oregonians who died by suicide and more than 1,800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon with more deaths due to suicide among Oregonians than car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded $4 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 578 million dollars. The loss to families and communities broadens the impact of each death.

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors." This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

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QuickStats: Age-Adjusted* Suicide† Rates, by State§ — United States, 2012

Weekly

November 14, 2014 / 63(45);1041-1041

* Age-adjusted rates per 100,000 based on the 2000 U.S. standard population. Populations used for computing death rates are postcensal estimates based on the 2010 census estimated as of July 1, 2012.

† Intentional self-harm (suicide) as the underlying cause of death includes codes for by discharge of firearms (X72–X74), and Intentional self-harm (suicide) by other and unspecified means and their...