What You Should Know About:

►*Suicide*

National Statistics

Approximately 30,000 Americans die each year as a result of suicide.[1] Overall, suicide is the 11th leading cause of death, and the third leading cause of death among persons aged 15-24 years.[2] For every two victims of homicide in the United States, there are three deaths from suicide.[3]

Suicide rates vary by race, sex, age and method of injury. Whites and Native Americans are almost twice as likely to complete suicide than African Americans and persons of other races.[2,4] The Centers for Disease Control and Prevention reports that males are four times more likely to complete suicide than females,[5] but females attempt suicide three times more often than males.[6]

Suicide among older persons is disproportionately high. Suicide rates increase with age and are highest among persons aged 65 and older. Adults aged 65 years and over account for 13% of the U.S. population, yet nearly 20% of U.S. suicides.[2,5] White males aged 85 and over complete suicide at almost six times the national average.[2] It is estimated that one person aged 65 or over completes suicide every 90 minutes.[7]

In addition, a rapidly increasing number of suicides are being committed by adolescents and young adult males. In the last three decades, the suicide rate among young teens and young adults has increased by more than 300%. In 1999, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease combined.[8]

Suicide risk factors vary among age groups, however, depression, death of a family member, exposure to suicide, and a previous suicide attempt are risk factors common to all age groups. Youth risk factors are unique in that youth are more impulsive and reactive, and have less communication and coping skills. Parental or family discord, divorce, substance abuse,

high-risk behavior, financial problems, and access to firearms are additional risk factors. Often the precipitating factor may be stress-related due to the breakup of a boyfriend or girlfriend, family discord, or problems at school.[9] Among older persons, risk factors include social isolation, poor communication, diminished life goals, poor physical health, disability, chronic pain, and fading recuperative power.[10]

Oklahoma Statistics

According to Oklahoma State Department of Health Vital Statistics data, 2,356 Oklahoma residents committed suicide between 1997 and 2001. Data shows there were more than 450 suicides each year. The average annual rate for males (23.3 per 100,000) in Oklahoma was more than four times greater than for females (5.1 per 100,000). Rates were highest for males 65 years and older. The rate for whites (15.4 per 100,000) was more than twice the rate for Native Americans (8.5 per 100,000) and African Americans (6.8 per 100,000). Among the white population, the age-specific incidence rate was highest for persons 25-44 years of age. While the rate for whites dropped during this 5-year time period, the rate for Native Americans increased substantially. Firearms were the leading method for completing suicide for persons older than 14 years of age; persons younger than 14 years were more likely to use hanging as a method.

Blood alcohol content levels were tested on 2,048 (87%) of persons 15 years of age and older; 32% showed positive results. Persons 35-44 years of age were most likely to have a positive BAC. More than half of Native Americans had a positive BAC (54%) compared to 31% of whites and 30% of African Americans.

►What Works

Community Support for Suicide Prevention

Because the issues surrounding suicide are complex, prevention efforts must address psychological, and social factors to be effective. Community-wide support of individuals, public, private, faith-based, and health care organizations is needed to provide the most effective, comprehensive services. Such broad-based support will increase the likelihood of success in generating support for and improving suicide prevention efforts.

Reducing the Stigma Associated with Help-Seeking Behaviors

Suicide is closely linked to mental illness and substance abuse, and both can be effectively treated. However, the stigma associated with this type

of health care prevents many people from getting the treatment they need. Family members of suicide attempters often hide the behavior from others; those who have experienced the suicide of a loved one suffer not only the grief of loss but often suicide's associated stigma. Destigmatizing mental illness and substance abuse disorders could result in improved financial reimbursement, integrations of physical and mental health care, and increasing the willingness of individuals to seek treatment.

Direct Screening of Youth

Another prevention strategy that has received attention and has yielded encouraging results is direct screening of youth. One common method used to do this is a two-stage screening process. In the first stage, students complete a brief self-report questionnaire called the Columbia Teen Screen during a health class. Based on their answers, students who may have an increased risk are advanced to the second phase and assessed further through a computerized Diagnostic Interview Schedule for Children (DISC). An advantage of the two-stage process is that it reduces the number of students who have to be seen by a clinician by screening out those students who are not at risk.[11] When the DISC interview is completed, the computer produces a diagnostic report that is reviewed by a physician who then personally interviews students in the third stage of the screening process. The physician determines whether the identified student needs to be referred for further evaluation. A case manager contacts the students' parents to assist students who are deemed to be in need of additional intervention and also to ensure treatment compliance.[11] Although this strategy appears to be quite promising, it is important to remember that among teenagers, suicidal tendencies may come and go as crises occur and are resolved. Therefore, multiple screenings may be necessary in order to minimize false negatives.[12] Considerable effort must be made to assist the families and adolescents in obtaining help if it is needed.[12]

Reducing Access to Lethal Means and Methods of Self-Harm

Evidence suggests that removing or restricting access to lethal means of suicide (i.e., firearms, poisons, medications, alcohol, bridge railings, carbon monoxide, etc.) is an effective suicide prevention strategy that can decrease suicide.[13] Further, education on the restriction of access to lethal means is seen as one of the most promising suicide interventions. Often referred to as "means restriction," this approach is based on the premise that a small, but significant number of suicidal acts are impulsive in nature making suicidal thoughts and quick access to lethal means a deadly combination. Therefore, a self-destructive act can be prevented by eliminating access to such means of self-harm.

Easy access to a firearm, especially for the young, is an important risk factor for suicide.[14] A potentially suicidal adolescent's risk of actually committing suicide increases 75-fold if there is a gun in the home.[15] Among parents whose children visited an emergency department for a mental health assessment or treatment, those who received injury prevention education from hospital staff are significantly more likely to limit access to lethal means of self-harm than families who did not receive such education.[16]

Training To Recognize Persons At-Risk

Despite a growing awareness of suicide as a serious health problem, there is a significant need for training programs for health care professionals, as well as others who frequently come into contact with persons at risk. Evidence suggests that many health professionals are not adequately trained in assessing or treating suicidal clients, identifying clients who need referral for specialized care, or recognizing risk factors often found in family suicide survivors.

Therefore, community suicide prevention efforts should address the need to provide training to health care and other professionals. It has been recommended that greater emphasis be placed in undergraduate, graduate, and continuing medical education on recognition and effective treatment of depressive disorders and suicidal states in older people.[13]

Effective Clinical and Professional Practices

Many of those who commit suicide visit a non-mental health clinician within the last month of their lives. Several studies have shown that from 43% to 76% of older people who committed suicide saw a primary care provider within 30 days of death.[7,17-19] From 19% to 49% saw a physician within one week of their suicide. These findings point to the important role primary care providers can play. Depression is a common risk factor associated with suicide in later life, yet studies have demonstrated that primary care providers have difficulty recognizing treatable depression in their patients.[20,21] Self-administered screening tools for depression have been validated for use among older primary care patients, including the Geriatric Depression Scale and the Center for Epidemiologic Studies-Depression Scale.[22,23] It has been recommended that these measures be used routinely in primary care offices.[13]

Improve Access and Links to Mental Health and Substance Abuse Services

Many individuals are at increased risk of suicide due to disparities in the health care and treatment options available to them. Lack of

transportation, conflicting schedules, stigma, cultural or language barriers, lack of health care professionals to meet the needs, and little or no insurance coverage are barriers to identifying those at risk and providing adequate health care.

To be effective, services to prevent suicide must be available when and where people need them. Ideally, a community should provide a variety of confidential services in many different places. Providing mobile services, including information, education, screening, treatment, and consultation, to the general population as well as those at highest risk is an effective way of improving access to mental health and substance abuse services. In addition, improved coordination of various community organizations is also important to ensuring that all community members receive appropriate preventive care.

►What You Can Do

Build And Strengthen Community Coalitions and Programs

Work with Turning Point coalitions or other community organizations to coordinate groups and coalitions related to suicide injury prevention, as well as organizations involved in post-suicide support of family and friends. Actively recruit individuals and organizations from all parts of the community to participate, including mental health providers, faith communities, neighborhood centers, youth groups, senior centers, substance abuse advocates and facilities, private businesses, community leaders, volunteers, emergency vehicle personnel, and health care providers among others. When possible, integrate suicide prevention into existing and ongoing programs. Train at least one member of each group to be a community advocate for suicide prevention.

Establish and Implement Screening Programs

Partner with schools, youth organizations, local mental health programs, and mental health associations to implement professionally designed mental health screening instruments to identify youth with mental illnesses associated with suicidal behaviors. Partner with schools, local physicians, and mental health providers to implement the Adopt-a-Doc/Nurse model in schools.

Implement Gatekeeper-Training Programs

Provide in-service education programs to keep school system personnel or college resident advisors trained in suicide risk identification, crisis intervention and referral. Collaborate with parent-teacher groups and schools with a common goal of implementing district wide suicide

prevention strategies, as well as student services at the college level to implement or support suicide prevention efforts. When possible, utilize existing youth programs to promote suicide prevention programs. Work with local school systems and other youth organizations to provide "gatekeeper" training for adults and staff.

Provide training for health care workers, clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide. Include training that specifically addresses needs of suicide survivors.

Implement Programs for Older Persons

Adult day care centers, home care agencies, hospices, assisted living facilities, and nursing homes are the primary caretakers of older Americans. Work with these facilities and other area aging agencies to conduct needs assessments for suicide prevention programs for their residents. Develop resource kits for service organizations that include suggestions for activities designed to strengthen feelings of connectedness. Develop and implement a training program for employees and volunteers to help identify and refer persons determined to be at risk of suicide. Increase the number of services for older people that include evidence-based suicide prevention programs designed to identify older people at risk for suicide behavior and refer them for treatment.

Support or develop outreach programs to older adults that include regularly scheduled home visits and phone calls. Grief support and counseling, as well as senior peer-counseling programs can be implemented.

Support ongoing continuing education in screening and referral for providers and the availability of licensed professionals to provide referral services.

Improve Health Care Education

Incorporate suicide risk training programs for health care professionals, including physicians, physicians' assistants, medical residents, and nursing care providers. Increase the number of clinical social work, counseling, poison control center, and psychology graduate programs that include suicide prevention training. Ensure that individuals who typically provide services to suicide survivors, including emergency medical technicians, firefighters, police, and funeral directors, have also been trained to understand and respond appropriately to their unique needs. Ensure that persons treated for trauma, sexual assault, or physical abuse in emergency departments receive mental health services.

Utilize or develop educational materials to be distributed to health care professionals and settings. Support programs to educate family members and significant others of persons receiving treatment for mental health and substance abuse disorders about the risk of suicide.

Develop guidelines for discharge planning and follow-up procedures for patients and families of those at risk to increase the number of persons who receive and maintain treatment. Train emergency room staff in the use of protocols to increase treatment adherence.

Improve Access and Coordination with Mental Health Care Services

Promote collaboration between schools and existing community providers of mental health care. Take information and services (i.e. education, screening, treatment, and consultation) to onsite locations within the community (i.e., churches, malls, schools, nursing homes, youth organizations, ball fields or county fairs).

Integrate mental health and suicide prevention into health and social services outreach programs for at-risk populations. Also, work to increase the number of school-based health centers providing mental health services.

Advocate for low- or no-cost services and more mental and substance abuse insurance coverage. Support legislation that requires health insurance plans to cover mental health and substance abuse on par with physical health care. Implement utilization management guidelines for suicidal risk in managed care and insurance plans.

►Where You Can Go

The following organizations can provide information about reducing suicide as well as links to other organizations and web sites.

State

- Injury Prevention Service Oklahoma Department of Health
  405/271-3430 or 1-800-522-0204
  www.health.state.ok.us/PROGRAM/injury

- Child and Adolescent Health Division
  405/271-4471
  www.health.state.ok.us/program/ahd/index.html

National

- National Center for Injury Prevention and Control (CDC)
  www.cdc.gov/ncipc/stateProfiles/index.htm (state injury profiles)
  www.cdc.gov/ncipc/pub-res/pubs.htm (publications and resources)
  http://www.cdc.gov/ncipc/factsheets/yvfacts.htm (fact sheets)

- American Association of Suicidology
  1-202-237-2280
  1-403-245-3900 Information Center

- American Foundation for Suicide Prevention
  www.afsp.org/index-1.htm

- Suicide Prevention Advocacy Network (SPAN USA)
  1-888-649-1366

- *National Strategy for Suicide Prevention*
  www.mentalhealth.org/suicideprevention/default.asp

Local

Local mental health associations

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