American Foundation *for* Suicide Prevention

Suicide Prevention

Saving Lives
One Community at a Time

America Foundation for Suicide Prevention
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Facing the Facts

An Overview of Suicide

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Facing the Facts

- In 2009, 36,909 people in the United States died by suicide. About every 14.2 minutes someone in this country intentionally ends his/her life.
- Although the suicide rate fell from 1992 (12 per 100,000) to 2000 (10.4 per 100,000), it has been fluctuating slightly since 2000 – despite all of our new treatments.

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Facing the Facts

- Suicide is considered to be the second leading cause of death among college students.
- Suicide is the second leading cause of death for people aged 25-34.
- Suicide is the third leading cause of death for people aged 10-24.
- Suicide is the fourth leading cause of death for adults between the ages of 18 and 65.
- Suicide is highest in white males over 85.
  (46/100,000, 2009)

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Facing the Facts

- The suicide rate was 12.0/100,000 in 2009.
- It greatly exceeds the rate of homicide. (5.5/100,000)
- From 1981-2009, 901,180 people died by suicide, whereas 463,942 died from AIDS and HIV-related diseases.

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Facing the Facts

Death by Suicide and Psychiatric Diagnosis

- Psychological autopsy studies done in various countries over almost 50 years report the same outcomes:
  - 90% of people who die by suicide are suffering from one or more psychiatric disorders:
    - Major Depressive Disorder
    - Bipolar Disorder, Depressive phase
    - Alcohol or Substance Abuse*
    - Schizophrenia
    - Personality Disorders such as Borderline PD

*Primary diagnoses in youth suicides.

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Facing the Facts

Suicide Is Not Predictable in Individuals

- In a study of 4,800 hospitalized vets, it was not possible to identify who would die by suicide — too many false-negatives, false-positives.
- Individuals of all races, creeds, incomes and educational levels die by suicide. There is no typical suicide victim.

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Facing the Facts

Suicide Communications Are Often Not Made to Professionals

- In one psychological autopsy study, only 18% told professionals of intentions*
- In a study of suicidal deaths in hospitals:
  - 77% denied intent on last communication
  - 28% had "no suicide" contracts with their caregivers" **
- Research does not support the use of no-harm contracts (NHC) as a method of preventing suicide, nor from protecting clinicians from malpractice litigation in the event of a client suicide***

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Facing the Facts

Suicide Communications ARE Made to Others

- In adolescents, 50% communicated their intent to family members*
- In elderly, 58% communicated their intent to the primary care doctor**

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Facing the Facts

Research shows that during our lifetime:

- 20% of us will have a suicide within our immediate family.
- 60% of us will personally know someone who dies by suicide.

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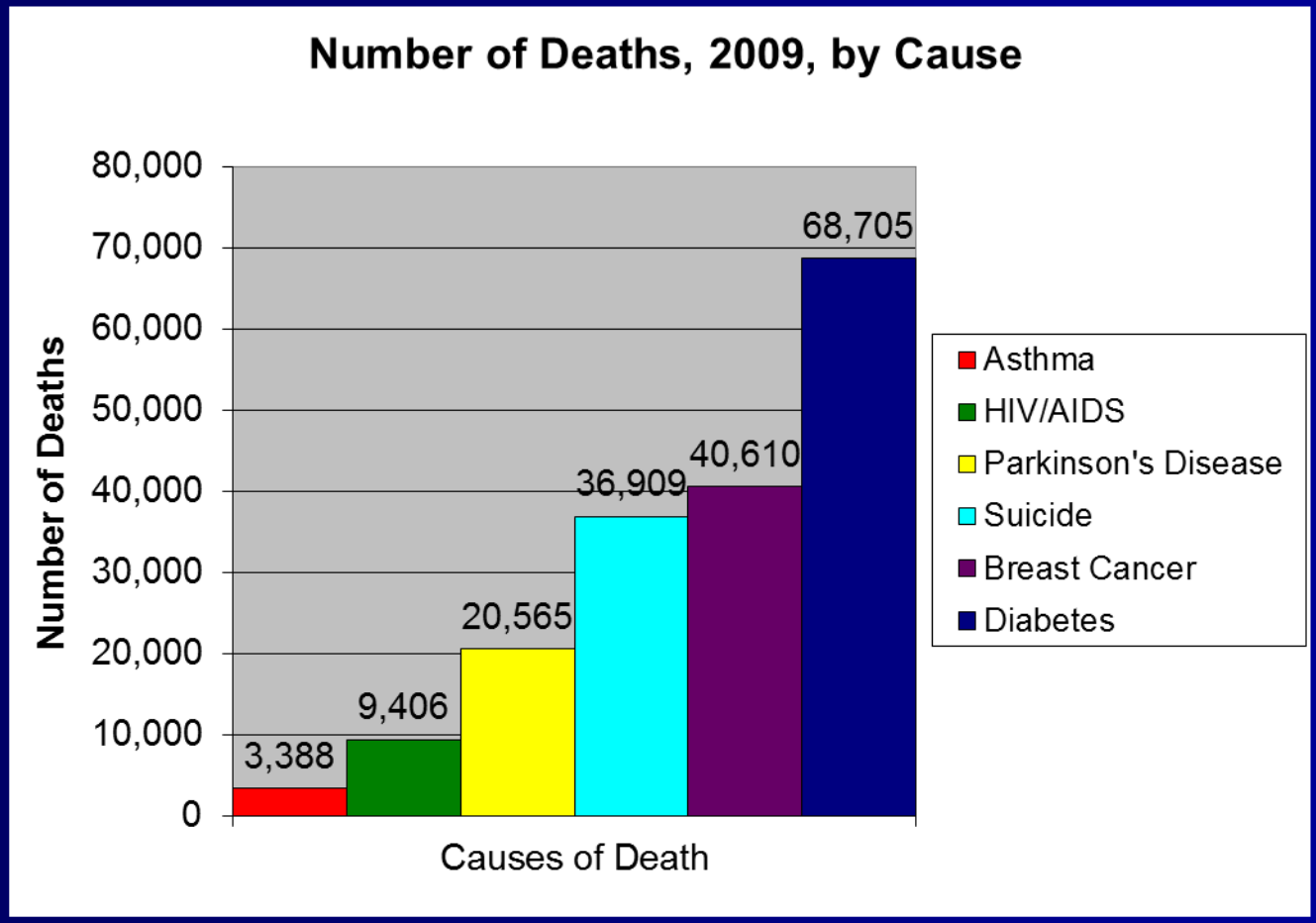
Annual Deaths, by Cause



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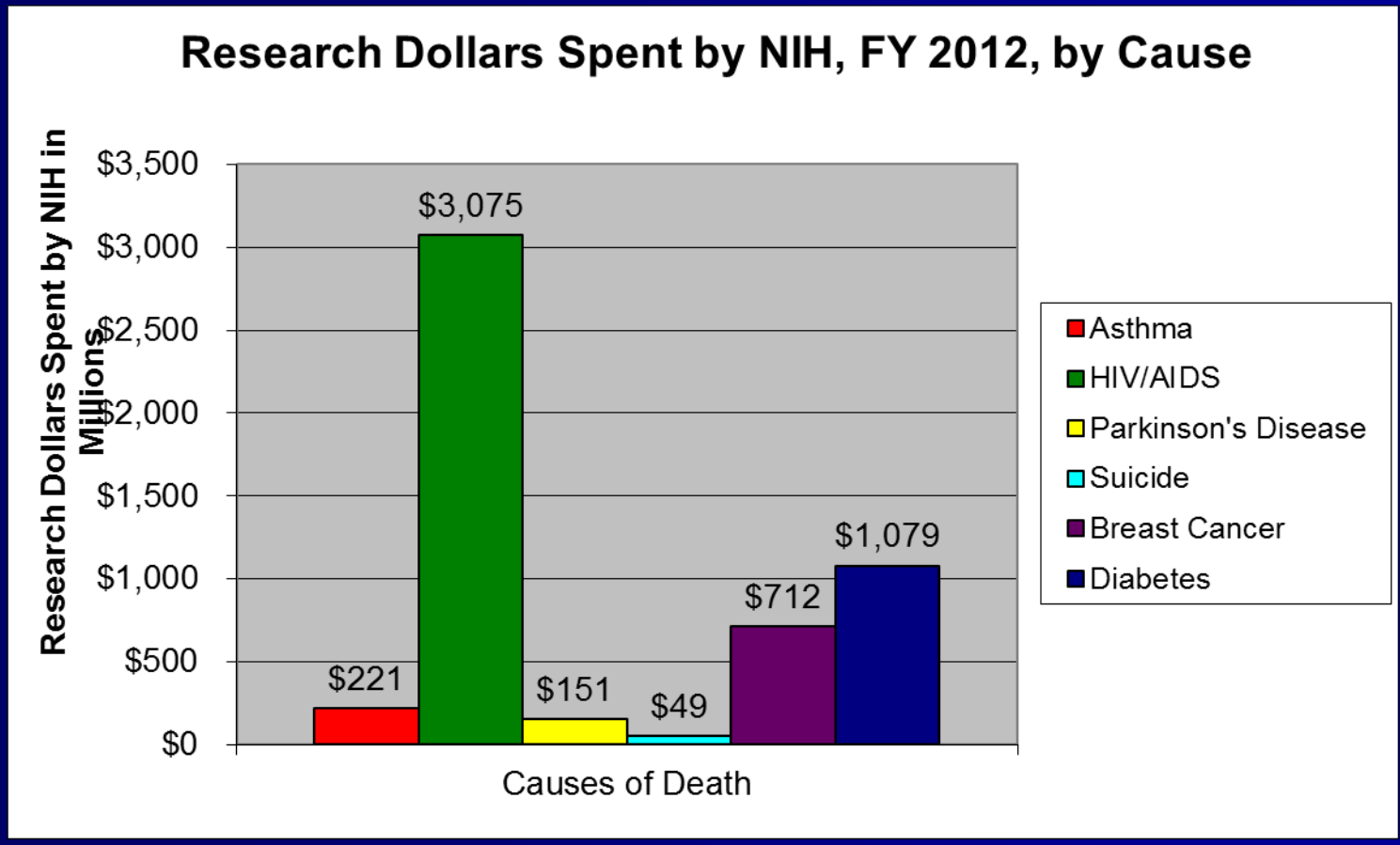
Spending for Medical Research



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Facing the Facts

Prevention may be a matter of a caring person with the right knowledge being available in the right place at the right time.

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Myths Versus Facts About Suicide

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Myths versus Facts

- **MYTH:**
  People who talk about suicide don't complete suicide.

- **FACT:**
  Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously.

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Myths versus Facts

- **MYTH:**
  Suicide happens without warning.

- **FACT**:
  Most suicidal people give clues and signs regarding their suicidal intentions.

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Myths versus Facts

- **MYTH:**
  Suicidal people are fully intent on dying.

- **FACT**:
  Most suicidal people are undecided about living or dying, which is called "suicidal ambivalence." A part of them wants to live; however, death seems like the only way out of their pain and suffering. They may allow themselves to "gamble with death," leaving it up to others to save them.

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Myths versus Facts

- **MYTH:**
  Men are more likely to be suicidal.

- **FACT:**
  Men are four times more likely to kill themselves than women.
  Women attempt suicide three times more often than men do.

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Myths versus Facts

- **MYTH:**
  Asking a depressed person about suicide will push him/her to complete suicide.

- **FACT:**
  Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.

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Myths versus Facts

- **MYTH:**

  Improvement following a suicide attempt or crisis means that the risk is over.

- **FACT**:

  Most suicides occur within days or weeks of "improvement," when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts. The highest suicide rates are immediately after a hospitalization for a suicide attempt.

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Myths versus Facts

- **MYTH:**

  Once a person attempts suicide, the pain and shame they experience afterward will keep them from trying again.

- **FACT**:

  The most common psychiatric illness that ends in suicide is Major Depression, a recurring illness. Every time a patient gets depressed, the risk of suicide returns.

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Myths versus Facts

- **MYTH:**
  Sometimes a bad event can push a person to complete suicide.

- **FACT:**
  Suicide results from having a serious psychiatric disorder. A single event may just be "the last straw."

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Myths versus Facts

- **MYTH:**

  Suicide occurs in great numbers around holidays in November and December.

- **FACT:**

  Highest rates of suicide are in May or June, while the lowest rates are in December.

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Risk Factors For Suicide

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Risk Factors

- Psychiatric disorders
- Past suicide attempts
- Symptom risk factors
- Sociodemographic risk factors
- Environmental risk factors

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Risk Factors

Psychiatric Disorders

- **Most common psychiatric risk factors resulting in suicide:**
  - Depression*
    - Major Depression
    - Bipolar Depression
  - Alcohol abuse and dependence
  - Drug abuse and dependence
  - Schizophrenia

*Especially when combined with alcohol and drug abuse

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Risk Factors

- **Other psychiatric risk factors with potential to result in suicide *(account for significantly fewer suicides than Depression):***
  - Post Traumatic Stress Disorder (PTSD)
  - Eating disorders
  - Borderline personality disorder
  - Antisocial personality disorder

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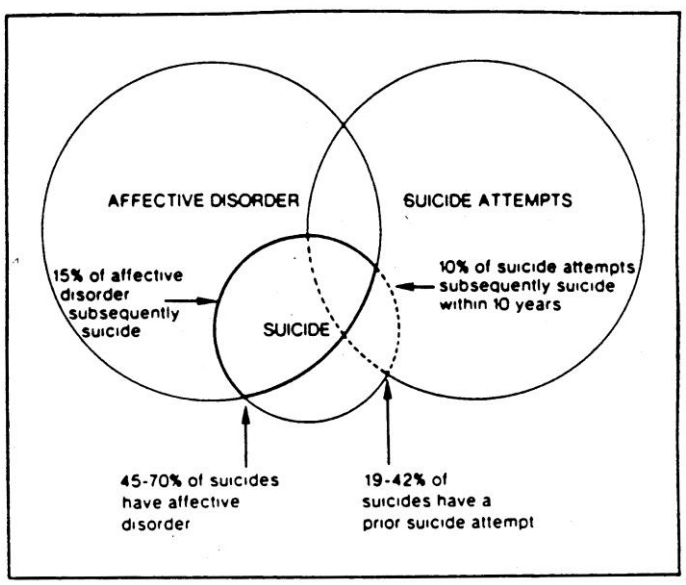
Risk Factors

Past suicide attempt

(See diagram on right)

- After a suicide attempt that is seen in the ER about 1% per year take their own life, up to approximately 10% within 10 years.
- More recent research followed attempters for 22 years and saw 7% die by suicide.



Venn diagram summarizing data concerning suicide and its relationship to affective disorder and suicide attempts.

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Risk Factors

Symptom Risk Factors During Depressive Episode:

- Desperation
- Hopelessness
- Anxiety/psychic anxiety/panic attacks
- Aggressive or impulsive personality
- Has made preparations for a potentially serious suicide attempt* or has rehearsed a plan during a previous episode
- Recent hospitalization for depression
- Psychotic symptoms (especially in hospitalized depression)

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Risk Factors

- Major physical illness, especially recent
- Chronic physical pain
- History of childhood trauma or abuse, or of being bullied
- Family history of death by suicide
- Drinking/Drug use
- Being a smoker

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Risk Factors

Sociodemographic Risk Factors

- Male
- Over age 65
- White
- Separated, widowed or divorced
- Living alone
- Being unemployed or retired
- Occupation: health-related occupations higher (dentists, doctors, nurses, social workers)
  - especially high in women physicians

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Risk Factors

Environmental Risk Factors

- Easy access to lethal means
- Local clusters of suicide that have a "contagious influence"

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Preventing Suicide
One Community at a Time

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Preventing Suicide

Prevention within our community

- Education
- Screening
- Treatment
- Means Restriction
- Media Guidelines

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Preventing Suicide

Education

- Individual and Public Awareness
- Professional Awareness
- Educational Tools

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Preventing Suicide

Individual and Public Awareness

- Primary risk factor for suicide is psychiatric illness
- Depression is treatable
- Destigmatize the illness
- Destigmatize treatment
- Encourage help-seeking behaviors and continuation of treatment

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Professional Awareness

- Healthcare Professionals
  - Physicians, pediatricians, nurse practitioners, physician assistants
- Mental Health Professionals
  - Psychologists, Social Workers
- Primary and Secondary School Staff
  - Principals, Teachers, Counselors, Nurses
- College and University Resource Staff
  - Counselors, Student Health Services, Student Residence Services, Resident Hall Directors and Advisors
- Gatekeepers
  - Religious Leaders, Police, Fire Departments, Armed Services

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Educational Tools

- Depression and suicide among college students:
  - *The Truth About Suicide: Real Stories of Depression in College* (2004)
    - Comes with accompanying facilitator's guide
- Depression and suicide among physicians and medical students:
  - *Struggling in Silence: Physician Depression and Suicide* (54 minutes)*
  - *Struggling in Silence: Community Resource Version* (16 minutes)
  - *Out of the Silence: Medical Student Depression and Suicide* (15 minutes)
    - Both shorter films are packaged together and include PPT presentations on the DVD's
- Depression and suicide among teenagers:
  - *More Than Sad: Teen Depression* (2009)**
    - Comes with facilitator's guide and additional resources
  - Suicide Prevention Education for Teachers and Other School Personnel (2010)
    - Includes new film, *More Than Sad: Preventing Teen Suicide, More Than Sad: Teen Depression*, facilitator's guide, a curriculum manual and additional resources

*received 2008 International Health & Medical Media Award (FREDDIE) in Psychiatry category
**received 2010 Eli Lilly Welcome Back Award in Destigmatization category

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Screening

- **Identify At Risk Individuals:**
  - Columbia Teen Screen and others
  - AFSP Interactive Screening Program (ISP):

    The ISP is an anonymous, web-based, interactive screen for individuals (students, faculty, employees) with depression and other mental disorders that put them at risk for suicide. ISP connects at-risk individuals to a counselor who provides personalized online support to get them engaged to come in for an evaluation. Based on evaluation findings, ISP was included in the Suicide Prevention Resource Center's Best Practice Registry in 2009. It is currently in place in 16 colleges, including four medical schools.

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Treatment

- Antidepressants
- Psychotherapy

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Preventing Suicide

Antidepressants

- **Adequate prescription treatment and monitoring**
  - Only 20% of medicated depressed patients are adequately treated with antidepressants – possibly due to:
  - Side effects
  - Lack of improvement
  - High anxiety not treated
  - Fear of drug dependency
  - Concomitant substance use
  - Didn't combine with psychotherapy
  - Dose not high enough
  - Didn't add adjunct therapy such as lithium or other medication(s)
  - Didn't explore all options including: ECT or other somatic treatment

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Psychotherapy

- **Research shows that when it comes to treating depression, all therapy is NOT created equal.**
    - Study shows applying correct techniques reduce suicide attempts by 50% over 18 month period
- **To be effective, psychotherapy must be:**
    - Specifically designed to treat depression
    - Relatively short-term (10-16 weeks)
    - Structured (therapist should be able to give step-by-step treatment instructions that any other therapist can easily follow)
- **Examples: C**ognitive **B**ehavior **T**herapy (CBT), **I**nter**p**ersonal **T**herapy (IPT), **D**ialectical **B**ehavior **T**herapy (DBT)
- **Implement teaching of these techniques**

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Means Restrictions

- Firearm safety
- Construction of barriers at jumping sites
- Detoxification of domestic gas
- Improvements in the use of catalytic converters in motor vehicles
- Restrictions on pesticides
- Reduce lethality or toxicity of prescriptions
  - Use of lower toxicity antidepressants
  - Change packaging of medications to blister packs
  - Restrict sales of lethal hypnotics (i.e. Barbiturates)

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Preventing Suicide

Media

- **Guidelines**
- **Considerations**

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Preventing Suicide

Media Guidelines

- Encourage implementation of responsible media guidelines for reporting on suicide, such as those developed by AFSP in partnership with government agencies and private organizations.

Reporting on Suicide: recommendations for the media

Can be found on AFSP website:
www.afsp.org/media

RECOMMENDATIONS FOR REPORTING ON SUICIDE

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.

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.

Suicide Contagion or "Copycat Suicide" occurs when one or more suicides are reported in a way that contributes to another suicide.

References and additional information can be found at: www.ReportingOnSuicide.org.

INSTEAD OF THIS:	DO THIS:
Big or sensationalistic headlines, or prominent placement (e.g., "Kurt Cobain Used Shotgun to Commit Suicide").	Inform the audience without sensationalizing the suicide and minimize prominence (e.g., "Kurt Cobain Dead at 27").
Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.	Use school/work or family photo; include hotline logo or local crisis phone numbers.
Describing recent suicides as an "epidemic," "skyrocketing," or other strong terms.	Carefully investigate the most recent CDC data and use non-sensational words like "rise" or "higher."
Describing a suicide as inexplicable or "without warning."	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.
"John Doe left a suicide note saying..".	"A note from the deceased was found and is being reviewed by the medical examiner."
Investigating and reporting on suicide similar to reporting on crimes.	Report on suicide as a public health issue.
Quoting/interviewing police or first responders about the causes of suicide.	Seek advice from suicide prevention experts.
Referring to suicide as "successful," "unsuccessful" or a "failed attempt."	Describe as "died by suicide" or "completed" or "killed him/herself."

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Media Considerations

- **Consider how suicide is portrayed in the media**
  - TV
  - Movies
  - Advertisements
- **The Internet danger**
  - Suicide chat rooms
  - Instructions on methods
  - Solicitations for suicide pacts.

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You Can Help!

Adapted with permission from the Washington Youth Suicide Prevention Program

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You Can Help

- **Know warning signs**
- **Intervention**

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You Can Help

- Most suicidal people don't really want to die – they just want their pain to end
- About 80% of the time people who kill themselves have given definite signals or talked about suicide

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Warning Signs

- **Observable signs of serious depression**
  - Unrelenting low mood
  - Pessimism
  - Hopelessness
  - Desperation
  - Anxiety, psychic pain, inner tension
  - Withdrawal
  - Sleep problems
- **Increased alcohol and/or other drug use**
- **Recent impulsiveness and taking unnecessary risks**
- **Threatening suicide or expressing strong wish to die**
- **Making a plan**
  - Giving away prized possessions
  - Purchasing a firearm
  - Obtaining other means of killing oneself
- **Unexpected rage or anger**

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Proposed DSM-V Suicide Assessment Dimension

Level of concern about potential suicidal behavior: (sum of items coded as present) 1. 0: Lowest concern 2. 1-2: Some concern 3. 3-4: Increased concern 4. 5-7: High concern		Suicide risk factor groups: 1. Any history of a suicide attempt 2. Long-standing tendency to lose temper or become aggressive with little provocation 3. Living alone, chronic severe pain, or recent (within 3 months) significant loss 4. Recent psychiatric admission/discharge or first diagnosis of MDD, bipolar disorder or schizophrenia 5. Recent increase in alcohol abuse or worsening of depressive symptoms 6. Current (within last week) preoccupation with, or plans for, suicide 7. Current psychomotor agitation, marked anxiety or prominent feelings of hopelessness

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Intervention

Three Basic Steps:

1. **Show you care**
2. **Ask about suicide**
3. **Get help**

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Intervention: Step One

- **Show You Care**
- **Be Genuine**

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You Can Help

- **Show you care**
  - **Take ALL talk of suicide seriously**
    - If you are concerned that someone may take their life, trust your judgment!
  - **Listen Carefully**
  - **Reflect what you hear**
  - **Use language appropriate for age of person involved**
    - Do not worry about doing or saying exactly the "right" thing. Your genuine interest is what is most important.

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- **Be Genuine**
  - **Let the person know you really care. Talk about your feelings and ask about his or hers.**
    - "I'm concerned about you… how do you feel?"
    - "Tell me about your pain."
    - "You mean a lot to me and I want to help."
    - "I care about you, about how you're holding up."
    - "I'm on your side…we'll get through this."

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Intervention: Step Two

- **Ask About Suicide**
- **Be direct but non-confrontational**

- **Talking with people about suicide won't put the idea in their heads.** Chances are, if you've observed any of the warning signs, they're already thinking about it. Be direct in a caring, non-confrontational way. Get the conversation started.

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- You do not need to solve all of the person's problems – *just engage them.* Questions to ask:
  - Are you thinking about suicide?
  - What thoughts or plans do you have?
  - Are you thinking about harming yourself, ending your life?
  - How long have you been thinking about suicide?
  - Have you thought about how you would do it?
  - Do you have __? (Insert the lethal means they have mentioned)
  - Do you really want to die? Or do you want the pain to go away?

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You Can Help

- Ask about treatment:
  - Do you have a therapist/doctor?
  - Are you seeing him/her?
  - Are you taking your medications?

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Intervention: Step Three

- **Get help, *but do NOT leave the person alone***
  - Know referral resources
  - Reassure the person
  - Encourage the person to participate in helping process
  - Outline safety plan

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You Can Help

Know Referral Resources

- **Resource sheet**
- **Hotlines**

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Resource Sheet

- **Create referral resource sheet from your local community**
  - Psychiatrists
  - Psychologists
  - Other Therapists
  - Family doctor/pediatrician
  - Local medical centers/medical universities
  - Local mental health services
  - Local hospital emergency room
  - Local walk-in clinics
  - Local psychiatric hospitals

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Hotlines

- **National Suicide Prevention Lifeline**
  - **1-800-273-TALK**
  - **www.suicidepreventionlifeline.org**
- **911**
  - **In an acute crisis, call 911**

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You Can Help

- **Reassure the person that help is available and that you will help them get help:**
  - "Together I know we can figure something out to make you feel better."
  - "I know where we can get some help."
  - "I can go with you to where we can get help."
  - "Let's talk to someone who can help . . . Let's call the crisis line now."
- **Encourage the suicidal person to identify other people in their life who can also help:**
  - Parent/Family Members
  - Favorite Teacher
  - School Counselor
  - School Nurse
  - Religious Leader
  - Family doctor

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You Can Help

- **Outline a safety plan**
  - Make arrangements for the helper(s) to come to you OR take the person directly to the source of help - do NOT leave them alone!
  - Once therapy (or hospitalization) is initiated, be sure that the suicidal person is following through with appointments and medications.