This topic-specific chapter is an excerpt from the Washington State Injury and Violence Prevention Guide, January 2013, DOH 530-090. For complete reference and to view the Guide in its entirety, please visit www.doh.wa.gov/Portals/1/Documents/2900/InjuryReportFinal.pdf.

SUICIDE

DESCRIPTION:
Suicide means the intentional killing of oneself. Attempted suicide means trying to kill oneself without completing suicide.

Washington State Goal Statement

To decrease deaths and hospitalizations due to suicide and suicide attempts

National Healthy People 2020 Objectives

- Reduce the suicide rate from 11.3 in 2007 to no more than 10.2 per 100,000.
- Reduce the rate of suicide attempts by adolescents in grades 9–12 from 1.9 in 2009 to 1.7 per 100,000.

Statement of the Problem in Washington State

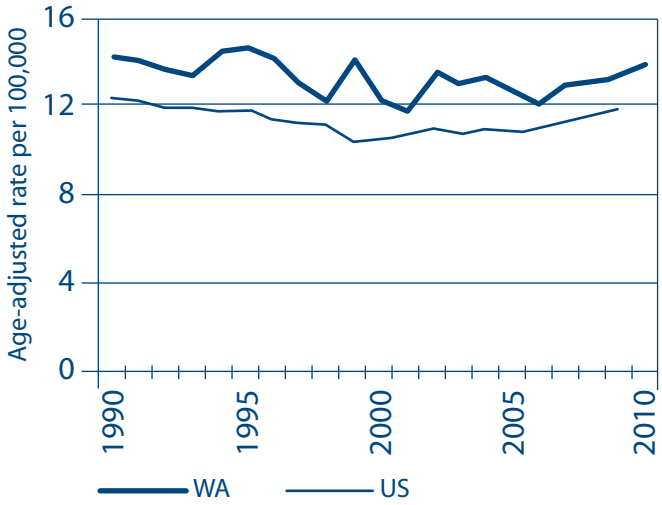
Washington State Data

In 2010, 947 Washington State residents committed suicide or died from self-inflicted injury. Suicide is the eighth leading cause of death for residents of all ages and the second leading cause among youth ages 15–24.

In 2010 in Washington State, the leading suicide methods were: firearms (49 percent), poisoning (22 percent), and suffocation (19 percent).

Between 1990 and 2010, there was a slight decline in Washington State's suicide rate. This decline is the result of higher suicide rates during the 1990s, and lower rates during most of the 2000s. In 2009, the U.S. suicide rate was 12 per 100,000. Washington State's rate in the same year was 14 per 100,000. This is consistent with the national finding that suicide rates are generally higher than the national average in the states west of the Rocky Mountains.[1]

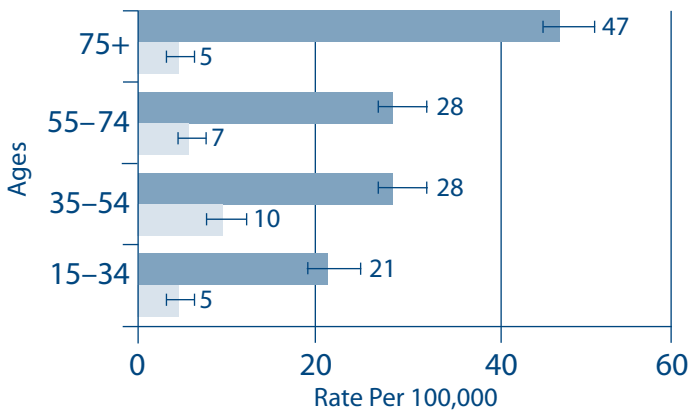
Suicide Deaths
Washington State & United States Death Certificates, 1990–2010



Age and Gender

From 2008–2010, men accounted for 78 percent of completed suicides. Men ages 75 and older had the highest suicide rates. Although older men's rates are

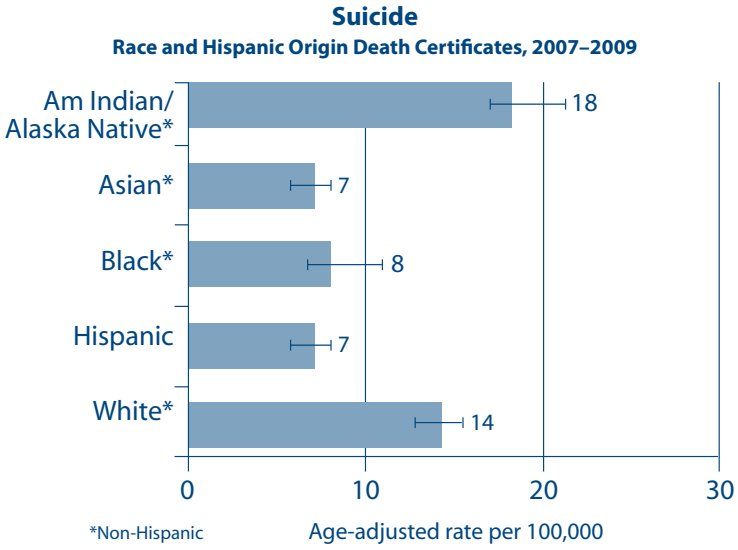
Suicide
Age and Gender Death Certificates, 2008–2010



the highest, men ages 35–54 have the highest number of suicides. The chart does not include age groups with fewer than 20 deaths.

Race and Ethnicity

In 2007–2009, age-adjusted suicide rates were highest for American Indians and Alaska Natives, and then whites. The interactions of race, ethnicity, poverty, and education for suicide have not been widely researched.



Non-fatal Suicide Attempts

In 2010, there were 3,730 hospitalizations in Washington for nonfatal suicide attempts. Women had a higher rate of hospitalizations for suicide attempts (69 per 100,000) compared to men (43 per 100,000).

In the 2010 Healthy Youth Survey, 18 percent of Washington State 10th graders reported they had seriously considered attempting suicide in the past year; 12 percent reported having a plan for their suicide attempts.

Washington adults, age 18 or older, were more likely to have serious suicidal thoughts (5 percent) in 2008–2009 compared to the national average. They were also more likely to make a plan (1.4 percent) or attempt suicide (0.7 percent). The West and Midwest had higher prevalence compared to other regions of the U.S.[2]

Depression Data

Depression contributes to suicide. In 2010, about 30 percent of 10th graders (about 24,000 youth) reported that at some point in the past year they had been depressed. These youth reported that they had been sad or hopeless almost every day for two weeks or more in a row. As a result of these feelings, they stopped doing their usual activities. About 15 percent of 10th graders, or around 12,000 youth, reported having no adults to turn to when they were depressed. About 42 percent of these youth reported they would be very unlikely to seek help if they were feeling depressed or suicidal. This translates to about 5,000 youth who would not seek help for themselves.

Risk and Protective Factors

The U.S. Department of Health and Human Services included a comprehensive list of suicide risk and protective factors in the Surgeon General's 2012 National Strategy for Suicide Prevention.[3]

The 2012 Surgeon General's report addresses risk factors related to populations at higher risk. Risks associated with suicide and suicidal behaviors include:

- Individuals with mental and/or substance use disorders
- Individuals bereaved by suicide
- Individuals in justice and child welfare settings
- Individuals who engage in nonsuicidal self-injury
- Individuals who have attempted suicide
- Individuals with medical conditions
- Individuals who are lesbian, gay, bisexual, or transgender (LGBT)
- Individuals with easy access to lethal methods
- Individuals with family history of suicide
- Individuals in high conflict or violent relationships
- Individuals with barriers to healthcare (e.g., lack of access to providers or medication)
- Individuals with few available sources of supportive relationships
- American Indians/Alaska Natives
- Members of the Armed Forces and veterans
- Men in midlife
- Older men

Protective factors for suicide include:

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical (including mental health) services and support
- Social connectedness, and family and community support
- Support from ongoing medical and mental healthcare relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts

The Surgeon General's 2012 National Strategy for Suicide Prevention[3] recommends a comprehensive approach to prevent suicide. This includes promoting health and empowerment, implementing clinical and community preventive services, and improving treatment and support. The National Strategy also states that suicide has many of the same risk and protective factors as interpersonal violence and other related problems. Therefore, efforts to address suicide risk and protective factors are also likely to help prevent these other problems as well. Two recent reports developed in 2010[4] and 2011[5] provide recommendations on the latest strategies for suicide prevention.

Recommended Strategies

Promising Strategies

Increasing awareness of suicide risk factors and how to respond

It is recommended that public and healthcare providers be made more aware of suicide and its risk and protective factors. Messages should focus on promoting help-seeking behavior and available resources. Messages should also emphasize that mental illness is treatable. Since no single message works for everyone, awareness campaigns should be tailored to many different audiences. An example is the Toolkit on Suicide Prevention for Senior Living Communities.[6] Awareness efforts are likely to be more effective when used as part of a comprehensive suicide prevention program.

"Gatekeepers" are community members or professionals, such as teachers and nurses, who have contact with people at risk for suicide. Improving the ability of gatekeepers to recognize the signs, and respond to suicide risk, supports early intervention. Counselors Care and Coping and Support Training (C-care/Cast)[7, 8] is recognized as an effective school-based program to decrease suicide risk factors and increase protective factors. Training military personnel and doctors has reduced suicidal ideation, suicide attempts and deaths.[9] Washington State recently passed legislation requiring certain health professionals to complete suicide prevention training as part of licensing requirements.[10]

Promoting protective factors

Several promising strategies focus on strengthening suicide protective factors such as social connectedness and problem-solving skills. Examples include school-based programs such as American Indian Life Skills Development, CAST (Coping And Support Training), and Reconnecting Youth. These programs provide education and skill-building activities over multiple sessions. Outcomes include reduced depression, hopelessness, anger and anxiety, lower drug involvement, and improved self-esteem and social support.[11, 8, 12]

Crisis call centers

The National Suicide Prevention Lifeline (1-800-273-TALK) serves as a central switchboard connecting callers to their local crisis center. One study found that crisis call hotlines were effective in reducing emotional distress among crisis callers.[13] They also significantly reduced suicidality among suicidal callers. The quality of services provided has been shown to vary across centers. Standards for suicide risk assessment might help ensure that all callers receive quality service.[14]

Restricting access to lethal means

Many people who attempt suicide are unsure about it or are acting on an impulse during a short period of crisis.[15] Those who have easy access to a highly lethal weapon, such as a firearm, are at higher risk for completed suicide.[16] For these reasons, the National Strategy for Suicide Prevention promotes reducing access to lethal means. Two evidence-based programs have been shown to be effective in the emergency department setting. One program provides lethal means restriction education for parents of youth who are seen in emergency departments for mental health assessment or treatment.[17] The other program is a multi-component intervention for female adolescent suicide attempters and their mothers.[18]

System changes

Some promising new strategies have combined organizational culture change, staff training and systems change for suicide prevention. Organizational culture change is needed to reinforce the idea that suicide can be prevented and encourage implementation of prevention programs.

Here are two examples:

The Henry Ford Health System implemented several system changes to prevent suicide among its members. They began universal suicide risk screening in their primary care clinics and created care plans based on patients' risk. They increased partnership with patients for treatment planning and care. They also improved access to immediate psychiatric care for patients in need. Clinicians were provided with increased training in Cognitive Behavioral Therapy. Within four years of implementing these changes, the suicide rate among its members had dropped by 75 percent.[19]

The Air Force Suicide Prevention Initiative created a culture change in the Air Force that dropped the suicide rate by one-third over six years. Strategies included clear and consistent communication from committed top leadership and training for all members. They also created privileged communication rights for members and encouraged mutual responsibility.[20]

Improving access to mental health services

Healthcare providers should be aware of community resources for treating substance abuse, depression, and other mental illness. An example of a suicide prevention program for primary care providers that shows promise is PROSPECT.[21, 22] PROSPECT provides guidelines for treatment and care management for adults ages 60 and older diagnosed with depression. Co-management of high risk patients by mental health and primary care physicians[23] is another promising practice. Integrating suicide prevention treatment with substance abuse treatment has also shown promise in reducing suicide. 2010 federal legislation made mental health benefits equitable with other medical benefits within group health insurance plans. This made mental health services more affordable.

For More Information

Washington State

Washington State Healthy Youth Survey
www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/HealthyYouthSurvey.aspx

Washington State Department of Health, Health of Washington State
www.doh.wa.gov/DataandStatisticalReports/HealthofWashingtonStateReport.aspx

Washington State Department of Health, Youth Suicide Prevention
www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/YouthSuicidePrevention.aspx

Washington State Youth Suicide Prevention Program
www.yspp.org

National

Centers for Disease Control, Preventing Suicide
www.cdc.gov/ViolencePrevention/suicide/index.html

Kids Health, *Understanding and Preventing Teen Suicide*
www.kidshealth.org/parent/emotions/behavior/suicide.html

National Adolescent Health Information Center
http://nahic.ucsf.edu/downloads/Suicide.pdf

National Suicide Prevention Lifeline: 1-800-273-TALK

Suicide Prevention Resource Center
www.sprc.org

National Institute of Mental Health
www.nimh.nih.gov

National Mental Health Association
www.thenationalcouncil.org/

National Suicide Prevention Lifeline: 1-800-273-TALK

National Strategy for Suicide Prevention
www.samhsa.gov/prevention/suicide.aspx

Endnotes

[1] Division of Violence Prevention, Centers for Disease Control and Prevention, Regional Variations in Suicide Rates–United States, 1990-1994. MMWR, 1997, Vol. 46, No. 34, pp. 789-793.

[2] A.E. Crosby et al., "Suicidal thoughts and behaviors among adults aged ≥18 years–United States, 2008-2009," MMWR, 2011, Vol. 60, No. 13, pp. 1-22.

[3] Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, 2012*, Washington, DC.

[4] Charting the Future of Suicide Prevention, 2010, www.sprc.org/sites/sprc.org/files/library/ChartingTheFuture_Fullbook.pdf, accessed on May 1, 2012.

[5] Suicide Care in Systems Framework, 2011, http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf, accessed on May 1, 2012.

[6] Substance Abuse and Mental Health Services Administration, *Toolkit on Suicide Prevention for Senior Living Communities*, 2010, http://content.govdelivery.com/bulletins/gd/USSAMHSA-6e9b8, accessed on June, 2012.

[7] L.L. Eggert et al., "A measure of adolescent potential for suicide (MAPS): Development and preliminary findings," 1994, Suicide and Life-Threatening Behavior, Vol. 24, pp. 359-381.

[8] E.A. Thompson et al., "Evaluation of indicated suicide risk prevention approaches for potential high school dropouts," 2001, American Journal of Public Health, Vol. 91, No. 5, pp. 742-752.

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[10] Summary of bill found at http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2366&year=2011.

[11] T. LaFromboise & Howard-Pitney, B, "The Zuni Life Skills Development curriculum: Description and evaluation of a suicide prevention program," 1995, Journal of Counseling Psychology, Vol. 42, No. 4, pp. 479-486.

[12] L.L. Eggert et al., "Reducing suicide potential among high-risk youth: Tests of a school-based prevention program," 1995, Suicide and Life-Threatening Behavior, Vol. 25, No. 2, pp. 276-296.

[13] M.S. Gould et al., "An Evaluation of Crisis Hotline Outcomes: Part 2:Suicidal Callers," 2007, Suicide and Life-Threatening Behavior, Vol. 37, No. 3, pp. 338-352.

[14] T. Joiner et al., "Establishing Standards for the Assessment of Suicide Risk among Callers to the National Suicide Prevention Lifeline," 2007, Suicide and Life-Threatening Behavior, Vol. 37, No. 3, pp. 353-365.

[15] O.R. Simon et al., "Characteristics of Impulsive Suicide Attempts and Attempters," 2001, Suicide and Life-Threatening Behavior, Vol. 32 (Suppl.), pp. 49–59.

[16] A.L. Beautrais et al., "Access to Firearms and the Risk of Suicide: A Case Control Study," 1996, Australian and New Zealand Journal of Psychiatry, Vol. 30, pp. 741-748.

[17] M.J.P. Kruesi et al., "Suicide and violence prevention: Parent education in emergency department," 1999, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 38, No. 3, pp. 250-255.

[18] M.J. Rotheram-Borus et al., "The 18-month impact of an emergency room intervention for adolescent female suicide attempters," 2000, Journal of Counseling and Clinical Psychology, Vol. 68, No. 6, pp. 1081-1093.

[19] B.K. Ahmedani et al., "Suicide thoughts and attempts and psychiatric treatment utilization: informing prevention strategies," 2012, Psychiatr Serv, Vol. 63, No. 2, pp.186-189.

[20] K.L. Knox et al., "Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study," 2003, BMJ, Vol. 327, No. 7428, p.1376.

[21] H.C. Schulberg et al., the PROSPECT Group, "Managing late-life depression in primary care practice: A case study of the Health Specialist's role, 2001, International Journal of Geriatric Psychiatry, Vol. 16, pp. 577-584.

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[23] Western Interstate Commission for Higher Education (WICHE) Mental Health Program and Suicide Prevention Resource Center, 2009, "Suicide Prevention Toolkit for Rural Primary Care," www.sprc.org/library/primer.pdf, accessed on September 17, 2012.