

SUICIDE

DESCRIPTION:

Suicide means the intentional killing of one's self. Attempted suicide means trying to kill one's self without completing the act of suicide. Data reflects actual deaths and hospitalizations due to suicide and attempted suicide.



Washington State Goal Statement

To decrease deaths and hospitalizations due to suicide and suicide attempts

National Healthy People 2010 Objectives

- Reduce the suicide rate from 11.3 in 1998 to no more than 5.0 per 100,000 in 2010
- Reduce the rate of suicide attempts by adolescents in grades 9-12 from 2.6 in 1999 to no more than 1.0 in 2010

Statement of the Problem in Washington State

In 2006, 796 Washington State residents committed suicide or died from self-inflicted injury. Suicide is the eighth leading cause of death for all residents and the second leading cause among youth ages 15-24.

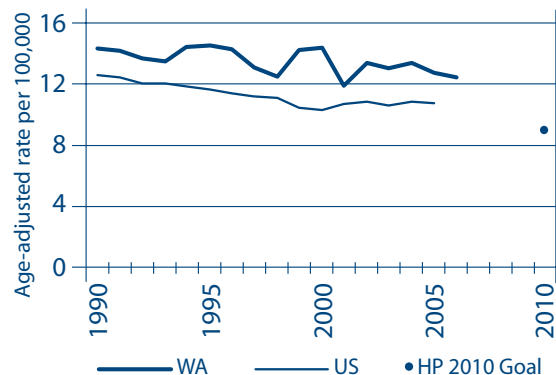
In 2006 in Washington State, the leading suicide methods were firearms (49%), poisoning (22%), and suffocation (19%).

Washington State Data

Between 1980 and 2006, Washington State's age-adjusted suicide rate declined slightly from 14 per 100,000 to 12 per 100,000.

In 2005, the U.S. age-adjusted suicide rate was 11 per 100,000. Washington State's rate in the same year was 13 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

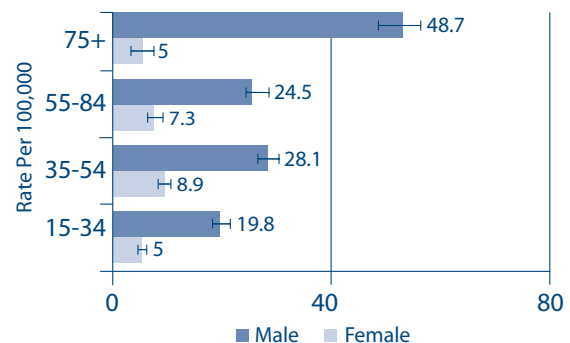
Suicide Deaths
Washington State & United States Death Certificates, 1990-2006



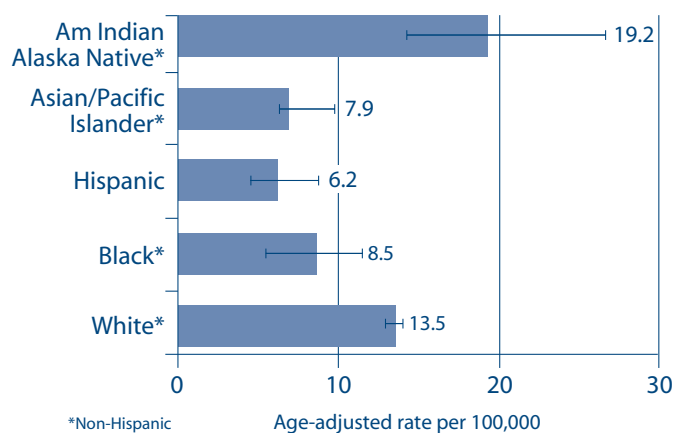
Age and Gender

From 2004-2006, men in Washington State accounted for 78% of completed suicides. Men ages 75 and older had the highest suicide rates. Although elderly men's rates are the highest, men ages 35-54 have the highest number of suicides. Residents younger than 15 had fewer than 20 deaths. The chart does not include them.

Suicide
Age and Gender
Death Certificates, 2004-2006



Suicide
Race and Hispanic Origin
Death Certificates, 2004-2006



Race and Ethnicity

In 2004-2006, 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 2006, there were 3,526 hospitalizations in Washington for nonfatal suicide attempts, for a rate of 55 per 100,000. Women had a higher rate of hospitalized suicide attempts at 65 per 100,000 than did men, 45 per 100,000. The number of patients treated but not hospitalized is much higher. Nationally, the 2006 rate for nonfatal suicide attempts treated in a hospital emergency room was 133 per 100,000.² This rate is 12 times higher than the national rate for completed suicides.

In the 2006 Healthy Youth Survey, 15% of Washington State 10th graders reported they had considered attempting suicide in the past year and 12% reported having a plan for their suicide attempts.

Economic Cost

Family members of those who have killed themselves experience significant emotional pain. Those who have attempted suicide experience both emotional and physical pain. These cannot be quantified. But financial costs can be measured.

The estimated total economic burden of suicide in the United States in 1995 was \$111 billion. This figure includes medical expenses of \$4 billion, work-related losses of \$27 billion, and quality of life costs of \$80 billion.³ These figures might underestimate the true costs because suicide deaths are not always reported.

Depression Data

Depression contributes to suicide. In 2006, about 30% of 10th graders (about 28,000 youth) reported that at some point in the past year they had been so sad or hopeless almost every day for two weeks or more in a row that they stopped doing their usual activities. About 16% of 10th graders – or around 15,000 youth – reported having no adults to turn to when they were depressed. About 43% of these youth reported it would be very unlikely for them to seek help if they were feeling depressed or suicidal. This translates to about 6,400 youth who would not seek help for themselves.

In a 2006 survey of Washington adults, about 16% of adults ages 18 and over – or around 750,000 adults – reported mild depression. Almost 7%, about 318,000 adults, reported either moderate or severe depression.

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 National Strategy for Suicide Prevention.⁴ Risks associated with suicide and suicidal behaviors include:

- Previous suicide attempt(s).
- History of mental disorders, particularly depression.
- History of alcohol and substance abuse.
- Family history of suicide.
- History of child maltreatment.
- Feelings of hopelessness.
- Impulsive or aggressive tendencies.
- Barriers to accessing mental health treatment.
- Personal losses (relational, social, work, or financial).
- Physical illness.
- Easy access to lethal methods.
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or suicidal thoughts.
- Cultural and religious beliefs – for instance, the belief that suicide is a noble resolution of a personal dilemma.
- Local epidemics of suicide.
- Feeling cut off from other people.

Protective factors include:

- Effective clinical care for mental, physical, and substance abuse disorders.
- Easy access to a variety of clinical interventions, including mental health services, and support for help seeking.

- Family and community support.
- Support from ongoing medical and mental health care 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 Call to Action To Prevent Suicide*⁵ says the most promising way to prevent suicide and

suicidal behavior is a multifaceted approach. This would include prevention, early recognition and treatment of depression and other psychiatric illnesses, and other strategies, including limiting access to lethal means. Both the *National Strategy for Suicide Prevention*⁴ and the Institute of Medicine's (IOM) report, *Reducing Suicide: A National Imperative*⁶ were developed in response to the *Call to Action*. These documents recommend strategies to increase awareness, improve intervention, and new research to reduce suicide.

Recommended Strategies

Evidence-Based Strategies

Treat and care for depressed older adults

Primary care providers can use PROSPECT^{7,8} which provides guidelines for treatment and care management for community-dwelling adults ages 60 and older who have been diagnosed with depression.

Reduce future risk among suicide attempters in emergency rooms

For health care providers working in an emergency room setting, evidence-based programs include lethal means restriction education for parents of youth who are seen in emergency rooms for mental health assessment or treatment⁹ and an intervention for female adolescent suicide attempters and their mothers.¹⁰

Train gatekeepers who work with youth

School personnel and other adults who work with youth should receive training to recognize the warning signs, and to intervene. Counselors Care and Coping and Support Training (C-care/Cast)^{11,12} is recognized as an effective school-based intervention to decrease suicide risk factors and increase protective factors.

Promising or Experimental Strategies

Raise awareness that suicide is a preventable

Work with local media to increase public awareness by developing and disseminating public service announcements.

Establish local coalitions to promote suicide prevention and to maximize the effectiveness of key public service announcement messages in communities.

Use information technology to expand public and professional awareness of the facts behind suicide and suicide prevention. Use existing web sites,

host webinars, and use other means to share information widely.

Health care providers can play an important role in the early identification and treatment of people who are suicidal. Health care providers need to be aware of community resources for treating substance abuse, depression, and other mental illness.

Promote education and training

Provide training to recognize both at-risk behavior and effective treatment. Conduct suicide prevention educational presentations for anyone who either works with or knows people at risk of suicide. Also include those who work with specific populations at risk. Presentations are designed to:

- Enhance awareness about suicide.
- Teach the warning signs of suicidal thinking and behavior (www.yspp.org/warningSigns/warningSigns.htm).
- Teach three basic intervention skills (www.yspp.org/warningSigns/whatToDo.htm) – show you care, ask the question, and get help – that can prevent a suicidal death.

Provide enhanced training for gatekeepers. This includes, for example, people who work with or lead activities with people in specific target populations. This training would cover the warning signs and how to respond. In Washington State, gatekeepers can include:

- Teachers.
- Counselors, psychologists and counselors.
- Nurses and other health care professionals.
- Law enforcement and first responders.
- Social workers.
- Clergy.
- Recreation workers.

Promote access to mental health care

For suicidal people, promote changes in the mental health system that lead to better access to care.

This includes:

- Making payment changes to support mental health care.
- Increasing the number of public and private mental health care providers who can assess and treat suicidal behavior.
- Increasing the number of practitioners who have priority openings in their practices for people in a suicidal crisis.

Establish relationships with local and statewide substance abuse prevention and provider leaders. Develop memorandums of agreement to coordinate care and follow-up needs with emergency departments.

Reduce access to lethal means of committing suicide

Train health care and mental health care providers when working with a suicidal patient or client to screen for access to lethal means.

Promote the LOK-IT-UP Campaign, which describes the safe storage or removal of firearms in the home. This is

especially important when someone is depressed or suicidal.

Encourage packaging and distribution of prescription and non-prescription drugs in limited dosages. Help promote a coordinated method for tracking prescription medication being dispensed across the state.

Gain broad support for suicide prevention, and enhance and support surveillance systems

Integrate suicide prevention activities into ongoing programs and activities. In Washington, establish a statewide coalition to implement the National Strategy for Suicide Prevention. Include private and public sectors, and ensure strong suicide survivor representation.

Improve and expand surveillance systems for suicide and suicidal behaviors throughout Washington State by:

- Supporting Child Death Review Teams.
- Establishing emergency department suicide attempt reporting.
- Establishing consistent coroner and medical examiner reporting requirements.

For More Information

Washington State

Washington State Healthy Youth Survey Website:
www3.doh.wa.gov/HYS/

The Washington State Department of Health, Health of Washington State

www.doh.wa.gov/HWS

Washington State Youth Suicide Prevention Program Website:

www.yspp.org

National

American Academy of Child and Adolescent Psychiatry, Go to Facts for Families, Teen Suicide, (Fact Sheet #10)

www.aacap.org

American Academy of Pediatrics, Some Things You Should Know About Preventing Teen Suicide

www.aap.org/advocacy/childhealthmonth/prevteensuicide.htm

Centers for Disease Control

www.cdc.gov/ncipc/factsheets/suicide-prevention.htm and
www.cdc.gov/ncipc/dvp/Preventing_Suicide.pdf

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

Knox, K. L., Doll, L.S., Bonzo, S. Mercy, J., & Sleet, D. (2006). Interventions for Suicide, Handbook of Injury and Violence Prevention, Springer, New Jersey

National Adolescent Health Information Center
<http://nahic.ucsf.edu/downloads/suicide.pdf>

National Institute of Mental Health
www.nimh.nih.gov/suicideprevention/suifact.cfm

National Mental Health Association
www.mentalhealth.org/suicideprevention/concerned.asp

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

National Strategy for Suicide Prevention
www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp

Suicide Prevention Resource Center
www.sprc.org

Endnotes

- ¹ Division of Violence Prevention, Centers for Disease Control and Prevention. (August 1997). Regional Variations in Suicide Rates – United States, 1990-1994. *Mortality and Morbidity Weekly Report*, 46(34), 789-793.
- ² Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. (2008). Web-based injury statistics query and reporting system (WISQRAS). Retrieved February, 2008 from www.cdc.gov/ncipc/wisqars.
- ³ Miller, T., Covington, K. & Jensen, A. (1999). Costs of injury by major cause, United States, 1995: Cobbling together estimates in measuring the burden of injuries. In S. Mulder & E.F. van Beeck (Eds.), *Proceedings of a conference in Noordwijkerhout*, May 13-15, 1998 (pp. 23-40). Amsterdam: European Consumer Safety Association.
- ⁴ *National Strategy for suicide prevention: Goals and objectives for action*. (2001). Rockville, MD: United States Department of Health and Human Services, Public Health Service. Retrieved on January 15, 2007 from <http://mentalhealth.samhsa.gov/suicideprevention/strategy.asp>.
- ⁵ United States Public Health Service. (1999). *Surgeon General's Call to Action to Prevent Suicide*. Washington, DC.
- ⁶ Institute of Medicine of the National Academies. (2002). *Reducing Suicide: A National Imperative*. Washington, DC.
- ⁷ Schulberg, H. C., Bryce, C., Chism, K., Mulsant, B. H., Rollman, B., Bruce, M. & et al. (2001). Managing late-life depression in primary care practice: A case study of the Health Specialist's role. *International Journal of Geriatric Psychiatry*, 16, 577-584.
- ⁸ Mulsant, B. H., Alexopoulos, G. S., Reynolds, C. F. III, Katz, I. R., Abrams, R., Oslin, D. & et al. (2001). Pharmacological treatment of depression in older primary care patients: The PROSPECT algorithm. *International Journal of Geriatric Psychiatry*, 16, 585-592.
- ⁹ Kruesi, M. J. P., Grossman, J., Pennington, J. M., Woodward, P. J., Duda, D. & Hirsch, J. G. (1999). Suicide and violence prevention: Parent education in emergency department. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(3), 250-255.
- ¹⁰ Rotheram-Borus, M. J., Piacentini, J., Cantwell, C. Beline, T. R. & Sone, J. (2000). The 18-month impact of an emergency room intervention for adolescent female suicide attempters. *Journal of Counseling and Clinical Psychology*, 68(6), 1081-1093.
- ¹¹ Eggert, L. L., Thompson, E. A. & Herting, J. R. (1994). A measure of adolescent potential for suicide (MAPS): Development and preliminary findings. *Suicide and Life-Threatening Behavior*, 24, 359-381.
- ¹² Thompson, E. A., Eggert, L. L., Randell, B. P. & Pike, K. C. (2001). Evaluation of indicated suicide risk prevention approaches for potential high school dropouts. *American Journal of Public Health*, 91(5), 742-752.