SUICIDE RISK & PREVENTION

IT’S VERY DIFFICULT TO PREDICT WHO WILL KILL THEMSELVES SINCE MOST PEOPLE WHO COMMIT SUICIDE DO NOT COMMUNICATE THEIR INTENTIONS.

True or False?

FALSE. THE NOTION THAT PEOPLE WHO TALK ABOUT THEIR SUICIDE DO NOT KILL THEMSELVES IS A MYTH. AN OVERWHELMING 75% OF PEOPLE WHO COMMIT SUICIDE COMMUNICATE THEIR INTENTIONS BEFORE TAKING THEIR LIVES. MOST SUICIDAL WARNINGS ARE VERBAL OR BEHAVIORAL, WHILE ONLY 15% INVOLVE LEAVING NOTES.

RISKS THAT CONTRIBUTE TO SUICIDAL BEHAVIORS

- SIGNIFICANT PHYSICAL ILLNESSES
- ALCOHOL/OTHER SUBSTANCE ABUSE
- LACK OF SOCIAL SUPPORT SYSTEMS
- LOSS OF HOME, JOB, STATUS, MONEY, ETC.
- **PREVIOUS SUICIDE ATTEMPTS**
- IMPULSIVITY
- PSYCHIATRIC DISORDERS
- GENETIC PREDISPOSITION
- HISTORY OF SIGNIFICANT LOSS, ABUSE, OR TRAUMA
- CHRONIC SLEEP DISTURBANCES
- FAMILY HISTORY OF SUICIDE

PROTECTIVE FACTORS

- EFFECTIVE, COMPREHENSIVE CLINICAL CARE
- ACCESS TO INTERVENTIONS AND SUPPORT
- RESTRICTED ACCESS TO LETHAL MEANS
- SUPPORT SYSTEM
- ONGOING THERAPEUTIC RELATIONSHIPS
- COPING SKILLS
- CONFLICT RESOLUTION
- CULTURAL AND/OR RELIGIOUS BELIEFS THAT DISCOURAGE SUICIDE

STIGMA

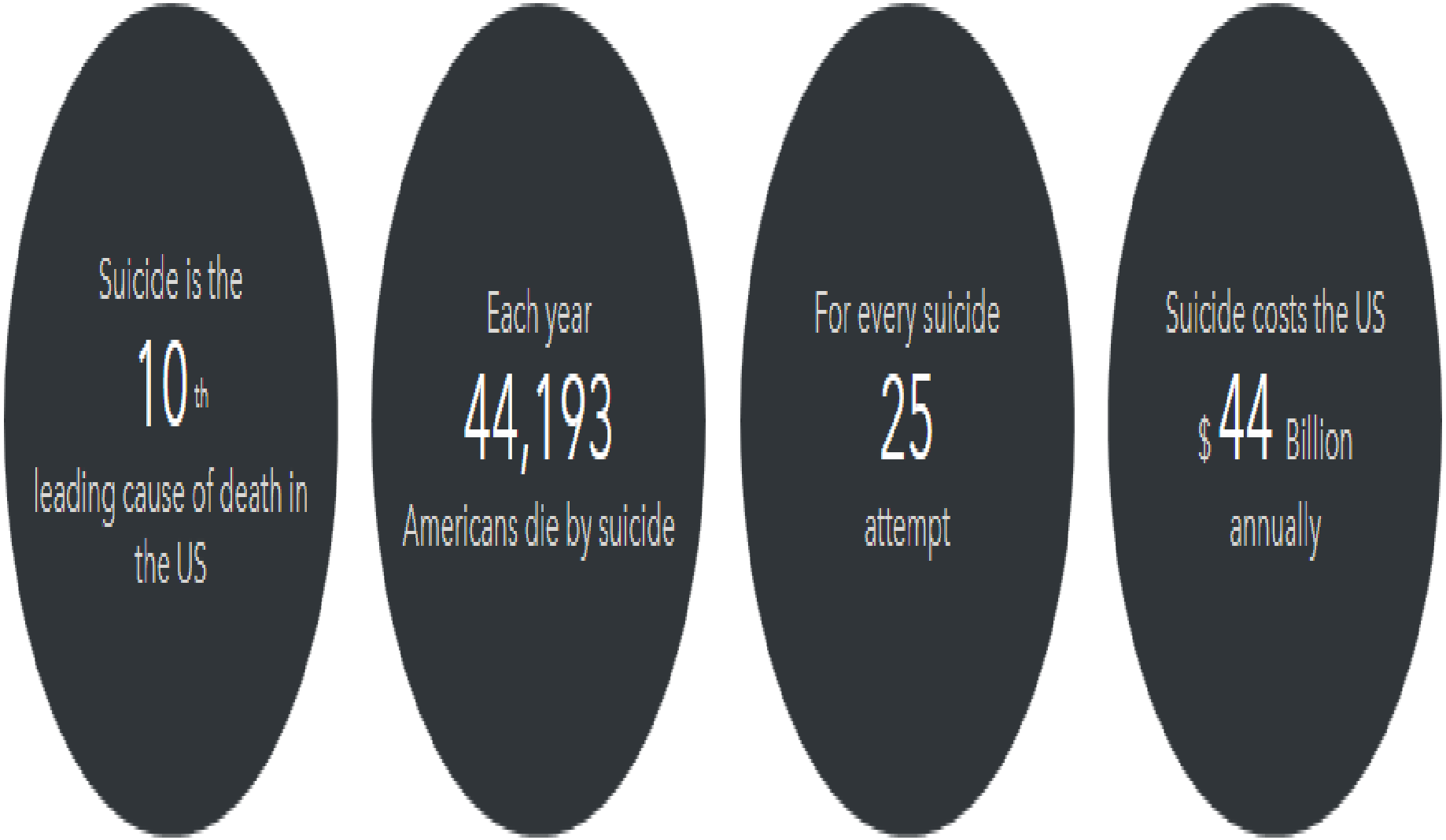
- 60-90% OF ALL SUICIDAL BEHAVIORS ARE ASSOCIATED WITH MENTAL ILLNESS AND/OR SUBSTANCE ABUSE
- 36-70% OF THOSE WHO COMMIT SUICIDE HAVE A MOOD DISORDER
- THE STIGMA (NEGATIVE STEREOTYPING) SURROUNDING MENTAL ILLNESS AND SUBSTANCE ABUSE CAN PREVENT PEOPLE FROM SEEKING HELP
- IT CAN ALSO BE A PROTECTIVE FACTOR, DISCOURAGING A PERSON FROM ATTEMPTING SUICIDE DUE TO SOCIAL IMPACT
- STIGMA USUALLY STEMS FROM A MORAL BELIEF THAT PEOPLE ARE FULLY IN CONTROL OF THEIR BEHAVIORS
- CERTAIN ETHNIC GROUPS, GEOGRAPHIC AREAS, RELIGIONS, ETC HAVE STRONGER STIGMAS

SIGNS OF INCREASED RISK

- LOSE INTEREST IN PRIOR ACTIVITIES OR RELATIONSHIPS
- PREPARE FOR DEATH BY GIVING AWAY PRIZED POSSESSIONS, MAKING A WILL, OR PUTTING OTHER AFFAIRS IN ORDER
- WITHDRAW FROM THOSE AROUND THEM
- INCREASINGLY RECKLESS & IMPULSIVE BEHAVIOR
- CHANGE IN HABITS (EATING, SLEEPING, HYGIENE, ETC)
- FEELING TRAPPED
- DRAMATIC CHANGES IN MOOD

SIGNS OF INCREASED RISK

- MAKES INDIRECT STATEMENTS ABOUT DEATH
- FEELINGS OF HOPELESSNESS, WORTHLESSNESS, AND POWERLESSNESS
- PESSIMISM
- LACK OF MOTIVATION
- INABILITY TO TOLERATE FRUSTRATION
- PREOCCUPATION WITH DEATH
- THE RISK OF SUICIDE MAY BE GREATEST AS DEPRESSION LIFTS BECAUSE THEY NOW HAVE THE ENERGY TO COMMIT THE ACT



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Suicide Rates by Age

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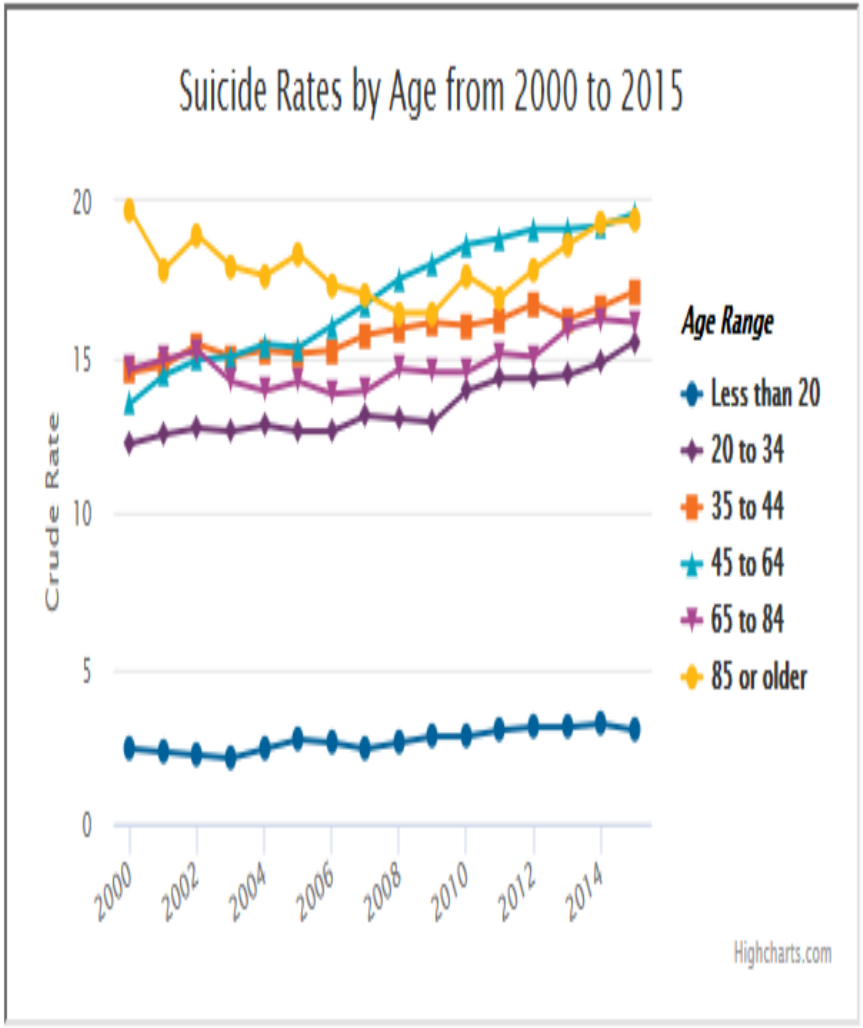
In 2015, the highest suicide rate (19.6) was among adults between 45 and 64 years of age. The second highest rate (19.4) occurred in those 85 years or older. Younger groups have had consistently lower suicide rates than middle-aged and older adults. In 2015, adolescents and young adults aged 15 to 24 had a suicide rate of 12.5.



Suicide Rates by Race/Ethnicity

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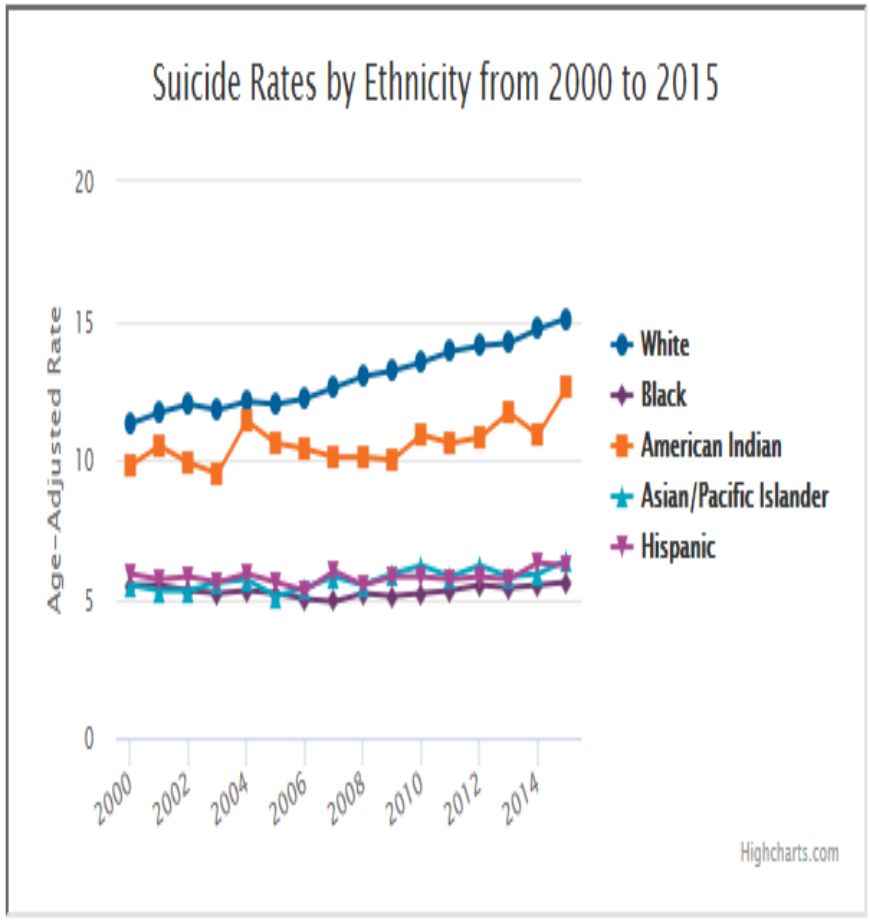
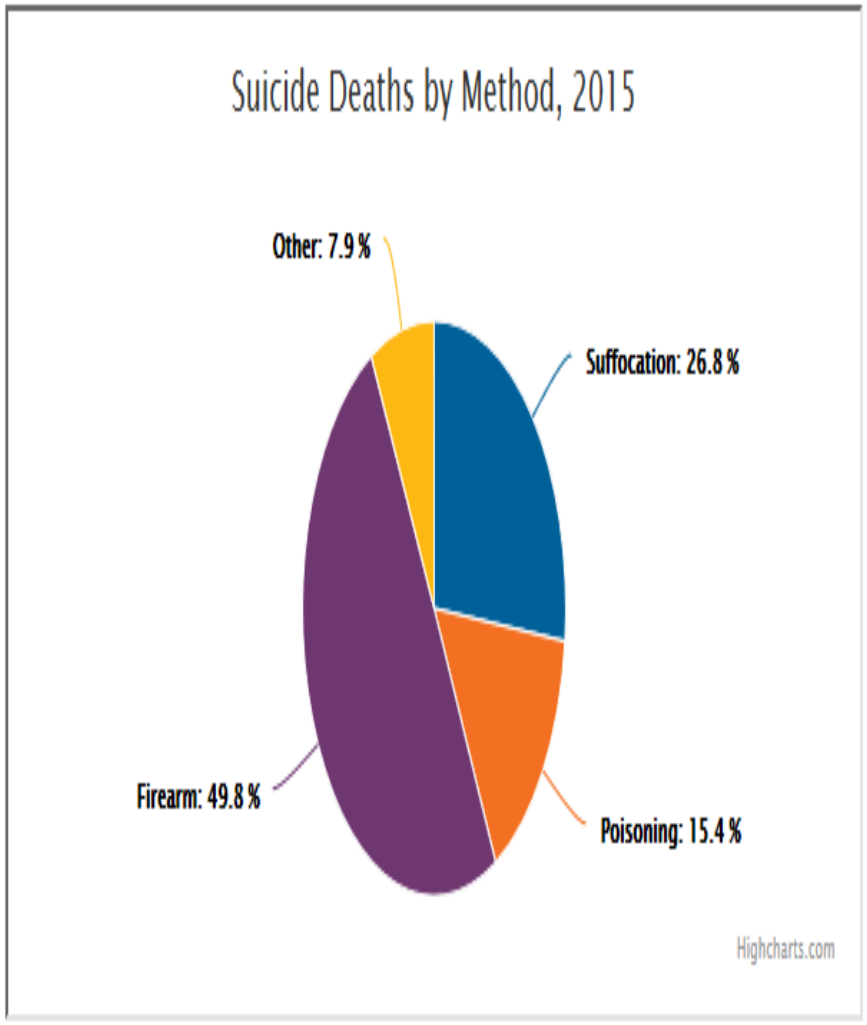
In 2015, the highest U.S. suicide rate (15.1) was among Whites and the second highest rate (12.6) was among American Indians and Alaska Natives (Figure 5). Much lower and roughly similar rates were found among Hispanics (5.8), Asians and Pacific Islanders (6.4), and Blacks (5.6).

Note that the CDC records Hispanic origin separately from the primary racial or ethnic groups of White, Black, American Indian or Alaskan Native, and Asian or Pacific Islander, since individuals in all of these groups may also be Hispanic.



Suicide Methods

In 2015, firearms were the most common method of death by suicide, accounting for a little less than half (49.8%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 26.8% and poisoning at 15.4%.



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2015 NATIONAL STATISTICS

- THE ANNUAL AGE-ADJUSTED SUICIDE RATE IS 13.26 PER 100,000 INDIVIDUALS.
- ON AVERAGE, THERE ARE 121 SUICIDES PER DAY.
- FIREARMS ACCOUNT FOR AROUND 50% OF ALL SUICIDES.
- MEN DIE BY SUICIDE 3.5X MORE OFTEN THAN WOMEN.
- WHITE MALES ACCOUNTED FOR ***7 OF 10*** SUICIDES IN 2015.
- THE RATE OF SUICIDE IS **HIGHEST IN MIDDLE AGE** — WHITE MEN IN PARTICULAR.
- RATES ARE HIGHER THAN REPORTED BECAUSE OF MISCLASSIFIED DEATHS.

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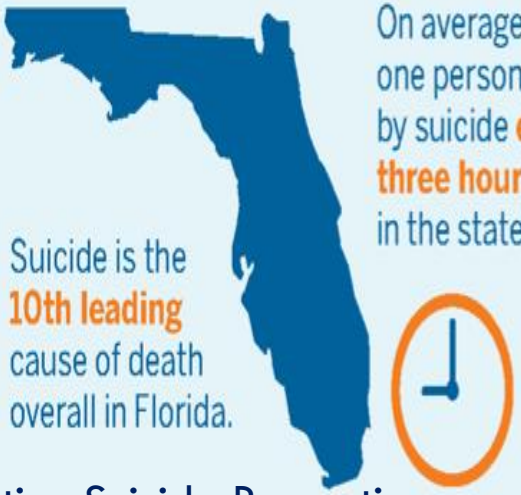
SUICIDE: FLORIDA 2016 FACTS & FIGURES

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Florida	3,035	13.84	28
Nationally	42,773	12.93	



On average, one person dies by suicide **every three hours** in the state.

Suicide is the **10th leading** cause of death overall in Florida.

Based on most recent 2014 data from CDC

Suicide cost Florida a total of **$2,841,739,000** of combined lifetime medical and work loss cost in 2010, or an average of **$1,018,910** per suicide death.

IN FLORIDA, SUICIDE IS THE...

- **2nd leading** cause of death for ages 25-34
- **3rd leading** cause of death for ages 10-24
- **4th leading** cause of death for ages 35-44
- **5th leading** cause of death for ages 45-54
- **8th leading** cause of death for ages 55-64
- **16th leading** cause of death for ages 65 & older

Over twice as many people die by suicide in Florida annually than by homicide; the total deaths to suicide reflect a total of **49,282** years of potential life lost (YPLL) before age 65.

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IT MAY BE HELPFUL TO ASK PEOPLE WHO APPEAR OVERLY DEPRESSED, WITHDRAWN, OR GRIEF-STRICKEN WHETHER THEY HAVE EVER CONSIDERED SUICIDE AS A SOLUTION TO THEIR PROBLEMS.

True or False?

TRUE. FOR PEOPLE IN THESE EXAGGERATED, EMOTIONALLY DISTRESSED STATES, BRINGING UP SUICIDE DOES NOT ENCOURAGE IT. ON THE CONTRARY, RAISING THE QUESTION OF SUICIDE ENCOURAGES THEM TO TALK ABOUT SUICIDE AND SHOWS THAT YOU RECOGNIZE THE DEPTH OF THEIR PAIN. ASKING THEM ALSO SHOWS THE PERSON THAT YOU CARE ABOUT THEM.

SUICIDE RISK ASSESSMENT

REMEMBER PLAID

- **P**LAN? DO THEY HAVE ONE?
- **L**ETHALITY? HOW LETHAL ARE THE MEANS THEY HAVE?
- **A**VAILABILITY? DO THEY HAVE ACCESS TO THE MEANS?
- **I**LLNESS? DO THEY HAVE A CHRONIC OR CRITICAL HEALTH CONCERN?
- **D**EPRESSION? DO THEY SEEM DEPRESSED?

SUICIDE RISK ASSESSMENT

- 34% OF PEOPLE WITH SUICIDAL IDEATION WILL MAKE A PLAN
- 72% OF PLANNERS WILL ATTEMPT
- 60% OF PLANNED ATTEMPTS OCCUR IN THE FIRST YEAR OF IDEATION
- 90% OF UNPLANNED ATTEMPTS OCCUR WITHIN THE FIRST YEAR

BOTTOM LINE: WHETHER OR NOT SOMEONE HAS A SUICIDE PLAN IS A CRITICAL FACTOR IN RISK ASSESSMENT, BUT IMPULSIVE ATTEMPTS ARE STILL POSSIBLE IF IDEATION IS PRESENT.

CRISIS INTERVENTION

DO

- BE AVAILABLE, AWARE, DIRECT, WILLING TO LISTEN, AND NON-JUDGMENTAL
- OFFER HOPE AND ALTERNATIVES
- REMOVE MEANS
- GET HELP FROM OTHERS

DON'T

- ACT SHOCKED
- ASK "WHY"
- KEEP IT A SECRET
- DARE THEM TO TRY SUICIDAL BEHAVIORS
- GIVE A LECTURE OR DEBATE WITH THEM WHETHER IT IS RIGHT OR WRONG

MOST PEOPLE WHO COMMIT SUICIDE HAVE MADE A CLEAR DECISION THAT DEATH IS THEIR BEST OPTION.

True or False?

FALSE. MOST PEOPLE WHO KILL THEMSELVES ARE IN A STATE OF PRONOUNCED CONFLICT AND CONFUSION OVER WHETHER TO COMMIT SUICIDE. THEY ARE ALL SURE, HOWEVER, THAT THEY DESPERATELY WANT AN END TO THEIR EMOTIONAL SUFFERING. THERE ARE MANY MORE SUICIDAL ATTEMPTS THAN THERE ARE SUCCESSFUL SUICIDES. SUICIDE ATTEMPTS ARE SOMETIMES MADE IMPULSIVELY.

HOW TO HELP INDIVIDUALLY

1. ACKNOWLEDGE AND ACCEPT THEIR FEELINGS
2. BE AN ACTIVE LISTENER
3. TRY TO GIVE THEM HOPE AND REMIND THEM THAT WHAT THEY ARE FEELING IS TEMPORARY
4. BE THERE FOR THEM
5. SHOW LOVE AND ENCOURAGEMENT
6. GET THEM HELP
7. REMOVE ANY MEANS OF SUICIDE

HOW TO HELP SYSTEMICALLY

- NO WEAPONS OR DRUGS/ALCOHOL BEING ALLOWED ON THE PREMISES DRAMATICALLY DECREASES RISK
- MEDICAL AND MENTAL HEALTH STAFF ARE ALWAYS AVAILABLE FOR A CRISIS SITUATION
- GETTING TRAINED ON PREVENTION AND ASSESSING RISK INCREASES SAFETY
- DAILY MONITORING OF SUICIDE RISK VIA GROUP THERAPY, SHIFT REPORTS, MEDICATION ADMINISTRATION, ETC.