

SUICIDE

Defining The Problem

Suicide continues to be a major health concern in Ohio. As the ninth leading cause of death in Ohio, suicide remains an ongoing challenge for health care policymakers, providers of care, schools, faith communities, and law enforcement. Over 1,200 Ohioans die by their own hand every year. Unfortunately, the impact of suicide does not stop there. The economic losses and loss to community do not match the grief and frustration felt by the families, friends, and loved ones left behind in the wake of these deaths. It has been estimated that, for every suicide death, there are six individuals who will be profoundly affected for the rest of their lives.

Goals

Reduce the suicide rate

<i>HP 2010 Goal</i>	<i>5.0 per 100,000</i>
Ohio	9.78
US 1998	11.3

Data source: National Vital Statistics System (NVSS), CDC, NCHS.

Reduce the rate of suicide attempts by adolescents

<i>HP 2010 Goal</i>	<i>12-month average of 1%</i>
Ohio	12-month average of 8%
US 1999	12-month average of 2.6% of adolescents in grades 9 through 12 attempted suicide

Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Data

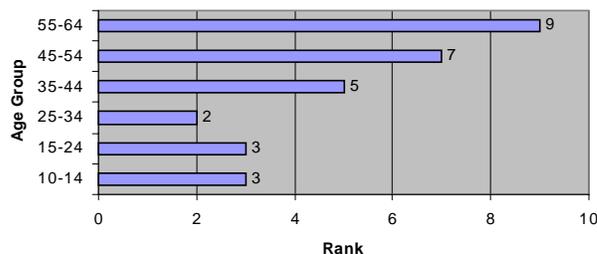
Despite a recent decline in the age-adjusted suicide rate among Ohio residents, suicide remains a major cause of death and a critical health behavior issue for Ohio. During 1998, 1,165 Ohio residents completed suicide or, statistically, about 3.2 persons a day (1). Suicide is the ninth leading cause of death among all persons in Ohio and the eighth leading cause of death among males (1). Suicide is a major cause of death among Ohio youth and young adults, ranking third among youth age 10 – 14 years, second among persons age 15 – 19 years, third among person age 20-24 years, and second among persons age 25 – 29 years. Suicide remains in the top five leading causes of death among persons age 30 – 39 years of age, when after age 50 it is surpassed by death from chronic diseases.

A total of 11,170 Ohio residents completed suicide during 1990-1998, or more than 1,200 per year. The age-adjusted death rate declined about 13%, from 12.0 per 100,000 in 1990-1992 to 10.4 per 100,000 in 1996-1998. The Ohio age-adjusted rate of 10.4 suicides per 100,000 persons in 1996-1998 is about 11% lower than the national rate of 11.5 suicides per 100,000, however Ohio's rate is still more than the Healthy People 2010 target of 5.0 per 100,000. (2).

Ohio statistics have continued to mirror national trends over the last few decades in striking increases in suicide rates among certain populations. Adolescents and young adults are some of those at highest risk, as are older Ohioans 65 years of age and Ohio men 25 to 44 years of age. These deaths are particularly tragic because suicide is largely preventable.

The 1999 Ohio Youth Risk Behavior Survey reports that 20 percent of all high school students have thought about killing themselves. Economic downturns, terrorism-related stress, and the inability to effectively problem-solve and cope with these challenges increase risk across the age spectrum, indicating an urgency in the development of suicide prevention policies. Suicide must be addressed as both a health care concern and a cultural problem. To effect suicide, however, it is critical to first eliminate the enormous barriers of stigma, taboo, and shame that surround the issue.

1990-1998, Ohio, Suicide Ranking as Leading Cause of Death by Age Group



Ohio Suicides by Age, Race, and Gender, 1990-1998, Number and Rate/100,000								
Age Group	White				Black			
	Male		Female		Male		Female	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
10-29	1925	15.6	315	2.6	243	13.9	46	2.5
30-49	2842	21.5	762	5.6	267	18.7	61	3.6
50-74	1998	22.3	525	5.1	101	11.9	33	3.0
75+	888	47.9	150	4.3	30	20.8	3	1.2
Total	7653	21.1	1752	4.5	641	15.4	143	2.9

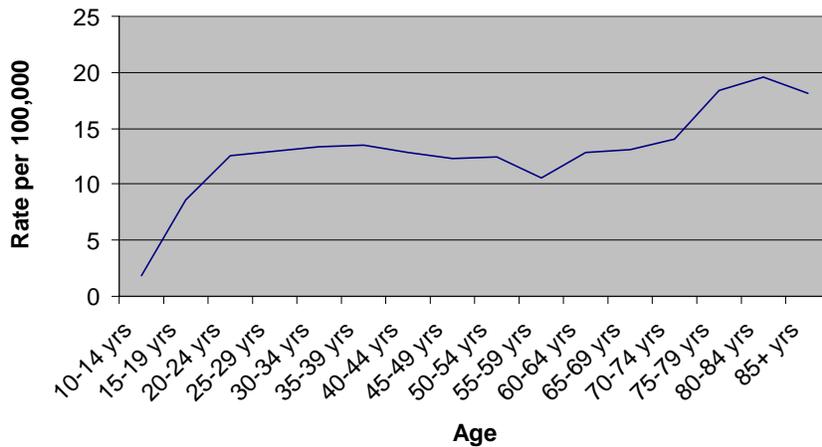
Risk Factors

- **Age:** Risk factors for suicide vary among age groups. Death rates increase with age and the highest age-specific rates are for individuals older than 75. It is notable that suicide is one of the top 3 leading causes of death for Ohioans in age groups 10 to 34.
- **Gender:** Males are at greater risk for completing suicide than females. White males are the highest risk group for all age groups, followed by black males.

The Centers for Disease Control and Prevention conducted a study among people who attempted suicide and would have died without medical care. These interviews revealed significant factors that motivated the victims.

- **Impulse:** Nearly one in four of those who made nearly lethal suicide attempts reported that less than five minutes passed between their decision to attempt suicide and their actual attempt. This reveals a need for 24-hour statewide suicide crisis intervention.
- **Alcohol:** Drinking within three hours of the attempt was the most important alcohol-related factor, more important than a history of alcoholism or binge drinking. Persons who are alcohol or other substance dependent have an increased risk of suicide.
- **Change of residence:** Moving in the past 12 months is an increased risk. Frequency of moving, distance moved, recency of move, and difficulty staying in touch were all significant factors.
- **Mental disorders:** Findings from a study conducted by the International Association for Suicide Prevention reveal that of the 5,588 people studied, only 2% had no indication of mental disorder at the time of death. (Source: *I.A.S.P Guidelines for Suicide Prevention. Crisis, 20(4), 155-163.*)
- **Other Risk Factors:**
 - 1 People with a **history of suicide attempts** are far more likely to actually complete suicide in the future. This risk is particularly high during the first year following the attempt.
 - 2 The **presence of severe physical illness** is associated with an increased rate of suicide, particularly when the illness involves chronic pain.
 - 3 A **diagnosis of major depression** is associated with an increased risk for suicide and suicide attempts.

1990-1998, Ohio, Suicide Death Rates



During 1998, the total number of suicides in Ohio equals more than 3 per day.

Costs & Consequences

National

It is estimated that the cost of completed and medically treated youth suicides in the United States (ages 0 to 20 years) in 1996 totaled \$15.6 billion. Additionally it is estimated that approximately 30,000 lives are lost each year, leading to a total lifetime loss of 978,000 person-years, and a total lifetime loss in productivity and wages valued at nearly \$12.4 billion.

State

It is estimated that the cost of completed and medically treated youth suicide in Ohio is \$591 million. This includes \$36,000,000 in medical expenses, \$108,000,000 in lost future earnings and \$447,000,000 in quality of life. Quality of life included the value of pain, suffering, and quality of life loss to victims and their families.

Existing Programs

The Ohio Coalition for Suicide Prevention provides information and guidance regarding suicide prevention.

Ohio Department of Mental Health

Local Mental Health and Alcohol, Drug Addiction and Mental Health (ADAMH) Boards include suicide prevention in their mental health services.

Crisis hotlines exist, however their coverage is not statewide.

Discussion of Prevention Strategies:

In 1999, David Satcher, M.D., Surgeon General of the United States issued a Call to Action to Prevent Suicide. This introduces an initial blueprint for reducing suicide and the associated toll that mental and substance abuse disorders take in the United States. As both evidence-based and highly prioritized by leading experts, the 15 key recommendations serve as a framework for immediate action. These recommended first steps are categorized as Awareness, Intervention, and Methodology, or AIM.

Awareness: Appropriately broaden the public's awareness of suicide and its risk factors

- Promote public awareness that suicide is a public health problem and, as such, many suicides are preventable. Use information technology appropriately to make facts about suicide and its risk factors and prevention approaches available to the public and to health care providers.
- Expand awareness of and enhance resources in communities for suicide prevention programs and mental and substance abuse disorder assessment and treatment.
- Develop and implement strategies to reduce the stigma associated with mental illness, substance abuse, and suicidal behavior and with seeking help for such problems.

Intervention: Enhance services and programs, both population-based and clinical care

- Extend collaboration with and among public and private sectors to complete a National Strategy for Suicide Prevention.
- Improve the ability of primary care providers to recognize and treat depression, substance abuse, and other major mental illnesses associated with suicide risk. Increase the referral to specialty care when appropriate.
- Eliminate barriers in public and private insurance programs for provision of quality mental and substance abuse disorder treatments and create incentives to treat patients with coexisting mental and substance abuse disorders.
- Institute training for all health, mental health, substance abuse and human service

professionals (including clergy, teachers, correctional workers, and social workers) concerning suicide risk assessment and recognition, treatment, management, and aftercare interventions.

- Develop and implement effective training programs for family members of those at risk and for natural community helpers on how to recognize, respond to, and refer people showing signs of suicide risk and associated mental and substance abuse disorders. Natural community helpers are people such as educators, coaches, hairdressers, and faith leaders, among others.
- Develop and implement safe and effective programs in educational settings for youth that address adolescent distress, provide crisis intervention and incorporate peer support for seeking help.
- Enhance community care resources by increasing the use of schools and workplaces as access and referral points for mental and physical health services and substance abuse treatment programs and provide support for persons who survive the suicide of someone close to them.
- Promote a public/private collaboration with the media to assure that entertainment and news coverage represent balanced and informed portrayals of suicide and its associated risk factors including mental illness and substance abuse disorders and approaches to prevention and treatment.

Methodology: Advance the science of suicide prevention

- In May, 2001 the Surgeon General introduced the first part of the National Strategy for Suicide Prevention. This is considered to be a national blueprint of goals and objectives to address the problem of suicide. The National Strategy for Suicide Prevention: Goals and Objectives for Action (NSSP or National Strategy) is designed to be a catalyst for social change, with the power to transform attitudes, policies, and services. It reflects a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors in the United States. Aims of the National Strategy include: Prevention of premature deaths due to suicide across the life span; reduction in the rates of other suicidal behaviors; reduction in the harmful

aftereffects associated with suicidal behaviors and the traumatic impact of suicide on family and friends; and the promotion of opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities.

State Initiatives

In January 2001, The Report of Ohio's Mental Health Commission, *Changing Lives, Ohio's Action Agenda for Mental Health*, included a recommendation that Ohio should build an initiative to reduce suicides. To develop a statewide plan, the Ohio Department of Mental Health established a partnership with the Ohio Coalition for Suicide Prevention. Together, utilizing a format that included public forums to collect information they have developed Ohio's Suicide Prevention Plan (May, 2001). The plan's goals and objectives account for three levels of prevention strategies: universal, selective and indicated. Universal prevention is focused on providing needed interventions to keep communities healthy. These programs benefit everyone in a community universally by providing general awareness information and education. Selective prevention is dedicated to prevent the onset of suicidal behavior in priority risk groups. These strategies may include screening and assessment, training of natural community "gatekeepers," and community-based mental health treatment. Indicated prevention strategies identify priority groups known to be at high risk for suicide. This may be done through skill building and services and treatment that reinforce protective factors. Three priority groups have been identified in the Department of Mental Health plan. Those groups include the young, middle-aged men and the elderly. The Ohio plan similar to the format utilized in the National Strategy for Suicide Prevention focuses on three types of goals: awareness, intervention and methodology.

Because suicide is complex behavior and not well understood, efforts must be designed to provide for broad-based dissemination of information. This information may contain: prevalence and causes of suicide and community resources available for those at-risk families.

The Ohio Department of Mental Health has granted twenty mini-grants of \$1,000 - \$2,000 for projects making people aware of the warning signs of suicide and symptoms of clinical depression, the risk factor most closely

associated with suicide. These awareness tools include 30,000 lifesaver cards distributed in middle and high schools in six counties; 10,000 bookmarks for the elderly; a suicide prevention video for students in a rural county; clergy breakfasts; and distribution of the Surgeon General's Call to Action.

Recent studies have linked hazing or bullying in the environment with suicide risk. Other factors also contribute to the constellation of elements in a suicide, including financial concerns and woes; personal losses, such as divorce, death, loss of a job, loss of a relationship; personal health status; coping skills; social skills; social connections and supports; and developmental changes in young people.

According to the National Strategy for Suicide Prevention, in the month prior to their suicide, 75 percent of elderly persons had visited a physician. Because many suicidal individuals make contact with their physicians within a few weeks prior to their death (Beautrais et al., 1998; Pirkis & Burgess, 1998) and their imminent risk for suicide may have gone undetected due to the lack of training in assessing and managing suicide risk by their care provider. With such training, fewer suicidal patients will go unrecognized and untreated (Shea, 1999).

Those on the "front line" in assessing and treating individuals who are at increased risk for suicidal behaviors are in a vital position to intervene on behalf of a distressed individual or family. They are very often the only ones to be able to identify risk and then seek appropriate care or find resources in the community for the individual.

Creating greater infrastructure and resources in Ohio for distressed and suicidal adolescents is essential. Since the 1970s, the trend toward lower-cost, outpatient care has severely undermined the ability of physicians and other care providers to ensure that suicidal adolescents will receive the care that need.

Health care has undergone radical changes over the past few decades and a shift to cost control by managed care has signaled a move to more outpatient care and treatment. As a result, costly inpatient psychiatric care in times of imminent crisis has diminished over time. In some communities, inpatient services don't even exist. This shifts the burden during a suicide crisis to private mental health care providers and local community mental health

centers and crisis centers. In some cases, home health nurses are dispatched to monitor suicidal patients in their homes. In some instances, particularly among adolescents and young adults, suicidal kids are sent home, relying solely upon appointments doctor office visits, because of the lack of inpatient psychiatric bed for adolescents in hospitals in Ohio.

The development of infrastructure to do meaningful suicide prevention, however, is not the sole responsibility of government, hospitals, community mental health agencies, suicide hotlines, and other systems, which rely upon public and taxpayer monies. Mental health care is fragmented at best and this creates multiple challenges for suicide prevention. Just as the very problem of suicide is complex and multidimensional, the solution to developing infrastructure, creating competent, dependable resources and building awareness within the community may be as well. This job can be accomplished if the brushstrokes of these prevention plan efforts on both the state and local levels are broad. Any statewide and local suicide prevention strategy should include varied disciplines, across cultures, ages, locations, and backgrounds.

In order to continue to adequately plan for the prevention of suicide, surveillance, data collection, and dissemination must be improved. Data and surveillance strategies may be improved to ask several questions which will help us to better understand suicide, suicidal behavior, and develop more effective interventions. These questions may include: seasonality of death; time of day; day of the week.

Little infrastructure exists in Ohio to effectively and, in a coordinated fashion, prevent suicide. Suicide hotlines may provide some of the best opportunities to intercede in a potential suicide. According to a recent "Nearly Lethal Suicide Study," many suicides are "impulsive" and the individual who attempts decides to do so less than five minutes from their decision to attempt suicide. Suicide hotlines may be the only outlet or resource the suicidal individual would have when contemplating suicide. Hotline volunteers may actually be the difference between life and death for many of these individuals.

In Ohio, there are roughly six service areas offering hotlines services to individuals in those

regions. Ohio is divided into the Northwest, Northeast, North Central, Southwest, Southeast – roughly corresponding to the area codes of the regions. Each of the six areas is served by at least three local crisis hotlines. In general, the more populated urban areas have more crisis lines available than do rural areas. Of the 88 counties in Ohio, 27 have local crisis hotlines, leaving 61 counties without this critical service.

Ideally there should be a trained suicide prevention specialist in every county, with a single well-publicized toll-free access number, that would automatically reroute the call to the closest local crisis line number. Trained crisis line workers would assess the situation and mobilize the local county prevention specialist when appropriate. This would decrease the risk of suicidal individuals "falling through the cracks" because they lived far from the nearest crisis center, had transportation problems or were simply unaware of the services available. It would be necessary to implement standards of training and certification for the participating crisis line volunteers and county suicide prevention specialists.

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Recommendations to Prevent Suicide

Improve surveillance

1. Create a statewide surveillance system and database to track suicide attempts and completions.

Target resources toward high-risk groups

2. Implement a statewide suicide awareness and education program focusing on high-risk populations, and evaluate its effectiveness. The goals of the campaign should include:
 - Reducing the stigma associated with suicide.
 - Increasing people's ability and willingness to seek help.
 - Improving lay person recognition of signs, the need to intervene, and intervention skills.
 - Increasing awareness of available resources and access to those services.
3. Encourage development of mental wellness initiatives that reduce risk factors associated with suicide.

Evaluate programs

4. Encourage research-based initiatives to improve knowledge of causes, effective interventions, and current capacity to intervene.
5. Promote the dissemination of proven, best-practice intervention strategies to prevent suicide among high-risk groups.

Empower communities

6. Create a permanent and stable funding mechanism to maintain statewide suicide prevention and response initiatives. This should include funding for trained suicide prevention specialists and a single toll-free access number.
7. Encourage social support and contact for elders through the development of networking programs. Include elders in the planning process.
8. Increase funding for mental health intervention services.
9. Encourage improved coverage of mental health benefits through health insurance plans.
10. Promote the establishment of integrated services and service delivery systems that cover the entire continuum of health.

Expand training

11. Encourage the incorporation of age-appropriate suicide prevention programs into school curricula.

Total Population, 1998	Suicides
	Rate per 100,000
TOTAL	11.3
Race and ethnicity	
American Indian or Alaska Native	12.6
Asian or Pacific Islander	6.6
Asian	DNC
Native Hawaiian and other Pacific Islander	DNC
Black or African American	5.8
White	12.2
Hispanic or Latino	
Hispanic or Latino	6.3
Not Hispanic or Latino	11.8
Black or African American	6.0
White	12.8
Gender	
Female	4.3
Male	19.2
Education level (aged 25 to 64 years)	
Less than high school	17.9
High school graduate	19.2
At least some college	10.0
Age (not age adjusted)	
10 to 14 years	1.6
15 to 19 years	8.9
20 to 24 years	13.6

Students in Grades 9 Through 12, 1999	Suicide Attempts
	Percent
TOTAL	2.6
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	3.1
White	2.2
Hispanic or Latino	
Hispanic or Latino	3.0
Not Hispanic or Latino	2.6
Black or African American	2.9
White	1.9
Gender	
Female	3.1
Male	2.1
Parents' education level	
Less than high school	DNC
High school graduate	DNC
At least some college	DNC
Sexual orientation	DNC

DNA = Data have not been analyzed. DNC = Data are not collected.
DSU = Data are statistically unreliable.