



Defining the Problem

It is important that we understand suicide statistics in order to have a better understand of how suicide is impacting individuals and their families globally, nationally, and in our own communities. Once we have an understanding of the problem, we can create suicide prevention and early interventions programs that are targeted for individuals who are at high risk for suicide.

Global Suicide Statistics

- The World Health Organization considers suicide to be a global crisis. In 2015, they reported that every 40 seconds someone in the world dies by suicide. That averages out to 2,160 deaths each day.
- There are an estimated 800,000 annual suicides worldwide, and according to studies these numbers are projected to steadily increase.
- According to the WHO, 79% of suicides in the world occur in low- and middle-income countries, though data is still unavailable for an estimated 73% of these countries.
- For young individuals, suicide accounts for nearly $\frac{1}{3}$ of all deaths globally, with suicide being the second leading cause of death for those between the ages of 15 to 29.
- Studies show that suicide rates are higher in males than in females

National Suicide Statistics

- The Centers for Disease Control and Prevention reports that the rate of suicides have continued rise each year, with suicide being the 10th leading cause of death in the United States.
- Suicide rates have increased in nearly every state in America. According to the American Foundation for Suicide Prevention, nearly 44,965 individuals died by suicide in 2016 (more than twice the number of homicides reported).
- More than half of the individuals who died by suicide over the last two decades did not have a diagnosable mental health condition. This is why it is important that all individuals are assessed for suicide when meeting with mental health professionals, regardless of if they have a diagnosed mental illness. It is not just mental health challenges that create the crisis; there are other factors such as interpersonal concerns, financial strain, substance abuse, and more.

- It is reported that for every suicide, there are 25 individuals who have attempted suicide. If an persons is a suicide attempt survivor, their risk for suicide increases dramatically.

Understanding how suicide impacts different demographic groups, such as gender and age, can help professionals best target those at the highest risk for suicide in order to provide early intervention and preventative care.

- Males in the United States are more likely to die by suicide compared to females.
- People in middle-age are at a higher risk for suicide within the United States.
- Firearms were utilized in more than half of the reported suicide deaths in the year 2016 alone.
- According to recent statistics released by the Centers for Disease Control and Prevention, in 2016 males were more likely to use firearms as a methods for suicide, with more than half of male suicide deaths involving a firearm.
- Females' most-utilized method for suicide is poisoning, with studies showing that 33% of female deaths by suicide in the year 2016 alone involved poisoning.
- When you are speaking with an individual experiencing thoughts of suicide, be sure to ask them about access to means for suicide, such as firearms, medication, and methods for suffocation.
- In the year 2016, 9.8 million adults reported serious thoughts of suicide within the past year, while 2.8 million made plans for suicide. Additionally, it was shown that 1.3 million adults attempted suicide within the past year.

Missouri Suicide Statistics

- According to the Centers for Disease Control and Prevention, in 2016 suicide was the 10th leading cause of death in Missouri, with 1,133 reported suicide deaths that year.
- One person died by suicide every eight hours (on average).
- Studies have shown that Missouri residents are more likely to die by suicide than homicide
- More than half of the suicide deaths occurring in Missouri in the year 2016 involved the use of a firearm, followed by suffocation and poisoning.

Myths about Suicide

There are many myths surrounding suicide, and it is important that professionals are aware of these myths so that they can treat them as such.

Myth 1

People who talk about suicide are just trying to get attention.

- Individuals who are talking about thoughts of suicide are often times in pain, and are reaching out in order to get help. If an individual reports thoughts of suicide, always take it seriously.

Myth 2

People who are suicidal, will always be suicidal.

- This is not always the case, thoughts of suicide can come back later in life but that does not mean that they're permanent. Contrary to this myth, Individuals can experience thoughts of suicide on a short term basis.

Myth 3

People who attempt suicide and survive, will not attempt again.

- Research shows that this is not true. Suicide attempt survivors, are at a higher risk of re-attempting. Often times individuals may have multiple suicide attempts within their lifespan.

Myth 4

Only people with mental disorders are suicidal.

- This is false. Statistics show that 54% of individuals who died by suicide in 2016 did not have a diagnosed mental illness. It is important that mental health professionals are assessing all clients for suicide, as mental health is just one risk factor among many others.

Myth 5

Asking if someone is suicidal plants the seed and will make them suicidal.

- Asking an individual about thoughts of suicide, will not give them the idea for suicide. Talking about thoughts of suicide actually allows the individual to express how they feel openly and honestly. It is after talking about suicide, that one can begin to learn more about the individuals situation and circumstances.

Warning Signs

Knowing the warning signs for suicide and how to get help can help to save lives.

Things The Client May Say

When individuals are experiencing thoughts of suicide, you may hear:

- The individual making remarks or jokes about wants to kill themselves. Statements such as these are a strong indicator that one may be having thoughts of suicide. You may hear the individual say things like "Just kill me now," or "I wish this was all over."
- The individual may make threats of suicide. For instance, saying "If I don't get medical care immediately, I will suicide." Take all of these statements seriously, and ensure the individual expressing thoughts of suicide is connected to help.

- Other times it may sound more passive, with statements such as: “I feel like a burden to others,” “I just want it all to end,” “I wish I could sleep and never wake up,” “I no longer have a purpose or hope.”

Behaviors

Additionally, the following behaviors could be indicators that one is experiencing thoughts of suicide.

- When an individual experiences uncontrollable anger, **rage** is a behavior that can be observed. It is important to note that rage can be displayed differently in individuals. For instance, some individuals may display physical aggression towards themselves and others while others may engage in only verbal aggression.
- An individual engaging in **reckless behaviors** may be an indicator of thoughts of suicide. You may observe that the individual is acting in ways that are detrimental, with no regard for the consequence. These reckless behaviors can include self-harming behavior, reckless driving, and picking fights with others.
- If you notice an increase in **substance use** with the individual. Substance abuse raises one’s risk for suicide. The individual may be turning to substances to help them cope with pain, or escape their reality.
- If a person is suddenly giving away **personal belongings** this can be a sign that they are making preparations for suicide. These personal belongings can be personal possessions, household items, and jewelry. Giving these things to loved ones may lead the individual to think that these possessions can help their loved ones to cope and remember them after their death.
- If you notice that an individual has persistent and/or excessive worry, or just appears to be on edge they may be experiencing anxiety. **Anxiety** can be a warning sign for suicide. Behavioral responses to anxiety include avoiding anxiety producing situations, trembling or shaking, and restlessness.
- Watch for changes in the individual’s **eating and sleeping habits**. Some may begin to eat less, while others may increase their normal food intake; the same can be said for sleeping. The individual may sleep more, experience changes in sleep patterns, or report not being able to sleep at all. All of these behaviors can indicate that one is having thoughts of suicide.
- The individual may experience **dramatic mood changes** that begin to interfere with their daily functioning, changes such as intense shifts in mood from extreme highs to extreme lows.
- The individual may **withdraw** from family and friends, choosing to spend more time alone and secluded. They may also stop engaging in activities and hobbies that they once enjoyed.

Recommended Terminology

- When talking about suicide, remember that language **always** matters! In the suicide prevention field the phrase “committed suicide” is highly discouraged. Using the word “committed” tends to invoke negative connotations, and may suggest that the individual committed a crime.
- Phrases such as “died by suicide” or “suicided” are considered appropriate, and factual. By altering one’s language, we can help those experiencing thoughts of suicide to feel safe and comfortable discussing suicide, rather than feeling stigmatized or like a criminal.
- The phrase ‘successful suicide’ is discouraged as the word successful is usually connected with positive connotations. Instead, it is suggested that one uses the phrases “completed suicide” or “death by suicide.”
- If an individual has attempted suicide in the past, they are referred to as a ‘suicide attempt survivor.’
- The phrase “survivor of suicide” refers to loved ones of the individual who died by suicide.

The importance of being prepared

Asking the Question

Observing warning signs in your clients is a cue that you should ask directly about whether the client is having thoughts of suicide. There are several factors to consider when asking someone if they are experiencing suicidal ideation to ensure that clients feel they can be honest and open with you.

- Suggestion 1

It is important to make sure that you are directly asking about suicide. When we phrase the question as “Are you thinking about harming yourself?” this can lead to confusion for both you and the client. Harming oneself can mean different things to different people.

To avoid confusion, it is recommended that phrases such as, “Are you having thoughts of suicide?” or “Are you thinking about killing yourself?” be used instead.

Openly using the word suicide instead of vague phrases can be a cue to clients that you are okay with talking about this difficult topic and are a safe person to discuss this with.

- Suggestion 2

Ask the question in a way that gives permission for your client to say yes. It can be easy for facial expressions, body language, or tone of voice to convey that we are uncomfortable with this topic. Try to ask confidently and without hesitation.

Tips for an effective conversation

- Try to remain calm when your client shares their suicidal thoughts with you. Thank the client for being honest and convey concern by letting them know you are hearing that they are struggling and want to help.
- Don't immediately try to solve the problems. When we move too quickly to fixing the client's problems, we miss out on important opportunities to build rapport with clients and make sure they feel understood and cared about. Clients who feel heard and cared about are more likely to work with you on a way to stay safe.
- Accept their concerns as real and remain nonjudgmental. It is important to remember that what matters most is the client's interpretation of the situation rather than the clinician's. Focus on providing support and accepting all client concerns as real and valid.
- Take the situation seriously.
- It's not always the time for advice. Clients are much more likely to follow through with ideas for how to stay safe or improve their situation if they are an active participant in a collaborative discussion as opposed to being told what to do. Authoritative advice can lead to clients feeling dependent on the clinician for direction, which doesn't help to foster skills in clients that they can use on their own.

How to React to a Suicidal Client

- Active listening is when we concentrate fully on understanding what someone is saying rather than passively listening. Active listening requires a combination of verbal and nonverbal factors and skills.
 - Common verbal skills used are paraphrasing, summarizing, and asking open ended questions.
 - Nonverbal cues such as nodding, making eye contact, and using appropriate tone of voice and posture are also signs to a client that you are listening and care about the conversation.
- Empathy and validation are equally important during suicide intervention.
 - Empathy is being able to understand a client's point of view and experience without having to live it yourself.
 - Validation is when you recognize a client's thoughts or feelings and convey acceptance of them regardless of whether you agree with them or not.



Suicide Risk Assessment

The purpose of a suicide risk assessment (SRA) is “not to predict which patient might take his or her own life but, rather, to do the best job we can to increase safety, reduce risk, and promote wellness and recovery.” - Zero Suicide/Suicide Prevention Resource Center

Suicidal Ideation

Suicidal ideation is when an individual is thinking about suicide to a varying degree. It can range from a person simply acknowledging the possibility and their own ability to kill themselves to considering methods to formulating a detailed plan of how, when, where. The importance of a suicide risk assessment is to understand the severity and details surrounding an individual’s suicidal ideation. An assessment will evaluate:

- Is there a plan? Plans could include an attempt, timeframe, location, method, or preparatory steps taken.
- Is there intent? During this questioning, it’s important to find out if they have social support, mental health access, if they’re ambivalent about suicide, whether they have future plans or goals they’re nervous about, and whether they have religious beliefs concerning suicide.

Risk Factors for Suicide

Risk factors include:

- **History of past suicide attempts** - Research shows that one of the strongest predictors of death by suicide is a previous suicide attempt. That is why it is important to reach out to individuals who have previously attempted suicide to ensure their safety and help to connect them to long-term mental health resources.

It is important to also be able to differentiate between non-suicidal self injury and a suicide attempt. It can be done by referencing the recent act (e.g. cutting) and asking if *any part* of the individual wished to die *as a result* of the self injurious act. An individual can wish they were dead and cut solely for the purpose of distraction or emotional relief. If the self injurious act is done solely 100% for the purpose of emotional relief, this is not an attempt.

- **Substance use or abuse** - It is important to inquire about both past and current substance use and abuse. If an individual is currently under the influence they are much more susceptible to impulse and may be unable to adequately safety plan. Many times substance use can be a part of an individual's plan or the plan itself. It is important to inquire what substance and how much an individual has taken and pass this information on to the next appropriate care provider. A current substance use disorder or addiction can be a foundation for an individual's suicidal ideation as they may be experiencing intense feelings of shame and helplessness.
- **Exposure to suicide** - Exposure to suicide through the death of a friend or family member creates a bigger risk due to complicated grief that includes guilt, self blame, and stigma that can increase isolation.
- **Precipitants/triggering events** - With suicidal ideation, there usually is an underlying foundation of pain such as depression, bi-polar, anxiety, PTSD, substance abuse disorder, or chronic physical illness. Singular event loss of a loved one, rape, violence, break up, physical health concerns, fight, and abuse can also be triggering. Each individual has unique struggles and adversities that underpin their ideation. It is important to at least know the beginnings of the story.

Protective Factors for Suicide

If individuals who are experiencing thoughts of suicide have easy access to mental health professionals within their community, they are more likely to seek support. However, access alone is not the only protective factor. The effectiveness of the mental health resources matter as well.

Protective factors:

- **Ambivalence about suicide**
- **Access to mental health resources**
- **Strong connections to social supports and institutions**
- **Future plans or goals**
- **Problem solving skills**
- **Coping skills**
- **Religious beliefs**

Screening Tools

There are several free screening tools available to mental health and healthcare professionals to provide formal assessment and documentation. These tools help determine if someone is at risk, assesses the immediacy and severity, and gauge how much support is needed. The three most commonly used screening tests are:

- **Columbia Suicide Severity Rating Scale (c-SSRS)** Free to use with detailed training available at cssrs.columbia.edu
- **Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)** Provided by the Substance Abuse and Mental Health Services Administration
- **Ask Suicide-Screening Questions (ASQ)** Short questionnaire designed for medical settings; provided by the National Institute of Mental Health



Involving Emergency Services

While intervening with a suicidal individual, there may be instances in which involving emergency services is required. For instance:

1. If the individual has already done something harmful to themselves
2. The individual has an immediate time frame for suicide. They may say something such as, "I am going to suicide tonight" or "By tomorrow morning I will no longer be here."
3. The individual refuses to safety plan despite attempts

Involving emergency services allows for the police to check on the welfare of the individual at risk and transport them to the hospital if necessary.

To involve emergency services, one must first contact their local police department and inform them that they want to initiate a wellness check for an individual who may be at risk for suicide. Tell the dispatcher all of the information about the individual at risk, such as the individual's address, last known location, general demographic information, mental health history, and if the individual has access to lethal means.

Many communities have Crisis Intervention Team (CIT) programs, which are composed of police officers within the department who have received crisis intervention training. Ask for a CIT officer if you call.

Involving emergency services is not always necessary. Many individuals are simply needing someone to talk to and are already capable of keeping themselves safe. It is your role to provide support, and engage in them in discussions about safety.

Be sure to consult with your agency's policies and procedures to ensure that the correct plan of action is followed.

Safety Contract vs. Plan

In the past, when individuals would report thoughts of suicide, the clinical approach was to have the client sign a safety contract. This is a written contract in which the client promises the clinician they will not harm themselves or they promise to call a professional for help during a crisis. The client would sometimes have to sign this agreement before leaving sessions.

Safety contracts are no longer considered best practice in the mental health field due to research showing overall ineffectiveness.

Creating a Safety Plan

A safety plan is meant to be created collaboratively with a client. It is strength-based and empowering, helping them recognize that they may not always be able to control their suicidal thoughts but do have options for how they react.

- Safety plans are meant to be created in a short amount of time, in an easy-to-read format, in the client's own words.
- When developing a safety plan with a client, it is usually helpful to explain the purpose of the safety plan and how it will help. For example, you may want to talk to clients about how thoughts of suicide often come and go and having a plan of what they can do to help themselves can prevent future suicide attempts.

Reducing the Means

One of the key parts of a safety plan is reducing access to means for suicide. This can be done by making the means less accessible or less deadly. Many suicide attempts are made impulsively during a short-term period of crisis. SAMHSA reports that 25% of those aged 13 to 34 who almost died from suicide say that less than five minutes passed between the time they decided to kill themselves and an actual attempt.

Firearms are the most lethal method for suicide and therefore may require special attention. It is suggested that access to firearms be assessed for all clients experiencing suicidal ideation, regardless of whether they mention a firearm as a possible method for suicide.

- The best way to keep someone safe from suicide with firearms is to remove the firearms from the individual's possession. You may suggest that they give their guns to a friend or family member who does not live in the house for a period of time.
- Some police departments may store firearms for periods of time and may also dispose of guns if your client decides that is the best option for them.
- There are times when clients do not feel comfortable moving firearms from their home for various reasons. In these cases, it may be a good idea to suggest safety measures such as cable locks, lock boxes, gun cases, and full size gun safes. Assess whether a client would feel comfortable giving the key to someone else for a while until they feel they can be safe around firearms again.

Other methods of suicide such as when clients are considering overdosing on prescribed medications may require a level of creativity when safety planning. Discuss how the client can reduce access to means to make their environment more safe. Questions to ask may be, "Can a friend or family member keep excess medication while you keep the smaller necessary amounts?" "Can you talk to your doctor about writing prescriptions that need to be filled more often to avoid receiving too much medication at once?" or "Can you keep your medications locked up at times when you do not need them?"

To learn more about reducing access to means for suicide, we recommend the free online training titled Counseling on Access to Lethal Means (CALM). This training can be found online at the Suicide Prevention Resource Center (<https://www.sprc.org>).

Stanely-Brown Safety Plan

The Stanley-Brown Safety Planning Intervention has six steps that increase in level of intervention for your client. Clients are meant to follow the steps in order and proceed to the next step should the current one not help them effectively cope with their suicidal thoughts.

1. The first step is identifying warning signs that a crisis might be developing. Warning signs are a cue to clients that they may be entering a state of crisis and may begin to have suicidal thoughts. A good question to ask is, "What do you experience when you start to think about suicide?"
2. The second step is determining internal coping strategies or things your client can do on their own to help cope with their suicidal thoughts. Coping skills vary depending on the person but may include activities such as relaxation techniques, engaging in hobbies, or activities that provide a distraction.
3. The third step is listing people or environments that can provide a distraction. These social contacts do not necessarily have to be individuals that your client feels comfortable talking to about their crisis but could simply be people that are enjoyable or distracting to be around.
4. The fourth step is reaching out to friends or family who can help. The contact listed in this step are people that your client could talk to about their crisis and share that they are experiencing suicidal thoughts. Ideally, have your client list multiple people and prioritize the list.
5. The fifth step is reaching out to mental health agencies and professionals for help. This is the step that would involve reaching out for emergency care. Have clients identify any mental health professionals they are working with and write down phone numbers. Clients will also list a hospital they would be comfortable going to if they absolutely could not keep themselves safe. The National Suicide Prevention Lifeline is a resource for everyone (1-800-273-8255).
6. The final step is making the environment safe, which involves safety planning around access to means. This step is helpful for anyone who has a potential method for suicide in mind.

After completing the plan, discuss where the client will keep it. It will ideally be in an easily accessible place so it can be used quickly when needed. There are some apps for mobile devices where clients can store their safety plan, such as the My 3. Let your client know that their safety plan can be updated and revised at any time and revisit the safety plan regularly if you continue to work with them.



Considerations for Special Populations

There are different things to take into consideration when working with special populations who are experiencing thoughts of suicide, particularly children and individuals with developmental disabilities.

- Children
 - According to the Center for Disease Control and Prevention, in 2016, suicide was the 2nd leading cause of death for children ages 10-14.
 - A good way to keep everyone on the same page when working with children experiencing thoughts of suicide is to involve caretakers in the safety planning process. This ensures continuity of care once the child formulates a safety plan with a helping professional, goes home, and needs to put that plan into action.
 - With this in mind, we can better understand the importance of normalizing suicide intervention for not only the child's benefit, but for the caretakers as well. Remove the stigma and help them understand they're not alone.
 - Make home environments safer for children by reducing access to the means.
- Individuals with developmental disabilities
 - Those with developmental disabilities have a higher likelihood of having risk factors for suicide when compared to the general population.
 - When assessing, be sure to ask directly about thoughts of suicide or killing oneself. Clear language is important.
 - One thing you can do during the assessment process is to make sure the information you obtain is as accurate as possible. Involving the primary caregiver can help because they may be able to offer additional insight or important information that the individual didn't mention.
 - It can be beneficial to include the primary caregiver in the discussion for safety planning, including access to lethal means.

Treatment Options

The first step in treating someone who is suicidal is making sure they have access to a mental health professional as suicidal thoughts may be a symptom of a larger mental health disorder.

- Hospitalization - Voluntary
 - Involuntary Hospitalization provides intensive treatment in a controlled setting.
 - Partial hospitalization, where the client returns home in the evening, is less disruptive to the client's life and can be helpful with the transition from full hospitalization to returning home.
- Hospitalization - Involuntary
 - Done against someone's will for safety.
 - Involuntary hospitalization usually occurs when someone is a threat to themselves and/or others.
 - Average involuntary hospital stay is 96 hours but this may be extended based on presenting needs.

- Individuals discharged from the hospital for suicidal ideation or behavior are at an increased risk for suicide. The greatest risk is in the first 24-48 hours after leaving the hospital.
- Risk for suicide is 100 times greater for individuals post-hospitalization compared to the general population.
- Post-discharge follow-up is crucial.
- Dialectical Behavioral Therapy (DBT)
 - Dialectical Behavioral Therapy is an intervention developed by Marsha Linehan initially as a treatment for individuals suffering from Borderline Personality Disorder.
 - DBT is shown to significantly reduce frequency and severity of suicidal ideation. Main components are:
 - Individual sessions
 - Group skills teaching
 - Coaching calls
 - Consultation team for the therapist
 - Individual sessions seek to help the individual integrate the skills into their personal lives.
 - Group teaching skills include:
 - Mindfulness
 - Distress tolerance
 - Emotion regulation
 - Interpersonal effectiveness
 - Coaching calls are a unique option where an individual within DBT treatment has emergency numbers for their therapist as well as the other therapists on their team that they can reach out to for on-the-spot coaching of a skill the individual can use during difficult life events.
 - Consultation teams allow therapists to work together to protect each other from burnout, collaborate on problem solving, teach each other DBT skills, and encourage their daily usage within the therapist's lives so they may be taught to clients more effectively.
- Cognitive Behavioral Therapy (CBT)
 - Cognitive Behavioral Therapy is designed around behavioral and cognitive change. The word cognition is defined as the mental action of acquiring knowledge and understanding through thought, experience, and the senses.
 - CBT is a goal-oriented psychotherapy treatment that works to change people's patterns of thinking or behavior.
 - When using CBT with an individual who has experienced suicidal thoughts, it works to build upon client learning to recognize their suicidal thoughts and then promote use of different tools to combat negative cognitive/behavioral patterns. Therapist and client have to collaborate and work together to make change.
 - Sessions can be administered in as little as 5 weeks, but it's common for individuals to attend 5-20 weekly session. The length will depend on the severity of the presenting issues and will be determined by the individual and therapist based on factors like needs, progress, and barriers.

Resources

Resources include not only crisis lines and the Suicide Prevention Lifeline, but different services such as mobile outreach services and walk-in crisis services.

Mobile outreach services include trained professionals that can pre-assess for hospitalization and connect clients with appropriate resources.

Walk-in crisis services offer immediate help and recommend hospitalization when necessary.

A few additional referrals for clients seeking treatment and more information about suicide prevention and treatment:

- SAMHSA Treatment Services Locator can be found online or by calling 1-800-662-HELP (4357)
- National Alliance on Mental Illness Helpline: 1-800-950-NAMI (6264)
- The Suicide Prevention Lifeline: 1-800-273-8255
- American Association of Suicidology ([AAS](#))
- Suicide Prevention Resource Center ([SPRC](#))
- American Foundation for Suicide Prevention ([AFSP](#))
- Center for Disease Control and Prevention ([CDC](#))
- Substance Abuse and Mental Health Services Administration ([SAMHSA](#))