

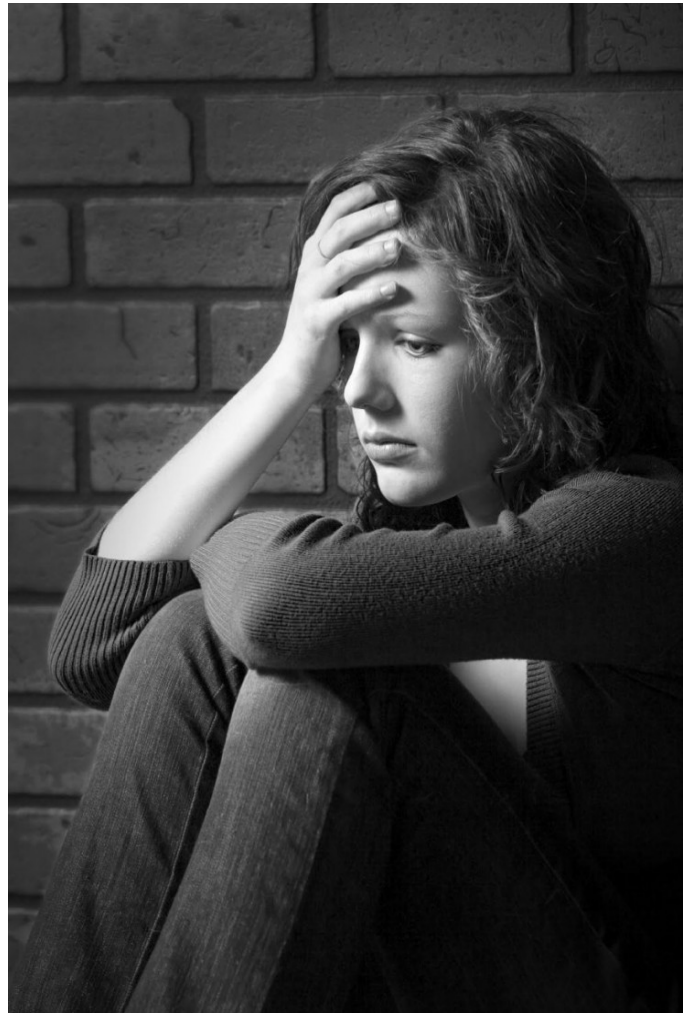
Suicide Among The Young



Facts, Figures, and
Formulas for
Prevention

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“Suicide is a particularly awful way to die: the mental suffering leading up to it is usually prolonged, intense, and unpalliated. There is no morphine equivalent to ease the acute pain, and death not uncommonly is violent and grisly. The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description.”

Kay Redfield Jamison, Ph.D.

Professor of Psychiatry

Johns Hopkins University

“Night Falls Fast: understanding suicide”, pg. 24

Youth Suicide Fact Sheet

- In 2010, suicide ranked as the **third leading** cause of death for young people (ages 15-24); only accidents and homicides occurred more frequently.
- In 2010, **38,364 people** completed suicide (up from 36,909 in 2009). Of these, **4,600 were completed by people between the ages of 15 and 24 (up from 4,371 in 2009)**
- Suicide rates, for 15-24 year olds, have more than **doubled since the 1950’s**, and remained largely stable at these higher levels between the late 1970’s and the mid 1990’s. There was a 29% decline between 1994 and 2003, but then an **8% increase in 2003-2004**.
- In the past 60 years, the suicide rate has **quadrupled for males 15 to 24 years old**, and has **doubled for females of the same age** (CDC, 2002).
- For every completed suicide by youth, it is estimated that **100 to 200 attempts** are made.
- Each day, there are approximately **12 youth suicides**.
- Every **2 hours**, a person under the age of 25 completes suicide.
- **Firearms** remain the most commonly used suicide method among youth, accounting for **50% of all completed suicides**.

Suicide Among Children

- In 2010, **274 children ages 5 to 14 completed suicide in the U.S. (up from 265 in 2009)**
- Suicide rates for those between the **ages of 10-14 increased 60%** between 1981 and 2010.
- In the 10 to 14 age group, **Caucasian** children (ranked 3rd leading cause of death) were far more likely to **complete suicide** than **African American** children (ranked 5th leading cause of death).

Other factors

- Research has shown that most adolescent suicides occur **after school hours** and **in the teen’s home**.
- Within a typical high school classroom, it is likely that **three** students (one boy and two girls) have made a suicide attempt in the past year.
- The typical profile of an adolescent nonfatal suicide attempter is a female who ingests pills, while the profile of the typical suicide completer is a male who dies from a gunshot wound.
- *Most* adolescent suicide attempts are precipitated by **interpersonal conflicts**. The intent of the behavior appears to be to **effect change in the behaviors or attitudes of others**.
- Repeat attempters (those making more than one nonfatal attempt) generally use their behavior as a means of coping with stress and tend to exhibit more chronic symptom logy, poorer coping histories, and a higher presence of suicidal and substance abuse behaviors in their family histories.

Suicide among College Students

- It is estimated that there are more than **1,100 suicides on college campuses per year**.
- **1 in 12** college students have made a suicide plan (2nd leading cause of death)
- In 2000, the American College Health Association surveyed 16,000 college students from 28 college campuses.
 - ❖ **9.5% of students had seriously contemplated suicide.**
 - ❖ 1.5% has made a suicide attempt.
 - ❖ Of the 16,000 students surveyed, only 6.2% of males and 12.8% of females reported a diagnosis of depression. Therefore, **there are a large number of students who are not receiving adequate treatment and/or who remain undiagnosed.**
- Of the students who had seriously considered suicide, 94.8% reported feeling so sad to the point of not functioning at least once in the past year, and 94.4% reported feelings of hopelessness.

Source: American Association of Suicidology webpage. www.suicidology.org , July 20, 2010

Suicide in Montana

Data Source: 2010 National Vital Statistics Reports (December, 2012), Montana Office of Epidemiology and Scientific Support (August, 2012), Montana YRBS (July, 2013)

- ❖ For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past thirty years. **In a report for 2010 in the National Vital Statistics Report, Montana has the 3rd highest rate of suicide in the nation.** ([227 suicides for a rate of 22.9 compared to a national rate of 12](#))
- ❖ Suicide has ranked as the 7th or 8th leading cause of death for Montanans for more than two decades. Gender differences are similar with national statistics, with males at greater risk.
- ❖ In Montana for 2010 there were 29 youth suicides (ages 15-24) for a rate of 21.66. This compares to the national rate for the same age group of 10.54.
- ❖ In Montana for 2010-2011, the highest rate of suicide is among American Indians (27.2 per 100,000) although they only constitute 6% of the state's population. Caucasians are second at 22.2 per 100,000.
- ❖ Firearms (64%), suffocation (17%), and poisoning (15%) are the most common means of suicide in Montana. Other means include carbon monoxide, overdose, motor vehicles accidents, and jumping from heights.
- ❖ According to the 2013 Youth Risk Behavior Survey, during the 12 months before the survey, 7.9% of all Montanan students in grades 9 through 12 had made a suicide attempt. For American Indian students on reservations, 15.1% had attempted suicide one or more times in the twelve months before the survey and for American Indian students attended public school in urban areas, 20.6% have attempted suicide in the past 12 months.
- ❖ Suicide is the number **one** cause of preventable death in Montana for children ages 10-14
- ❖ Over the past ten years (1999-2009), suicide is the number **two** cause of death for children ages 10-14, adolescents ages 15-24 and adults ages 25-34.

"I think of stabbing myself with a knife. When Mom yells at me, I think she does not love me. I worry a lot about my family. Mom is always depressed and sometimes she says she will die soon. My brother becomes very angry, often for no reason. He tried to kill himself last year and had to go to the hospital. Mom was in the hospital once also. I worry a lot about my family. I worry that if something happens to them, no one will take care of me. I feel sad about this."

10 year old girl as quoted in "Night Falls Fast"

FREQUENCY AND RATE OF SUICIDE BY COUNTY OF RESIDENCE

MONTANA RESIDENTS, 1997 - 2011

Montana counties with the highest rate of suicide between 1997 and 2011



County	Suicides	Population*	Crude Rate
BEAVERHEAD	29	135,458	21.4
BIG HORN	26	191,937	13.5
BLAINE	20	100,489	19.9
BROADWATER	16		
CARBON	22	144,985	15.2
CARTER	<5		
CASCADE	224	1,216,092	18.4
CHOUTEAU	13		
CUSTER	45	171,987	26.2
DANIELS	<5		
DAWSON	19		
DEER LODGE	40	137,661	29.1
FALLON	6		
FERGUS	33	173,821	19
FLATHEAD	230	1,222,514	18.8
GALLATIN	179	1,171,236	15.3
GARFIELD	<5		
GLACIER	33	199,749	16.5
GOLDEN VALLEY	<5		
GRANITE	10		
HILL	38	247,398	15.4
JEFFERSON	24	158,531	15.1
JUDITH BASIN	8		
LAKE	83	410,940	20.2
LEWIS & CLARK	141	875,249	16.1
LIBERTY	<5		
LINCOLN	64	281,890	22.7
MCCONE	<5		

County	Suicides	Population*	Crude Rate
MADISON	25	106,453	23.5
MEAGHER	<5		
MINERAL	11		
MISSOULA	263	1,522,942	17.3
MUSSELSHELL	15		
PARK	56	235,902	23.7
PETROLEUM	<5		
PHILLIPS	9		
PONDERA	13		
POWDER RIVER	<5		
POWELL	17		
PRAIRIE	0		
RAVALLI	113	573,021	19.7
RICHLAND	19		
ROOSEVELT	35	156,486	22.4
ROSEBUD	30	139,580	21.5
SANDERS	41	160,221	25.6
SHERIDAN	12		
SILVER BOW	105	505,049	20.8
STILLWATER	23	126,697	18.2
SWEET GRASS	13		
TETON	11		
TOOLE	13		
TREASURE	<5		
VALLEY	13		
WHEATLAND	6		
WIBAUX	0		
YELLOWSTONE	310	2,044,162	15.2



Non-Suicidal Self-Injurious Behavior
“Habitual self-injury may be best thought of as a purposeful, if morbid, act of self-help which enables the subject to re-establish contact with the world”

Armando Favazza, M.D.
 (1996) *Bodies Under Siege. 2nd Ed*
 Baltimore: John Hopkins Press

Facts about Non-Suicidal Self-Injurious Behavior

- Self-injury is a maladaptive mechanism by which troubled teens **cope** with extreme and painful emotions.
- Behaviors include cutting, burning, hitting, poking, hair pulling and head banging; the most common form is **cutting**.
- Self-injurers are typically **not attempting suicide**. By expressing their inner pain through injury, they are keeping themselves from suicide (Only about 0.2% of suicide related deaths were due to cutting 2). Self-injurers can become suicidal or accidentally kill themselves. When it has been determined that the behavior does not have suicidal intent, it is called **Non-Suicidal Self-Injury or NSSI** 2
- Self-injury is an Impulse Disorder, similar to eating disorders, shoplifting, and substance abuse.
- Approximately 4% (12.2 million) of the general population and 15% (2.3 million) of middle and high school students have reported a history of deliberate self-harm 2
- More than 70% of self-injurers are girls, many of whom were abused (although some community samples suggest the rate is similar between genders)
- Self-injurers have low self-esteem and difficulty regulating their emotions. Many come from families characterized by divorce, neglect, and poor parental connectedness.
- Self-injurers can have underlying personality or mood disorders and depression.
- Self-injury appears to have a contagious affect among peer groups.

Source 1: Lieberman, R. (March, 2004) Understanding and Responding to Students who Self-Mutilate, Principal Leadership, pp 10-13.

Source 2: SPRC Research-to-Practice Webinar: Understanding Nonsuicidal Self-Injury in Suicide Prevention, July 27, 2010

Source 3: Source: Am J Psychiatry 2003; 160:1501–1508

Most Common Methods in Adolescents

- | | |
|-----------------------------------|-----|
| • Cutting and Scratching | 75% |
| • Burning | 35% |
| • Picking at scabs | 25% |
| • Self-inflicted tattoos/piercing | 15% |
| • Biting oneself | 10% |
| • Hair pulling | 5% |
| • Hitting oneself | 2% |
| • Bone breaking | 2% |

Source: Source: Am J Psychiatry 2003; 160:1501–1508

Demographics of the young “cutter”

- 70% are females 2
- Average educational level is one year of college. 1
- Average age of first incident of self-injury was 13.5 years 1
- Average number of times they have engaged in self-injury is fifty (50) 1
- 50-90% of those studied report having been sexually abused as children 2

Source: 1. *Cutting and Self-Mutilation: When Teens Injure Themselves* (2003). Kathleen Winkler, Enslow Publishing, Berkeley Heights, NJ.

Source: 2. *Beyond the Pain: Hope and Healing from Self-Injury and Self-Mutilation*, Mark Hirschfeld, LCSW. October 10, 2006 conference in Missoula, MT.

Detecting youth with self-injurious behavior

- **Frequent or unexplained scars**, cuts, bruises, and burns, (often on the arms, thighs, abdomen) and broken bones (fingers, hands, wrists, toes)
- Consistent, inappropriate **use of clothing designed to cover scars**
- **Secretive behavior**, spending unusual amounts of time in the bathroom or other isolated areas
- General signs of **depression**
- Refuse to be involved in activities that involve revealing skin or to change for Physical Education.
- Show evidence of self-injury in their creative writing, journals, or art projects.
- Social and **emotional isolation** and disconnectedness
- Substance abuse
- Possession of **sharp** implements (razor blades, thumb tacks)
- Indications of extreme **anger, sadness, or images of physical harm in class work**, etc
- **Extreme risk taking behaviors** that could result in injuries.

Source: Lieberman, R. (March, 2004) *Understanding and Responding to Students who Self-Mutilate*, Principal Leadership, pp 10-13.

Why Do Young People Do This?

- It is a maladaptive coping skill to manage intense emotions
- Make selves feel “real” instead of numb.
- Feel rush of pleasure, like a runner’s high (endorphin release).
- To physically express emotional pain
- Communicate their pain in the absence of words.
- To re-enact physical or sexual abuse
- To take control over something in their lives.

Source 1: *Cutting and Self-Mutilation: When Teens Injure Themselves* (2003). Kathleen Winkler, Enslow Publishing, Berkeley Heights, NJ.

Source 2: Lieberman, R. (March, 2004) *Understanding and Responding to Students who Self-Mutilate*, Principal Leadership, pp 10-13.

Source 3: Lukomski, J. (2004), *Self-Mutilation: Information and Guidance for School Personnel. Helping Children at Home and School II: Handouts for Families and Educators*, National Association of School Psychologists, pp 91-93.

But, does it work?

Feelings about self-harming

- | | |
|---------------------|--|
| • immediately after | 70% feel better
21% feel worse
9% no change |
| • a few hours later | 30% feel better
47% feel worse
23% no change |
| • a few days later | 18% feel better
50% feel worse
32% no change |

Source: *Beyond the Pain: Hope and Healing from Self-Injury and Self-Mutilation*, Mark Hirschfeld, LCSW. October 10, 2006 conference in Missoula, MT.

Initial Response to Students Engaging in NSSI

Do

- ❖ Approach the student in a calm & caring way
- ❖ Accept the person even though you may not accept the behavior
- ❖ Let the student know that people care
- ❖ Understand that this is a way of coping
- ❖ Use the student's language for NSSI
- ❖ Show respectful willingness to listen
- ❖ Show non-judgmental compassion for their experience

Don't

- ❖ Over-react. It will alienate the student
- ❖ Respond with panic or shock
- ❖ Try to stop the behavior with ultimatums
- ❖ Show interest in the actual behavior
- ❖ Permit the student to relive the experience
- ❖ Talk about it in front of the class or peers
- ❖ Tell the student that you won't tell anyone

Source: Toste, J.R. & Heath, N.L., "School Response to Non-Suicidal Self-Injury". *The Prevention Researcher*, Vol. 17, No. 1, Feb. 2010.

Treatment for People who Self-Injure

Unfortunately, no single definitive approach has been identified to treat RSM. The most promising treatments involve a **combination of cognitive behavioral therapy with medications** (SSRIs, Atypical Antipsychotics) for underlying disorders. 1,2,3,4

Cognitive behavioral therapy focuses on:

- **not telling them to stop cutting** unless you have a replacement behavior. Remember, cutting is a coping skill, a way they are surviving.
- **not condemning their anger**, teach them healthier ways of expressing their anger.
- teaching the youth how to label and **articulate a broader range of emotions**.
- encouraging **journal writing** to enhance awareness and insight.
- helping youth identify **triggers that start cycle of cutting**
- preparing the youth to stop (a **list of 10 things** you could do instead of cutting)
- thinking of it in terms of being a **control issue** and addressing what the control issue is centered around.
- addressing issues of **shame/guilt**
- teaching **stress reduction**/relaxation techniques

Source 1: *Cutting and Self-Mutilation: When Teens Injure Themselves* (2003). Kathleen Winkler, Enslow Publishing, Berkeley Heights, NJ.

Source 2: Lieberman, R. (March, 2004) *Understanding and Responding to Students who Self-Mutilate*, *Principal Leadership*, pp 10-13.

Source 3: Lukomski, J. (2004), *Self-Mutilation: Information and Guidance for School Personnel*, *Helping Children at Home and School II: Handouts for Families and Educators*, National Association of School Psychologists, pp 91-93.

Source 4: *Beyond the Pain: Hope and Healing from Self-Injury and Self-Mutilation*, Mark Hirschfeld, LCSW. October 10, 2006 conference in Missoula, MT.

Suicide Among The Young

Facts, Figures, and Formulas for Prevention

Approximately 90% of those who complete suicide suffer from mental illness.

- The most frequent diagnosis are the mood disorders (Major Depression, Bipolar)
- The 2nd most frequent diagnosis is Alcoholism

REMEMBER: Depression is Treatable!

Depression is one of the most treatable of all psychiatric disorders in young people

- ❖ 86% treatment success rate with a combination of antidepressants and therapy*
- ❖ Only 40-70% with either by themselves.

*Source: The TADS Team. The Treatment for Adolescents with Depression Study (TADS): Long-term Effectiveness and Safety Outcomes. *Archives of General Psychiatry*. Oct 2007; VOL 64(10).

Rebound Effect – This is a very important effect to watch for. People do not recover overnight unless there is a very important reason. People tend to come out of wanting to commit suicide slowly. Some times people who have decided to kill themselves may appear quite happy. This is because they have finally made up their minds and see an end to their pain and anguish. They aren't really happy. They are simply relieved of their burden or stress or pain. Also, sometimes people who are severely depressed and contemplating suicide don't have enough energy to carry it out. But, as the disease begins to "lift" they may regain some of their energy but will still have feelings of hopelessness.

You can't tell the difference by looking at them. Studies of people who have been institutionalized for depression who later killed themselves all indicate that the period of greatest suicidal risk is not when the people are in the depths of depression, but during the first 90 days after the depression begins to lift.

Factors involved in adolescent suicidal ideations

- Lack of parental connectedness is the most important variable (defined as a lack of parental support, poor communication, and not feeling understood or accepted.) 86% of parents of kids who died by suicide reported not knowing their child was suicidal
- Depression by the youth
- Suicidal behavior by the parents
- Family violence

Traits that are highly associated with suicide are:

- Immaturity
- Ego Centricity
- Dependency
- Hostility
- Anxiety
- Low Tolerance for Frustration
- Impulsivity

A few things to remember concerning the method of the **attempted** suicides.

- 70-90% of attempted suicides involve drug overdose.
- Both sexes prefer overdose, but males tend toward violent means (guns, autos)
- In recent years, there has been an increase in wrist cutting. However, this is rarely the sole cause of death in completed suicides.
- Wrist cutting is a common method of self-mutilation seen in people suffering from personality disorders, especially borderline personality disorder. After the attempt many of these youth describe a feeling of relief from cutting on themselves whereas a depressed individual often will express a sense of disappointment or failure.

Some of the demographics associated with the youth who attempts suicide

- Females make more attempts (about 3:1)
- Males succeed more often (about 5:1)
- Average age is 16
- History of previous out of home placements
- Committed criminal offenses, including violence
- Previous suicide attempts

THIS INFORMATION IS GIVEN AS A MEANS OF HELPING PEOPLE BETTER UNDERSTAND THE SUICIDAL YOUTH, NOT AS A MEANS OF TREATING THE YOUTH THEMSELVES. ALWAYS REFER THE YOUTH FOR PROFESSIONAL HELP. IT IS BETTER TO BE SAFE THEN SORRY.

Warning signs that people should be aware of concerning adolescent suicide:

- Abrupt change in personality
- Giving away prized possessions
- Previous suicide attempts
- Increase in drug or alcohol use
- Eating disturbance, either weight gain or loss
- Sleep disturbance, either too much or too little
- Inability to tolerate frustration
- Withdrawal and rebelliousness
- Isolating on the unit and choosing to spend time alone.
- Unwillingness or inability to communicate
- Sexual promiscuity
- Decline in personal hygiene
- Uncharacteristic theft or vandalism
- Flat affect or depressed mood
- Exaggerated or extended apathy
- Complaints of being bored
- Carelessness or increase in accidents
- Unusually long grief reaction (varies with different youth)
- Overall sense of sadness and hopelessness
- Increase in hostility
- Decrease in academic performance
- Difficulty concentrating
- Recent family disruption
- Recent history of running away
- Abrupt end to a romance

The key is that the youth is **acting out of character** and is exhibiting many of these cues. The only way to know if a youth is acting out of character is if you know the youth. If you work with kids, spend the time on developing a **RELATIONSHIP WITH THE YOUTH**.

Understand the role of **ambivalence** in suicide. Very few times is somebody 100% suicidal. Most of the time there is a part of them that wants to live and a part that wants to die. The part that makes a suicidal statement is the part that wants to live. It is a cry for help. Focus on building the part that wants to live.

VERY IMPORTANT - All suicidal ideations are serious and every precaution needs to be taken, even if you believe the action is purely to gain attention. NEVER PUT A YOUTH IN THE POSITION OF NEEDING TO PROVE THAT THEY ARE SERIOUS. Suicidal ideations are a cry for help. DON'T AVOID THE TOPIC, TALK ABOUT THE FEELINGS AND DON'T BE AFRAID TO MENTION THE WORD "SUICIDE." Most youth will respond honestly. Many people are hesitant to bring up the subject of suicide for fear that they will be planting the idea in the mind of the youth. This is a serious mistake! If the youth is suicidal, asking them might lead to a conversation that could prevent the suicide.

Assessing the Degree of Risk – Mental health professionals should be used whenever possible, but once you suspect potential suicide, the best procedure is to approach the youth in a **warm, accepting, non-judgmental manner** and ask a question similar to:

“Have you had thoughts of killing yourself?” or “Are you suicidal?”

Be careful with how you word your questions. Avoid asking questions that start with “why...”. This elicits a defensive response and may cause the youth to close down. For example, don’t ask a youth, “Why would you want to do something like that?” Instead ask, “**How would you harm yourself?**” This will let you quickly know if the youth has a **suicide plan**.

If the youth does have a **suicide plan**, remember the four factors that help you determine the seriousness of the risk.

- **Specificity** – How specific are the details of the plan of attack. The greater the amount of detail, the higher the risk.
- **Lethality** – What is the level of lethality of the proposed method of self-attack? The higher the lethality, the higher the risk.
- **Availability** – What is the availability of the proposed method? The more readily available the proposed method is the higher the risk.
- **Proximity** – What is the proximity of helping resources? The greater the distance the youth is from those you could help him, the higher the risk.

Five factors to use to assess the current level of risk (given an attempt). **The strongest behavioral warning is an attempted suicide.**

- **Dangerousness** – The greater the dangerousness of the attempt, the higher the current level of risk. *e.g. Did the youth take five pills or twenty five?*
- **Intent** – Did the youth **believe** that taking five pills was going to actually kill him?
- **Rescue** – Did the youth tell anyone that they made the attempt? Did the youth leave any signs (notes, give away possessions), or just acted normally?
- **Timing** – The more recent the attempt, the higher the current level of risk.

Talking with a Suicidal Person

This is not meant to be therapy, it is a way of offering hope.

<u>Do</u>	<u>Don't</u>
<ul style="list-style-type: none">• Voice concern• Ask if they have a plan• Tell someone else	<ul style="list-style-type: none">• Leave the person alone• Be sworn to secrecy• Act shocked• Challenge or dare• Argue or debate

Tips for Asking the Suicide Question

- ❖ If in doubt, don’t wait, ask the question
- ❖ If the person is reluctant, be persistent
- ❖ Talk to the person alone in a private setting
- ❖ Allow the person to talk freely
- ❖ Give yourself plenty of time
- ❖ Have your resources handy; phone numbers, counselor’s name and any other information that might help

Remember: How you ask the question is less important than that you ask it

Asking the Question

Direct Approach:

- ❖ “You know, when people are as upset as you seem to be, they sometimes wish they were dead. I’m wondering if you’re feeling that way, too?”
- ❖ “You look pretty miserable, I wonder if you’re thinking about suicide?”
- ❖ “Are you thinking about killing yourself?”

NOTE: If you cannot ask the question, find someone who can.

How NOT to ask the suicide question

- ❖ “You’re not thinking of killing yourself, are you?”
- ❖ “You wouldn’t do anything stupid would you?”
- ❖ “Suicide is a dumb idea. Surely you’re not thinking about suicide?”
- ❖ Never start with “why”. It elicits a defensive response.

Offering Hope

LISTEN, DON’T LEAVE THEM ALONE, GET OTHERS INVOLVED

- ❖ Listen to the problem and give them your full attention.
- ❖ Encourage them to talk about their reasons for dying without challenging them or telling them they “shouldn’t feel that way.” Validate their experience.
- ❖ Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- ❖ Do not rush to judgment
- ❖ Offer hope in any form

Then Ask:

- ❖ “I don’t want you to kill yourself, I want to help”
- ❖ “Will you go with me to get help?”
- ❖ “Will you let me get you some help?”
- ❖ “Will you promise me not to kill yourself until we’ve found some help?”

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE, AND MAKE ALL THE DIFFERENCE.

Getting Help

- ❖ Suicidal people often believe they cannot be helped, so you may have to do more.
- ❖ The best referral involves taking the person directly to someone who can help (therapist, emergency room, pastor, police).
- ❖ The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- ❖ The third best referral is to give referral information and try to get a good faith commitment not to complete or attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

HELP REDUCE THE MEANS OF ATTEMPTING SUICIDE BY REMOVING OR LOCKING UP ALL FIREARMS AND MEDICATIONS.



Handling a Suicidal Caller

“Suicide is not chosen; it happens when pain exceeds

the resources for coping with pain."

1. **Be yourself.** "The right words" are unimportant. If you are concerned, your voice and manner will show it.
2. **Listen. Let the person unload despair, ventilate anger.** If given an opportunity to do this, he or she will feel better by the end of the call. No matter how negative the call seems, the fact that it exists is a positive sign, a cry for help.
3. **Be sympathetic, non-judgmental, patient, calm, accepting.** The caller has done the right thing by getting in touch with another person.
4. If the caller is saying "I'm so depressed, I can't go on," ask **The Question: "Are you having thoughts of suicide?"** You are not putting ideas in his head, you are doing a good thing for him. You are showing him that you are concerned, that you take him seriously, that it is OK for him to share his pain with you.
5. If the answer is yes, you can begin asking a series of further questions: **Have you thought about how you would do it?** (PLAN); **Have you got what you need?** (MEANS); **Have you thought about when you would do it?** (TIME SET). 95% of all suicidal callers will answer no at some point in this series or indicate that the time is set for some date in the future.
6. Simply talking about their problems for a length of time will give suicidal people relief from loneliness and pent up feelings, awareness that another person cares, and a feeling of being understood. They also get tired -- their body chemistry changes. These things take the edge off their agitated state and help them get through a bad night.
7. **Avoid arguments, problem solving, advice giving, quick referrals, belittling and making the caller feel that has to justify his suicidal feelings.** It is not how bad the problem is, but how badly it's hurting the person who has it.
8. **If the person is ingesting drugs, get the details (what, how much, alcohol, other medications, last meal, general health) and call Poison Control at 1-800-525-5042.** Another person can call while you continue to talk to the person, or you can get the caller's permission and do it yourself on another phone while the caller listens to your side of the conversation. If Poison Control recommends immediate medical assistance, ask if the caller has a nearby relative, friend, or neighbor who can assist with transportation or the ambulance. In a few cases the person will initially refuse needed medical assistance. Remember that the call is still a cry for help and stay with him in a sympathetic and non-judgmental way. Ask for his address and phone number in case he changes his mind. (Call the number to make sure it's busy.) If your organization does not trace calls, be sure to tell him that.
9. Your caller may be concerned about someone else who is suicidal. **Just listen, reassure him that he is doing the right thing by taking the situation seriously, and sympathize with his stressful situation.** With some support, many third parties will work out reasonable courses of action on their own. In the rare case where the third party is really a first party, just listening will enable you to move toward his problems. You can ask, "Have you ever been in a situation where you had thoughts of suicide?"
10. **If the person is resistant to help and presents as being at imminent risk of suicide, have another person call 911 with any information that you have about the caller (name, location, etc.).** Do not notify the caller that you are contacting authorities and remain on the line until the authorities arrive or another party arrives that will agree to get the person to medical assistance. Remember that the call is still a cry for help and stay with him in a sympathetic and non-judgmental way. Ask for his address and phone number in case he changes his mind.
11. Do not go it alone. **Get help during the call and debrief afterwards.**

Evidenced-Based Suicide Prevention Programs for Schools

- **ASIST** - A two-day workshop designed to provide participants with gate-keeping knowledge and skills. Gatekeepers are taught to recognize the warning signs and to intervene with appropriate assistance.

- **SOS: Signs of Suicide** - School-based program which combines a curriculum that aims to raise awareness of suicide and reduce stigma of depression. There is also a brief screening for depression and other factors associated with suicidal behavior.
- **Parents as Partners** - 9 page booklet that helps parents recognize the symptoms of depression and the warning signs of suicide in their children and how to respond.
- **Preventing Suicide: A Toolkit for High Schools** was funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to help high schools, school districts, and their partners design and implement strategies to prevent suicide and promote behavioral health among their students. The toolkit is available for download for free at www.prc.mt.gov/suicideprevention

Other Prevention Programs

- **Suicide Prevention Toolkit for Rural Primary Care Physicians** – Assessment and intervention material for physicians in rural communities.
- **Crisis Intervention Training** - CIT came out of the Memphis Police Dept. and is training for law enforcement officers to help them manage mental health issues when they respond to a call.
- **Good Behavior Game** The classroom management strategy is designed to improve aggressive/disruptive classroom behavior. It is implemented when children are in 1st or 2nd grade in order to provide students with the skills they need to respond to later, possibly negative, life experiences and societal influences. Studies have suggested that implementing the “Good Behavior Game” may delay or prevent onset of suicidal ideations and attempts in early adulthood (Wilcox, H.C, Sheppard, K., Hendricks, B., Jeanne, M, Poduska, N.S., Ialongo, W.W., Anthony, J.C. (June, 2008). The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. *Drug and Alcohol Dependence*, 95(1), S60-S73.)

Suicide Prevention Resources

- **In the event of an immediate crisis, Call 911, law enforcement, or take the person to the nearest hospital emergency room or clinic.**
- **Montana Statewide Suicide Hotline - 1-800-273-TALK (8255).** National number then routed regionally to either Voices of Hope (Great Falls) or the Help Center (Bozeman) depending on prefix of phone number.
- **Helpline Mental Health Center, Billings (406) 252-5658**
- **The Community Crisis Center, Billings, 704 N 30th, MT 59102, 259-8800**
- **Voices of Hope, Great Falls, North Central and North East Montana, 406-268-1330**
- **The Help Center, Bozeman, South Central and South East Montana, 406-586-3333**
- **District XI Human Resource Council, Missoula, South West Montana, 406-728-3710**
- **United Way of NW Montana, North West Montana, 406-752-7266**
- **Center for Mental Health, Helena, 443-5353**
- **Hays Morris House Crisis Line, Butte, 1-800-221-0106**
- **Shodair Children’s Hospital (Acute Crisis Unit), Helena, 1-800-447-6614**
- **Montana Suicide Prevention Website.** *Download handouts, flyers, brochures, the toolkit for rural primary care providers, the toolkit for senior living communities, and more.*
www.prc.mt.gov/suicideprevention
- **American Association of Suicidology (202) 237-2280**
Call for written material on suicide and suicide prevention or visit www.suicidology.org
- **Suicide Prevention Resource Center (SPRC) 877-GET-SPRC (438-7772)**
Provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. Includes materials for students, parents, school staff, and others. Includes state suicide data on state pages www.sprc.org.

Depression is Treatable, Suicide is Preventable

If you are in crisis, Hope is available.

Call the Montana Suicide
Prevention Lifeline at

1-800-273-TALK (8255)

www.prc.mt.gov/suicideprevention

