

**Youth Suicide Prevention 101:
What Community Organizations
Need to Know and Do**

Tony Salvatore

**Montgomery County Emergency Service, Inc.
Norristown, PA**

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**Questions or comments may be directed to the author
at tsalvatore@mces.org or at 610-279-6100.**

**Montgomery County Emergency Service, Inc.
50 Beech Drive
Norristown, PA 19403-5421**

Summary:

Youth suicide receives a lot of attention. This booklet offers basic information on what's happening and what could be done so that organizations that relate to young people will have a better understanding of the problem and possible approaches to helping. These are the main points:

- The way suicide is usually described is part of the problem. Saying that someone “committed suicide” stigmatizes the individual, the death, and those left behind. Speaking of “unsuccessful attempts” is not the best way to describe a potentially fatal act involving high ongoing risk.
- Youth suicide is beset by widely held gross misconceptions. Most are perverse as well as wrongheaded and may discourage intervention and prevention.
- In PA, the five-county region, and Montgomery County, youth suicide deaths are a fraction of those among adults and elders. On the other hand, suicide attempts are more common in youths but receive far less attention.
- A suicide attempt imposes a life-long risk of suicide. One-half of all victims made a prior attempt. Youths make more attempts than adults or elders. There may be 30 medically serious attempts yearly in the county and many more that did not receive or need medical care.
- Guns are far and away the most common means of suicide in the young and in all age groups in PA. In 2000-04, firearms were involved in 2% of the attempts and in 54% of the fatalities. 60% of suicides among male youths in PA are by gun.
- Risk factors are variables strongly associated with suicide. Some of the main risk factors for youth suicide are being a white male, using alcohol, hopelessness, having access to guns, poor coping skills, and a history of abuse or other trauma.
- Protective factors offset risk factors and other things that can bring on or aggravate suicidality. They include having good social supports, resilience, self-esteem, problem-solving skills, spirituality, not using alcohol, and not having firearms available.
- According to a new theory, two conditions are necessary for a suicide attempt that is intended to result in death. The individual must have strong desire to die and the ability for lethal self-harm. The former is caused by seeing oneself as a burden to others and a sense of aloneness. The latter is caused by past attempts and self-injury, abuse, and trauma.
- A consensus has been established among experts on the danger signs and warning signs for suicide. Danger signs include hopelessness, social withdrawal, drastic mood changes, and anxiety. The warning signs are talking about dying or suicide, threats of self-harm, seeking lethal means.
- A wide-range of community and school-based youth suicide prevention programs are on hand. Among the most commonly used are training those in routine contact with potentially at-risk youths to recognize the danger and warning signs and what to do about it, and suicide awareness education for students.
- A community agenda for action on youth suicide is needed. This should center on suicide attempt prevention, follow-up after attempts, more evidence-based prevention programs in all schools, more involvement by agencies, reducing access to guns, and increasing the availability of support resources for youth who experience a suicide loss.

Youth suicide prevention is a complex and multi-faceted problem. It has many aspects other than those that are covered here. This is an orientation to the fundamental concerns and a place to start.

The Language:

Basic Definitions:

The following glossary offers definitions of the key terms of suicide prevention:

Suicide Attempt – Deliberate self-harm intended to be fatal that does not result in death.

Suicide Completion – A suicide attempt that results in death.

Lethal Means – The act, process, or instrument by which suicide is completed (e.g., pills or drugs, a handgun, suffocation, etc.)

Parasuicide – Deliberate self-harm with no intent to die that would not lead to death if untreated.

Suicidal Ideation – Thoughts of self-harm or of completing suicide.

Suicidality – Any level of suicidal behavior from ideation to making a plan to an attempt.

Postvention – Aid following a suicide attempt or a suicide loss.

Suicide Risk – The foreseeable and fluctuating likelihood of a completed suicide.

Suicide Survivor – Someone who has experienced the loss of a relative or friend to suicide.

Problematic Usage:

The suicide prevention field is moving away from use of the phrase “committed suicide.” This is because “committed” conveys a strong sense of criminality or illegality and immorality. Suicide was decriminalized many decades ago and most religions do not regard it as a sin. Nonetheless these changes have been slow in being picked up by the media and general public.

The alternative phrasing is “completed suicide.” This reflects recognition that suicide is the outcome of a process of emotional and psychological debilitation rather than a purely voluntary act or decision. This phrase is also nonjudgmental and reduces some of the stigma and disapproval that is often felt by the family and close friends of a suicide victim.

Some descriptions of suicidal behavior minimize the danger inherent to the act. Consider the use of “failed” or “unsuccessful” in regard to a suicide attempt. Both imply a lack of accomplishment. Another example is “suicide gesture” (see “parasuicide” above), which suggests manipulation or even harmlessness. All suicidal behaviors increase risk and vulnerability.

Negative references to suicide abound after one has occurred. For example, the victim of a recent suicide at a high school in the county was repeatedly called “the shooter” by both public officials and the media despite the fact that there was no evidence of homicidality or any effort to harm anyone but himself. Criminalizing such tragedies may deter other at-risk youth from seeking help.

The Myths:

Suicide is a highly stigmatized phenomenon that most people know very little about, and much of what they know is wrong. Some of the most common and invidious myths and misconceptions appear below:

Misconception	Reality
<ul style="list-style-type: none">Those who talk about suicide are “all talk” and won’t complete suicide.	Talking about suicide is a warning sign and many who talk about it do complete suicide.
<ul style="list-style-type: none">Those who have attempted suicide really wanted to die.	Suicidal people only want to be pain-free and would go on if their pain could be ended.
<ul style="list-style-type: none">Asking someone if they are thinking about suicide will only give them “ideas.”	Asking is often the only way to determine risk and to show that you care.
<ul style="list-style-type: none">Those who have attempted suicide are at very low risk of actually completing suicide.	Many suicide victims made one or more previous suicide attempts.
<ul style="list-style-type: none">If someone says that he is suicidal, telling him to “do it” will snap him out of it.	This may be the single worst thing that anyone can do. Never say “go ahead and do it.”
<ul style="list-style-type: none">A suicide attempt that does not result in death shows that the individual wasn’t really serious about dying.	An attempt that doesn’t become a completion doesn’t mean that there was no serious intent to die.
<ul style="list-style-type: none">Most suicides occur with little or no warning	Most people do mention what they are feeling and what’s driving them toward suicide
<ul style="list-style-type: none">Improvement following a suicidal crisis means that the suicidal risk is over.	Many suicides occur following ‘improvement’. Suicidal feelings can return
<ul style="list-style-type: none">Non-fatal acts are only attention-getting behaviors or only attempts to be manipulative	For some people, suicidal behaviors are serious invitations to others to help them. In all cases, it is better to err on the side of safety.
<ul style="list-style-type: none">Once a person is suicidal, he or she will be suicidal forever.	Most suicidal crises are temporary, and will pass if help is provided. However, risk is forever.

These erroneous beliefs are widely accepted. They may deter intervention or cast suicide as inevitable. Eliminating such fallacies is the first step to understanding the true nature of suicide as a preventable community health problem.

The Completions:

The following two tables (Source: PA Department of Health) offer the basic data on suicide deaths among youths and other age groups in the county and in the region. The data indicates that, in terms of mortality, suicide has a much higher incidence among adults and elders than among youths. For the three-year period presented there were 6 suicides in the county representing less than 3% of all suicides. There were almost 5 times as many elders lost to suicide and nearly 30 times as many adults. The county experienced fewer youth suicides than its neighbors in the region.

Table 1. Suicides in Montgomery County by Age, Gender, and Race, 2002-2004

Gender/Race	Age 19/Under	Ages 20-64	Age 65/Over	Totals
White Males	3	128	23	154 (72.3%)
White Females	2	34	5	41 (19.2%)
Black Males	1	10	0	11 (5.2%)
Black Females	0	2	0	2 (0.9%)
Other Males	0	3	0	3 (1.4%)
Other Females	0	2	0	2 (0.9%)
Totals	6 (2.8%)	179 (84.0%)	28 (13.1%)	213

Table 2. Suicides x Age for Southeastern Pennsylvania, 2002-2004

County	<20	% County	21-64	% County	65/Over	% County
Bucks	14	7.5	138	74.2	34	18.3
Chester	8	7.2	87	78.4	16	14.4
Delaware	11	7.1	126	80.2	20	12.7
Montgomery	6	2.8	179	84.0	28	13.2
Philadelphia	32	6.7	389	81.9	54	11.4
Region	71	6.2	919	80.5	152	13.3

In 2005, there were 3 youth suicides in Montgomery County and 2 victims were males.

The Attempts:

Suicide attempts, especially among young people, are often not given the gravity that they warrant. Suicide attempts are the subject of many of the myths of suicide. Here's why suicide attempts are a deadly serious matter:

1. The intent to die was present.
2. A doable plan was present
3. Lethal means were present.
4. The ability to lethally harm oneself was present.
5. The warning signs were missed or ignored.

A suicide attempt puts the individual at permanent life-long risk of suicide. This is because about half of all suicide victims made at least one previous attempt. 40% of these deaths occurred within one-year of the initial suicide attempt.

Surviving a suicide attempt is not a benign event. A suicide attempt is highly traumatizing and many who have made a suicide attempt experience post-traumatic stress disorder (which is often overlooked). A suicide attempt greatly heightens risk.

An attempted suicide is the closest thing that there is to a completed suicide. The only difference is that death did not occur but everything else is the same. This should be borne in mind when we consider the low number of suicides among young people. These only are the tip of the iceberg.

There is a greater frequency of suicide attempts among young people than among adults and elders. With teens, girls make many more attempts than boys. Use of guns by males accounts for this variance. Guns turn suicide attempts into completions.

Data on suicide attempts at the community or county level is not readily available, but we have some state information from the Suicide Prevention Resource Center (SPRC):

Table 3. Suicide Attempts in PA Requiring Hospitalization, Age 19 and Under, 2004

Suicides			Attempts		
Male	Female	Total	Male	Female	Total
66 (79.5%)	17 (20.5%)	83	263 (29.6%)	626 (70.4%)	889

Among young males there were 4 medically serious suicide attempts for each suicide; the ratio for young females was 36:1. State-wide there are 11 medically serious suicide attempts for each suicide among youths or a rate of about 95 occurrences for each 100,000 young people. There are about 2.5 such attempts among youths everyday somewhere in this state.

In Montgomery County there may be as many as 20-30 or more physically injurious suicide attempts in the under age 20 population annually. There are doubtlessly scores more that either did not require medical treatment or that were not brought to the attention of a medical provider. All attempts should receive appropriate aftercare and follow-up.

The Means:

Many different means are used in youth suicides in PA, but one-half of the deaths involve firearms. In 2003-05, 61.3% of the male victims used guns and almost all (60.3%) were white. Only 13 females in this age group used guns, which was 8.2% of all suicides in female youths in the state.

In 2000-04, 2% of the suicide attempts in the Commonwealth across all ages involved firearms, but these attempts produced 54% of the fatalities (SPRC). A 2007 study found in a national sample that guns played a role in 5% of suicide attempts and in 90% of the fatalities. The same study reported that drugs of some kind were used in 75% of attempts but were associated with only 3% of the deaths.

Accordingly, separating those at risk of suicide from guns would seem to merit a prominent place in any suicide prevention strategy. This definitely applies to youths, particularly males, where impulsiveness has been determined to be a major suicide risk factor.

The State of New Jersey and New York City have more restrictive gun laws than Pennsylvania. Both have suicide rates just over one-half of those in PA. Guns are linked to only 30% of NJ suicides and only 20% of those in New York City (SPRC). Both areas have a significantly lower incidence of youth suicide than PA (and overall suicide rates about two-thirds that of Montgomery County).

The 2007 study previously referenced found that household firearms ownership levels are strongly correlated with high rates of suicides for all ages. Numerous studies have directly tied the presence of guns in the home to greater suicide risk in youths living in such households. Guns already present in the home are used in virtually all firearms suicides among youths.

A common counter argument to means restriction with guns is that suicidal individuals will simply substitute another means such as poison or suffocation. Research shows the opposite. Acutely suicidal individuals do not immediately turn to another means to die when the method that they planned to employ becomes unavailable.

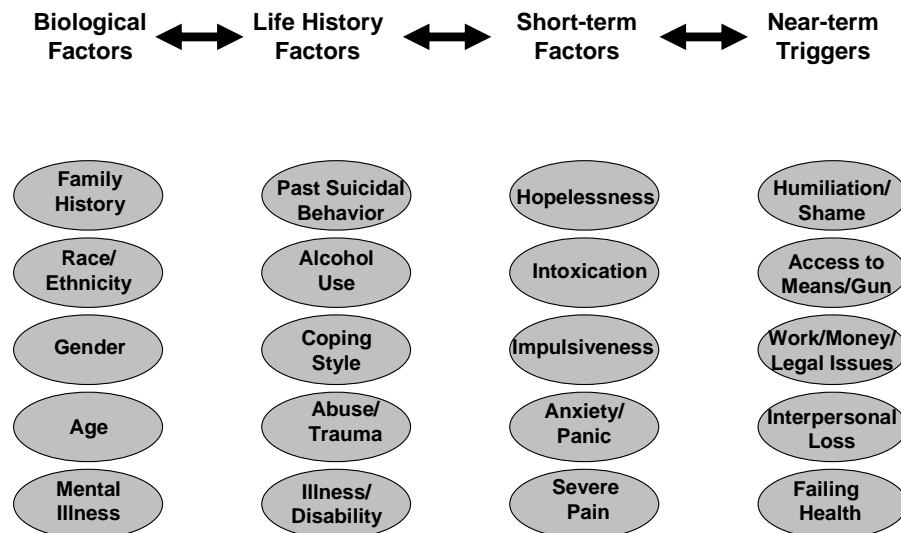
As noted above, impulsiveness is rampant as a risk driver with male youths and it is often abetted by alcohol. Adding at-hand firearms to this mix is a sure recipe for tragedy. Taking guns out of the picture will likely stymie an attempt, at least temporarily, and that's a help.

Impeding access to guns by removing them from the home or at least securely storing them apart from any ammunition would create a window of opportunity for intervention and help before the individual finds other guns or considers other means. Most local police departments can help with gun locks and other gun safety advice as well as with disposal of unneeded firearms. MCES's Outreach Services Department can also help.

The same may be said for prescription and over-the-counter medications. These account for far fewer deaths than guns but are used in many times more attempts. Expired and unused medications should be discarded. Making these products less available is an accepted suicide attempt prevention tactic.

The Risk Factors:

Risk factors are variables found to be strongly associated with suicides. Risk factors alone and in combination facilitate suicide, but do not *cause* suicide. Risk factors may be present without there being any risk of suicide. Risk factors vary in terms of when and how they are acquired and in modifiability as shown in this grid:



Risk factors accumulate and cluster as well as interact. Generally speaking, more risk factors means more risk, but serious risk may be present in individuals with only a few identifiable risk factors.

The risk factors correlated with most suicides among youths are:

- One or more past suicide attempts
- White male
- Alcohol use
- Hopelessness
- Availability of firearms
- Poor coping, problem-solving, help-seeking
- Background of abuse, trauma, violence

A past suicide attempt is the most serious risk factor. About one-half of all suicide victims have made one or more prior attempts. A past attempt is the closest thing we have to a predictor of suicide.

Risk factors are the principal (but not exclusive) focus in evaluating an individual's potential for completing suicide. They are also the targets of suicide prevention and crisis intervention. *The absence of identifiable risk factors does not indicate the absence of suicide risk.*

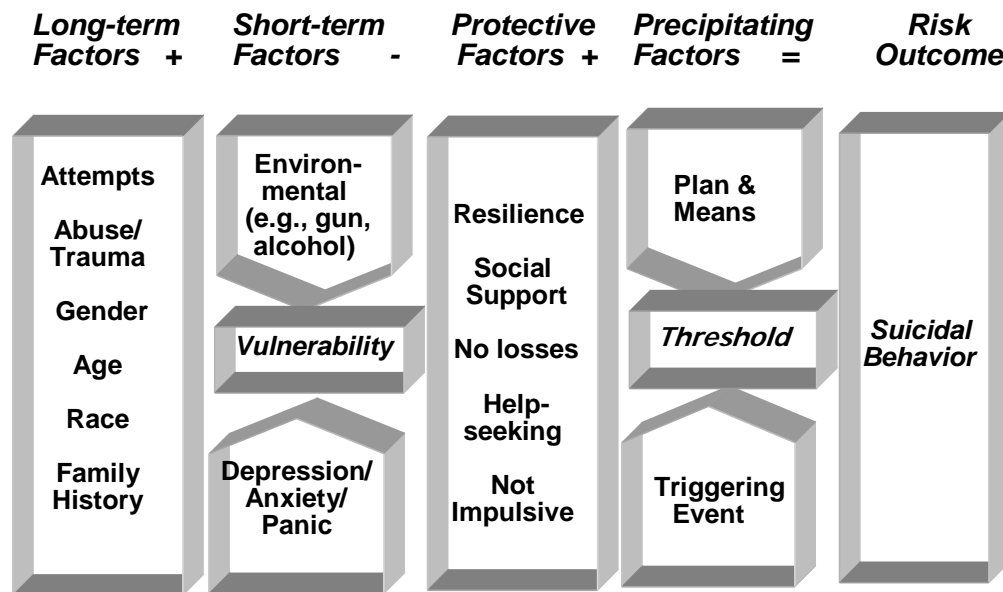
The Protective Factors:

Protective factors are behaviors, traits, characteristics, and other variables that have been found to offset risk factors of suicide and other precipitants of suicidal behavior in an individual. Here are some of the main protective factors for youth suicide:

- Strong family, social ties, support sources
- Optimism, resilience
- Emotional stability (not impulsive)
- Strong self-esteem, sense of self-worth
- Good problem-solving, coping skills
- Willingness to seek help
- Religiosity, spirituality
- No firearms in household
- No use of alcohol

These factors can be developed and enhanced (though this may be easier with some than others). Female gender and being non-white are also protective factors.

This diagram illustrates how protective factors function in the suicide risk process:

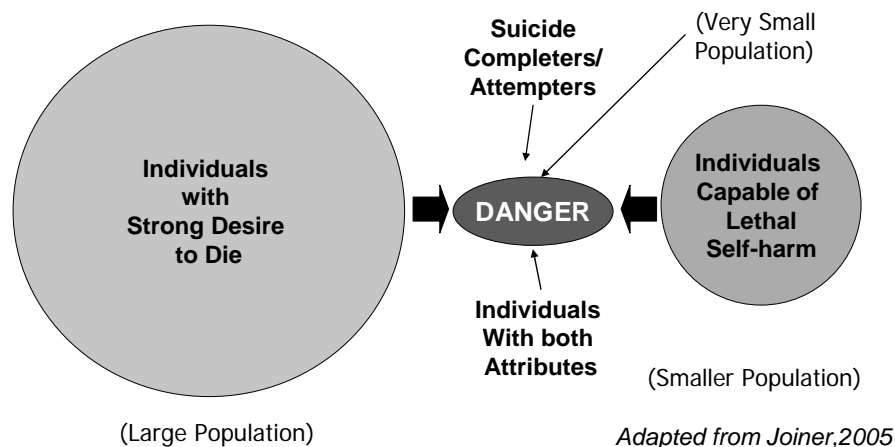


Protective factors are an individual’s safety net on the pathway to suicide.

The Cause:

Recently, a theoretical model of suicide was proposed that promises to be a major step forward in our ability to explain suicide among all age groups. In *Why People Die by Suicide* (Harvard University Press, 2005), Thomas Joiner notes that two conditions must be present to overcome the instinct for self-preservation. The first is a desire to die caused by a lost sense of social belonging and the perception that one is a burden. The second is the capacity for lethal self-harm acquired by experience with abuse, pain, past suicidality, and other factors. Both must be present for a completed suicide as shown below:

Joiner Model:



This conceptualization gives some insight as to why suicide occurs so infrequently (30,000 deaths yearly in a US population of 300 million). Chronic and transient cases of depression may total in the millions and many of the individuals affected may experience thoughts of self-harm or suicide, but few proceed further. This is because the ability to complete suicide is far less common than suicidal ideation. It is only when the two coincide that a suicide attempt may occur.

The model is especially applicable to youths. Interpersonal and peer group relationship losses (or being cut from a team or activity) can lead to a young person feeling that he or she doesn't belong. Likewise school or legal problems may cause someone to feel that they are a burden to her or his family. Both may lead to thinking about death, one of the prerequisites for suicidal behavior.

Risk increases and suicidality becomes a possibility when the young person has made a prior attempt (regardless of lethality), uses alcohol, has a history of trauma or violence, has experienced abuse, engages in cutting, suffers severe physical or emotional pain, or has access to firearms or other lethal means. These and similar factors break down the inhibition to self-harm and increase one might be called "suicide competence."

The Signs:

In 2003, an interdisciplinary panel convened by the American Association of Suicidology developed a consensus statement of the key danger signs and warning signs of suicide. Danger signs are pre-crisis, early indications of emerging risk that should result in the individual having immediate contact with a health care provider. Warning signs are the earliest detectable indicators of heightened suicide risk in the near-term (i.e., minutes, hours, days), and should trigger an immediate crisis intervention response (calling MCES at 610-279-6100 or 9-1-1).

The Danger Signs:

- Hopelessness
- Feeling trapped - No way out
- Withdrawal from family or friends
- Anxiety, agitation, sleep problems
- Dramatic mood changes
- No reason for living
- Reckless, risk-taking behavior

The Warning Signs:

- Threatening to hurt or kill self
- Looking for ways to kill self
- Talking or writing about death, dying, or suicide

Both sets of signs apply to young people as well as other age groups.

Do's and Don'ts if Warning Signs are Present:

<ul style="list-style-type: none">[✓] Ask if he/she is thinking about suicide[✓] Take the threat very seriously[✓] L-I-S-T-E-N !!![✓] Show that you care and <u>say it</u>[✓] Call MCES crisis center or 9-1-1[✓] Keep her/him lethal means (and car keys	<ul style="list-style-type: none">[✓] Do not leave him/her alone[✓] Do not let him/her go off alone[✓] Do not be judgmental[✓] Do not argue or analyze[✓] Do not try to shock (e.g. "Go ahead!")[✓] Do not accept "I'm okay now."
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Five Commandments of Suicide Prevention:

- I. Thou shalt believe that anyone can become suicidal.
- II. Thou shalt understand that when someone is suicidal it is her or his immediate problem.
- III. Thou shalt always give the suicidal the benefit of the doubt.
- IV. Thou shalt get suicidal individuals a psychiatric evaluation ASAP.
- V. Thou shalt not assume that voiced suicidal intent is manipulation or that suicidality will just pass.

The Programs:

Below is a partial inventory of programs that have been used in youth suicide prevention efforts. Some of these programs are present in various communities and school districts in the county.

Community-wide Programs

Community Suicide Prevention Education/Information: This involves basic information on suicide, risk and protective factors, warning signs, sources of help, and how to handle an emergency through the media, group presentations, and other means. It may also include the use of health fairs, walks, etc.

Community Gatekeeper Training: This involves training individuals in the community who may have contact with individuals who may be at risk of suicide. This includes police, postal workers, clergy, merchants, recreation and community organization staff, municipal personnel, and others. .

Means Restriction: This involves activities to reduce access to firearms, drugs, and other lethal means. It may include education about risk of firearms or other means in the home, and may involve local leaders, gun owners, hunters, physicians, mental health specialists, and others.

Post-suicide Postvention: This involves peer and/or professionally led assistance and support to individuals and families who have experienced a suicide loss. Services may include intervention at the scene, in-home visits, telephone counseling, support groups, and self-help information.

School System-based Programs

School Gatekeeper Training: This involves training administrators, teachers, nurses, aides, counselors, coaches, bus drivers, security officers, and others to recognize students at risk of suicide and refer them to sources of help.

Screening Programs: The use of surveys, questionnaires, or other self-reports or data collection means to identify at-risk students for further assessment and help as indicated. Screening generally directly asks students about depressive symptoms, past or current suicidality, and risk factors.

Suicide Awareness Curriculum: This involves educating students on the incidence of suicide, suicide warning signs and risk factors, and community resources. It recognizes that adolescents are peer-oriented and are more likely to self-disclose about suicidality to a friend than an adult. Multiple sessions to semester-long programs appear to be the most beneficial.

Suicidal Crisis Postvention: This is a policy-guided school-wide response to a suicide threat, attempt, or completion by a student, former student, staff, or other member of the school community. . Elements include informing students and parents about the incident, staff debriefing, student counseling and support, media relations, and mobilization of community resources.

Post-crisis School Re-entry: Support of a student's return to school after a suicide attempt, hospitalization, or other crisis-related absence. It involves re-connecting the student to the school and its services and deterring any prospects for stigmatization or humiliation. Components include a school designated liaison working with the outside providers and parents.

The Agenda:

Here's what can be done in youth suicide prevention in Montgomery County:

- 1. Frame a youth suicide attempt prevention strategy:** The high incidence of suicide among youths warrants direct attention. An appropriate strategy will address: (i) promoting understanding of the ongoing risk that follows a suicide attempt; (ii) correcting the myths surrounding suicide attempts; and (iii) developing resources to support those trying to recover from a suicide attempt.
- 2. Develop additional community-based and school-based postvention and aftercare services for youths who have made a suicide attempt:** Those who have survived a suicide attempt are the group at highest risk of suicide. These youths would benefit from prevention in the form of postvention. The need immediate and ongoing support after the attempt in a setting where they feel safe and psychoeducation on understanding and managing their ongoing risk.
- 3. Integrate existing youth suicide prevention efforts into a county-wide suicide prevention strategy:** Present youth suicide prevention efforts are fragmented and discontinuous. Youth-oriented prevention is typically not coordinated with other efforts. All suicide prevention measures in a community should be integrated in a county strategy that produces a prevention continuum
- 4. Destigmatize the language used to describe suicide in the media and to discuss it in the classroom:** Mistaken beliefs about suicide are part of the problem and an obstacle to meaningful prevention. This problem can be particularly pernicious among youths who may be misinformed by peers or by adults who should know better.
- 5. Assure that all school districts as well non-public and private schools have evidence-based suicide prevention programs.** Students at high-risk of suicide typically do not self-refer or seek help from school staff. Schools must make it easy to identify such students and offer them aid.
- 6. Increase the number of community youth organizations that have suicide prevention programs.** School-based programs must be complemented by recourses that are available when they are not.
- 7. Promote reduction of access to guns by youths at home and in the community.** This must include community education on suicide risk and guns, involving pediatricians and family practitioners in assessing access to firearms among their patients, and publicizing the availability of gun safety devices and safe disposal of unwanted firearms.
- 8. Promote school and community-based suicide loss support for youths who have a close relative or peer to suicide.** Youth bereavement after suicide is often marginalized and typically only offered after a school-related suicide. Suicide loss puts those close to the victim at risk and postvention must always be available.

Readings:

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On-line Sources:

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American Foundation for Suicide Prevention	www.afsp.org
Children’s Safety Network	www.childrensafetynetwork.org
Columbia University Teen Screen Program	www.teenscreen.org
Jason Foundation	www.jasonfoundation.org
National Youth Violence Prevention Resource Center	www.safeyouth.org
Services for Teens at Risk (STAR) Center	www.starcenter.pitt.edu/
Suicide Prevention Resource Center	www.sprc.org