
Emergency Responders Management of Patients Who May Have Attempted Suicide

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Abstract

According to Lanny Berman, Ph.D., a psychologist who is the Executive Director of the American Association of Suicidology, EMS professionals' role in managing patients at risk for suicide or who have attempted suicide is critical: "To the regard that someone has not already carried out a fatal act, EMS professionals play an extraordinarily important role in helping to have an emergency intervention or a rescue occur and transporting the patient to a medical or mental health facility."

Dr. Berman continued, "People who have made an attempt or who are threatening a lethal attempt are quite at risk for another attempt... in fact about 30 to 40 percent of individuals who kill themselves have attempted suicide before--so the effectiveness of that intervention is extraordinarily important in relation to the future life or potential death of that individual." Dr. Berman emphasized that one of the factors that decreases the risk for subsequent suicidal behavior is if the patient is "treated with respect and is engaged in a caring way" by professionals.

Another expert who spoke about the role of EMS professionals is Douglas Jacobs, M.D., Associate Clinical Professor of Psychiatry at Harvard Medical School. The information that EMS professionals bring to the emergency department is very important, said Dr. Jacobs, who served as the Chairperson for the American Psychiatric Association's "Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors" and was the Editor of The Harvard Medical School Guide to Suicide Assessment and Intervention.

Additionally, Dr. Jacobs is the Founder and Executive Director of "Screening for Mental Health" <http://www.mentalhealthscreening.org>, a non-profit organization that provides screenings for depression, bipolar disorder, anxiety disorders, eating disorders, and alcohol problems. In conjunction with offering its National Depression Screening Day, "Screening for Mental Health" introduced a unique suicide intervention training called "SOS: Signs of Suicide."

STATISTICS

Managing these patients properly is especially important when one considers the number of individuals who attempt suicide or who kill themselves each year. "In 2002, 132,353 people were hospitalized following the suicide attempts; 116,639 were treated in emergency departments and released. ¹ These figures do not include people who received treatment at a non-hospital facility or whose suicide attempt was misdiagnosed or not reported.

Here is some additional information on suicide attempts copied from the American Association of Suicidology's (AAS) fact sheet "Suicide in the U.S.A." ²

"Although there are no official statistics on attempted suicide (e.g. non-fatal actions), it is generally estimated that there is 25 attempts for each death by suicide.

- Risk of attempted (nonfatal) suicide is greatest among females and the young.
- Females have generally been found to make 3 times as many attempts as males.
- Ratios of attempted to completed suicides for youth are estimated to range between 100 to 1 and 200 to 1."

Information about suicide attempts is also available in “U.S.A. Suicide: 2002 Official Final Data,” prepared for the American Association of Suicidology by John L. McIntosh, Ph.D:³

“All figures are estimates; no official U.S. national data [on attempts] are compiled

- 790,000 annual attempts in U.S. (using 25 to 1 ratio)
- 25 attempts for every death by suicide for nation. 100-200:1 for young; 4:1 for elderly
- 5 million living Americans (estimate) have attempted to kill themselves
- 3 female attempts for each male attempt.”

STATISTICS: DEATH BY SUICIDE

Although this article only covers individuals who are at risk for attempting suicide or who have made a suicide attempt, medical professionals may be surprised to learn that, according to 2002 data, suicide is the 11th ranking cause of death in the United States (N=31,655).⁴ Although suicide is commonly associated with young adults; in actuality, people of all ages kill themselves, and the elderly are actually at greatest risk:

- College Students: Suicide is the second leading cause of death among college age students. In 2004 alone, it was predicted that more than 1,000 college students would kill themselves⁵
- Young People: “Suicide is the third leading cause of death among young people ages 15 to 24. In 2001, 3,971 suicides were reported in this group,” according to Anderson and Smith.⁶
- Men: “Suicide is the eighth leading cause of death for all U.S. men” Anderson and Smith, 2003.⁷ “Males are four times more likely to die by suicide than females,” CDC, 2004⁸
- Elderly: “Suicide rates increase with age and are very high among those 65 years and older.”⁹ “Elderly have rates of suicide close to 50% higher than that of the nation as a whole (all ages).”¹⁰
- According to 2002 data, 5,548 adults over the age of 65 committed suicide, which is a rate of 15.6% per 100,000 population.¹¹

Laura Fochtmann, M.D., a Professor in the Departments of Psychiatry and Behavioral Sciences, Pharmacological Sciences, and Emergency Medicine at Stony Brook University School of Medicine in Stony Brook, New York, pointed out that “these demographic features [which are for people who complete suicide] differ from those of the typical individual who attempts suicide. For example, those making a suicide attempt are more likely to be younger and more likely to be female than those who die by suicide.”¹²

POSSIBLE CHARACTERISTICS OF THESE PATIENTS

MENTAL ILLNESS

“The biggest thing for EMS professionals to understand is that suicide is associated with mental illness [including drug and alcohol dependency] and that they are doing the patient a service by getting these people into an evaluation,” said Dr. Jacobs.

Morton Silverman, M.D., a psychiatrist who is the Senior Advisor to the Suicide Prevention Resource Center, said, “Keep in mind, that most mental illnesses, as well as suicidal behaviors, are treatable.”

Here are some information about the relationship between mental illness (including alcohol and chemical dependency) and attempted suicide and death by suicide. This information is copied from the American Association of Suicidology's (AAS) fact sheet “Suicide in the U.S.A.”:¹³

- “Psychological autopsy studies reflect that more than 90% of completed suicides had one or more mental disorders.”
- “Approximately 60 percent of those who die by suicide had a diagnosable depression.”
- “The risk of suicide [death by suicide] in alcoholics is 50 to 70 percent higher than the general population.”
- “The vast majority of individuals who are suicidal often display cues and warning signs.”

According to “Suicide in the USA,”¹⁴ “Individuals may display one or more of the problems or ‘signs’ detailed below. The following list describes some of the potential factors of risk for suicide [both attempted suicide and death by suicide]. If observed, a professional evaluation is strongly recommended.

- Presence of a psychiatric disorder (e.g. depression, drug or alcohol, behavior disorders, conduct disorder [e.g., runs away or has been incarcerated])
- The expression/communication of thoughts of suicide, death, dying or afterlife (in a context of sadness, boredom, hopelessness, or negative feelings)
- Impulsive and aggressive behavior; frequent expressions of rage
- Increase use of alcohol or drugs
- Recent severe stressor (e.g. difficulties in dealing with sexual orientation, unplanned pregnancy, significant real or anticipated loss, etc.)
- Family instability; significant family conflict.”

In addition to the above-mentioned potential risk factors, Dr. Fochtmann, noted, (as did Dr. Berman previously) that “prior suicide attempts place an individual at higher risk for later suicide attempts or suicide.”

Some people who have attempted suicide, according to Dr. Fochtmann, “are in the midst of a crisis (such as the loss of job or break up of a relationship) that is superimposed on one or more risk factors such as a mood disorder or use of alcohol or other substances. The important point is that the more risk factors that exist, the more the patient's risk would be increased.”

UNPREDICTABLE BEHAVIOR

Before interacting with patients who have attempted suicide, keep in mind that their behavior may be unpredictable. Dr. Jacobs said, “Many of these patients can be intoxicated and unpredictably violent.”

Patty Hesse, EMT-I, the Assistant Chief of the Oxford Fire/Rescue in Oxford, Maine, also commented on these patients' behavior. She has worked in this field for 16 years. Additionally, Ms. Hesse has been an instructor for the “Maine Youth Suicide Prevention Program” <http://www.maine.gov/suicide> since the program began five years ago. “The program's goals are to reduce the incidence of fatal and non-fatal suicidal behavior among Maine youth aged 10-24 and to improve youth access to appropriate prevention and intervention services,” according to Cheryl DiCara, the Program's Coordinator. The program, a priority initiative of the Maine Children's Cabinet, is supported by

Departments of Health and Human Services, Education, Public Safety and Corrections.

Ms. Hesse said, “You never know what to expect with these patients. They may be very calm, or they could be very angry... That's why it's important to keep the situation on a very calm level.”

Nels Sanddal, M.S., REMT-B, is the President of Critical Illness and Trauma Foundation and the Director of the Rural Emergency Medical Services and Trauma Technical Assistance Center in Bozeman, Montana. Additionally, he volunteers as an EMT with the Gallatin River Ranch Volunteer Fire and Rescue Squad in Manhattan, Montana.

Sanddal said, “Even though the patient may be exhibiting erratic behavior, a compassionate and professional demeanor can go a long ways towards building trust and stabilizing the situation.”

FIREARMS

Another very important factor to keep in mind is that “firearms remain the most commonly utilized method of completing suicide by essentially all groups,” according to “Suicide in the U.S.A.”¹⁵

Firearms are used in 55 percent of instances in which people kill themselves, but “far less frequently” in attempted suicides, according to Dr. Berman. For example, Dr. Fochtmann noted, “for the year 2002, the CDC reported 3,295 nonfatal firearm injuries due to self-harm, which corresponds to an age-adjusted population based rate of 1.15 injuries per 100,000 persons. In contrast, in that same year there were 17,108 suicide firearm deaths, corresponding to an age-adjusted population based rate of 5.91 per 100,000 persons.”¹⁶

BEFORE ARRIVING ON THE SCENE

EMPATHIZE

Here are some ideas that responders may wish to keep in mind before arriving on the scene: empathize with the patient, respect the patient, and take all suicide threats seriously.

Dr. Silverman suggested that EMS professionals recognize that the individual is in “extreme psychological pain.” “Just the recognition that the individual is emotionally suffering and physically hurting is important. Once you recognize that the individual is in psychological pain, you can approach them with a certain degree of understanding, and you can

talk to them in a calm and supportive manner, recognizing that they may not be catching every word. You will start your interaction in a different place, on a different level.”

Mr. Sanddal said, “When death looks better than life, you are at a place that very few of us have ever been, and we shouldn't be quick to judge, and we shouldn't just blow this whole issue off as—‘they are just crazy folks and there is nothing we can do for them.’ There are things we can do... Anything we can do to prevent a suicide is worthwhile.”

RESPECT THE PATIENT

Another factor responders may wish to keep in mind before arriving on the scene is--respecting the patient. Dr. Berman previously mentioned that one of the factors that decreases the risk for subsequent suicidal behavior is if the patient is “treated with respect and is engaged in a caring way” by professionals. “Don't blame the patient, adopt a moral stance, ... or make statements that make the patient feel guilty,” Dr. Berman said.

Similarly, Dr. Silverman said, “You don't want to in any way to demean the individual, suggest they failed, or say something like: ‘you don't know how to do this right ’or ‘you must be crazy to have done this.’”

SERIOUS MATTER

Frank W. Nagorka, J.D., EMT-P, emphasized the importance of taking all suicide threats seriously. Mr. Nagorka is a partner in the law firm Mora Baugh Waitzman & Unger, LLC, in Chicago, Illinois. He frequently represents EMS operations. Additionally, he has worked as an EMT-P for 21 years. Currently he works in Cicero, Illinois, as a paramedic for the fire department and in Chicago for MASE (Medical And Safety Enterprises), a company that provides EMS at public events and private venues. Mr. Nagorka has spoken nationally and internationally at EMS conferences. Additionally he is on the adjunct faculty at various teaching institutions. Pulse Productions, now Thomson Delmar Learning, sells videotapes that feature Mr. Nagorka's presentations on various medical-legal topics. In his previous position as the Assistant Corporation Counsel for the City of Chicago, Mr. Nagorka's primary responsibility was the defense of the Chicago Fire Department, 9-1-1, and assorted safety services.

Mr. Nagorka said, “... Always, always take seriously a threat to kill themselves. The moment you don't take the threat seriously is the moment you will have a problem.”

Similarly, Dr. Berman said, “It may not seem like the patient wanted to commit suicide from the EMS professionals' perspective; however, the patient may have wanted to kill themselves. Therefore, it is very important to take seriously whatever the person says.”

Dr. Fochtmann expanded on this idea and noted, “For example, someone in a suicide attempt may have taken four aspirins. Medical personnel would not see that as particularly serious from a medical standpoint. However, the individual taking the aspirin may have been absolutely serious about killing themselves when they made this attempt. Anyone who has made a suicide attempt is in a state of emotional crisis that is very, very serious to them.”

Dr. Fochtmann continued, “You can't draw any correlations between actual medical severity and their [the patient's] intention. It is their intentions that tend to be more correlated with the patient's eventual risk of killing themselves.”

AT THE SCENE

SCENE SAFETY

In general, for many calls involving attempted suicide, Mr. Nagorka said the police would be dispatched with the ambulance. The police will secure the scene. While waiting for the scene to be secured, Mr. Nagorka waits on the periphery of the area and turns off the ambulance's lights. “You don't want to interfere with the police,” he said

After the police have secured the scene, Mr. Nagorka said that EMS professionals should take a number of safety precautions.

MEDICAL CONSIDERATIONS

The patient may be suffering from medical abnormalities. According to Mr. Sanddal, the treatment will be dictated by the physiologic condition of the patient, beginning with the ABC's.

Dr. Fochtmann explained, “With a patient who presents with what looks like a behavioral presentation, you shouldn't assume that it's just a psychiatric problem. It may be possible for someone who has an underlying metabolic problem to behave in an unusual fashion or for someone to think a person is suicidal and call EMS. [For example, someone might call 9-1-1 if] a patient is wandering around confused in the middle of the traffic. The patient might not be actually thinking of killing themselves; instead, they might be confused because of a low blood sugar.”

Dr. Fochtmann emphasized that “you have to make sure that there is not an underlying medical condition contributing to the [psychiatric] problem. You have to be just as attentive to physical abnormalities [as mental health abnormalities] and, in some instances, more attentive to physical abnormalities because the person with a psychiatric presentation may not tell you everything they know, or they may be less able to give you a clear cut history of what is going with them, what their past medical history is, and what medications they may or may not be taking on a regular basis.”

In addition to an underlying medical condition, Dr. Fochtmann noted that “there may be an unrecognized physical complication of an actual suicide attempt that the patient may or may not be telling you about.”

Keeping in mind that the patient may not provide a complete history, Dr. Fochtmann emphasized, “it's really important to get as much history as possible from other people to be able to pinpoint other possible physical causes of their symptoms that you might not have picked up otherwise.”

Mr. Nagorka reiterated the importance of assessing for physical problems such as metabolic imbalance, low blood sugar, and/or polypharmacy when evaluating these patients.

SIGNS OF MENTAL ILLNESS

Dr. Silverman suggested, “looking for signs to aid in determining whether the individual is at increased risk for suicide.” He said that some of the questions EMS professionals may ask are the following:

1. Is the patient under the influence of a drug? Is their speech slurred? Are they lethargic?
2. Did the individual state that their intent was to die?
3. Can the person assure you what they would do if they should feel suicidal in the future? Whom would they call? What would they do to avoid acting in a self-destructive manner?”

Mr. Nagorka said that emergency professionals may wish to consider looking for pills. If the pills are in the bottle, look at the date of the prescription. “If the bottle is empty, and it's a sedative, one can draw a reasonable conclusion that the person attempting suicide may have taken those pills, and you can then alert the physician to that possibility,” he said.

Additionally, Mr. Nagorka said responders may wish to consider looking for a note. If you find one, bring it with you

to the hospital, he said.

Similarly, Dr. Jacobs also said that responders may wish to consider looking for pills, notes, a rope, and “any other evidence that a person has made or contemplated a self-destructive act.” Dr. Jacobs recommended that EMS professional should bring any items that may be helpful in evaluating the patient, such as a note or empty pill bottle to the hospital.

Mr. Sanddal noted, “Anything taken from the scene should also be documented and catalogued. In the event that the person should die, there will be a death scene evaluation.”

MANAGE PEOPLE AT THE SCENE

EMS professionals may have to manage the other people at the scene. Ms. Hesse said, “If possible, while assessing the patient, try to clear the room of family members unless they are having a calming affect on the patient. Keep the police or another EMS responder in the room with you for safety. Try to get the patient out to the ambulance as soon as possible. This may not be easy because they are scared of what will happen to them.”

COMMUNICATING WITH THE PATIENT ASSESS

When first speaking with the patient, Dr. Berman said that responders may wish to consider doing a quick assessment of the individual's ability to understand so that “your explanations and the wording you choose have the potential to be understood [by the patient].”

Furthermore, Dr. Silverman suggested that responders may wish to consider trying to determine the best way to approach the patient “by picking up cues from the setting, from others who may be present, or by quickly assessing the patient's demeanor, facial expressions, and body language.” He noted that some patients may be relieved if EMS professionals establish a sense of control and authority; whereas, this may frighten other patients.

EXPLAIN

Keep in mind that the patient may be very afraid and having fearful thoughts such as “Who are all these strangers?” “Will I be committed to a psychiatric hospital?” said Dr. Silverman. To help calm the patient, he suggested that EMS professionals may wish to consider calmly and slowly explaining the following: “who they are, why they are there, how they were called, how they can help, what they need to know from the patient, and what their [EMS Professionals]

responsibilities are.”

DIRECT QUESTIONS

Dr. Jacobs said that EMS professionals may wish to consider asking several direct questions about suicide such as the following:

- “Have you ever considered suicide?”
- If you have, for how long?
- If you haven't made an attempt, have you been rehearsing an attempt?
- Have you tried to commit suicide before?”

Dr. Jacobs said that these questions may be followed up by asking, “What are you considering?” And then finally say: “We would like to help you. We would like you to go to talk to someone and be evaluated.”

Some EMS professionals may be surprised that experts recommended asking direct questions. Mr. Sanddal explained why this was critical: “There have been a lot of misconceptions that if we [EMS professionals] talk about suicide somehow we are promoting it and putting ideas into people's heads that weren't already there, but the reality is that clinical studies show that if you talk about it, people are more apt to give you useful information.”

NO PROMISES

Additionally, Dr. Jacobs, who had served for ten years as the Director of Psychiatric Emergency Service at the Cambridge Hospital, in Cambridge, Massachusetts, emphasized that EMS professionals “shouldn't promise that the patient will or will not be admitted [to a psychiatric hospital]. Don't say, ‘just come down to the hospital and talk to someone, they won't keep you.’ Don't make any promises one way or another.” This is very important, Dr. Jacobs said, because if EMS professionals tell the patient that they won't be admitted and then the hospital staff needs to admit them, this may create a lot of unnecessary problems for the hospital's staff.

Similarly, Dr. Berman said, if the patient does feel hopeless, don't try to counsel the individual or offer “false hope.”

AT THE HOSPITAL

When the patient arrives at the hospital, Mr. Nagorka hands his report to the Emergency Department. Then he speaks with the attending Emergency Department physician. Mr.

Nagorka explained, “I don't offer conclusions; rather, I offer specific factual details. Yes, factual details will be in the report, but the physician may have questions—and need additional information to make an appropriate diagnosis—that I would be able to answer by having a brief dialogue with him... For example, there have been circumstances where I thought there may have been carbon monoxide poisoning and that would explain the mental status changes. By alerting the physician to my suspicions, the appropriate tests could be ordered and treatment provided.”

Asked how the physicians usually respond, Mr. Nagorka replied, “Not only are they responsive, they are writing down the things I told them.”

POTENTIAL PROBLEMS

PATIENTS WHO SAY, “I'M FINE, LET ME GO.”

Dr. Jacobs said that it is not uncommon for these patients to change their mind and suddenly say that they feel fine and that they would never attempt to kill themselves or that they were just joking when they said they were going to kill themselves: “People in suicidal crisis can be emotionally labile and provocative. They may try to talk ER professionals out of bringing them for help either because of their intent to act on their suicidal impulses or their beliefs that they are hopeless and not worthy of help. When people come to the hospital after having made a suicide attempt, it is not uncommon for them to say: ‘I'm fine, let me go.’ So certainly they will also say this to EMS, and EMS needs to understand that this phenomenon can occur.”

What can EMS professionals do if the patient still refuses to go to the hospital? According to U.S. law, do patients have this right?

Dr. Fochtmann noted, “Although the laws vary from state to state, someone who has shown evidence of dangerousness to him or herself or to others as a result of a mental disorder can generally be taken for an emergency assessment upon authorization by a physician. This is true even if the individual objects to transport.”

Mr. Nagorka said: “What EMS providers should do very early in the game is call medical control... The physician is qualified by the mental health code of every state to make a determination of whether a person can be brought to the hospital for a mental health assessment and possible confinement pursuant to the Mental Health Code of the state for a certain period of time for psychiatric evaluation.”

TRYING TO ENGAGE RESPONDERS

Another expert who mentioned problems that may occur with this population is William Bake, M.P.H., E.M.T.-P, a Research Specialist for the National Association of EMS Educators and a part-time paramedic in Pittsburgh, Pennsylvania, with 16 years experience in pre-hospital care.

Mr. Bake said, “No matter how depressed the patients may present or how hopeless the patient may present, the EMS professionals should never take it personally. The patient may inadvertently attempt to bring the EMS professional into their live and make them feel bad as well. For instance, a patient may say ‘there is just so much wrong, you wouldn’t understand.’ A portion of the EMS professional’s job is attaining a basic understanding of the problem. This is necessary for appropriate patient care. However, by hearing the surface problems, an EMS professional may become too involved. If this happens, try your best to remain non-judgmental, show sympathy, and stay calm.”

INAPPROPRIATE REMARKS

A number of individuals reported to Dr. Silverman that people at the scene had made inappropriate remarks. Dr. Silverman emphasized that these individuals did not specify who these first responders were, and thus, they may not have been emergency medical services personnel. These remarks included the following: “I’ve seen other people who tried to do this. And your attempt is not very successful.”

Ms. Hesse reported that she had heard some inappropriate remarks: “You are going to have that. It is human nature--that would be your first response because you can’t imagine somebody wanting to do that. I have heard people say, ‘Why did you do that? It is pretty stupid.’” She noted that responders who complete the Maine Youth Suicide program no longer have this perspective.

Similarly, Mr. Nagorka said that it is “not uncommon that inappropriate remarks are made.” Asked why this was the case, Mr. Nagorka replied, “I don’t think that EMS providers are sufficiently trained in dealing with mental health emergencies... Because of this lack of training, I think sometimes EMS providers are uncomfortable around someone who presents in an acute state of mental illness.”

Like other medical professionals, EMS professionals, themselves, may face increased risk of suicide. However, it is beyond the scope of this article to offer in-depth information about this topic.

FUNDING FOR SUICIDE PREVENTION

Keeping in mind, the prevalence of attempted and completed suicides, the possibility of responders saying inappropriate remarks, and the possible increased risks associated with responders; emergency professionals may want to apply for funding to establish a prevention and/or educational program to address these issues.

Funding sources, including grants, often require that responders include statistics about suicide in their locality. But how do they obtain these statistics?

Alan Smith, Ph.D., M.P.H., an epidemiologist for the County of San Diego, Health and Human Services Agency, Division of Emergency Medical Services, developed a toolkit—consisting primarily of specially formulated Excel worksheets--that emergency professionals can use to collect data relating to suicide in their jurisdiction.

The toolkit consists of the following components, which are listed on this Web page:

<http://www.emsa.ca.gov/emsddivision/dct.asp> under the heading “Elderly Patients” in the lower left side:

- A paper outlining the findings pertaining to suicide rates in California
- A specially formulated Excel worksheet that contains data and charts on the suicide rates, suicide attempts, and suicide methods, by California county, from 1996 to 2001
- A blank specially formulated Excel worksheet that EMS professionals can use to collect data on suicide-related incidents
- Instructions for California EMS professionals on using the blank worksheet
- A comprehensive listing of resources about suicide and suicide prevention

Although he developed the toolkit for employees of EMS Departments in California, Dr. Smith said that it could also be used by any EMS department to collect data in their locality. He explained why he designed it so that other departments can use it: “This [suicide] was a topic I had been working on for awhile. I was mainly doing data analysis of our local medical examiner data. As I doing this, I realized that the County of San Diego is one of the few counties [in the United States] that actually has an

epidemiologist that is working within emergency medical services and that a lot of other places don't have the personnel or resources to do this sort of data analysis.”

According to Dr. Smith, the toolkit is very easy to use. EMS professionals do not have to have a background in statistics or any special training. Funding for the toolkit was provided by the State of California Emergency Medical Services Authority Under Special Project Grant #EMS-2058.

What is the main reason it is necessary to use these specially designed Excel sheets to collect this data? Dr. Smith explained, when collecting data from different sources it is necessary to convert all the data so that it has the same denominator such as “per 100,000 people.” “For example, how would you compile these two sets of data: 1,500 people who are 85-year-olds with a frequency count of five deaths from suicide and a population of 45 to 64 years olds of 25,000 with a frequency of 20 deaths from suicide?” asked Dr. Smith. In order to do this, you must determine the frequencies per a common denominator (i.e. per 100,000). Then you can compare the data sets in a meaningful way. Dr. Smith's worksheet automatically determines the number of incidents per a population of 100,000.

USING DR. SMITH'S TOOLKIT

Before you start, you may want to look at the workbook filled in with data from 1996 to 2001:
<http://www.emsa.ca.gov/emdivision/suipivot.xls>. The directions that accompany this completed worksheet can be viewed by clicking on this link:
http://www.emsa.ca.gov/emdivision/using_worksheet.pdf.

Your finished product should look similar--with three worksheets: one for suicide rates; one, suicide methods; and one, attempt rates. The specially configured Excel sheets will automatically generate charts for these three data sets.

To complete a worksheet for your jurisdiction follow these steps:

1.) View the “Toolkit for Elderly Suicide Prevention”
<http://www.emsa.ca.gov/emdivision/suiprevtk.pdf>. The last page lists places that usually have data relating to suicide. It also provides information about assessing each of these sources.

Once you have collected data, the next step is to open the blank worksheet that you will be using:
<http://www.emsa.ca.gov/emdivision/suiworksheetblank.xls>. Also open the link “Using the Suicide data Worksheet” :

http://www.emsa.ca.gov/emdivision/using_worksheet.pdf and review the information in the third paragraph.

Simply enter your suicide incidence and population data as appropriate in the three different worksheets: suicide rates, suicide methods, attempt rates. The worksheets will automatically calculate the rate per 100,000 and create charts for each of the three data sets, Dr. Smith explained.

Regarding the data he collected from 1996 to 2001, Dr. Smith said, “California's suicide rate is pretty comparable to the nation's rate; however, what we found looking demographically [at data from California] was that the elderly, particularly, the elderly men, have the highest rates of suicide across the spectrum. Therefore, researchers and suicide interventions should focus on elderly men.” In terms of national data, elderly men also have the highest rate of death by suicide, he noted.

If you need additional information, Dr. Smith can be reached at Alan.Smith@sdcounty.ca.gov.

RESOURCES

Here is more information about some of organizations, programs, and resources mentioned in the article as well as other resources:

1.) “Screening for Mental Health”
<http://www.mentalhealthscreening.org> is a non-profit organization that provides screenings for depression, bipolar disorder, anxiety disorders, eating disorders, and alcohol problems. In conjunction with offering its National Depression Screening Day, “Screening for Mental Health” introduced a unique suicide intervention training called “SOS: Signs of Suicide.” This training features a video depicting the right and wrong ways to react to someone exhibiting suicide distress signals as well as interviews with real people who attempted suicide or lost someone to suicide. To learn more about the “SOS” program, call 1-781-239-0071 or visit the Web site <http://www.MentalHealthScreening.org>. Additionally, the organization has created the Web site <http://www.StopaSuicide.org> that is endorsed by the American Psychiatric Association. The Web site's section for health care providers offers a wide variety of resources including a PowerPoint presentation: “Suicide Assessment Guidelines” and a listing of state and local suicide prevention organizations.

2.) Maine Youth Suicide Prevention Program:

<http://www.maine.gov/suicide> “The Maine Youth Suicide Prevention Program is a priority initiative of the Maine Children's Cabinet. The program is supported by Departments of Health and Human Services, Education, Public Safety and Corrections. “Program goals are to reduce the incidence of fatal and non-fatal suicidal behavior among Maine youth aged 10-24 and to improve youth access to appropriate prevention and intervention services,” according to Cheryl DiCara, Program Coordinator of the Maine Youth Suicide Prevention Program.

3.) The National Suicide Prevention Lifeline:

<http://www.suicidepreventionlifeline.org/default.aspx>

According to the Web site, “The National Suicide Prevention Lifeline's mission is to provide immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number—1-800-273-TALK (8255). It is the only national suicide prevention and intervention telephone resource funded by the Federal Government.”

4.) The Web site address for the American Association of Suicidology is <http://www.suicidology.org>. The Web site contains many fact sheets on suicide and suicide prevention, as well as links to other organizations.

5.) Lanny Berman, Ph.D., Executive Director of the American Association of Suicidology, recommended the following book:

Maris, R.W., Berman, A. L., & Silverman, M. M. (2000). *Comprehensive Textbook of Suicidology*. NY: Guilford.

6a.) The Jed Foundation: <http://www.jedfoundation.org>. “The Jed Foundation is a New York-based 501(c)(3) charitable organization that works to reduce the suicide rate among college and university students in the United States. It focuses on understanding the underlying mental health causes of suicide and producing more effective programs of information and intervention that are used on college and university campuses,” according to the Web site. “The Web site contains program initiatives, articles of interest, a page for parents and for students, about the foundation and suicide facts,” said Donna Satow, co-founder of the Jed Foundation.

6b.) The Jed foundation invites colleges and universities, at no charge, to utilize its web-based mental health resource: <http://www.Ulifeline.org>. “Ulifeline is an anonymous, Internet-based resource that provides students with a non-

threatening and supportive link to their college mental health or counseling center. It was created to give students more knowledge about mental health and the signs and symptoms of emotional problems.

“Lifeline is a sophisticated and anonymous website enabling students to address such issues as depression, stress, and the pressures of college life. The site includes a library of mental health information and an interactive screening tool to help students uncover whether they or a friend are at risk. Importantly, the site was created by students for students and is maintained by the highly supervised involvement of the most respected professionals in the mental health field,” according to the Web site. Today, Ulifeline.org serves over 3.5 million college students on 450 campuses nation-wide.

6c.) Liz Lipton's, M.A., article, “Jed Foundation” was featured in the fall 2004 issue of *The Bulletin*, published by the New York State Psychiatric Association. To view the article, go to <http://www.nyspsych.org> and then click on “Bulletin,” (which is on the top bar,) and then click on “Visit The Bulletin's Archives,” and then “Fall 2004.”

7.) <http://www.omh.state.ny.us/omhweb/speak> Suicide Prevention Education and Awareness Kits (SPEAK) for distribution across the New York State. SPEAK is a statewide public awareness and education program that is part of New York's larger suicide prevention effort. It includes information kits designed to help you become aware of the facts about suicide, help you become familiar with its warning signs, and show you how to help someone who may be considering suicide.

8.) The New York Times article “Social Isolation, Guns and a ‘Culture of Suicide’” by Fox Butterfield, February 13, 2005, provides information about rural areas and the risk of suicide. The article features quotes by Nels Sanddal, M.S., REMT-B, the President of Critical Illness and Trauma Foundation and the Director of the Rural Emergency Medical Services and Trauma Technical Assistance Center in Bozeman, Montana. Additionally, he volunteers as an EMT with the Gallatin River Ranch Volunteer Fire and Rescue Squad in Manhattan, Montana.

9.) The American Foundation for Suicide Prevention: <http://www.afsp.org>.

The American Foundation for Suicide Prevention (AFSP) is the only national not-for-profit organization exclusively dedicated to funding research, developing prevention initiatives and offering educational programs and

conferences for survivors, mental health professionals, physicians and the public.

10.) Suicide Prevention Resource Center:

<http://www.sprc.org>. As the nation's first federally funded suicide prevention resource center, SPRC supports suicide prevention with the best of science, skills, and practice to advance the National Strategy for Suicide Prevention. The Center assists states in furthering their efforts in suicide prevention, and provides resources, including a website, library, evidence-based practices, and training. Supported by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center is operated by Health and Human Development Programs at Education Development Center, Inc. (EDC).

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