NEW MEXICO DEPARTMENT OF HEALTH

Question Persuade Refer

Presented by the OFFICE OF SCHOOL & ADOLESCENT HEALTH (OSAH)

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HOW DO YOU KNOW WHEN YOU'RE NOT OK?

For many people, this is not an easy topic.

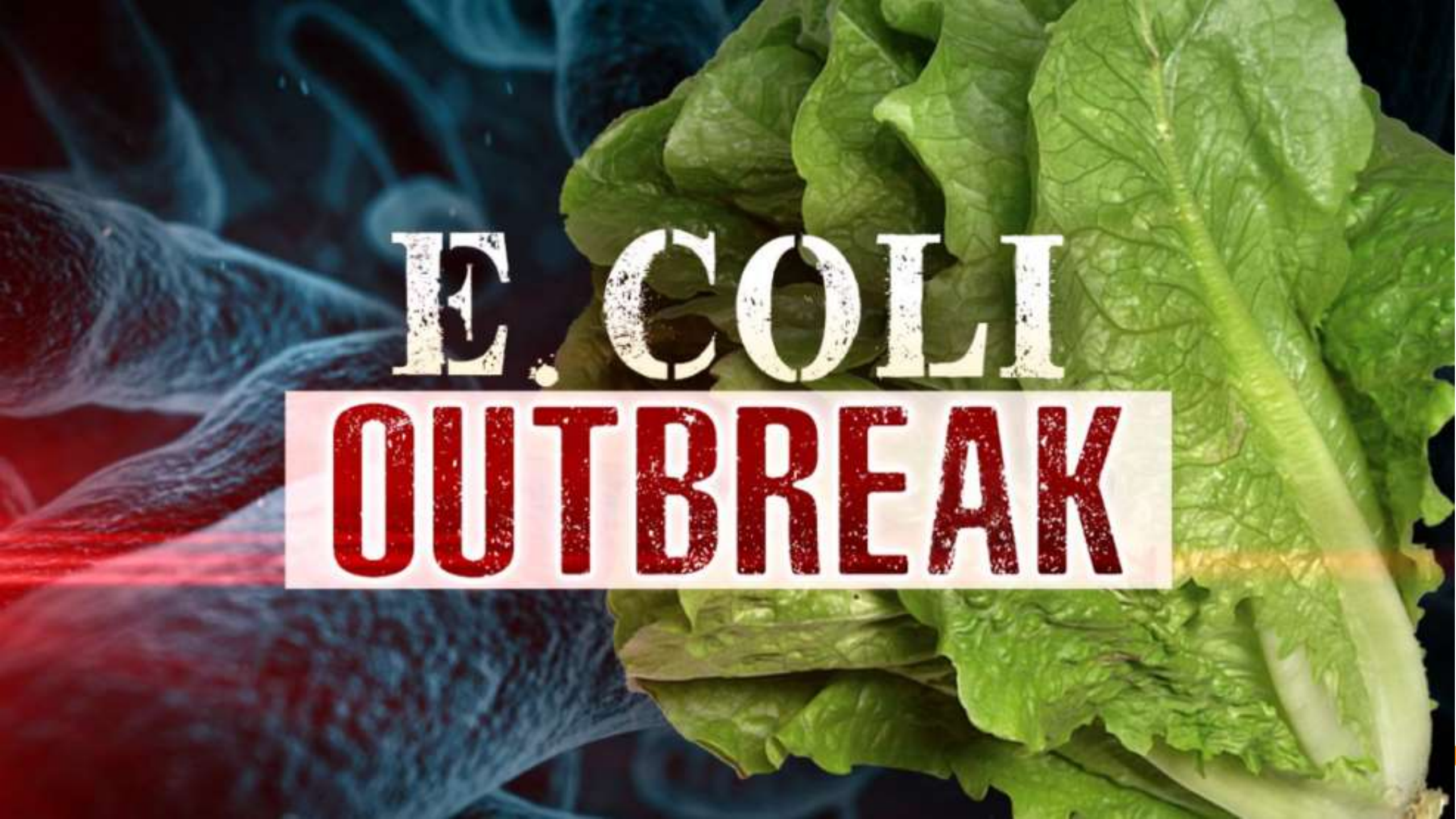
Preventionists often experience compassion fatigue and may be more susceptible to the impact of suicide.

Please monitor yourself closely, and seek out help when needed.

1-855-662-7474 NM Crisis & Access Line

AND

Save your EAP phone # in your cell for easy access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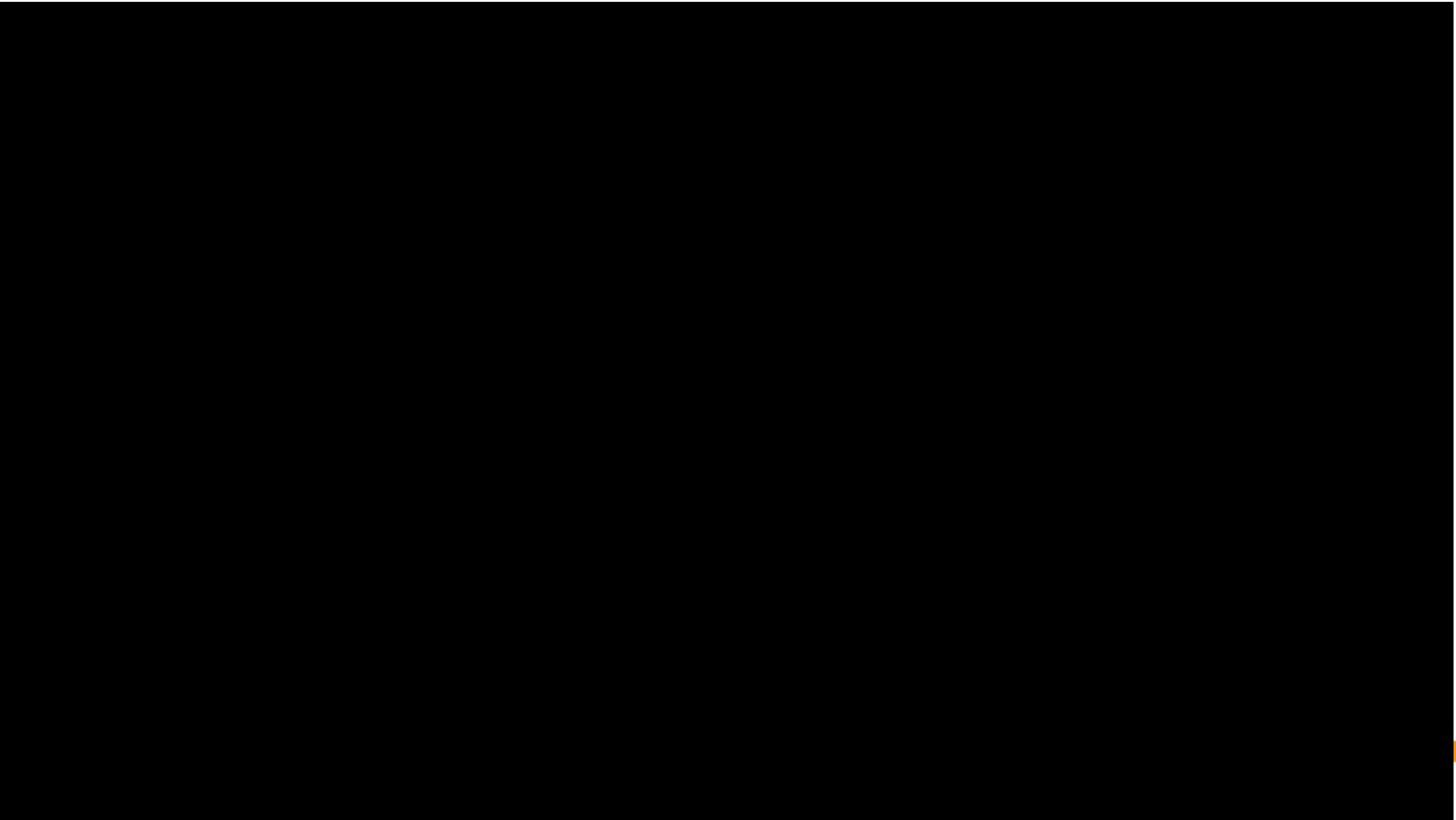
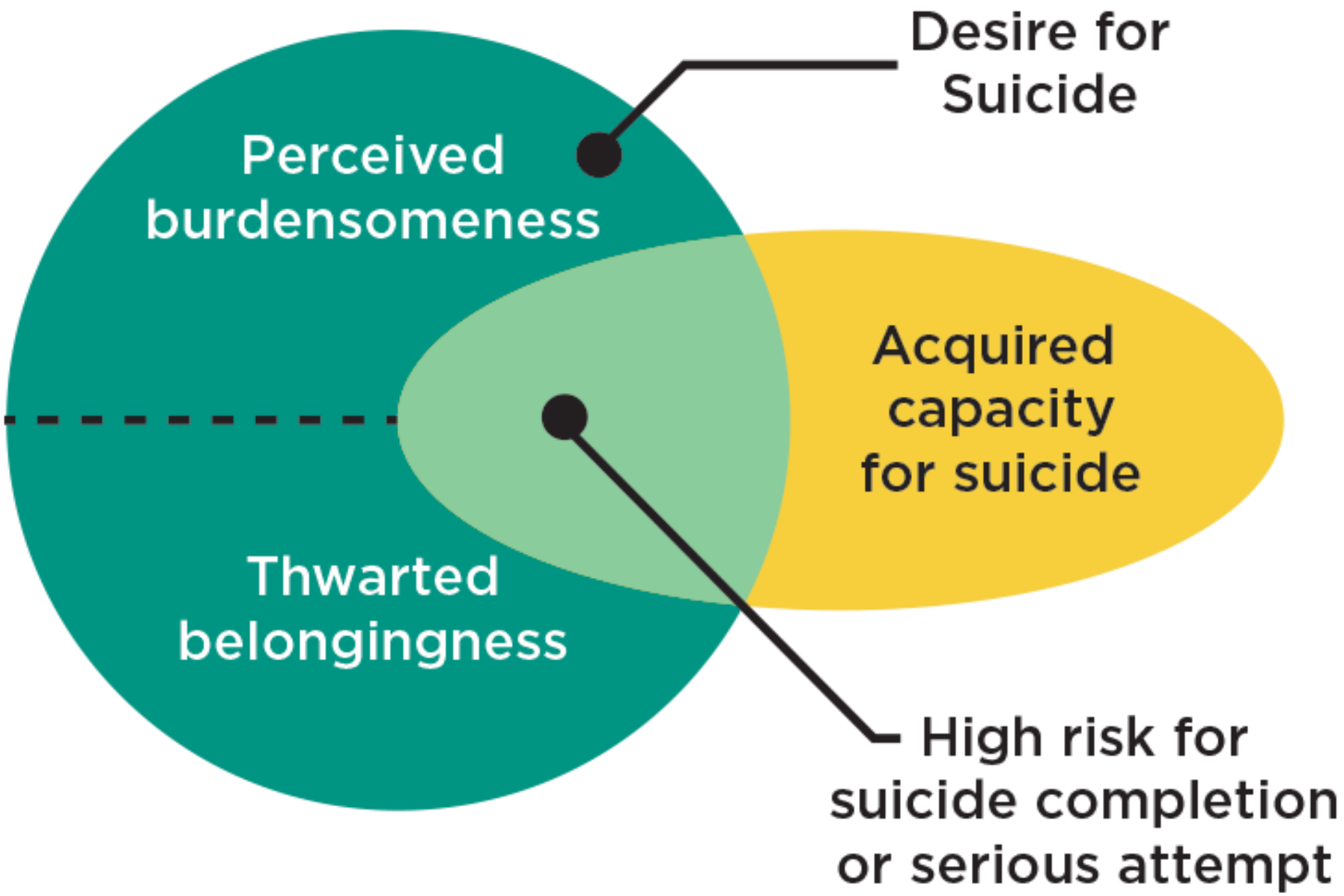


INTRO VID

Terms

- Completed or Successful?
- Died by vs. Commit
- Suicide Loss Survivor
- Suicide Attempt Survivor



From Thomas Joiner's Suicide Theory, *Why People Die by Suicide*, Cambridge, MA: Harvard University Press

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Protective Factors

Family & School Connectedness

Reduced Access to Firearms

Safe Schools

Academic Achievement

Self-Esteem

Risk Factors

Mental Illness

Substance Abuse

Firearms in the Household

Previous Suicide Attempts

Non-Suicidal Self-Injury

Exposure to Suicide

Low Self-Esteem

American Association of Suicidology Youth Suicidal Behavior Fact Sheet

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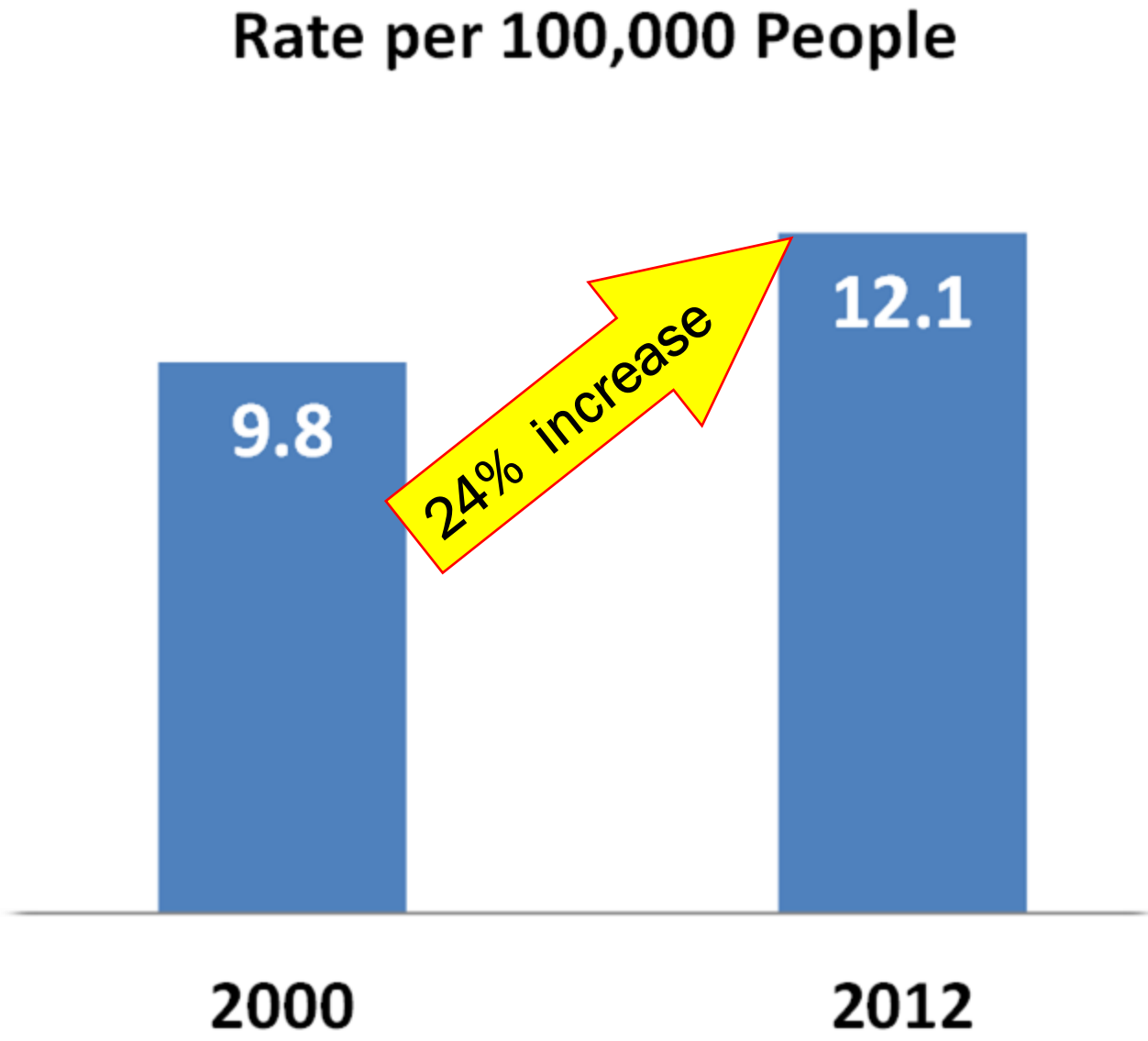
Perspective: Suicide in the U.S.



World Health Organization 2014 report: "Preventing Suicide: A Global Imperative"

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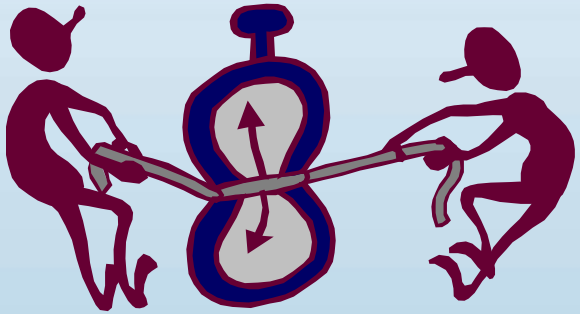
47,000 deaths annually
attributed to suicide

2017	47,173
2016	44,965
2015	44,193
2014	42,773
2013	41,149
2012	40,600
2011	39,518
2010	38,364
2009	36,909

Nationally

6,252 young people (age 15-24)

died by suicide in 2017



That's a rate of 1 suicide every 2 hours

Suicide is a leading cause of death (2017)

Rank & Cause	*Number of deaths*
1. Diseases of the heart	647,457
2. Malignant neoplasms (cancer)	599,108
3. Accidents (unintentional injury)	169,936
4. Chronic obstructive pulmonary diseases	160,201
5. Cerebrovascular diseases (stroke)	146,383
6. Alzheimer's Disease	121,404
7. Diabetes mellitus	83,564
8. Pneumonia and influenza	55,672
9. Nephritis, nephrosis	50,633
10. Suicide (Intentional Self-Harm)	47,173

(Homicide ranks 16th at 19,510)

By the Numbers . . . New Mexico

- Historically ranked in the top 10 for highest suicide rates the country (often in the top 5)
- In 2017, NM ranked 1st for youth suicide (15-24yo)
- 53% were firearms deaths (51% nationally)
- Rates of suicide are highest in the intermountain states

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2017 State Ranks + Rates of Suicide

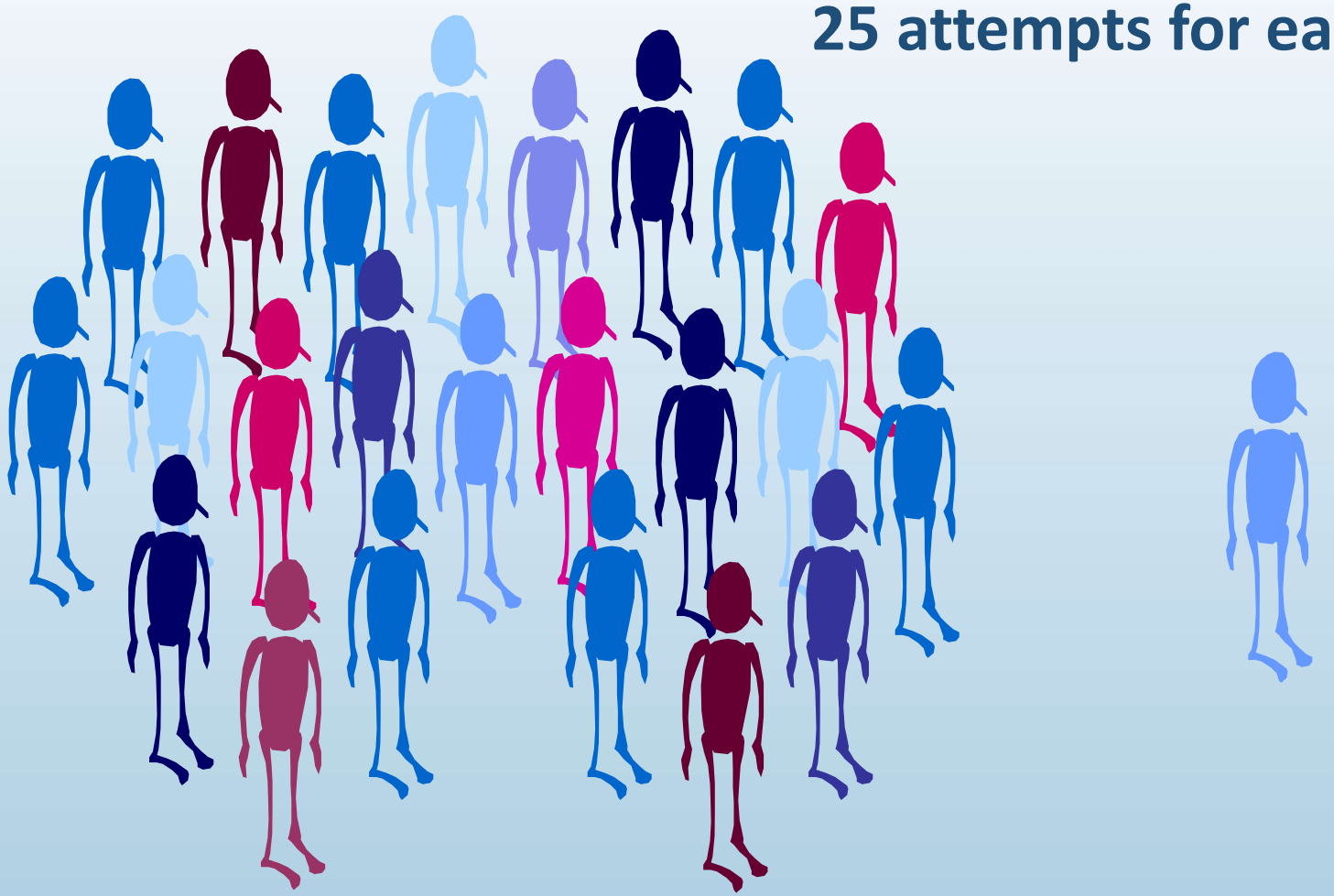
(deaths per 100,000)

1	Montana	29.6
2	Wyoming	27.1
3	Alaska	27.0
4	New Mexico	23.5
5	Idaho	22.8
6	South Dakota	22.0
7	West Virginia	21.6
8	Utah	21.4
9	Colorado	21.1
10	Arkansas	21.0
11	Nevada	20.9
12	Maine	20.5
13	North Dakota	20.4
14	Oregon	19.9
15	New Hampshire	19.7
16	Oklahoma	19.2
17	Kansas	19.0
18	Arizona	18.9
19	Missouri	18.8
20	Vermont	18.0
21	Washington	17.5
22	Tennessee	17.4
23	Kentucky	17.3
24	Alabama	17.1
25	South Carolina	16.7
26	Indiana	16.4
27	Wisconsin	16.0
28	Hawaii	15.9
29	Pennsylvania	15.9
30	Florida	15.4
31	Louisiana	15.4
32	Iowa	15.2
33	Ohio	14.9
33	Mississippi	14.9
35	North Carolina	14.6
36	Michigan	14.6
37	Nebraska	14.3
38	Minnesota	14.0
39	Virginia	13.9
39	Georgia	13.9
41	Texas	13.3
42	Rhode Island	12.2
43	Delaware	11.6
44	Illinois	11.5
44	Connecticut	11.3
46	California	10.9
47	Maryland	10.4
48	Massachusetts	9.9
48	New Jersey	8.8
50	New York	7.5
51	Washington, DC	6.8

USA Rate 13.9

Attempt Estimates

25 attempts for each documented death



*(Note: 47,000 suicides translates into **1,200,000 attempts annually**)*

Impact of Suicide

Inclusive of blood relatives, a study at the University of Kentucky reported the following additional impacts from a single death by suicide:

- 115 are exposed
- 53 have short term disruption in life
- 25 have a major life disruption
- 11 have devastating effects on their life

Impacts especially severe in small, tight-knit communities.

Numbers of those impacted by and exposed to suicide

- Suicide risk is greater in survivors (e.g., 4-fold increase in children when a parent dies by suicide)
- If roughly 47,000+ Americans die by suicide each year over ONE MILLION people suffer devastating effects on their life and/or suffer a major life disruption.

Scope of the problem in the US, and over the past 12 months…

- 15.8% seriously considered suicide
- 12.8% made a plan for suicide
- 7.8% attempted suicide one or more times
- 2.4% made a suicide attempt that lead to treatment by a doctor or nurse
- For 15-24 year olds, suicide was the 2nd leading cause of death in 2011

Source: 2011 Youth Risk and Behavior Survey

Numbers to remember

- Boys die 4.34 X as often as girls
- Girls attempt 3 X as often as boys
- Boys use firearms more and are more likely to die from an attempt
- Lethality of method contributes to outcomes
- 90% of youth who die by suicide are suffering from an Axis I mental disorder (mood disorder, substance abuse and often both).

Do the math

Of 1,000 students this year:

- 159 will think seriously about suicide
- 13 will plan how to kill themselves
- 8 will make a suicide attempt
- 2 to 3 will make and attempt and receive medical care

Youth Suicide Prevention is all about…

Reducing risk factors and increasing protective factors

"More teenagers died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease *combined*."

Source: U.S. Public Health Service (1999)

National Strategy (NSSP) Snapshot

- Prevent premature deaths due to suicide across the life span
- Reduce the rates of other suicidal behaviors
- Reduce the harmful after-effects associated with suicidal behaviors and their impacts on others
- Promote opportunities and settings to enhance resiliency, resourcefulness, respect and interconnectedness for individuals, families and communities.

NSSP Major Goals

1. Promote awareness that suicide is a preventable public health problem
2. Develop broad support for suicide prevention
3. Develop and implement SP strategies for consumers of health services
4. Develop and implement SP programs
5. Promote means restriction

NSSP Major Goals

6. Implement training for recognition of at-risk behavior and delivery of effective treatment
7. Develop and promote effective clinical care
8. Improve access to services
9. Improve reporting in the media
10. Promote and support research
11. Improve and expand surveillance systems

Historical School-based Suicide Prevention Programs

- Educate teachers, school counselors, and parents about suicide warning signs
- Raise student awareness, encourage self-referral, train peers to recognize and refer
- Identify highest risk students through combination of screenings, multi-stage assessments, and education of school staff

Current Status

- Many youth-focused suicide prevention programs are available
- Too few of them have supporting research to establish that they are safe and effective
- Most include enhance resiliency, encouraging help-seeking, and education teachers, counselors, students and family in suicide warning signs and positive interventions.

Where to find programs

- Best single listing: Suicide Prevention Resource Center
  www.sprc.org

Research Challenges

- Operational definitions and methods of assessment vary widely
- Lack of consensus regarding warning signs or what should be taught
- Concerns regarding large group impacts
- Cannot randomly assign high risk kids to either participate in a prevention program or a control condition
- No one wants to do research in their school or college as it suggests they have a problem
- Low base rates of completed suicide require huge samples to evaluate whether there is an impact on suicide completion

Major Barrier: Talking about suicide will encourage the behavior…

‘Not so!’

Studies now show that discussion of suicide with young people does not increase suicidal ideation or behaviors.

Gould, MS, Marrocco, FA, Kleinman M, Thomas JG, Mostkoff K, Cote J, Davis, M. Evaluating iatrogenc risk of youth suicide screening programs: a randomized controlled trial, *JAMA*, 2005 Apr 6l 293 (13): 1635-43 Gould et al., JAMA, 2005

Bryan, C.J., Dhillon-Davis, L.E., & Dhillon-Davis, K. (2010). Emotional impact of a video-based suicide prevention program on suicidal viewers and suicide survivors. *Suicide and Life-Threatening Behavior*, 39, 623-632.

Eynan, R., Bergmans, Y., Antony, J., Cutliffe, J.R., Harder, H.G., Ambreen, M…. & Links, P.S. (2014). The effects of suicide ideation assessments on urges to self-harm and suicide. *Crisis 35*(2): 123-131.

Some things we do know . . .

- In children and adolescents, the most frequently diagnosed mood disorders are major depressive disorder, dysthymic disorder, and bipolar disorder.
- In children & adolescents, an MDD episode lasts an average of 7-9 months.
- Majority of depressed young adults don't receive treatment.
- Untreated depression is the **#1 cause of suicide**.
- Depression is **treatable**.

Symptoms of youth depression

- Changes sleep patterns (either more or less)
- Changes in appetite (either more or less)
- ↓ Self-esteem (criticize themselves, feels criticism by others)

- ↑ Social Isolation
- ↓ Concentration
- ↓ Energy & Motivation
- ↑ Alcohol/substances

Symptoms continued..

- ↑ Irritability (especially true of adolescents!)
- ↑ Worrying & brooding (fears of separation or reluctance to meet others)
- ↑ Somatic Complaints (stomachaches, headaches, etc.)
- ↑ Sadness & Tearfulness
- Less enjoyment of previously pleasurable activities
- Hopelessness, pessimistic outlook
- Thoughts of death, suicide, or self-harm

The Deadly Triad

Shortest route to preventing the next suicide?

1. Remove alcohol by denying access
2. Remove firearms by denying access
3. Reduce distress by warm, compassionate, active listening and caring
4. Maintain contact during and after crisis
5. *Access counseling and care by a well-trained, competent professional*

References

- (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury
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- www.cdc.gov/ncipc/wisqars) and Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury
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QPR Theory and Practice in School Settings

QPR stands for Question, Persuade and Refer, an emergency mental health intervention that teaches lay and professional Gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors.

Why QPR?

- Each letter in QPR represents an *idea and an action step*
- QPR intentionally rhymes with CPR – another universal emergency intervention
- QPR is easy to remember
- Asking Questions, Persuading people to act and making a Referral are established adult skills

"Out of clutter, find simplicity"
Albert Einstein

QPR Theory

Assumption: *passive systems don't work*

- Those most at risk for suicide:
  - tend not to self-refer for treatment
  - tend to be treatment resistant
  - often abuse drugs and/or alcohol
  - cloak their level of despair
  - go undetected
  - go untreated (and remain at risk for suicide)

QPR Theory

- Most suicidal people send warning signs

- Warning signs can be taught

- Gatekeepers can be trained to:
  - recognize suicide warning signs
  - intervene with someone they know

- Gatekeepers must be fully supported by policy, procedure and professionals in their community

QPR Theory

Effective Gatekeepers:

- Are alert to the possibility of suicide
- Know suicide risk factors
- Recognize symptoms of distress and depression
- Recognize suicide warning signs
- Know what to say, when to say it, and what to do

The QPR Chain of Survival (like CPR)

4 links . . .

1. Early recognition of warning signs
2. Early application of QPR
3. Early referral to professional care
4. Early assessment and treatment

Knowledge + Practice = Action

7 Life-Saving Goals

- Detection of suicidal persons
- Active intervention
- Alleviation of immediate risk factors
- Accompanied referral
- Access to treatment
- Accurate diagnosis
- Aggressive treatment

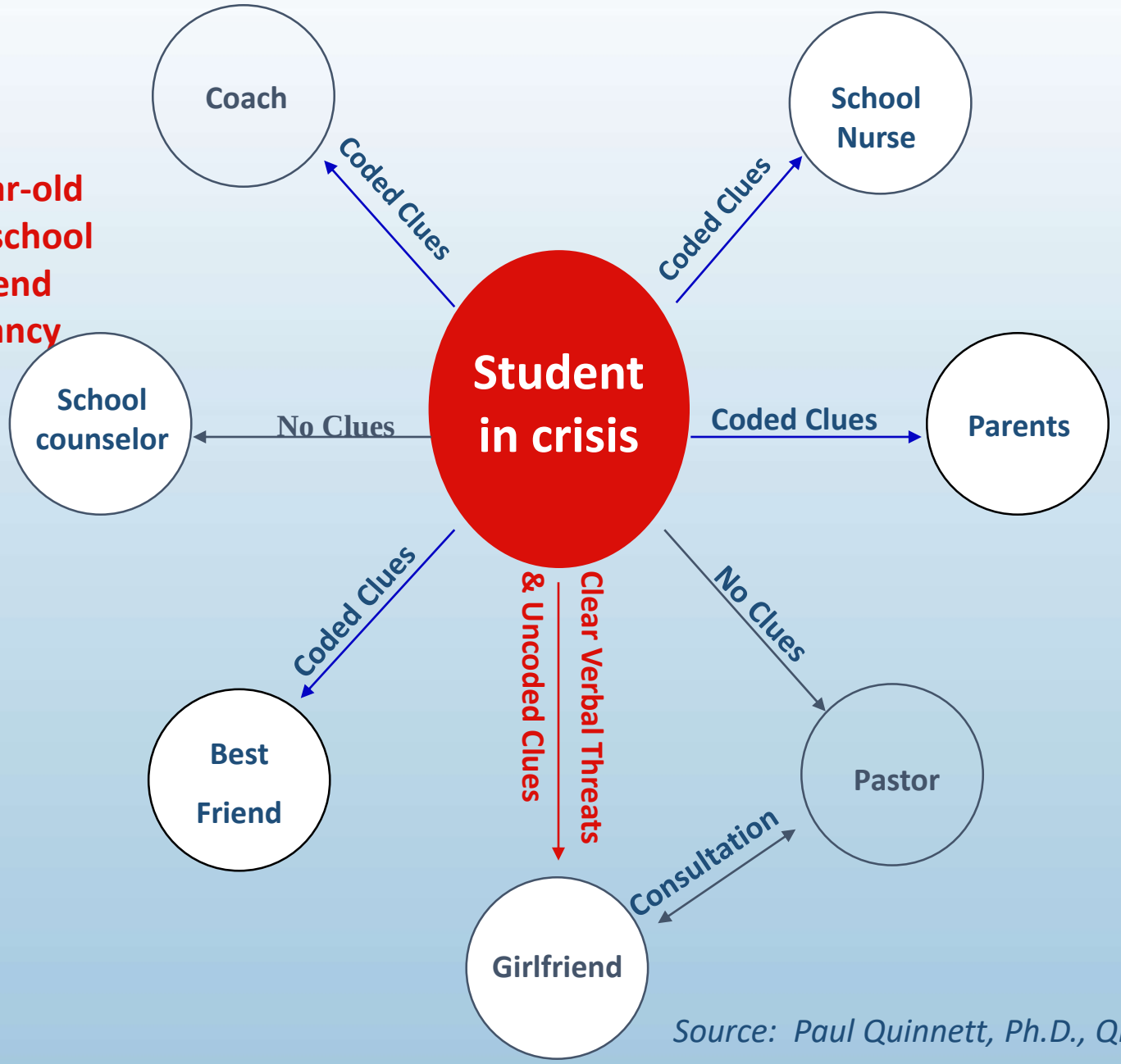
"Ask the question, save a life."

QPR PREVENTION STRATEGY

The application of network theory to suicide prevention: the person most likely to prevent you from taking your own life is someone you already know.

Untrained Social Network

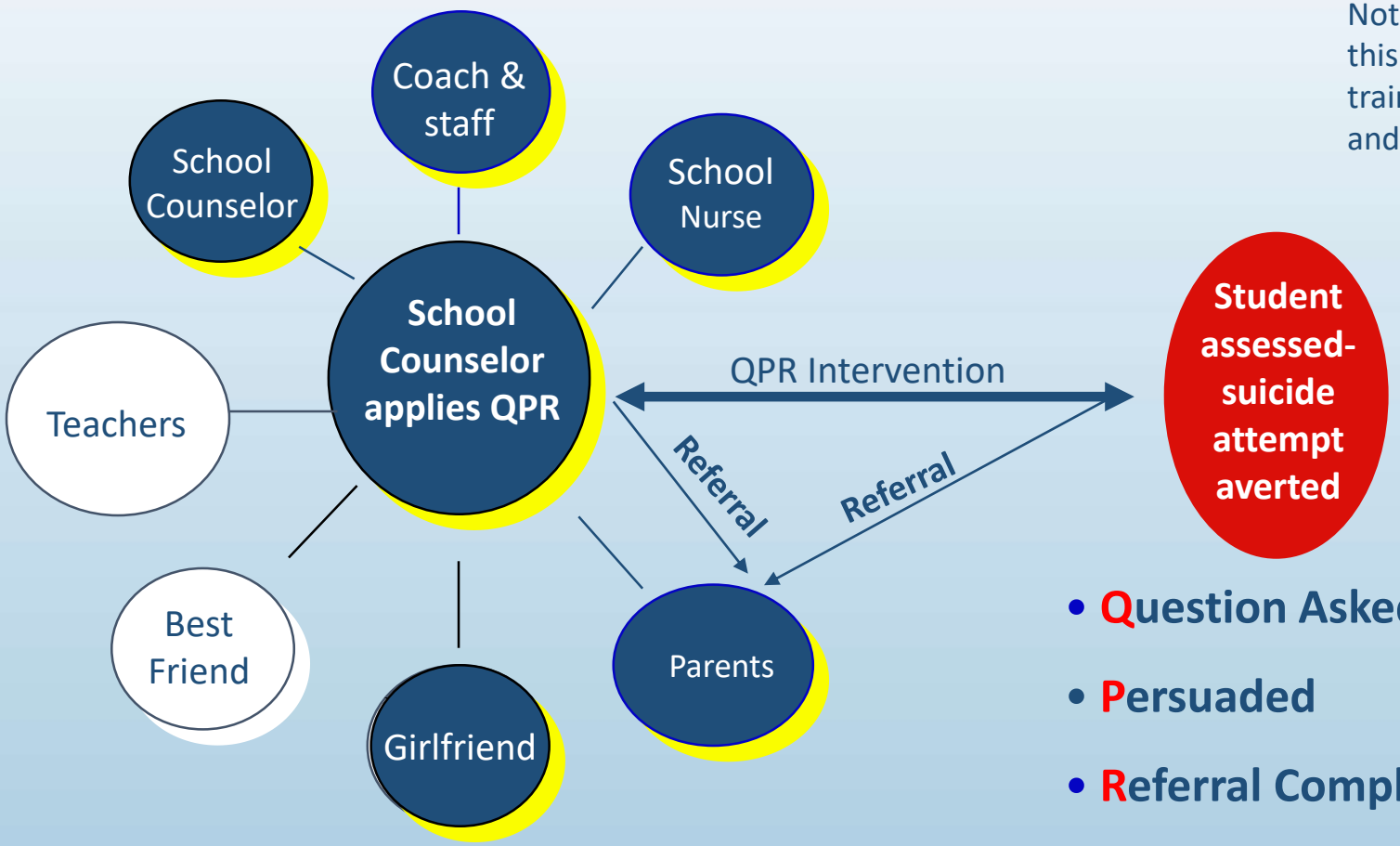
Scenario: Depressed 16-year-old student in crisis over poor school performance review, girlfriend leaving him and recent truancy



- Self-referral unlikely
- Hotline call unlikely
- Intervention unlikely

Source: Paul Quinnett, Ph.D., QPR for Suicide Prevention

Trained social network



Network Trained

Note: girlfriend trained in this network. If everyone is training odds detection and survival are increased.

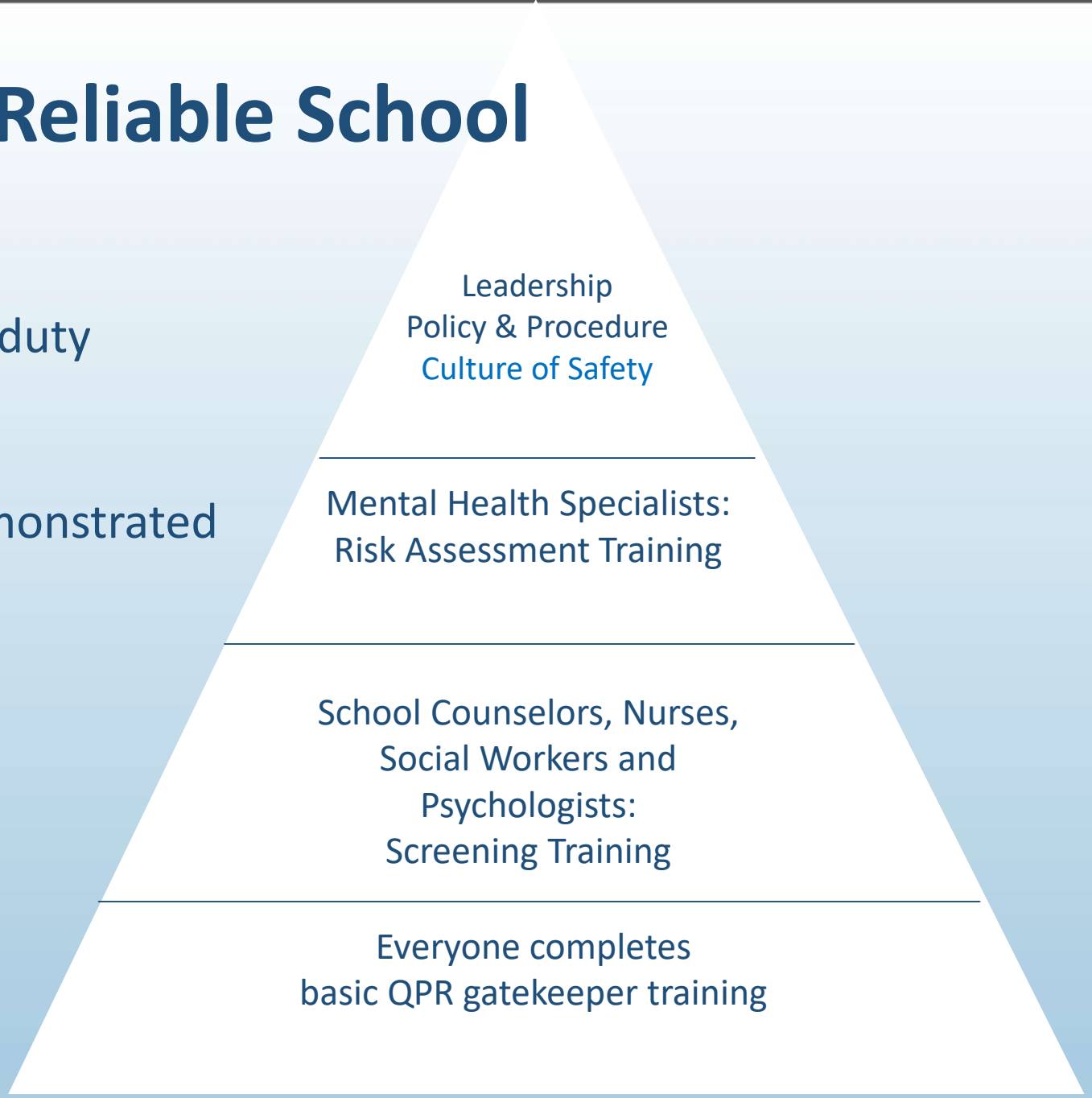
- **Question Asked**
- **Persuaded**
- **Referral Completed**

Suicide attempt averted!

Source: Paul Quinnett, Ph.D., QPR for Suicide Prevention

Highly Reliable School

- Training matches level of duty
- Everyone is trained
- Training is mandatory
- Competency must be demonstrated



To prevent the next youth suicide, who should be trained?

- Traditional gatekeepers: nurses, social workers, clergy, mental health professionals, 1st responders and others with a duty to preserve the health and safety of young people

- Non-traditional gatekeepers: teachers, advisors, administrative support staff, and anyone in frequent and/or strategic contact with potentially at-risk youth, e.g., coaches, scout leaders, mentors, and all adults who play a role in the life of a young person.

- *PLUS: Anyone* identified by the youth as someone important in his or her life – whether through face-to-face relationships or social media or text or any other emerging form of communications – to include best friends, family members, teammates, etc.

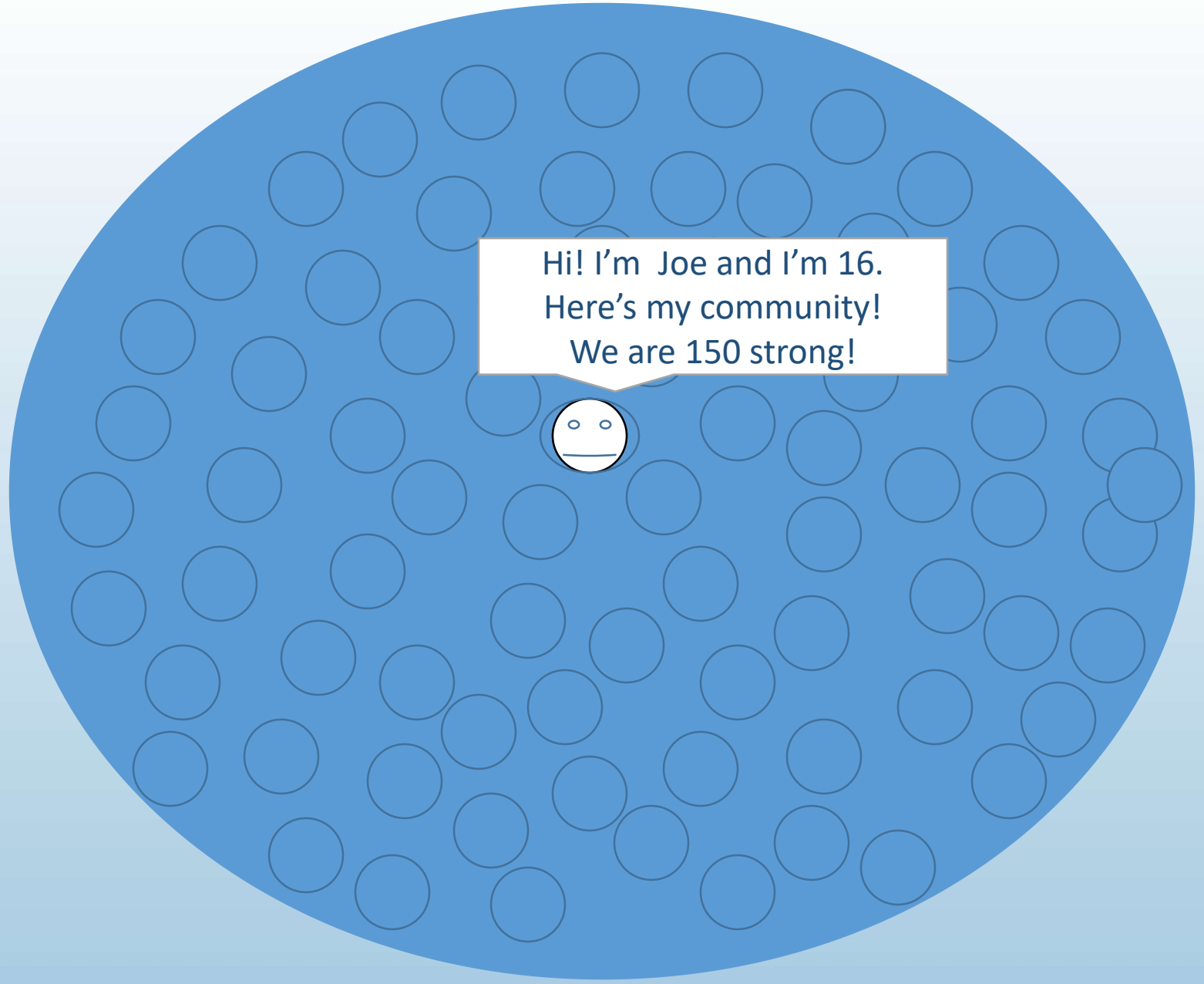
If it takes a village, do you live in one?

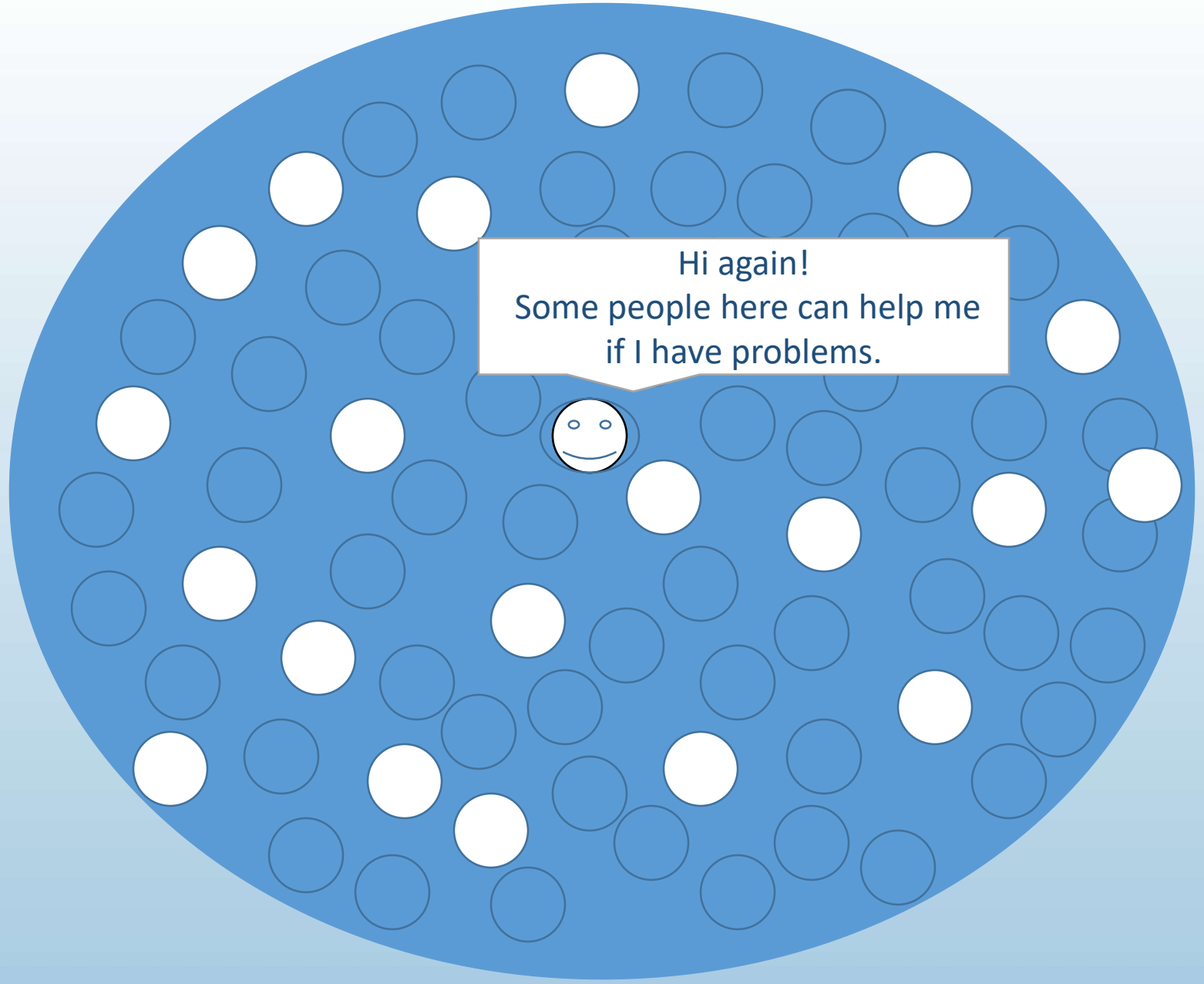
Research shows humans belong to groups of ~150 people they know on a first-name basis.

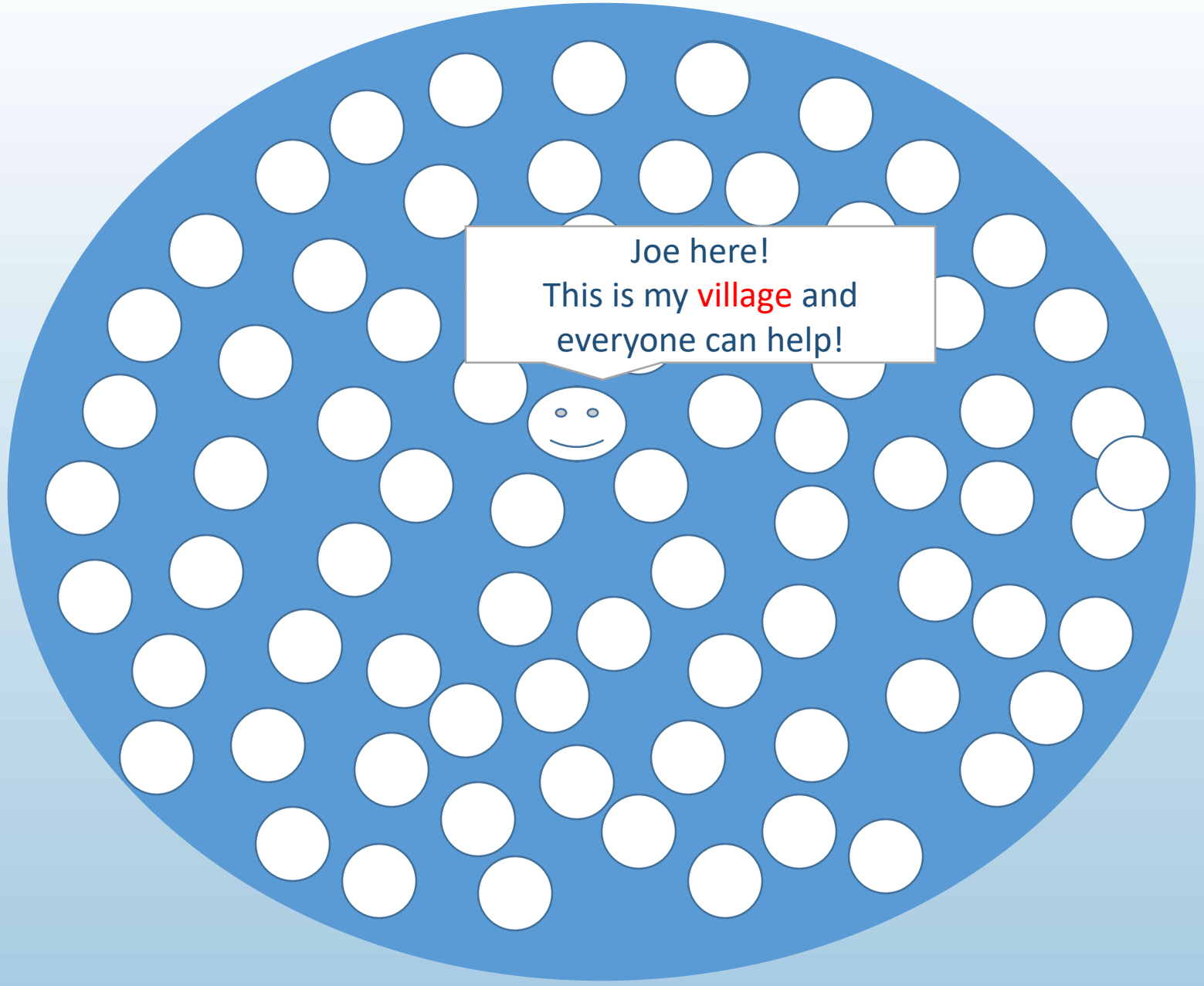
That group is: friends, family, teachers, coaches, peers, colleagues, and those known on social media.

When in distress, troubled youth communicate to 1 or more people in this group. If they send suicide warning signs, they will be sent to members of this social network.

The more people trained in how to recognize and respond to these warning signs the better the odds the young person will get help and survive the crisis.







Finally . . .

- We know *who* to train
- We know *what* to teach them
- We have evidence that interventions work
- We have measures to monitor our outcomes
- We have leadership -- all we need is a “go!”

Visit the QPR Institute web site to download the free e-book:
Suicide: the Forever Decision

Counseling on Access to Lethal Means

Recommendations for Suicide Prevention Gatekeepers

What you are about learn is an approved derivative program from Means Matter and from Counseling on Access to Lethal Means (CALM) an American Foundation for Suicide Prevention/Suicide Prevention Resource Center Registered Best Practice training program.

The QPR Institute wishes to thank Elaine Frank of Harvard & Cathy Barber of Dartmouth for their contributions to this QPR gatekeeper training program!

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We are beginning to understand that how people attempt suicide plays a crucial role in whether they live or die.

United Kingdom & Domestic Gas, Painkillers

- In 1998 UK reduced blister pack sizes for paracetamol (Tylenol).
- 1998 – 2009 paracetamol suicide deaths ↘ 43%, similar % ↘ in accidental overdoses.
- Liver transplants for paracetamol toxicity ↘ 61%

- Pre 1960 UK, domestic gas = #1 method of suicide.
- By 1970, most UK domestic gas was non-toxic.
- Suicide rates ↘ over 30%.
- Non-gas suicides ↗ only slightly.

Source: Kreitman 1976, Brit J Prev Soc Med.

Why Does Reducing Access to Lethal Means Prevent Some Suicides?

- Suicidal crises are often relatively brief.
- Suicide attempts are often undertaken quickly w/little planning.
- Some suicide methods are far more deadly than others ("case fatality" ranges from 1% for some methods to 85-90% for the most deadly, like firearms).
- 90% of those who survive even nearly-lethal attempts do not go on to later die by suicide.

See: www.meansmatter.org for studies examining each of these concepts.

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Why Focus on Firearms?

- Firearms are the leading suicide method in the U.S.
- Gun owners & their families are at about 3x higher risk of suicide than non-gun owners.
- This isn't because they're more suicidal. Gun owners are NO more likely to be mentally ill, to think about suicide, or to attempt suicide than non-gun owners.
- Rather, they're more likely to die in a suicide attempt because guns are more lethal than most other methods.

Sources: Betz M, Suicide Life Threat Behavior, 2011. Miller M, Injury Prevention, 2009. Ilgen M, Psychiatry Serv, 2008. Sorenson & Vittes, Eval Rev, 2008.

Reducing a Suicidal Person's Access

- A simple step to increase a suicidal person's safety is to reduce access to firearms at home.
- Many counselors and providers and family members of at-risk people don't think to do this.
- This temporary safety intervention is not anti-gun.

Making a Difference

- Family and friends can protect a suicidal person by temporarily storing all firearms away from home.
  - Have a trusted person outside the home store them until the situation improves.
  - Some storage facilities, police departments, gun clubs, & gun shops will store guns.
- Off-site storage not an option?
  - Lock the guns at home with new locks or combinations.
  - Keep ammunition out of the home or locked separately.
  - Remove a key component of the guns

Duration of Suicidal Crisis

People who attempted were asked how long before their suicidal act they started thinking about making an attempt:

- 48% attempted w/in 10 minutes or less of first thinking about
- 2% said 11-60 minutes
- 9% said 1-24 hours
- 16% said 1-7 days
- 15% said 1-4 weeks
- 11% said 1-12 months

For more information

Means Matter

www.meansmatter.org

CALM Training Online, free

http://training.sprc.org/

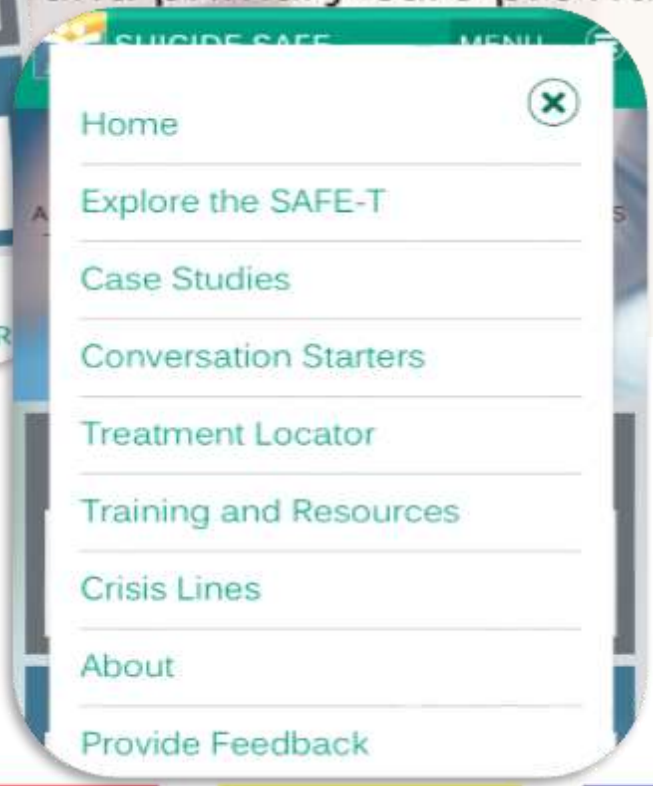
Request technical assistance from Means Matter

cbarber@hsph.harvard.edu

Request an in-person CALM training

ElaineFrank603@gmail.com

SUICIDE SAFE
SAMHSA's free suicide prevention app: a learning tool for behavioral health and primary care providers.



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THANK YOU

for your time, passion,
& commitment

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