Suicide: The Challenges and Opportunities Behind the Public Health Problem

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TOUGH REALITIES

- ➔ **~ 36,000 Americans die by suicide each year**
- ➔ **1.1 million (.05 percent) Americans (18 & older) attempted suicide in the past year**
- ➔ **2.2 million (1 percent) Americans (18 & older) made a plan in the past year**
- ➔ **8.4 million (3.7 percent) Americans (18 & older) had serious thoughts of suicide in the past year**

TOUGH REALITIES

~30 percent of deaths by suicide involved alcohol intoxication – BAC at or above legal limit

TOUGH REALITIES

2005-2009: 55% higher in emergency department visits for drug related suicide attempts by men 21 to 34

2005-2009: 49% higher in emergency department visits for drug related suicide attempts by women 50+

TOUGH REALITIES

50 percent of those who die by suicide were afflicted with major depression, and the suicide rate of people with major depression is eight times that of the general population

90 percent of individuals who die by suicide had a mental disorder

TOUGH REALITIES

- ➔ 2005 – 2009: More than 1,100 members of the Armed Forces took their own lives; an average of 1 suicide every 36 hours
- ➔ 2010 Army suicide rate (active-duty) soldiers down slightly
    - (2009 = 162; 2010 = 156)
- ➔ Number of suicides in the Guard and Reserve up by 55%
    - (2009 = 80; 2010 = 145)
- ➔ More than half of the National Guard members who died by suicide in 2010 had not deployed
- ➔ Suicide among veterans accounts for as many as 1 in 5 suicides in the U.S.

MISSED OPPORTUNITIES = LIVES LOST

➔ Individuals discharged from an inpatient unit continue to be at risk for suicide

- **~10% of individuals who died by suicide had been discharged from an ED within previous 60 days**
- **~ 8.6 percent hospitalized for suicidality are predicted to eventually die by suicide**

MISSED OPPORTUNITIES = LIVES LOST

77 percent of individuals who die by suicide had visited their primary care doctor within the year

SUICIDE: DATA AND DISPARITIES

➔ **Suicides**

- 4 males : 1 female
- Highest risk: elderly white males (85+)
- Largest numbers: middle-aged (40-60) males at 2x's baseline rate of other Americans and working-aged males (20-64) = 60 percent of suicides
- Higher risk: young and middle-aged AI/AN

➔ **Suicide attempts**

- Female > male
- Rates peak in adolescence and decline with age
- Higher risk: LGBT youth and young Latinas

3 PRIORITY AREAS FOR CONSIDERATION

➔ **Issue One:** Too many missed opportunities to save lives in primary care settings

➔ **Issue Two:** Millions of Americans still lack access to evidence-based care and BH professionals that can reduce suicidal behavior

➔ **Issue Three:** Too many discharged from EDs/inpatient units following suicide crisis at significantly elevated risk yet 50 percent referred to care following discharge do not actually receive outpatient treatment

A DIFFERENT NATIONAL DIALOGUE: THE PROBLEM

- ➔ Behavioral health (prevention, treatment, recovery supports) seen as social problem rather than a public health issue
- ➔ Communities/Governments respond to social problems rather than to health needs of people and community
- ➔ BH field has multiple philosophies resulting in multiple and inconsistent messages
    - Disease; disability; chronic medical condition; social reaction to difference; brain/genetic; environment/psychosocial

TRAGEDIES

PUBLIC EVENTS LEAD TO
INACCURATE PUBLIC DIALOGUE

- ➔ Individual blame based on misunderstanding

E.g., moral judgment, discrimination, prejudice, social exclusion

OR

- ➔ Attention to symptoms
- ➔ E.g., homelessness; drug-related gangs; child welfare issues due to addiction and mental illness; amount of jail time by persons with M/SUDs; institutional, provider, or system failures

LEADING TO

- ➔ Insufficient responses
- ➔ E.g., increased security & police protection; tighter background checks; controlled access to weapons; legal control of perpetrators & their treatment; more jail cells, homeless shelters, institutional/system/provider oversight

PERCEPTION CHALLENGES

- ➔ >60% of people who experience MH problems & 90% of people who experience SA problems and need treatment do not perceive the need for care
- ➔ Suicides vs. homicides - Suicides outnumber homicides by 3:2
- ➔ Suicides vs. HIV/AIDS - Twice the number of people die by suicide than who die as a result of complications related to HIV/AIDS

WHAT AMERICANS KNOW

➔ Most know *or* are taught:

- Basic First Aid and CPR for physical health crisis
- Universal sign for choking; facial expressions of physical pain; and basic terminology to recognize blood and other physical symptoms of illness and injury
- Basic nutrition and physical health care requirements
- Where to go or who to call in an emergency

➔ Most do not know *and* are not taught:

- Signs of suicide, addiction or mental illness or what to do about them or how to find help for self or others
- Relationship of behavioral health to individual or community health or to health care costs
- Relationship of early childhood trauma to adult physical & mental/substance use disorders

SO, HOW DO WE CREATE . . .

➔ A national dialogue on the role of BH in public life

➔ With a public health approach that:

- Engages everyone – general public, elected officials, schools, parents, churches, health professionals, researchers, persons directly affected by mental illness/addiction & their families
- Is based on facts, science, common understandings/messages
- Is focused on prevention (healthy communities)
- Is committed to the health of everyone (social inclusion)

HELP US CHANGE THE CONVERSATION!