



Suicide Prevention Issue

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TSPN Works to Increase Prevention Efforts

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Calendar of Events

Events relating to helping children are available at:
www.tennessee.gov/tccy/webcalen.pdf.

TCCY

For more information on the Tennessee Commission on Children and Youth and its programs, check out the website at: www.tn.gov/tccy.

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Suicide is the third-leading cause of death for people ages 10 to 19 in Tennessee, with 32 people in

this age group lost to suicide in 2007. To bring this problem into the open, the Tennessee Suicide Prevention Network (TSPN) observed and promoted Suicide Prevention Awareness Month in September. TSPN staged a number of events during September, most notably a series of Suicide Prevention Awareness and Educational Events across the state.

Tennessee Suicide Prevention Network

TSPN is the statewide organization responsible for implementing the Tennessee Strategy for Suicide Prevention as defined by the 2001 National Strategy for Suicide Prevention. This grass-roots association includes counselors, mental health professionals, physicians, clergy, journalists, social workers and law enforcement personnel, as well as survivors of suicide and suicide attempts. TSPN organizes and promotes regular regional activities, provides suicide prevention and crisis intervention training to schools and community organizations, and conducts post-vention sessions for schools after suicides occur.

The Network has offices in Nashville and eight regional networks across the state. It maintains quasi-autonomous task forces in Blount, DeKalb, Giles and Hickman counties, as well as an Intra-State Departmental Group composed of high-ranking state employees who advise the Network on an ex officio basis.

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Suicide Prevention

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TSPN’s observance of Suicide Prevention Awareness Month coincided with World Suicide Prevention Day, which occurred this year on September 9. Many other suicide prevention agencies dedicated a day or a week for their observances, but TSPN set aside an entire month to accommodate events and activities all across our state.



Youth Suicide in Tennessee, By the Numbers

Of the 37 people ages 10 to 19 who died by suicide in 2006:

- All but one of the victims were male.
- Thirty victims were white, and seven were black. Two of the White victims were of Hispanic origin.
- The majority of the deaths (21) involved firearms. Hanging was the second most common method, with 11 recorded deaths.

"Giving Hope, Saving Lives"

According to the 2007 Tennessee Youth Risk Behavior Survey:

- One of every four, or 26.8 percent, of all Tennessee high-school students reported a depressive period over the past 12 months – a feeling of sadness and hopelessness lasting for two weeks or more, so severe they stopped doing some usual activities.
- 14.1 percent of the students surveyed, or one in seven, seriously considered suicide during that period.
- 10.2 percent, or one in 10, made a plan about how they would attempt suicide.
- 7.4 percent, or one in 14, actually attempted suicide one or more times over the past 12 months.
- Of these, 29.7 percent, or 2.2 percent of all Tennessee high-school students, required medical attention for a suicide attempt.
- Generally speaking, younger teens – those 15 or younger – were more likely to plan and make suicide attempts than their older counterparts.
- Females were more likely to experience depression and to consider and attempt suicide than males, even though males made up the majority of fatal suicide incidents.
- Hispanic teens of any race were far more likely to suffer from depression and suicide attempts. They were approximately twice as likely to suffer from periods of depression as non-Hispanic youth, two to three times more likely to consider suicide, twice as likely to make a suicide plan, three times more likely to attempt suicide, and three times more likely to make a suicide attempt that required medical attention.

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Current Projects

TSPN staged 11 Suicide Prevention Awareness and Educational Events across the state during the month of September. These events were

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Suicide Prevention

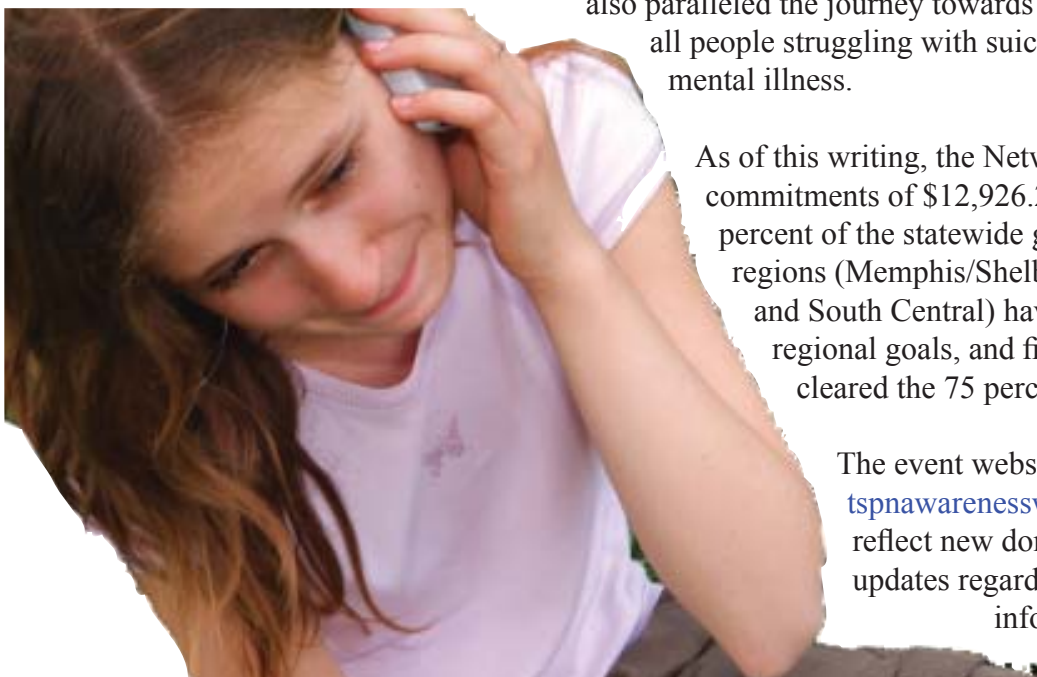
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intended to remember those lost to suicide, encourage survivors of suicide, survivors of suicide attempts and people who have triumphed over mental illness, and recognize individuals who have made notable contributions to suicide prevention efforts in our state. The events are intended to demonstrate an active and dynamic commitment to suicide prevention across the state of Tennessee.

While regional event agendas varied slightly, each one included the following elements:

- A memorial walk at a high-profile local venue;
- Dedication of the “Love Never Dies” Memorial Quilt, an ongoing Network project;
- Reading of the Suicide Prevention Awareness Month proclamation issued by the Office of the Governor and announcement of local proclamations;
- Presentation of the Regional Suicide Prevention Awards and the Madge and Ken Tullis Suicide Prevention Award;
- A candle-lighting ceremony in memory of those lost to suicide and in honor of survivors of suicide and suicide attempts;
- A symbolic balloon release; and
- Acceptance of donations to further local and statewide awareness efforts.

The walks illustrated the steps we take to raise awareness of the problem of suicide as outlined in the Tennessee Strategy for Suicide Prevention and the steps members of the general public need to take to understand the warning signs of suicide, learn about area resources and work to prevent suicides in our communities. The walk also paralleled the journey towards healing and recovery taken by all people struggling with suicide loss, suicidal impulses and mental illness.



As of this writing, the Network had received commitments of \$12,926.25 across the state, or 86 percent of the statewide goal of \$14,984. Three Network regions (Memphis/Shelby County, Mid-Cumberland and South Central) have already surpassed their regional goals, and five of the eight regions have cleared the 75 percent mark.

The event website (<http://sites.google.com/site/tspnawarenesswalks>) is regularly updated to reflect new donors and sponsors, as well as updates regarding regional events. It featured information on events in each TSPN region, a full listing of event donors and sponsors

Risk Factors for Suicide Among the Young

- ▶ suicidal thoughts;
- ▶ psychiatric disorders;
- ▼ depression,
 - ▼ impulsive aggressive behavior,
 - ▼ bipolar disorder,
 - ▼ certain anxiety disorders;
- ▶ drug and/or alcohol abuse;
- ▶ previous suicide attempts;
 - ▼ situational stress;
 - ▼ access to firearms.

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Suicide Prevention

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and regional and state donation tallies. The events and sponsors were also listed in the September edition of the TSPN Call to Action on the TSPN homepage (www.tspn.org) and the Network's recently established Facebook page.

The TSPN homepage has been updated to include a set of seven articles on suicide prevention, suitable for submission to local newspapers and other media outlets. These articles address a variety of subtopics related to suicide prevention, including youth suicide, the connection between substance abuse and suicide, and suicide among older adults. The homepage also includes a double-sided church bulletin insert with information on suicide prevention and documents for use by prospective Suicide Prevention Awareness and Educational Event donors.



Finally, Network members worked to secure Suicide Prevention Awareness Month proclamations from city and county mayors in all 95 Tennessee counties. Governor Bredesen has already committed to signing a proclamation on behalf of the state of Tennessee.

If you are interested in supporting or for more information on Suicide Prevention Awareness, please contact the TSPN central office at (615) 297-1077 or tspn@tspn.org.

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Information is Critical to Addressing Suicide

The Tennessee Suicide Prevention Network (TSPN) and other advocates draw on the available knowledge and research in its prevention programs. Although much is known about suicide, many gaps in information exist. The bulk of research on youth suicide has focused on White males, who have traditionally had higher rates of suicide completion. However, research on other groups is needed. For example, a recent analysis of the National Survey of American Life, a survey to study issues of race and mental health in the United States, found African-American youth, especially girls, at a high risk for suicide attempts. A literature review of research on suicide behavior (suicide ideation, suicide attempts and suicide completions) among cultural and gender groups identified risk factors.

Gender Paradox

Women attempt more frequently, but men complete suicide more frequently. Non-fatal suicidal behavior is three times as likely to occur in women as in men (Office of Women's Health, 2009). Although a disproportionality between the rates of suicide ideation and attempts and of suicide completion between the genders has long been identified, surprisingly little research has been done explaining the differences.

Mental illness is frequently a factor in suicidal behavior and occurs differently in men and women. Women experience major depression twice as often as men, and anxiety disorders two to three times as often as men (Office of Women's Health, 2009). Rates of schizophrenia and bipolar disease are similar between the genders, and usually strike women later. Men are more prone to impulse control and substance abuse disorders. The difference in illness incidence may explain some of the suicide differences.

Most surveys find a greater level of suicide behavior and ideation among women. However, research using the Life Attitudes Schedule, which expands the concept of self harm to include risky and physically dangerous behaviors and lack of self-care or healthy behaviors, males showed more self-injurious behavior than did females.

A difference in method used has been identified – men are more likely to use consistently deadly methods, such as firearms. A logical conclusion is males have more access and familiarity with guns, but it is also suggested

Depression in Adolescents

- Physical symptoms such as dizziness, headaches, stomach aches, neck aches, arms or legs hurt due to muscle tension, digestive disorders (ruling out other medical causes).
- Persistent unhappiness, negativity, irritability.
- Uncontrollable anger or outbursts of rage.
- Overly self-critical, unwarranted guilt, low self-esteem.
- Inability to concentrate, think straight, remember, or make decisions, possibly resulting in refusal to study in school or an inability (due to depression or attention deficit disorder) to do schoolwork.
- Slowed or hesitant speech or body movements, or restlessness (anxiety).
- Loss of interest in once pleasurable activities.
- Low energy, chronic fatigue, sluggishness.
- Change in appetite, noticeable weight loss or weight gain, or abnormal eating patterns.
- Chronic worry, excessive fear.
- Preoccupation with death themes in literature, music, drawings, speaking of death repeatedly, fascination with guns/knives.
- Suicidal thoughts, plans, or attempts.

Source: SAVE: Suicide Awareness Voices of Education

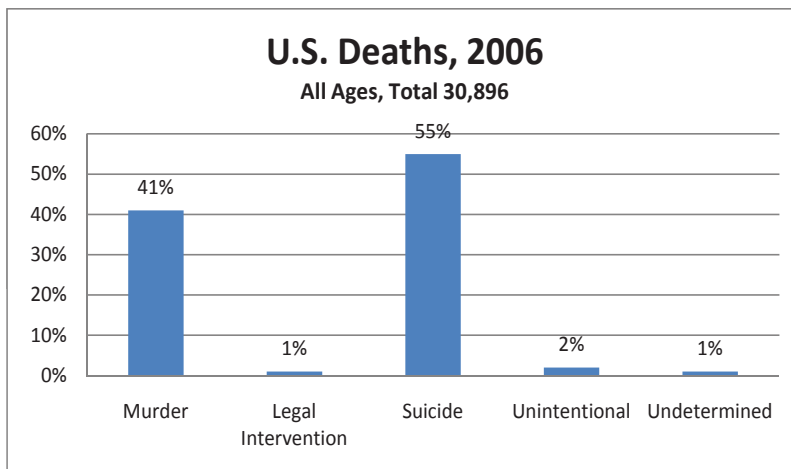
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Information

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gender identification plays a role. For example, suicidal males know guns are the method of choice by males.

This gender paradox has led to a belief woman's choice of methods, which allow more opportunities for intervention, mean their attempts are not real attempts to end life but "cries for help." However, according to the Harvard School of Public Health, research has found little relationship between strength of intent and method chosen (2009). Methods chosen by women – poisoning, drug overdoses – usually require a greater level of planning than the more lethal methods, which may actually indicate a stronger intent.



Guns are used in only one percent of suicide attempts, but are used by 54 percent of all suicide completions (Anderson, 2008). States with high levels of gun ownership have higher suicide rates. Studies reported by the Harvard School of Public Health found a gun in the home was a risk factor for suicide completion. Ironically, use of firearms and jumping from bridges, etc., are associated with a higher level of impulsivity, and people who chose those methods generally have lower levels of mental illness symptoms.

Depression

A significant risk for suicide is depression. It is estimated mental illness is an issue in 90 percent of completed suicides (NIMH, 2009), with depression being more common.

A **Ask your buddy**

- Have the courage to ask the question, but stay calm
- Ask the question directly, e.g. Are you thinking of killing yourself?

C **Care for your buddy**

- Remove any means that could be used for self-injury
- Calmly control the situation; do not use force
- Actively listen to produce relief

E **Escort your buddy**

- Never leave your buddy alone
- Escort to the chain of command, a Chaplain, a behavioral health professional, or a primary care provider



A recent study found depression was as big a risk factor for mortality as smoking (Jade, 2009). Mental health and physical health are linked. Survival for illnesses such as heart disease increases when depression is treated (Office for Women's Health, 2009).

According to the National Survey on Drug Use and Health (NSDUH), based on 2004 and 2005 data, 9.15 percent of youth ages 12 to 17, reported experiencing a major depressive episode during the past year. The percentage of people older than 18 was 8.25 percent.

Current Issues

Military Suicides

According to the July 2009 Tennessee Suicide Prevention Network newsletter, Fort Campbell experienced more Army suicides in 2009 than any other base in the country. The deaths at Fort Campbell, home of the 101st Airborne Division, represented a significant percentage of the 64

Card being issued to Fort Campbell soldiers by the U.S. Army under the ACE suicide prevention program.

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TCCY

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confirmed or suspected Army suicides this year as of April, according to a May 7 *Military Times* report. According to a May 27 CNN.com story, a record 133 military deaths were confirmed in 2008. This figure was nearly twice the number five years earlier in 2003.

The National Institute of Mental Health (NIMH) has begun a major study of suicide in the military. Prior to 2008, the suicide rate of people serving in the military was lower than that of people with similar demographics in the total population.

However, this has changed, and the military has worked to improve its response. Fort Campbell shut down for three days in late May for a suicide prevention training event, the base's second this year.

Economy

Many people fear the current economy will raise the suicide rates.

One of the clichés of the Great Depression is the myth of the investor who leapt from a window when confronted with economic catastrophe. However, a recent study in the British journal, the *Lancet* found the murder and suicide rates increased by 2.4 percent when unemployment went up 3 percent in European Union countries. A 2003 study found the risk of suicide in the unemployed is two to three times greater than in the employed (Britt, 2009).

A University of Pennsylvania study found nearly half the people studied while undergoing foreclosure reported depressive symptoms. Over a third, 37 percent, were identified as having major depression. In contrast, only 10 percent of the general U.S. population has a mood disorder. The situation of these individuals is complicated by cost-cutting behavior, such as failing to purchase prescription drugs or skipping meals. People dealing with foreclosure were also more likely to be uninsured, nine percent of the people responding said a medical condition in their family was the primary reason for their home loss and more than a fourth of them had significant unpaid medical bills (*More than 1/3*, 2009).

Tennessee

Suicide Deaths*

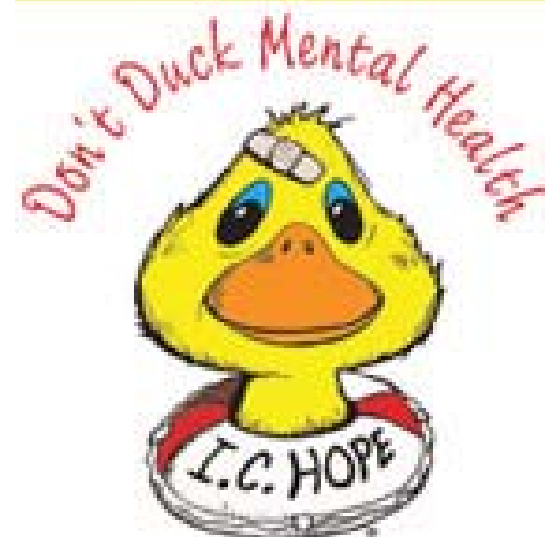
Number of Deaths	874
Rate	14.5
State's Rank	14
US Rate	11.1

Gun Ownership**

Households with Guns	43.9%
State Rank	14

*American Society of Suicidology

** 2001 Behavioral Risk Factor Surveillance System



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Stigma

A national survey found half of respondents had reported a mental illness during their lifetimes. However, those with chronic problems delayed seeking help for 10 years on average (Harvard Medical Letter, 2006).



A risk factor of suicide across all groups is unwillingness to seek help because of stigma and barriers to accessing mental health treatment. Gender expectations, such as “boys don’t cry,” may make it more difficult for males to seek help. Stigma and fear of discrimination also isolate people.


As reported by the Office of Women’s Health, factors related to stigma include:

- Fear of the unpredictable and difficult to understand behavior;
- A perceived link between mental health and violence;
- A misunderstanding of mental illness as weakness or poor judgment.

It found stigma higher in older adults, racial and ethnic minorities, and rural residents.

The Tennessee Department of Mental Health and Developmental Disabilities program “Erase the Stigma” is a statewide educational program to increase understanding of mental health. For more information contact The Mental Health Association of Middle Tennessee at 615-777-DUCK, toll free at 866-535-DUCK or visit www.ichope.com.

Best Practices

In one effort to improve the nation’s response to suicide, the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center created a Best Practices Model of Suicide Prevention. Information about this program is available at http://www.sprc.org/featured_resources/bpr/index.asp 

States Expand Suicide Prevention Training for School Staff through Jason Flatt Acts

Mississippi, Louisiana and California have each passed a “Jason Flatt Act” similar to the one passed in 2007 in Tennessee. In January 2008, the Department of Education reported to the governor it was working with the Jason Foundation, the Tennessee Lives Count Project and the Tennessee Suicide Prevention Network to help schools provide the required two hours per school year in-service. Colorado and New Jersey also mandate suicide awareness training in schools, with no annual requirement. 