Suicide Prevention
Self Study Module

1 Contact Hour for Registered Nurses

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Organizational Learning

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Suicide Prevention Self Study Module

The incidence of suicide is low in the American general public (0.01%), yet each year approximately 32,000 people die from suicide. According to the Center for Disease Control, suicide kills more people than homicide each year. (See the CDC Fact Sheet on page 13.) Overall, suicide is the 11th leading cause of death for all Americans, and is the third leading cause of death for young people aged 15-24. Suicide rates increase with age and are highest among Americans aged 65 years and older, with men accounting for 84% of suicides among persons aged 65 years and older in 2005. This means that in our roles as family, religious, and community members, we may someday be in the position to recognize the suicidal warning signs in a loved one, neighbor, or fellow church member, and possibly prevent a suicide. In addition, the National Institute of Mental Health estimates that there are between eight and twenty-five suicide attempts for every completed suicide. This data was approximated from emergency room admissions for self-inflicted injuries (Burt & McCraig, 2001), which indicates that each year, approximately 650,000 people in the United States receive emergency treatment after attempting suicide. Obviously, this places healthcare professionals in a unique position to positively intervene due to the frequency of interactions with suicidal patients.

The purpose of this self-study module is twofold. The first is to enable the acute care nurse to meet current professional and legal standards of care when identifying and managing the suicidal patient. The second is to acquire a basic working knowledge of the dynamics of suicide, and provide support and education to anyone who may be affected within your circle of influence. Participants will demonstrate the ability to recognize suicidal risk factors and warning signs, identify elements of a safe environment for the suicidal patient, provide support and education to survivors and their families, and adhere to Florida's Mental Health Act requirements until appropriate mental health services are available.

Suicide Prevention Objectives

1. Describe six standards of care for self-harm/suicidal patients in the emergency room.
2. List the definitive criteria for implementing the Baker Act process with a patient.
3. Discuss the basic elements of a safe environment for a self-harm/suicidal patient.
4. Define a minimum of three behavioral warning signs of patients with suicidal ideation.
5. Verbalize the difference between higher and lower predictors of suicide risk.
7. Outline two steps to take if someone you know exhibits suicidal warning signs.
8. Detail a minimum of two empathic responses that support suicide survivors.
9. Learn the risk factors associated with suicidal behavior in the adolescent versus the elderly.
Suicide Prevention In The Acute Care Setting

The Management of Self-Harm/Suicidal Patients in Emergency Departments

Suicidal ideation and behavior are among the most serious and frequent of psychiatric emergencies. The risk of suicide should be considered imminent (i.e. suicide may be attempted in the next 48 hours) in patients who have an active plan or intent to harm themselves and have a lethal means that is readily accessible. Also at high risk are those who are psychotic (particularly if they hear voices that are telling them to commit suicide), cognitively impaired, or lack judgment. Guidelines have been developed from the National Institute of Nursing Research and National Institute of Health to address the needs of individuals who self-harm and are at risk for suicide completion. The goal, first and foremost, is to reduce the immediate risk. Recommendations include the following:

1. When an individual presents in the emergency department following an episode of self-harm, the triage staff should quickly assess emotional, mental, and physical status to determine suicide risk.
2. People who have self-harmed should be treated with the same respect, care, and privacy as any patient. Staff should also consider the likely distress associated with self-harm.
3. People who have self-harmed, and who exhibit diminished mental capacity or significant mental illness, must have a mental health assessment prior to leaving.
4. When assessing people who have self-harmed, staff should ask patients to explain their feelings and understanding of their behavior in their own words.
5. Healthcare professionals should involve people who self-harm in all discussions and decision-making about their treatment and care. Full information about the different treatment options should be offered.
6. Patients should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept mental health treatment. Adequate pain relief for painful treatments, (suturing, for example), should be offered.

Nurses worry at times that asking about suicide will initiate suicidal thoughts or actions, but there is no data to support this concern. In contrast, many patients appreciate the opportunity to discuss suicidal thoughts, and may not verbalize these issues without being prompted. The best approach is to directly ask the patient if they have thought of ending their own life.

Implementation of the Baker Act

The self-harm/suicidal patient presents a unique challenge in the emergency department. Facilities that do not have inpatient psychiatric services are not exempt from providing emergency psychiatric care. Patients expressing suicidal or homicidal ideation require immediate intervention to prevent injury to self or others. The Baker Act (Florida Statue 394), also known as the Mental Health Act, was enacted to protect the rights and safety of all psychiatric patients. A psychiatric patient may be held for a time against his or her express wishes for a time in order to receive a psychiatric evaluation, if their mental illness has rendered them incapable of making an informed decision. If a patient with suicidal or homicidal ideation refuses voluntary examination, they should be held in the emergency room or as an inpatient until medically cleared. If a patient resists transfer to a psychiatric facility, the local police should be requested to escort the patient to ensure safety.
In-Patient Suicide Precautions

The highest priority is to assure the patient's safety, which may necessitate having a staff member supervise the patient while arrangements for further care are made (National Collaborating Center for Mental Health). The room should be cleared of objects that could potentially be used to inflict harm. The patient's belongings may also need to be searched since potential methods for self-harm may be easily accessible. If a patient demands to leave, security staff or local police may need to be called to detain or bring them to a psychiatric facility. Policies for the care of patients at risk for suicide should outline a safe, comfortable, and supportive environment. Nursing documentation should describe the patient's behavior and reason for interventions. In addition, the Certificate of Involuntary Examination must be completed by the initiating physician and become part of the medical record. Attendants assigned to monitor the patient and the environment for any potential threats to safety and well-being should be specifically trained. Some examples of attendant duties for suicide precautions are as follows:

- Stay within arm's length of the patient at all times.
- Never leave the patient unsupervised, even with family and visitors.
- Accompany patient to all tests and procedures.
- Restrict access to unsecured windows, sharp objects, or glass/mirrors.
- Notify nurse immediately for any changes in behavior and/or mood.
- Document the patient's status every fifteen minutes.

Alcoholism and Suicide

There is a clear relationship between alcohol dependence (addiction) and the risk of suicide (Conner & Duberstein, 2004). That relationship has not been demonstrated for those that abuse alcohol, but who are not dependent on it. Severe alcoholism, especially when accompanied by aggression and impulsivity, increases the likelihood that stressful life events will occur. This initiates a cycle of negativity, hopelessness, and depression, which in turn increases the possibility that the reactive aggressive act of suicide will occur. Understandably, interpersonal relationships are difficult and problematic in this population, which elevates the risk of suicide as well. At times it may be difficult to assess patients brought to the emergency department while intoxicated. They may well be agitated and in a suicidal state while intoxicated, but when sober do not experience suicidal thoughts. In fact, they may have no recall of having expressed a desire to commit suicide at all.

Supporting Suicide Survivors

The Suicide Awareness / Voices of Education Organization, or SAVE, is an organization whose mission is to prevent suicide through public awareness and education, by helping to eliminating the stigma associated with suicide, and serving as a resource to those touched by suicide. SAVE was started in 1989 when six suicide survivors (people who have experienced the loss of a loved one to suicide) met and agreed on the need for an organization. The organization is comprised mostly of suicide survivors, and people that have suffered from depression. Their website address is http://www.save.org/, or they can be reached at 1-800-273-TALK (8255). One of the founders has posted his personal story on the website to help comfort and educate the family and friends of those who have committed suicide. His story is included on page 10.
Recommendations from SAVE for responding to suicide survivors begins with the acknowledgement that coping with death is never easy. When suicide is the cause of death, the situation can be even more uncomfortable. Although there is no one right way to grieve a death by suicide, through experience the people of SAVE have found the following recommendations useful and relevant:

- Understand that the primary cause of suicide is untreated depression.
- Understand that mood and mental disorders such as clinical depression, anxiety disorders, bipolar illness, and schizophrenia cause 95% of suicides.
- Depression is a no-fault disorder of the brain. It is biological and is not caused by life events such as the break-up of a relationship or loss of a job.
- Express sympathy. Avoid statements like, “You’re young, you’ll marry again.” Or, “At least you have other children.” Although well intentioned, these statements can be upsetting. A heartfelt, “I'm sorry for your loss,” is appropriate.
- Understand that the survivor may be experiencing a number of intense emotions.
- Shock, pain, anger, bewilderment, disbelief, yearning, anxiety, depression, and stress are emotions expressed by some suicide survivors.
- Remember that grief is an intensely individualistic journey.
- Although you may have experienced grief in your life, avoid statements like, “I know how you feel.” Instead ask how the person is feeling.
- Listen. Listening can be the most helpful thing you can do for a suicide survivor. Acknowledge the difficulty of the situation and be available if the survivor wants to talk.
- Find out about suicide survivor grief/support groups in your community.
- Many survivors have found it helpful to attend a suicide survivor support group. Encourage the survivor to attend at least three or four meetings.
Suicide Prevention in Your Community

Why Seemingly "Normal" People Attempt Suicide

Emotionally healthy, stable individuals do not commit suicide. Most people who attempt suicide are not psychotic, but they are experiencing extreme emotional distress and pain. They may be frightened, grief-stricken, depressed or despairing, but these are not necessarily signs of severe psychiatric illness. Education and frank discussion are simple ways to help reduce the stigma that prevents a depressed person from seeking the help he or she needs. A suicide attempt is a cry for help that should never be ignored, because it is a warning that he or she needs immediate attention. Chronic major depression can lead to feelings of desperation and hopelessness, and a suicide attempt is one way some people choose to express these feelings. *Most people who attempt or commit suicide don’t really want to die – they just want their suffering to end.* A suicide attempt must always be taken seriously. Without intervention and proper treatment, a person who has attempted suicide may be at risk of another attempt, and possible suicide.

There exists a fairly common belief that once a person's mind is made up to commit suicide, there is nothing anyone can do to stop it. As health care professionals, we must never take this view. For a person determined to commit suicide, the desire to live is overshadowed by the seeming hopelessness of the disease, therefore the decision to commit suicide is really a desire to stop suffering. Depression is a crisis of energy and intervening to help the person regain perspective and aggressively treat the disorder can help reverse the downward trend toward suicidal thoughts.

Risk Factors and Warning Signs

- Mood disorders.
- Substance abuse.
- History of deliberate self-harm.
- Talking about suicide.
- Statements about hopelessness, helplessness, or worthlessness.
- Preoccupation with death.
- Suddenly happier, calmer.
- Loss of interest in things one cares about.
- Visiting or calling people one cares about.
- Making arrangements; setting one's affairs in order.
- Giving things away.

Suicide risk is assessed along a continuum of relatively less severe risk to most severe risk (Newberry, 1998). Suicidal ideation alone signifies less risk, while suicidal ideation with a specific plan of action is associated with a significant risk of suicide (U.S. Preventive Services Task Force). The four greatest predictors of suicide risk are as follows:

1. A suicide plan that is specific with an available, highly lethal method which does not include the possibility of rescue.
2. A history of suicide attempts which were highly lethal; rescue was probably accidental.
3. Very limited or nonexistent social and psychological resources.
4. Feels cut off from resources and unable to communicate effectively.
Logically, if all four predictors are present, the individual is considered very high risk for suicide. On the other hand, the risk of suicide is somewhat less if they are on the other end of the continuum. For example, if the suicide plan is less lethal and includes a plan for rescue, if they are in emotional turmoil but have some resources, and they use self-injury as a means of communicating when all other methods fail.

It is important to mention at this time that risk factors for adolescents include those of the adult, with the addition of aggressive or disruptive behavior and history of physical and/or sexual abuse (National Institute of Mental Health). For the elderly, the most direct warning sign is a failed suicide attempt. However, the elderly who attempt suicide should be considered very high risk, because they make much fewer suicide attempts in relation to completed suicides. Indirect behavioral clues for the elderly include the following activities:

- Stockpiling medications.
- Purchasing a gun.
- Making or changing a will. Putting personal affairs in order.
- Giving money or possessions away.
- Self-neglect. Sudden interest or disinterest in religion.

Suicide in Youth

Social changes that might be related to the rise in adolescent suicide include an increased incidence of childhood depression, decreased family stability, and increased access to firearms. Suicidal behaviors are often associated with depression. However, depression by itself is seldom sufficient. Other co-existing disorders, such as attention deficit hyperactivity disorder, substance abuse or anxiety can increase the risk of suicide. Recent stressful events, can trigger suicidal behavior, particularly in an impulsive youth. Girls may be more likely to make suicidal attempts, but boys are more likely to make a truly lethal suicide attempt.

Risk factors for suicide include:

- Previous suicide attempts
- Close family member who has committed suicide.
- Past psychiatric hospitalization
- Recent losses: This may include the death of a relative, a family divorce, or a breakup with a girlfriend.
- Social isolation: The individual does not have social alternatives or skills to find alternatives to suicide
- Drug or alcohol abuse: Drugs decrease impulse control making impulsive suicide more likely. Additionally, some individuals try to self-medicate their depression with drugs or alcohol.
- Exposure to violence in the home or the social environment: The individual sees violent behavior as a viable solution to life problems.
- Handguns in the home, especially if loaded.

According to the American Psychiatric Press Textbook of Psychiatry, research suggests that there are two general types of suicidal youth. The first group is chronically or severely depressed or has Anorexia Nervosa. Their suicidal behavior is often planned and thought out. The second type is the individual who shows impulsive suicidal behavior. He or she often has behavior consistent with
conduct disorder and may or may not be severely depressed. This second type of individual often also engages in impulsive aggression directed toward others.

Adolescents often will try to support a suicidal friend by themselves. They may feel bound to secrecy, or feel that adults are not to be trusted. This may delay needed treatment. If the student does commit suicide, the friends will feel a tremendous burden of guilt and failure. It is important to make students understand that one must report suicidal statements to a responsible adult. Ideally, a teenage friend should listen to the suicidal youth in an empathic way, but then insist on getting the youth immediate adult help.

Warning Signs:

- Suicidal talk
- Preoccupation with death and dying.
- Signs of depression
- Behavioral changes
- Giving away special possessions and making arrangements to take care of unfinished business.
- Difficulty with appetite and sleep
- Taking excessive risks
- Increased drug use
- Loss of interest in usual activities

Elderly Depression and Suicide

It is a myth that depression is part of the aging process. It is NOT normal for people of any age to suffer from depression; this includes our elderly population. Major depression (also known as clinical depression and/or unipolar depression) is an illness. Watch for the standard symptoms of depression, as well as these symptoms common among the elderly suffering from depression:

- Complaints of aches and pains (back, stomach, arms, legs, head, chest), fatigue, slowed movements and speech, loss of appetite, inability to sleep, weight increase or decrease, blurred vision, dizziness, heart racing, anxiety.
- Inability to concentrate, remember or think straight (sometimes mistaken for dementia). An overall sadness or apathy, withdrawn; unable to find pleasure in anything.
- Irritability, mood swings or constant complaining; nothing seems to make the person happy.
- Talk of worthlessness, not being needed anymore, excessive and unwarranted guilt.
- Frequent doctor visits without relief in symptoms; all tests come out negative.
- Alcoholism can mask an underlying depression.

A complete physical examination to rule out other problems is critical before a diagnosis of depression is made. Other physical diseases (Parkinson’s, multiple sclerosis, diabetes, thyroid disorders, certain viral infections, strokes, tumors) and certain medications (steroids, hormones, blood pressure and arthritis medications) used to treat those illnesses can mimic the symptoms depression; they can CAUSE a chemical imbalance in the brain. Therefore, a thorough exam is extremely important, as well as, a complete medical history and list of medications currently being taken (both over-the-counter and prescription drugs). Family history of depressive illness should also be noted, due to the genetic component of brain illnesses. Untreated or mistreated depression can result in suicide.
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In Addition to the standard warning signs of depression watch for the following behaviors:

- Talk about suicide, e.g. “I have nothing left to live for.” “I won’t be a burden on my family much longer.” “I should just kill myself.”
- Statements of hopelessness, helplessness or worthlessness.
- Preoccupation with death.
- Suddenly happier, calmer.
- Loss of interest in things one cares about.
- Unusual visiting or calling people one cares about – saying goodbyes.
- Making arrangements; setting one’s affairs in order.
- Giving things away.
- Stockpiling pills or obtaining a weapon.
- Refusal to follow doctor-prescribed medications and/or special diet.

If Someone You Know Is Suicidal

The Journal of the American Medical Association has reported that 85% of all suicides occur at the peak of a depressive episode. Education, recognition and treatment are the keys to suicide prevention. Stigma associated with depressive illnesses can prevent people from getting help. Your willingness to talk about depression and suicide with a friend, family member, or co-worker can be the first step in getting help and preventing suicide.

If you see the warning signs of suicide, begin a dialogue by asking questions. Suicidal thoughts are common with depressive illnesses and your willingness to talk about it in a nonjudgmental way can be the push a person needs to get help. Questions to ask might include:

“Do you ever feel so badly that you think of suicide?”
“Do you have a plan?”
“Do you know when you would do it (today, next week)?”
“Do you have access to what you would use?”

Asking these questions will allow you to determine if your friend is in immediate danger, and get help if needed. A suicidal person should see a doctor or psychiatrist immediately. Calling 911 or going to a hospital emergency room are valid options. Always take thoughts of or plans for suicide seriously. Never keep a plan for suicide a secret. Don’t worry about endangering a friendship if you truly feel a life is in danger. It's better to regret something you did, than regret something you didn't do to help a friend.

Don't try to minimize problems or shame a person into changing her mind. Your opinion of a person’s situation is irrelevant. Trying to convince a person it's not that bad, or that she has everything to live for will only increase her feelings of guilt and hopelessness. Reassure her help is available, that depression is treatable, and that suicidal feelings are temporary. If you feel the person isn't in immediate danger, acknowledge the pain as legitimate and offer to work together to get help. Make sure you follow through. This is one instance where you must be tenacious in your follow-up. Help find a doctor or a mental health professional, participate in making the first phone call, or go along to the first appointment. If you're in a position to help, don't assume that your persistence is unwanted or intrusive. Risking your feelings to help save a life is a risk worth taking.
My son Michael suicided on March 22, 1997 at age 38 just eight days and twelve years after my daughter Amy’s suicide on March 30, 1985. One wonders how a person can handle such tragedies. What else can one do but just cope, and play out the hand dealt to them. The difference between Amy’s suicide and Michael’s was we were totally blindsided by Amy whereas Michael had been treated for depression for over ten years and was later diagnosed with manic depression. Michael was living at our home, a nurturing and close environment, when he suicided; Amy died alone. What difference does it make — dead is dead!

The difference is that Michael had many people who loved and worked with him to try to stop this terrible brain disease that was spiraling his life downward to the deepest of black holes. Amy was also trying to stop the same deadly spiral but had few if any people helping her. What difference does it make? For some reason I believe that Amy may have been able to control her brain disease if she and the people around her only knew what was happening. After spending a semester at Providence College, she transferred to Iowa State University to study Entomology. She was one of only nineteen other undergraduate students in the department. Amy had a 3.9 GPA in college and was ready to graduate in June of 1985. In high school, Amy played soccer and was a cheerleader. One of her favorite past times was playing the flute; she always played first or second chair. The last time I heard Amy play was at her brother Kevin’s wedding. Her other brothers Michael and Philip were ushers at the wedding.

The family was doing just great — in fact fabulous. Kevin, a graduate of the University of St. Johns, recently returned from South Africa where he worked after a short stint in New York City. Philip, a graduate of Saint Mary’s University just received the highest all around award as “Redman of the Year” from Saint Mary’s and was off to teach and coach at a high school in New Hampshire. Michael recently transferred from Stetson College in Florida to the University of Wisconsin in Madison where upon graduation he was offered a position as a teacher’s assistant in the communications and German departments. He refused and decided to come home to Minneapolis.

This is the way life should have remained; we learned to ski, canoe and play tennis together, we vacationed together from Nantucket Island to Vermont, from Florida to Colorado and we went to church together. But things were to change suddenly and drastically. On March 28, 1985 my wife Mary and I received a letter from Amy. It was a buoyant upbeat letter with a handwriting style full of flourish. This handwriting style was quite different for Amy but at that moment I felt very happy — things seemed to be going well for her. We gave the university a high school girl and our daughter was returning as a confident young woman. I was excited to catch the plane and meet up with Mary in Florida. We also had tickets to a horse jumping show in Tampa. Two days later when we returned from the horse show, we had a phone call from our son Kevin — Amy suicided. She was in the back seat of the family car with her Raggedy Ann doll and her favorite blanket. I couldn’t accept it, it was too cold in the house; she slept in the car to get warm. At that point, our lives changed and would change again. In January 1997 Mary knew that Michael’s depression was deepening despite the treatment. She knew that we were losing Michael. Five weeks before his death she said to me that she didn’t think Michael would make it. I didn’t agree because he had the best team of doctors, psychiatrists, psychologists and mental health counselors in Minneapolis. He was hospitalized four weeks earlier -and still we lost him. Mary was with Michael at the last session with his doctors. He cried openly at that time pointing out that “the pain is too great.” When asked why he didn’t suicide, he said “I can’t do it because of my
family.” He had struggled with alcohol and drugs since high school. Michael’s depression was “early onset” but he was not medically treated until he was 30 years old. Depression robbed Michael of personal relationships, good jobs, good humor, grace and social ease. When his depression eased up he was charming, caring, social and lovable. This was Michael’s letter to us written one day before he suicided.

To my family:
I don’t understand how a loving God would allow my head to be filled with such terrible thoughts all the time. Ever since coming out of the hospital the world has seemed like cardboard, as if all the faces and everything I see aren’t “right,” that death is around me much of the time. What is God trying to prove? It’s horrible and I didn’t want to fully admit how bad it is. I didn’t want to end up in the hospital as a psychotic. I’ve had a couple of good days here and there. The medication seemed to help for a little while, but nothing is taking away this feeling that the world is a freaky place where I don’t belong. The job interviews and phone calls and everyday conversations I have feel forced, unnatural, creepy. I’m not blaming the medical community. They did the best they could, but the doctors really don’t understand what it’s like to live this way 24 hours a day. This brain disease is hideous for those of us seriously affected. The genetic factor is huge. We understand so little about it. Please forgive me. I can’t go on like this. It’s too horrible. I’m sorry I plan to use alcohol at the very end. I don’t want to go to the hospital again. I’m sure I would feel the same if I had a great job and a great marriage. This is a chemical disorder that has been worsening over the years. I believe God has a reason for this, mysterious as it is, and that He has a place for me that is peaceful. I love you all very much.

4:15 p.m. 3/21/97

Love, Michael

Mike bought a used rifle, twelve bullets, and then drove his van to a beautiful park by a lake and shot himself at approximately 3:00 p.m. on March 22, 1997.

Lithium and Electro Convulsive Therapy were treatments not used for Michael who was suffering from manic depression which was diagnosed late in his illness. Perhaps these treatments would have helped. In Amy’s case her school had some indication that she was having trouble but we were never told. She never had a chance for treatment that might have made a difference.

In response to our grief Mary and I, along with five other couples, started the organization Suicide Awareness Voices of Education (SAVE) two years after Amy’s death to publicly speak out for suicide survivors and to educate the public about suicide prevention. SAVE is dedicated to public awareness programs that encourage the identification and treatment of depression and the elimination of the stigma often associated with the illness and with suicide. The organization is based in Minneapolis and has developed a billboard and poster awareness campaign for the local community. Recently, SAVE started a pilot program in Cleveland with AFSP-NE Ohio and has been developing sponsorship to expand its message across the U.S. Ad slicks on suicide prevention are provided to over 1500 college newspapers today. To date these ads have appeared in many newspapers including, Columbia, Harvard, Stanford, and Purdue.

Taken from the SAVE website at http://www.save.org/

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References


Resources

The Suicide Awareness / Voices of Education Organization, or SAVE. Their website address is http://www.save.org/, or they can be reached at 1-800-273-TALK (8255).

Suicide Survivors – A Guide for Those Left Behind, by Adina Wroblewski.
The Basics: Suicide Fact Sheet from the Center for Disease Control  Summer 2008

Fatal Suicidal Behavior
- In 2005, suicide was the eleventh leading cause of death for all ages.
- Suicides accounted for 1.3% of all deaths in the U.S.
- More than 32,000 suicides occurred in the U.S. This is the equivalent of 89 suicides per day; one suicide every 16 minutes or 11.01 suicides per 100,000 population.
- The National Violent Death Reporting System examined toxicology tests of those who committed suicide in 13 states: 33.3% tested positive for alcohol; 16.4% for opiates; 9.4% for cocaine; 7.7% for marijuana; and 3.9% for amphetamines.

Nonfatal Suicidal Thoughts and Behavior
- Among young adults ages 15 to 24 years old, there is one suicide for every 100-200 attempts.
- Among adults ages 65 years and older, there is one suicide for every four suicide attempts.
- In 2007, 14.5% of U.S. high school students reported that they had seriously considered attempting suicide during the 12 months preceding the survey. More than 6.9% of students reported that they had actually attempted suicide one or more times during the same period.

Gender Disparities
- Males take their own lives at nearly four times the rate of females and represent 79.4% of all U.S. suicides.
- During their lifetime, women attempt suicide about two to three times as often as men.
- Suicide is the eighth leading cause of death for males and the seventeenth leading cause for females.
- Among males, adults ages 75 years and older have the highest rate of suicide (rate 37.97 per 100,000 population).
- Among females, those in their 40s and 50s have the highest rate of suicide (rate 7.53 per 100,000 population).
- Firearms are the most commonly used method of suicide among males (57.6%).
- Poisoning is the most common method of suicide for females (39.1%).

Racial and Ethnic Disparities
- Among American Indians/Alaska Natives ages 15- to 34-years, suicide is the second leading cause of death.
- Suicide rates among American Indian/Alaskan Native adolescents and young adults ages 15 to 34 (21.7 per 100,000) are 2.2 times higher than the national average for that age group (10.0 per 100,000).
- Hispanic female high school students in grades 9-12 reported a higher percentage of suicide attempts (14.0%) than their White, non-Hispanic (7.7%) or Black, non-Hispanic (9.9%) counterparts.

Age Group Differences
- Suicide is the second leading cause of death among 25-34 year olds and the third leading cause of death among 15- to 24-year olds.
- Among 15- to 24-year olds, suicide accounts for 12.3% of all deaths annually.
- The rate of suicide for adults aged 65 years and older was 14.7 per 100,000.

Nonfatal, Self-Inflicted Injuries
- In 2005, 372,722 people were treated in emergency departments for self-inflicted injuries.
- In 2006, 162,359 people were hospitalized due to self-inflicted injury.
- There is one suicide for every 25 attempted suicides.