

**Unanswered Questions
DSHS Grand Rounds
April 27, 2016**

1. What are the trends in suicide by geographic regions? What are the theories to explain the geographical variation?

This question was answered during the presentation.

2. How does Texas compare to other states in the incidence of suicide?

The rate of suicide in Texas is smaller than the national rate (12.1 vs. 13.4 in 2014), with Texas ranked the 9th lowest number of suicide deaths per 100,000. However, Texas had 3,254 deaths by suicide in 2014, which represents almost 8% of all deaths by suicide within the U.S. Only California had more deaths by suicide in the same year.

3. In recent years, has there been an increase in suicide among children?

Yes, the suicide rate has been increasing among children in recent years. For children age 10 to 14, the rate has increased 61.5%, from a rate of 1.3 per 100,000 in 2010 to a rate of 2.1 per 100,000 in 2014. For children ages 15 to 19, the rate has increased 16%, from 7.5 per 100,000 in 2010 to 8.7 per 100,000 in 2014.

4. Are you aware of any projects in which community health workers or faith community nurses are used to engage people who have suicide ideation? Have any studies been done on the benefits of using these types of non-threatening workers to help prevent suicide?

There have been a variety of “gatekeepers” trained to recognize the warning signs of suicide and engage and refer individuals at risk, including teachers, pastors, and community health workers. Research has shown that community health workers who have received suicide prevention training, specifically ASIST (Applied Suicide Intervention Skills Training) or QPR (Question, Persuade, & Refer), were more knowledgeable and confident in their ability to engage and manage individuals at risk of suicide (Smith, Silva, Covington, & Joiner, 2014). Similar findings, suggesting the importance of high quality training, have been shown with nurses, as well (Bolster, Holliday, Oneal, & Shaw, 2015). I am not aware of any research documenting an advantage to community health providers over other providers in engaging individuals at risk of suicide, as generally both gatekeepers and mental health specialists are important to the identification and management of suicide risk. There is some evidence to suggest that preparing community gatekeepers may reduce the incidence of suicide, although the impact does not appear to sustain without additional training (Garraza, Walrath, Goldston, Reid & McKeon, 2015).

5. Does research indicate that Mental Health First Aid has an impact on suicide rates?

There is no current research demonstrating that Mental Health First Aid training reduces suicide rates. A meta-analysis of studies on MHFA conducted in 2014 (Hadlaczky, Hokby, Mkrtchian, Carli, & Wasserman) demonstrated an increase in participants' knowledge about mental health, a decrease in negative attitudes, and increases in supportive outreach behaviors.

6. How can we register for the trainings mentioned by Dr. Lopez?

A variety of trainings were mentioned. A few can be accessed online:

- Columbia Suicide Risk Rating Scale – http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/cssrs_web/course.htm
- Counseling on Access to Lethal Means – <http://training.sprc.org/enrol/index.php?id=3>
- Safety Planning Intervention – <http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/sp/course.htm>
- ASK about Suicide to Save a Life - <http://www.texasuicideprevention.org/training/video-training-lessons-guides/ask-about-suicide-ask/>

Other training resources are described within our zero suicide toolkit at <http://sites.utexas.edu/zest/toolkit/>.

7. Can you discuss the disparities of suicide by sex, race, and income?

Research has consistently shown that men are significantly more likely (3.5 times) to die by suicide than women. However, women are three times more likely to attempt suicide. In 2014, the highest U.S. suicide rate (14.7 per 100,000) was among Whites and the second highest rate (10.9 per 100,000) was among American Indians and Alaska Natives. Significantly lower suicide rates were found among Hispanics (6.3), Asians and Pacific Islanders (5.9), and Blacks (5.5). Income information is not collected within national surveillance systems and research on the relationship between socioeconomic status and suicide have shown varied results depending on the methodology and population studied. Research has suggested that extremes of wealth or poverty may be a risk factor for suicide, as well as changes in social or economic status, such as the loss of a job.

8. Are there suicide prevention strategies targeting specific high-risk groups?

While some suicide prevention efforts target the general public, most target high-risk populations. Zero suicide efforts in Texas have focused on individuals with behavioral health disorders, as an estimated 90% of individuals who die by suicide have a diagnosable behavioral health condition. Along with other high-risk groups, targeted prevention strategies have been directed at youth, middle-age men, people who identify as LGBTQ, active duty military and veterans, and the elderly (<http://www.samhsa.gov/suicide-prevention/at-risk-populations>).

9. Are primary care physicians required to ask their patients about suicide ideation? The practice appears to vary greatly.

There are no current requirements for physicians to screen for suicide, and the U.S. Preventative Services Task Force has reported insufficient evidence to either recommend or not recommend screening of adolescents, adults, or older adults in primary care (USPSTF, 2015). However, research does suggest that 45% of individuals who die by suicide have seen a medical provider within the month before their death, suggesting that health settings may be an important setting for identifying individuals at risk (Luoma, Martin, & Pearson, 2002).

10. We've heard in the media about the terrible rates of suicide among our service members. Has this high suicide rate always existed or is it a recent phenomenon?

While suicide rates in active duty military have fluctuated some over the past few years, rates have been higher in the late 2000's and early 2010's than in previous years. The cause of this increase in suicide is likely complex, and research is ongoing. To date, research has not demonstrated a relationship between suicide risk and deployment following Operation Enduring Freedom or Iraqi Freedom, as rates were similar amongst service members who had and had not deployed. However, increased risk was found to be associated with separations after fewer than 4 years of service and with discharges that were not honorable (Reger, Smolenski, Skopp, Metzger-Abamukang, et al., 2015). Additional research is needed to provide further information about possible factors contributing to the increased suicide rates in military personnel.