

## **Suicide Attempt Survivors**

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Most people who attempt suicide do not go on to die by suicide. In fact over 90% of people who attempt suicide end up dying by some other means. Yet this statistic alone does not reflect the complexity of the issues involved nor does it tell the full story. Consider that having made a previous suicide attempt is itself THE single highest risk factor for suicide.

Thus is the dilemma of the clinician called to assess someone who has made a suicide attempt. Which side of the equation will they fall on? While they all will be statistically at increased risk, most will not attempt again others will carry that risk forward and make another, possibly lethal, attempt.

It should be noted that getting accurate data regarding suicide attempts can be challenging, especially when looking retrospectively after a suicide death. While family or friends may be aware of known suicide attempts (for instance those that required medical attention) many suicide attempts go unreported. The Youth Risk Behavior Survey (YRBS) gives a good glimpse of this phenomenon. YRBS is a survey of high school students in NH and across the US which is conducted every two years and has standardized questions. Results from the 2009 national YRBS report indicate that 6.3 percent of students report having made a suicide attempt during the past year but only 1.9% report having sought medical attention.

This brings forth another facet of the complexity of the suicide attempt paradigm. How lethal was the suicide attempt? And perhaps equally important to consider is what was the intent? One aspect of determining lethality is to determine how the attempt was found out. Did the person reach out for help? Did the act take place in a public place where it was likely someone would intercede or did someone inadvertently happen by at the right moment? Or did no one know about the attempt at the time? How lethal was the means, was the means used likely to end in death? These all become critical factors in determining present and to some extent future risk.

Individual's whose attempts have a high degree of lethality and result in hospitalization have significant increased risk even while hospitalized. While suicide in inpatient settings is a rare event it does occur and can have a profound impact on staff and fellow patients. The period immediately following discharge is a very high period of risk with significant numbers of deaths occurring within a day, week, month or year of discharge. One study indicated that of the individuals who die by suicide who had received inpatient care, 9% took their life within one day of discharge and over 40% within a year of discharge.

These statistics highlight the essential need for rapid and consistent follow up for individuals following a suicide attempt/psychiatric admission. Too often significant gaps both in time and intensity of services occur between emergency department or inpatient discharge and follow up care in the community. When someone who has made a suicide attempt is leaving a hospital setting, providers need to think conceptually about *reintegration* rather than *discharge*

and develop individualized safety and transitions plans that address what will be involved in returning to family, work, friends, school, and community. Risk can be reduced by insuring timely follow up treatment and availability of crisis intervention services after a suicide attempt. Unfortunately, continued decreased funding of mental health services locally and nationally will likely result in decreased supports and services which have the potential to save lives in this high risk population.

Recent research involving direct follow up from inpatient and emergency departments have shown promise in this area. Studies involving the use of phone calls and or post cards or letters which express general concern and encourage follow up treatment have been shown to be effective in reducing short term risk of further suicide attempts/suicide deaths. This risk has been demonstrated even when the follow up has been somewhat impersonal eg. a form letter and not from the specific treatment provider who had seen the individual in the hospital. These findings hold promise for innovative follow up strategies after a suicide attempt.

Information is available on how to best provide support following a suicide attempt. The National Alliance On Mental Illness (NAMI) in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA) developed and issued a series of "*After An Attempt*" brochures which have received National Best Practice designation. There are separate brochures available for treatment providers, family members and the individual who has made an attempt. Copies of the brochures are available free from SAMHSA or can be viewed/downloaded at <http://www.theconnectproject.org/get-help/attempt-survivors>

There continues to be a great deal of stigma associated with suicide attempts which negatively impacts individuals from seeking help. In recent years, there have been a number of different strategies to promote help seeking and support for individuals who have attempted suicide. The National Suicide Prevention Lifeline produced a video of Terry Wise discussing her recovery process after a serious suicide attempt. The video can be viewed on YOU TUBE or at the lifeline website <http://www.suicidepreventionlifeline.org/> and many people have posted comments how helpful viewing this video has been for them. The Lifeline also has developed an online gallery of people telling their stories using avatars. Many of these have been posted by individuals who have made a suicide attempt and describe their path to wellness. NAMI NH's *In Our Own Voice* program is effective in reducing stigma by having individuals with mental illness, some of who have made a suicide attempt, speak publicly about their journey of recovery. Although there are none (I am aware of) operating in NH currently, some areas have ongoing support groups specifically for individuals who have attempted suicide.

Advances have also been made in the area of training of clinicians working with high risk individuals. As part of the federal Garrett Lee Smith grant in NH, NAMI NH is offering training in *Assessing and Managing Suicide* (AMSR) a Best Practice program for clinicians. Social workers need to carefully assess the history of clients whom they are working with and pay particular attention to individuals with a history of, or who have made a recent suicide attempt. Ongoing assessment and risk management are essential for minimizing risk with this population.

***It is everyone's responsibility to prevent suicide.*** Warning signs include: talking about death or dying, isolation, anger/rage, hopelessness, increased use of alcohol or other drugs and mood changes. If you are worried about someone you think is at risk of suicide call the National Suicide Prevention Lifeline 1-800-273-TALK (8255).

This is the seventeenth in a series of articles for the NH NASW newsletter on suicide prevention. Previous articles include: Suicide as a Public Health Issue, Suicide Prevention In NH, Survivors of Suicide Loss, No Harm Contracts, Military/Veterans and Suicide, Restricting Access to Lethal Means, Suicide and Older Adults, Suicide Risk and LGBT Youth, Clinicians as Survivors of Suicide Loss, Suicide and the Economy, Media, New Media, Safe Messaging & Suicide Prevention, Ethics and Suicide Prevention, Suicide and Self Harm, and Homicide and Suicide. Previous articles can be viewed in the news and media section of the Connect Program website [www.theconnectproject.org](http://www.theconnectproject.org) Ken Norton is the Director of NAMI NH's Connect Suicide Prevention Program and he can be reached at 225-5359 or [knorton@naminh.org](mailto:knorton@naminh.org)