

Advancing Suicide Prevention

Special Issue

US \$14.00 CAN \$19.00

Men at Risk

Apart and Alone

Suicide among men
and the toll on
families and society

Call to Action

The coming crisis
in mental health
treatments as
Baby Boomers age

The Primary Care Setting

A key arena for
suicide prevention

also inside:

- Integrating addiction
and mental health
treatment
- Senate Democratic
Leader Harry Reid on
national progress
- Gulf Coast sees rise in
suicide rate



THE FACE OF DEPRESSION.

He was the youngest of seven children in a close-knit family. He had supportive parents and 17 nieces and nephews. He earned a college degree and held a meaningful job in the financial industry. He had lots of good friends who would do anything for him.

Yet he still died by suicide.



Charlie Kubly took his life in 2003 after a long struggle with depression. He was just 28 years old. And he was one of more than 30,000 American who die by suicide each year. As a society, we talk openly about other diseases, yet we don't

talk openly about depression and mental illness. That has to change. So that people like Charlie, with so much to give and so much to live for, can find the hope and help they need to recover, carry on—and live life to the fullest.



THE CHARLES E. KUBLY FOUNDATION

A PUBLIC CHARITY DEVOTED TO IMPROVING
THE LIVES OF THOSE AFFECTED BY DEPRESSION.

Attend our annual **Beyond the Blues** music festival, Saturday, September 15, 2007, at the Milwaukee County Zoo. Funds raised support important mental health projects in Wisconsin. Visit www.charlesekublyfoundation.org or call 414.962.0918.

Senior Editor
Denise Pazur

Art Director
Ric Kositzke

Production Director
John Peroutka

Circulation Director
Hervey Evans

Web Director
Erika Hutchings

Copy Editor
Ann Bernard

Production Assistant
Ryan Hively

Editorial and Advertising Offices

629 North 8th Street, Suite 203
Sheboygan, Wisconsin 53081-4502
Phone 920-457-4033
Fax 920-457-4011
advancingsp.org

Advancing Suicide Prevention®
(ISSN 1554-4508) is published by
Point de Vue Communications Inc.

POSTMASTER: See page 31

Advancing Suicide Prevention and
*Powerful insights driving suicide
prevention forward* are service marks
of Point de Vue Communications Inc.
All rights reserved.

© 2007 Point de Vue
Communications Inc.

No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without prior written consent of publisher.

Special Issue
Printed in the U.S.A.

Message from the Editorial Advisory Board

Dying for help

In America today, men are at three to four times greater risk for suicide than women. That disparity becomes even more pronounced when you consider our aging population, with people living longer and often with chronic illnesses.

Recent statistics tell the story: In 2003, 25,203 men died by suicide, comprising 80 percent of suicide deaths in our nation that year. Incredibly, this is nearly twice the number of men who died by homicide.

What is it about being male that places us at risk to die by our own hand? This special issue of *Advancing Suicide Prevention* considers characteristics that make males vulnerable to suicide, and more so as they age: Underdiagnosis and undertreatment of depression and other mental illnesses; addictions, including excessive alcohol, drugs, gambling or other destructive behaviors; a lack of confiding relationships and inability to ask for help; isolation and loneliness; and ready access to firearms in men across the lifespan.

Prevention efforts that are effective must address those in the general population most at risk—men across the lifespan. Key groups include those age 65 and older, and men in their middle years, ages 25-54. Whereas older men have the highest rates for suicide of any group, suicide in younger and middle-aged men has by far the greatest societal burden in terms of potential years of life lost or potential earnings lost.

Only by recognizing the role that men play in the 30,000-plus suicides in our country each year, and developing effective interventions, can we hope to curb the tragic tide of violent, premature death in our nation by suicide.



Prevention efforts that are effective must address those in the general population most at risk—men across the lifespan. Key groups include those age 65 and older, and men in their middle years, ages 25-54.

Yeates Conwell, MD

Professor of Psychiatry
Co-Director, Center for the Study and Prevention of Suicide (CSPS)
University of Rochester Medical School, Rochester, New York

Update from Publisher Denise M. Pazur

Making inroads in advancing suicide prevention

Feedback has been extraordinary since the launch of *Advancing Suicide Prevention* in spring 2005. Delivered to 20,000 health policy leaders nationwide, this magazine is informing policy and spurring change in unprecedented ways.

School Nurse News, the key trade publication for this sector, reprinted our "Schools and Suicide" cover story (Volume II, Issue 1) in its Sept. 2006 issue. *Edutopia*, an award-winning magazine from the George Lucas Educational Foundation, chose to treat schools and suicide in its fall 2006 issue, informed by our coverage of this timely and tragic topic.



Following data published in our summer 2005 "Suicide in Rural Areas" issue, Tennessee formed a task force to address suicide rates in rural DeKalb County, which was among the six U.S. counties with the highest rates for suicide in the nation. Our story sparked this action at the state level, supported by pickup coverage in *The Tennessean*, the state's largest daily newspaper.

Building workforce capacity in underserved areas is a critical need in the mental health and suicide prevention arenas. *Advancing Suicide Prevention* is supporting this need by serving as a training tool for doctoral students at the university level and informing practicing physicians attending medical education workshops on suicidal populations.

Our content is also informing state leaders: The Michigan Governor's Task Force on Children's Justice and Michigan Supreme Court - State Court Administrative Office used our "Youth Suicide" issue as an educational tool at a spring 2006 conference focusing on mental health issues for children in foster care and their families. Conference attendees included prosecutors, judges and referees, foster care review board professionals, HHS leaders, community mental health agencies, private practitioners, school counselors and others interacting with vulnerable children in the Michigan foster care system.

This unique and robust health policy publication is committed to advancing suicide prevention at the federal, state and local levels. Only by partnering with entities at all these levels—while reflecting the state of the science to the broad field at large—can we hope to achieve a reduction in the 30,000-plus suicides every year in our nation. The staff of *Advancing Suicide Prevention*, together with our sponsors, advertisers, editorial board and readership, are proud to work together to dispel stigma, raise awareness and inspire action that may indeed save lives.

Denise Pazur

Publisher

Powerful insights driving suicide prevention forward™

PREMIER PARTNER



EDITORIAL ADVISORY BOARD

Aaron T. Beck, MD

Frank R. Campbell, PhD, LCSW

Yeates Conwell, MD

Diego de Leo, MD, PhD

Lindsay M. Hayes, MS

Michael F. Hogan, PhD

David A. Jobes, PhD

Sean Joe, PhD

John Kalafat, PhD

David Lester, PhD

Marsha M. Linehan, PhD

Spero M. Manson, PhD

John L. McIntosh, PhD

Ann M. Mitchell, PhD, RN

Cynthia R. Pfeffer, MD

Charles H. Roadman II, MD, CNA

Leslie Scallet, JD

Terry Wise, JD



Suicide a leading cause of preventable death

David Lester's comments on the suicide rate debate (Volume II, Issue 1) were both interesting and thought provoking. However, when I read the title I was hoping you might actually be discussing the real debate about how suicide deaths are calculated and presented to the public.

I have been a trainer and consultant in suicide risk management for several years. One of the points I always make is that the way suicide deaths are calculated may diminish their importance as a preventable cause of death.

In brief, suicide is typically listed as the 10th or 11th leading cause of death in most national surveys. But, other than accidents, the other nine or 10 causes are medical diseases, which have a variety of causes, some of which may be directly preventable.

If medical illnesses are aggregated and placed in a discrete category in the same way it is done for prison and jail deaths for example, suicide would be listed as the third-leading cause of death, behind medical illness/natural deaths and accidents. In that context, suicide takes on an entirely new perspective as a major cause of preventable death.

Looking at leading causes of deaths in this way may present suicide in a more important light than it currently occupies.

Thomas W. White, PhD
Training and Consulting Services
Kansas City, Kan.
consult@lwnworth.com

Reality and tragedy of suicide

I am a consumer of mental health services and head of a project here at the Division of Mental Health that provides training and state certification to folks living with a diagnosis. We work from the perspective of our lived experience with

mental illness—and recovery—within the Georgia Public Mental Health System. The profound issue of suicide is certainly part of that experience for many of us. The actual notes used in the article “Schools and Suicide” (Volume II, Issue 1) struck a deep chord in

me. Reading the words in this young man's own handwriting pulled me, quite profoundly, into the reality and tragedy of his death and the issue of suicide.

Beth Filson
Project Manager
Georgia Certified Peer Specialist Project
Georgia Division of MHDDAD, Atlanta
emfilson@dhr.state.ga.us

American Indian suicide

(Regarding the Rural Suicide issue of ASP Volume I, Issue 2)

I immediately put all work aside and read the issue, all of it. It is a remarkable and powerful educational tool and source of support for someone in my position who wants to help build community around the issue of American Indian youth depression and related mental health concerns. Having lived 40 years of my life on reservations, the "Special Report" (Volume I, Issue 2) moved me to tears for two reasons. First, because I know the feeling of the soul-piercing loss to the Native community when even one of our young people takes his or her life; and second, for the hope represented by the photo of the young American Indian woman testifying before the U.S. Senate Committee on Indian Affairs. Another important feature of the article is that it provides the context of suicide that includes poverty and truncated options and opportunity. I wish to thank you for developing such a meaningful publication.

Tassy Parker, PhD, RN (Seneca Nation)
Assistant Professor of Family and Community Medicine
University of New Mexico, Albuquerque
taparker@salud.unm.edu

CONTENTS features



14 Apart and Alone

Emotional isolation, coupled with the need to be in control and perceived as strong and independent, contribute to suicide among men, especially those age 65 and older.



PAGE 23 She was just an infant when her father showed signs of suicidal ideation. Sherry Becker was 8 years old when her dad, who had battled alcoholism and depression for decades, hung himself. His death in 1977 has impacted Sherry's life in profound ways in the 30 years since her dad completed suicide.



PAGE 18 American "gonzo journalist" Hunter S. Thompson exemplified a male psyche of independence, strength and resistance to seeking help. He also illustrates male risk for suicide, dying by his own hand in 2004.



24 The Primary Care setting

A key to suicide prevention is internal and family medicine, with experts calling for routine assessment of suicidal ideation in all depressed patients.



CONTENTS departments

PAGE 1

Prevention expert
Yeates Conwell
on those most
vulnerable to
suicide.



1

our turn

Message from the Editorial Advisory Board

Prevention efforts that are effective must address those in the general population most at risk. With the University of Rochester's Yeates Conwell, MD.

3

your turn

Letters to the editor

forward thinking

6

Dispelling denial

7

Americans speak out on suicide

8

state of mind

Prevention's legislative pioneer

U.S. Senate Democratic Leader Harry Reid on advances in mental health policy.

noteworthy

26

Suicides triple in the wake of Hurricane Katrina

Gulf Coast battered by rise in suicide rates.

27

Calendar

28

science matters

32

final analysis

Emergency workers at the edge

PAGE 6

He leads the federal response to treatment for alcoholism and drug addiction. And Dr. H. Westley Clark is adamant that integrating mental health into addiction treatment is critical to the health of millions of Americans debilitated by these frequently co-occurring disorders.

PAGE 11



PAGE 8 Suicide prevention's legislative pioneer Sen. Harry Reid of Nevada uses personal tragedy to shape mental health policy in our nation.



PAGE 28 Researchers are beginning to document the burden of nonfatal suicidality among blacks in the United States.



HURDLE

Dispelling denial

Increasing treatment-seeking behaviors among those with co-occurring disorders

Westley Clark will never forget the day in 1963 when a young man in his Detroit neighborhood shot himself. “I didn’t understand why he would do that,” Dr. Clark told an audience riveted by his remarks at a Sept. 2006 prevention conference in Washington, D.C., sponsored by SPAN USA, the Suicide Prevention Action Network. “Suicide was verboten then, at least in the African-American community,” Clark continued in his address on suicide and substance-use disorders.

Clark spoke of this friend who died by suicide in utterly personal terms, as a neighbor with self-destructive behaviors that Clark didn’t then understand. A person who was engaging, active and friendly—yet someone with incredible “psychache” who died by his own hand.

“I didn’t have any answer to this. Maybe that’s why I became a psychiatrist: I was seeking answers.”

Today Clark leads the federal response to treatment of Americans for substance-use disorders as director of one of three centers that comprise SAMHSA, the Substance Abuse and Mental Health Services Administration. In his role at the Center for Substance Abuse Treatment, or CSAT, Clark has called upon the mental health and substance-use disorder fields to work together to prevent suicide.

“We know alcohol, marijuana and other drugs are associated with suicidal thoughts and gestures,” noted Clark. “So is a history of violent behavior, a history of trauma and abuse. **We need a sense of perseverance, comprehensive support for each other. This is about community.**”

Clark’s comments reflect a recent and new emphasis on suicide as a preventable public health threat, one that SAMHSA and other federal agencies have embraced. Integrating suicide prevention with substance-use disorder treatment is key. Yet while 5.2 million Americans have co-occurring substance-use and mental disorders, 49 percent of these persons receive no treatment at all, and a mere 7.5 percent receive treatment for both disorders.

“People don’t feel a need for treatment, and so they don’t get it,” adds Clark, citing that 88 percent of people with excessive alcohol consumption do not perceive a need for treatment, reflecting the denial that is part and parcel of substance-use disorders. A key policy issue in Clark’s estimation? How to increase treatment-seeking behaviors in those who need treatment most. One answer: workforce development.

“You’ve got to have clinicians recognizing substance use *and* suicidal ideation, and promote the notion that suicidal ideation is symptomatic of other conditions.”



Dr. H. Westley Clark, who leads the federal response to treatment of Americans for substance-use disorders, believes that workforce development of professionals delivering care in co-occurring disorders—both mental and substance use—is one key need in meeting the needs of millions of Americans who are self-medicating the “psychache” of mental illness with drugs or alcohol.

TREND

Americans speak out on suicide in national poll

While nearly nine out of 10 Americans say mental health is just as important as physical health, only one-fourth believe physical and mental health are treated with equal importance in the nation's health care system.

These are among the findings of a national poll released by the Suicide Prevention Action Network (SPAN USA), Research!America and *PARADE* magazine. Published in the Oct. 1 issue of *PARADE*, the poll sheds new light on Americans' views on the importance of mental health and suicide prevention, and counters stigma surrounding these issues. Nearly all poll respondents (92%) say that mental health services, such as treatment for depression and suicide prevention, should be part of any basic health care plan.

The study also reveals important new findings about Americans' attitudes toward suicide prevention. For the first time, Americans were asked if they believe that appropriate intervention and services can help prevent suicide, and if the government should invest in suicide prevention. The poll finds that a vast majority of Americans (86%) think it is important for the U.S. to invest in suicide prevention. More than three-quarters believe that suicides could be prevented with research, interventions and services.



“Although 92 percent of Americans believe that mental health services should be part of any basic health care plan, we know that far too often people do not get the help they need because they lack health insurance coverage for treatment of depression and other mental health conditions.”

Jerry Reed, MSW, Executive Director,
Suicide Prevention Action Network (SPAN USA)

“Suicide is a preventable public health problem, as more than 90 percent of those who die by suicide suffer from depression or other mental or substance-use disorders,” says Jerry Reed, executive director of SPAN USA, a sponsoring partner of the national poll.

INSIGHT

Semantics of suicide

Few issues in society are as stigmatized as suicide. The language used to describe suicidal gestures, attempts, completions and people are a significant contributor to this stigma, say experts. The word “commit” suicide implies something morally wrong, as in the religious concept of “committing a sin.” And calling the suicidal

act, when completed, “successful” denotes a subjective judgment that is inappropriate in its positive implications for an act so tragic. Experts suggest the following:

COMPLETED suicide instead of COMMITTED suicide

DIED BY SUICIDE instead of COMMITTED suicide

PREVENTION'S LEGISLATIVE PIONEER

As a survivor of the suicide loss of his father, Sen. Harry Reid calls on a very personal tragedy to influence mental health policy in our nation

A public Senate hearing is a unlikely venue to hear a deeply moving story of loss, especially when a seasoned politician takes the microphone. Yet during a Senate Aging Committee meeting in 1996, Sen. Harry Reid did just that by revealing that his father completed suicide in 1972.

Since then, the Nev. senator has become a chief proponent of suicide public policy, introducing groundbreaking legislation that spurred the 2001 National Strategy for Suicide Prevention. "He gave the nation the permission to speak about suicide by sharing his story," said Jerry Reed, former legislative assistant to Reid and now executive director of SPAN USA, a suicide prevention advocacy group. "His legislation led to the first coordinated effort among states, municipalities and local governments to address suicide as a preventable public health problem and lift its veil of secrecy."

Reid also championed the Garrett Lee Smith Memorial Act, legislation named for Oregon Sen. Gordon Smith's son who completed suicide in Sept. 2003. The legislation provides federal funding for states, tribes and colleges to combat youth suicide and includes provisions to improve youth behavioral and mental health treatment.

ASP recently interviewed Reid and found him eager to discuss suicide prevention policy, calling it "encouraging," yet adding, "we have much work remaining to do." He also talks about the loss of his father and how it impacted his politics and his life: "Personal tragedy can serve as a catalyst for change."

Senator, recent evidence suggests that providing enhanced insurance coverage for behavioral health does not lead to exploding insurance costs. Would you reflect on your views on providing equal insurance coverage for both mental and physical conditions?

Given the close relationship between mental health and suicide, it's essential to eliminate the barriers to seeking and receiving effective mental health treatment. After all, good mental health is integral to overall health, as well as a key protective factor against

suicide. In contrast, mental disorders and poor access to mental health services are substantial risk factors. In fact, the Institute of Medicine reports that the overwhelming majority of those who

die by suicide has a diagnosable mental disorder. Yet, most suicide victims do not have their disorder diagnosed or adequately treated at the time of suicide.

As such, I believe that achieving parity in health insurance coverage of mental health services is critically important to the overall suicide prevention effort. Health insurance plans that cover mental health services should do so under the same terms and conditions as general medical and surgical services.

Recognizing this, the majority of states has already passed mental health parity legislation for state-regulated health plans.

As a member of the Senate, I have long sought to enact mental health parity legislation at the federal level. In the last Congress, I was pleased to see the primary legislative vehicle for this proposal, Paul Wellstone Mental Health Equitable Treatment Act, receive majority, bipartisan support in both chambers of Congress. Unfortunately, the legislation did not pass.

Even today, I can still recall the moment in 1972 when I received the tragic news about my father having taken his own life.





With suicide still needlessly claiming over 30,000 lives each year, and attempted or seriously contemplated by millions, widespread adoption of a clear and comprehensive strategy could not be more timely.

In the 109th Congress, the Paul Wellstone Mental Health Equitable Treatment Act was reintroduced in the House of Representatives. As before, I strongly support this measure and will work to move a companion bill forward in the Senate when it is reintroduced there.

If we are to achieve mental health parity nationally, we must also resist proposals that would dismantle the hard-won victories in the states. Recent defeat of Senate bill 1955, the Health Insurance Marketplace Modernization Act (HIMMA) was a victory for mental health care for millions of Americans. This seriously flawed legislation would have wiped out a wide range of state coverage protections, including those requiring coverage for mental health services. It ultimately would have led to greater market fragmentation in a system in which too many Americans already cannot get the mental health services they need and deserve.

Senator, given the strong bipartisanship support for the Garrett Lee Smith Memorial Act and given that one of the top 10 resolutions from the 2005 White House Conference on Aging addressed mental health needs of older adults, what can we all learn from this for suicide prevention legislation to address these vulnerable populations? Anyone can be affected by suicide, but certain populations are especially vulnerable. The suicide statistics for the young, in particular, are deeply troubling. For young people 15-24 years old, suicide is among the three leading causes of death. More teenagers

and young adults die of suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.

At the other end of the age spectrum, the elderly are disproportionately hit hard by suicide. In fact, the highest suicide rates of any age group occur among persons age 65 years and older. And, as many ASP readers know, the risk factors for seniors differ from those of the very young.

What do these figures tell us about effective suicide prevention and intervention? In a compelling and clear way, they point to the need for selective programs that address specific at-risk groups. I believe that was one of the key driving forces behind Congress passing the Garrett Lee Smith Memorial Act with strong bipartisan support.

The vast majority of seniors have medical insurance under Medicare, yet under current Medicare co-payment or co-insurance requirements, Medicare beneficiaries pay two-and-a-half times as much for outpatient psychiatric services. I support changing this to equalize Medicare co-payment requirements for psychiatric services with other physician services. Older adults seeking treatment for mental disorders should not have to face yet another barrier to care.

While the goal is to ultimately reach everyone who would benefit from suicide prevention, it can be easier to move forward legislation that reflects the needs of a subset of the American population. Fortunately, the two measures I just described ultimately

Sen. Reid has been a champion for health care in America for all Americans. Here Sen. Barack Obama (D-IL) and Sen. Hillary Clinton (D-NY) joined him in 2005 to spotlight racial and ethnic disparities in our nation.

benefit everyone, even though they call for action in a limited way, because the resulting gains build momentum and increase overall awareness of suicide as a serious but preventable public health challenge.

Senator, since the launch of the National Strategy for Suicide Prevention, what do you think is the greatest achievement made so far in moving NSSP recommendations and suicide prevention in our nation forward? Crafted to provide a comprehensive framework for decisive action, the National Strategy for Suicide Prevention is the nation's foundation for a suicide prevention agenda. When it was first published in May 2001, the NSSP was lauded as representing both the work accomplished and the progress yet to be made. The blueprint advances the cause of suicide prevention in many ways, but as we all know, fulfilling its main purpose ultimately takes implementation at the state, local and community levels.

All 50 states now have a statewide suicide prevention strategy in place, under development or recognized as a major public health goal. I am very heartened by this milestone, and I am hopeful that those states that have begun, but not yet completed, their own statewide plan will accelerate their efforts.

Senator, given the progress made thus far in suicide prevention, what do you feel is the next priority in this arena, the one that could have the greatest return on investment and impact on saving lives?

With suicide still needlessly claiming more than 30,000 lives each year, and attempted or seriously contemplated by millions, widespread adoption of a clear and comprehensive strategy could not be more timely. Under such a plan, the organized collaboration between various stakeholders—including health care professionals, government, health and policy experts, and grassroots members—would strengthen the overall mental health care infrastructure, raise public awareness and lead to better use of limited resources. Each individual step forward builds momentum, ultimately contributing to the work of everyone else involved in the national effort.

At the same time, we should not allow the lack of a formal statewide plan to be a barrier itself. We should be pressing forward with existing initiatives and examining what is working and why, keeping in mind that suicide is the outcome of a complex mix of risk and protective factors taking effect in a cultural, social, and economic context.

Our knowledge base about suicide is also still limited, whether it draws from existing programs or research studies.

Clearly, despite the encouraging progress made so far, we have much work remaining to do.



Senator, we applaud your courage in coming forward to share your own personal loss. Would you be willing to share with us a bit about how this loss continues to impact your life, your career, and your approach to public policy today?

Even today, I can still recall the moment in 1972 when I received the tragic news about my father having taken his own life. I had just returned to my Las Vegas law office after spending a memorable afternoon with the legendary Muhammad Ali when I was given an urgent message to call my mom in Searchlight, Nev., immediately. That was when I learned that my father had killed himself.

The years following my father's death, my family didn't talk about →

Prevention's Legislative Pioneer (*continued*)

his suicide. We were left alone and carried this experience in a very private way.

It wasn't until 1996, 24 years later, when I spoke publicly for the first time about my father's suicide. Shortly thereafter, my office was inundated with calls and letters from people around the country who had also lost a loved one to suicide. I quickly learned that suicide is a national problem, and one that is particularly severe in my home state of Nevada.

Senator, what do you feel are some of the best ways to increase interest in the field of suicide prevention among your colleagues?

No one should have to personally experience the tragedy of suicide to realize that it is not "something that happens only to other people."

Rather than something that we turn away from, suicide is something we should turn towards and work together to eradicate. With this in mind, I introduced Senate Resolution 84 on May 6, 1997, to call for a national strategy to address suicide in America. All senators agreed to its passage that same day, turning the resolution into a remarkable beginning for suicide prevention efforts nationally.

When our esteemed colleague from Oregon, Sen. Gordon Smith, lost his 21-year-old son, Garrett Lee Smith, to suicide, my Senate colleagues and I were again reminded that suicide truly can affect anyone. Like many other suicide survivors, Sen. Smith and his wife Sharon thus began their tireless work to advance the cause of suicide prevention, leading to the passage of the Garrett Lee Smith Memorial Act in 2004.

As you can see, personal tragedy can serve as a catalyst for change. It can even become a persuasive instrument of public policy.

In the case of suicide prevention, it is perhaps also the most powerful way of transcending personal loss to making an enduring difference in the lives of countless others.

Elected to the U.S. Senate in 1986, Sen. Harry Reid (D-NV) was unanimously elected as Democratic Leader by his fellow Senate Democrats after winning a fourth term to the U.S. Senate in 2004 by a wide margin. For more, see reid.senate.gov.



Imagine... a suicide-safer community.

LivingWorks has been helping communities become suicide-safer for almost 25 years. Our programs are an important part of national and regional prevention strategies worldwide. Comprehensive, layered and integrated, LivingWorks' programs prepare community helpers to intervene and prevent suicide. These learning experiences are interactive, easy to learn and practical. A place for everyone to learn ways to help:

- ▶ **SuicideTALK: An exploration in suicide awareness**
Invites your community to be aware of suicide prevention opportunities.
- ▶ **safeTALK: suicide alertness for everyone**
Helps all members of your community identify persons with thoughts of suicide and connect them to suicide first aid resources.
- ▶ **Applied Suicide Intervention Skills Training**
ASIST helps all kinds of caregivers learn suicide first aid intervention. Over half a million people have taken the ASIST workshop, which is available in English, French, Norwegian, Spanish and Inuktitut. Outcome studies show participants are more willing, ready and able to help a person at risk of suicide.
- ▶ **Training for Trainers (T4T)**
This intense, five-day course prepares trainers in your community to present ASIST. Currently, there are over 3,000 trainers around the world.
- ▶ **Clinician UpSkillling**
Refines the helping competencies of active helpers of persons at risk beyond the initial suicide crisis.



LivingWorks

suicide-safer communities · saving lives for tomorrow
TEL: (910) 867-8822 www.livingworks.net

Feeling blue, hopeless, alone?



**When it seems like there's
no hope, there is help.**

“Feeling blue” is not a normal part of getting older. In fact, feeling sad or hopeless for too long can cause health problems. If you feel like you have too little to look forward to in life... If you're going through big changes that have you feeling down, or if you are worried that someone you care about is feeling down, it's important to talk to someone.

You can talk to someone *right now* by calling the Lifeline. Help is available at any time of the day or night—and it's completely free and confidential. We're here to listen and to help you find your way back to a happier, healthier life.

If you or someone you know is thinking about suicide,
call the National Suicide Prevention Lifeline:

1-800-273-8255 (TALK)

With help comes hope.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org



A P A R T and alone

Bob Stern was one of a kind. He was a man's man. A free spirit and adventure seeker who enjoyed being different and more capable—in his estimation—than others. Bob was a calculated risk taker, successful business owner and entrepreneur who was in control of himself, his family and his destiny.



He could have retired at age 37 after earning his first fortune in steel, or after earning a second in Chicago real estate. This self-made man continued to pursue other new ventures—including pioneering solar energy—with an intensity and tenacity that astounded others.

Yet for all his uniqueness, Bob Stern was an extraordinarily typical man when it came to one thing: seeking help.

Bob would have none of it. He refused to be dependent on others. It showed weakness, vulnerability, potential incompetence—and loss of manhood. If Bob was anything, he was true to traditional societal expectations of masculinity and how men ought to behave.

There was one other thing that made Bob Stern all too typically male, and tragically so.

Suicide.

→

Like a gnarled fencepost wrapped in barbed wire to deter others, men old and young can construct a shield of strength as they succumb to societal expectations of what it means to be male. This facade—and these societal norms—place American men at considerably higher risk for suicide than women in our nation.



“I would like to remind you ... that I might look strong—physically—and I might act strong. And I might be strong. But my history of health problems has been a terrific burden to me over my life.”

—ENTREPRENEUR BOB STERN, in a videotape he recorded for his daughters the day before he died by suicide in 2001

Ending his life on Independence Day was Bob Stern's last message to his family and to the world.

It was about 5 in the morning on July 4, 2001, when this 77-year-old husband, father of three and grandfather of four walked out the front door of his home for the last time. Light was just beginning to appear over the family's ranch in central California.



Businessman and family man Bob Stern (left) took his life in 2001, the day before he was scheduled for surgery to repair an aortic aneurysm. Research shows that 40 percent of those who die by suicide have contact with their primary care provider within a month of their death. This points to the critical role that primary care physicians play in evaluating patients for potential for suicide, particularly elderly males who have consistently had the highest rates for suicide of any group in America.

Adele, Bob's wife of 56 years, and their only son Mike were inside the house. They heard his footsteps on the porch outside. Bob walked down the road carrying a handgun. He got to the gate leading to the horse's corral and sat down, leaning against the fence. Within seconds he used the firearm to end his life.

The suicide note in the pocket of Bob's shirt mentions love for his family over the course of his life. It was a spirited and autonomous life that Bob had shaped for himself. And it had been under a threat he would not—or could not—bear: recent diagnoses of an aortic aneurysm and prostate cancer.

While family members and friends attribute Bob's self-inflicted death to these diagnoses and surgery he faced, experts in suicide and its causes say it's not that simple.

“As a society we're looking for an easy answer, like Mr. Smith killed himself because of a stroke,” says academic researcher and noted authority on suicide Yeates Conwell, MD, with the Center for the Study and Prevention of Suicide at the University of Rochester Medical School in New York.

“As survivors (of suicide loss) we have to do something to manage this. And so we ‘package’ it in ways that help us make sense of it. But suicide is brought about by a complex combination of factors that can include difficulty adjusting to the aging process and losses in life. Also an unwillingness to seek mental health treatment, especially among males,” adds Conwell.

By the numbers

90%

U.S. suicide victims who have a diagnosable mental disorder.

\$105 billion

Economic productivity estimated as lost in the United States annually due to mental illness, according to the Campaign for Mental Health Reform.

40%

People of all age groups who complete suicide that have made contact with their primary care provider within a month before their death.

38-40 times

Increased risk of dying by suicide for those who have attempted suicide in the past.



An intense entrepreneur and individualist, Chicago native and businessman Bob Stern was a pioneer in California solar energy. Stern died by suicide in 2001 at age 77. "Before 7:30 tomorrow morning I can put an end to this very nice life that you girls have been a part of for many, many years," Bob said to his two daughters in a videotape he recorded the day before he took his life. Daughter Susan, a journalist and filmmaker, used her father's video as the basis of a 2005 documentary film about his life and self-inflicted death.

Susceptibility for suicide

Astoundingly males in the United States are killing themselves at about four times the rate of females (Weigel, 2001).

In 2003 (the most recent year for which data are available), 6281 American females died by suicide for a rate of 4.3 per 100,000. In stark contrast, 25,203 males died by suicide during that same year, for a disturbing rate of 17.6—nearly double the number of deaths by homicide.

What age groups of males are most at risk for suicide? That depends on if you consider actual numbers of deaths, or rates for suicide, as measured per 100,000 people.

By far the greatest numbers of deaths come from men in the middle years ages 25-64. In 2003 these comprised 17,168 or about 55 percent of all U.S. suicide deaths that year.

But for *rates* of suicide deaths, elderly white males by far exceed all other age groups (including youths), genders and races. In fact, of all the Caucasian males age 65 and older living in America in 2003, about one in every 3000 died by suicide that year. Troubling rates to say the least.

The picture only gets worse as men age. For the "old-old" age 85 and above, suicides among males soar to about one in every 2100 for a rate of 48.2 per 100,000—nearly five times the national rate across all age spans. And, of these, the vast majority—97.4 percent—are Caucasian. →

410,000

Americans who were treated for suicidal behavior in 2003, according to the Centers for Disease Control and Prevention.

26.2%

U.S. residents who had disorders—*anxiety, mood, impulse control or substance-use*—in the past 12 months, according to the National Comorbidity Survey Replication.

1/3

Of troops returning from Iraq who are seeking mental health treatment.

Male identity: A "guy thing"

These core requirements of male identity (Brannon, 1985) can contribute to lack of help-seeking behaviors among men across the lifespan, including those who become suicidal because they can no longer manage life's burdens on their own.

NO SISSY STUFF

The stigma of all stereotyped feminine qualities including openness and vulnerability. Never ever resemble women or display strongly stereotyped feminine characteristics for fear of being a sissy.

THE BIG WHEEL

Success, status and the need to be looked up to for what one can do or has achieved. Attained through wealth and fame, in excelling at sports, and being competent and knowledgeable.

THE STURDY OAK

A manly air of toughness, confidence and self-reliance. Real men ready to die, refusing to retreat at any cost. Think of Paul Newman in *Cool Hand Luke* or John Wayne in *True Grit*, all lacking social status but excelling at being The Sturdy Oak.

GIVE 'EM HELL!

The aura of aggression, violence and daring. The negative side of The Sturdy Oak. The need to hurt, conquer, embarrass, humble, outwit, punish, defeat. Think the aggressive ballplayer, aggressive businessman, aggressive thinker, with this aggression sometimes leading to violence.

A Continuum

How losses can lead
to potential for suicide

Loss
(divorce, retirement,
illness, death or other)

can threaten

Physical Integrity

Challenge to physical integrity
can threaten

Physical Power

Challenge to physical power
can threaten

Physical Autonomy

Challenge to physical autonomy
can threaten

Core Identity

Challenge to core identity
can bring about

**Potential for
Suicide**

Role of male psyche

Why do American men kill themselves so often? And why do their chances of dying by suicide increase as they move into the middle years and old age? Understanding the differences between men and women from a Western cultural and societal perspective provides clues. These gender differences and their effect on suicide have been a focus of research by Silvia Sara Canetto, PhD, professor of psychology at Colorado State University. Her findings are revealing and thought provoking.

“There is a perceived masculinity of suicide that is borne out in historical evidence,” notes Canetto. “In Western cultures suicide is generally considered a relatively powerful act, one requiring energy, courage and intelligence assumed to be found only in white educated men.” Moreover, suicide in males was rated as less wrong, foolish, weak and more permissible than suicide in females, according to research (Deluty, 1988-1989).

Canetto's own research shows that in Western industrialized countries it is considered unmasculine to survive a suicide attempt.

“The social pressure against males surviving a suicidal act may lead males to kill themselves without warning others about it, and even though they may be ambivalent about dying,” she notes. “Males may correctly anticipate being ridiculed if they survive a suicidal act.”

Additionally, Canetto's research suggests society considers male suicide a relatively understandable response to impersonal problems such as achievement failures, social problems such as an economic recession, or health problems like those encountered by Bob Stern.

“Suicide in response to a physical illness is consistently viewed as more understandable than suicide in response to any other stressor,” Canetto says. “A suicidal individual is perceived as less maladjusted if the suicidal behavior is precipitated by a serious physical illness.”

Violent end for a cultural icon



American “gonzo journalist” Hunter S. Thompson exemplified a male psyche of independence, strength and resistance to seeking help. Thompson, who died by suicide at age 67, had struggled with health problems in the years prior to his death including a broken leg and hip replacement. He shot himself at his Colorado ranch on Feb. 20, 2004. A skilled and cynical writer, Thompson's suicide note, published in *Rolling Stone* magazine, sheds light on his self-inflicted death:

*“No More Games. No More Bombs.
No More Walking. No More Fun. No More
Swimming. 67. That is 17 years past 50.
17 more than I needed or wanted. Boring.
I am always bitchy. No Fun—for anybody.
67. You are getting Greedy. Act your old age.
Relax—This won't hurt.”*

Like a massive tree that appears strong yet is weakened by exposed roots, those vulnerable to suicide often lack support systems that can sustain them when a storm strikes.

Yet evidence shows that a serious physical illness can often bring about clinical depression, which can in turn lead to thoughts of suicide. Treating the depression can lift self-destructive thoughts, improve quality of life and enhance a person's ability to cope with illness and cooperate with treatment. This may improve acceptance of their health condition, overall functioning, and chance for remission or even cure.

Could this have been Bob Stern's outcome? Perhaps, but maybe not. His suicide leaves that question forever unanswered.

Dying for help

Depression. Hopelessness. Lack of resiliency. All risk factors for suicide—and in all genders and age groups.

These factors often appear during a time of intense change in a person's life—divorce, retirement, death of a loved one, financial setback, diagnosis of an illness or perceived poor health. And if they were contemplating suicide or had attempted in the past, their risk of making a lethal attempt in the face of these life changes is increased.

“As someone's role changes in a profound way, their mood can change,” notes Conwell. “People have characteristics that are lifelong, strengths and weaknesses that they bring to the challenges of life. In the face of stressors, those with greater vulnerability—social, character, emotional—are at greater risk for becoming demoralized, hopeless, depressed.



And some of these will develop suicidal states.”

When this suicidal crisis surfaces, it's often too late to halt, particularly in the aged. That's because the elderly can be more frail and therefore more likely to die if they attempt suicide. Also, they are often living alone and isolated from support services.

“We need to move people back from the edge when suicide seems their only option, and intervene earlier,” adds Conwell, who calls on society and its social services to make early prevention methods available to those in need—particularly males and the elderly given their susceptibility to suicide. Tertiary prevention methods—those following self-injury—may be “too little, too late” for those at high risk of completing suicide, particularly men and the aged. →

DEPRESSION: Underdiagnosed, undertreated, life-threatening

FACT: Depression is not normal. It is a serious and potentially life-threatening illness with estimated costs of \$44 billion annually in the U.S.

FACT: Depression is a disorder that, much like conditions such as diabetes and arthritis, can require long-term treatment over time.

FACT: Depression magnifies the disability caused by physical medical illnesses. Moreover, physical illnesses such as stroke, Parkinson's disease, heart disease and pulmonary disease can predispose a person to depression. Onset of major depression in late life most often follows a suddenly disabling condition.

FACT: Most cases of depression respond to the current available treatments.

FACT: Social support, particularly from family members, is a critical component of depression treatment for most older patients.

Coming tsunami

Mental illness and aging populations—both precursors to potential for suicide. And both expected to increase dramatically over the next 30 years in the United States.

Consider this: The U.S. Census Bureau estimates that the number of elderly people over age 65 could rise from 34.6 million today to 82 million by the year 2050. This trend will be most evident between 2011 and 2030 when census experts predict that the number of senior citizens will soar from 13 percent to 20 percent of the population.

Additionally, the number of older adults with mental illness is expected to double to 15 million in the next 30 years, according to the President's New Freedom Commission on Mental Health, which released its final report in 2003.

Increased health care utilization and increased costs—all outcomes of a fragmented and inadequate system now in place to address what some have called a coming tsunami in mental disorders and potential for suicide among a rapidly aging population in the United States.



Inadequate mental health services are likely to meet a rapidly growing U.S. population over age 65, estimated to more than double to 82 million by the year 2050.

“The current mental health delivery system is inadequate and unprepared to address the needs associated with the anticipated growth in the number of older persons requiring treatment for late-life mental disorders,” says Michael Hogan, PhD, former commission chair.


Hogan cites three policy areas that must be addressed to ensure adequate and appropriate mental health care and suicide prevention for older adults:

1. IMPROVED ACCESS TO SERVICES

Older persons are most likely to tap mental health care in home- and community-based settings. Yet services covered

by insurance are typically in a physician's office setting. “We need a redesign of the mental health system to respond to the preferences and needs of older persons and the mismatch between covered and preferred services,” notes Hogan.

This includes better coordination across the federal aging network, mental health, general health and long-term care sectors. The focus? It should be on care management and care



“The current mental health delivery system is inadequate and unprepared to address the needs associated with the anticipated growth in the number of older persons requiring treatment for late-life mental disorders.”

—MICHAEL HOGAN, PhD, former chair of the 2003 President’s New Freedom Commission on Mental Health

plan oversight for community-based, culturally sensitive and age-appropriate services for older persons, according to Hogan and the New Freedom Commission.

This should include coordination of providers and systems for delivering mental health, medical, social and long-term care services. It should also include revamped Medicare reimbursement policies that are in sync with recent advances in care and provide timely access to mental health care.

2. BETTER, MORE INTEGRATED SERVICES

Older patients undergoing treatment for mental disorders do best in a collaborative setting, according to recent research. This setting is a primary care one, with a mental health provider to provide assessment, clinical treatment services and coordination with the PCP. Evidence-based models such as IMPACT and PROSPECT are based on this collaborative approach with a cross-functional team highly engaged with each patient; these models have shown noteworthy success in treatment of mental illnesses in aging populations.

3. MORE HEALTH CARE WORKERS

The rise in coming numbers of older Americans shines a stark light on a chilling reality: Given current estimates, there will not be enough health care workers, caregivers and peer support staff to meet the mental health needs of this population.

“There is a pressing need to develop a workforce with specialized training in gerontology and geriatric mental health,” notes Hogan. “We need HHS, state mental health authorities and other entities to develop a workforce with specialized skills to provide services to older persons with mental disorders. This includes psychiatrists, psychologists, nurses, social workers and frontline service providers. It also includes enhancing family caregiver and peer support services.” →



After a 40-year career in broadcasting followed by thoughts of suicide in 1997, Dave Robinson is now a senior peer counselor in Sacramento, Calif. “I went to zero,” he recalls of that low time in his life. “You could kill yourself, but you would never know what you could have done ... you can reinvent yourself.”

Continued inequity in coverage of mental versus physical health care reflects the continued stigma that surrounds mental illness. “This discrimination in our health care insurance programs must be rectified,” notes national advocate Jerry Reed with SPAN USA. “It’s outrageous that we allow our Medicare program to have a policy that requires a 50 percent co-payment for mental health care and only a 20 percent co-payment for physical health care ... it seems we are not connecting the dots.”



Senate Caucus a step forward

Citing suicide, unemployment, substance abuse, homelessness, incarceration and chronic illness as some of the effects of untreated mental illness, the newly formed bipartisan Senate Caucus on Mental Health Reform held its first briefing on Capitol Hill in September. Titled, “Mental Health: A Public Health Crisis,” the briefing aimed to raise awareness of mental health issues among congressional staff. The caucus was established in March 2006 by U.S. Senators Pete V. Domenici (R-NM), Edward Kennedy (D-MA), Gordon Smith (R-OR) and Tom Harkin (D-IA).

Featured speakers at this first caucus briefing were former Surgeon General David Satcher, MD, PhD, and Howard Goldman, MD, professor of psychiatry at the University of Maryland School of Medicine. Both called on governments at the local, state and federal levels to do better in addressing mental illness and suicide in the United States among all populations, young and old:

LOCAL GOVERNMENTS can develop and implement programs that address mental illness stigma in communities, schools and among law enforcement to enhance chances that those requiring care will actually receive it.

STATE GOVERNMENTS can be most effective by enacting laws that maximize mental health coverage that private insurers are required to include in any health plan. Thirty-eight states, noted Goldman, require some level of mental health parity for workers whose health insurance is provided through their employer. “All of the states have a responsibility for the care of those with mental illness,” Goldman said.

THE FEDERAL GOVERNMENT should implement recommendations of the 2003 President’s New Freedom Commission on Mental Health, Satcher told briefing attendees. He cited limited action from Congress and the White House on these recommendations, which decried the nation’s current mental health delivery system as fragmented and in disarray.

The significance of this caucus is profound, according to the Campaign for Mental Health Reform, which called for its formation. Campaign member organization SPAN USA is among those working to bring equality to both mental and physical health benefits for all Americans.

“We must take concrete steps to remove the stigma associated with seeking help and address the inequity that exists between coverage for physical and mental health care,” notes SPAN Executive Director Jerry Reed. “It’s outrageous that we allow our Medicare program to have a policy that requires a 50 percent co-payment for mental health care and only a 20 percent co-payment for physical health care. With older adults having the highest rate of suicide, it seems we are not connecting the dots. This discrimination in our health care insurance programs must be rectified. Many suicides are preventable through treatment and services, and it is in our national interest to help those suffering.” **A**

Societal effects *of* One father's suicide

Robert Becker was a Wisconsin farm boy who was educated only through middle school before he dropped out to keep the family farm afloat.

A lanky kid, Robert was 6' 9" by his 18th birthday.



Before death, 1977

Before he turned 44 years of age, he was dead by suicide.

Robert's only daughter was 8 years old at the time of his death. Her dad's suicide has taken its toll on Sherry Becker of Cedarburg, Wisconsin.

"Every single day it haunted me," says Sherry of her father's suicide in 1977.

She engaged in cutting and suicidal ideation as a teenager, and struggled for years with unhealthy relationships with men who are suicidal or alcoholic—just as her dad was.

Sherry Becker
Daughter, mother,
survivor of suicide
loss of her father

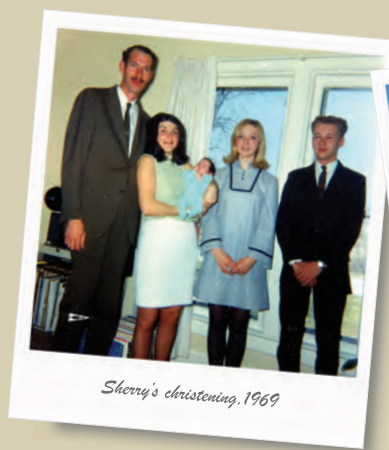
"I think I was trying to help them live because I couldn't help my dad live," adds Sherry.

Sherry's story is not uncommon.

It illustrates societal effects of suicide among men in the so-called middle years of life—ages 25-54. The greatest burdens of suicide, in terms of potential years of life lost or potential earnings lost, occur in this age group. Yet theirs is a group too often overlooked by prevention efforts.

"Suicide research related to men in their middle years is virtually nonexistent," notes Gregory K. Brown, PhD, with the Department of Psychiatry at the University of Pennsylvania.

"This is surprising given the public health significance of the problem. Increased community efforts that voice concern about this problem are sorely needed."



Sherry's christening, 1969



Fishing in Wisconsin

Brown suggests one approach for preventing suicide in this population is to identify individuals with major risk factors for suicide.

"Men who attempt suicide are frequently identified in medical care settings including emergency departments, behavioral health care settings or addiction treatment settings," notes Brown. "They frequently suffer from severe mental illness including major depression, bipolar disorder and post-traumatic stress disorder in war veterans."

Substance-use disorders are also common among this population, according to Brown, as are major social problems such as lack of housing and unemployment.

"Individuals with multiple psychiatric, addiction and major social needs are problematic because there is very little coordination of care among behavioral health care, chemical dependency and social service programs," Brown notes.

The end result of this lack of coordinated care?

"Patients most likely to kill themselves (as evidenced by their suicidal behavior) are the most likely to fall through the cracks in terms of receiving desperately needed treatment and services," he adds.

Brown, along with Aaron T. Beck, MD, and colleagues at the University of Pennsylvania have recently developed and tested an intervention for both men and women who attempt suicide. It includes targeted cognitive therapy and case management services to treat this difficult population.

"We've found that by using this approach, we can reduce the rate of repeat suicide attempts by 50 percent among those who attempt suicide," adds Brown.

For more on using cognitive therapy to reduce suicide risk, email Brown at gregbrow@mail.med.upenn.edu. **A**

"Patients who are most likely to kill themselves are the most likely to fall through the cracks in terms of receiving desperately needed treatment and services."

—GREGORY K. BROWN, PhD, University of Pennsylvania



the

Primary Care setting

A key to suicide prevention

“Routine assessment of suicidal ideation in depressed patients is necessary as these **patients will rarely explicitly inform their physicians** about suicidal thoughts or plans.”

—GEORGE S. ALEXOPOULOS, MD, Weill Medical College of Cornell University

Suicidal patients. They're passing through the offices of internists, family practitioners and other primary care providers (PCPs) in droves, often unbeknownst to physicians and their staff. In fact, as many as 70 percent of older patients who die by suicide have seen their PCP within a month of their death—20 percent of them within a week of when they died.

Bob Stern was one of these. This 77-year-old successful businessman (see cover story) had seen his doctor three days before he killed himself. The physician had even telephoned Bob within hours of his suicide to reassure him about the operation Bob was scheduled to undergo the following day to repair an aortic aneurysm.

What the doctor didn't know was that his phone call to the Stern ranch in rural central California had come at an inopportune time. Bob was in the midst of videotaping himself as he considered suicide the way to avoid the operation and the prostate cancer he had also been diagnosed with. Rather than be candid with his physician, Bob reassured the doctor that all was well.

What could this physician have done to see through the words that Bob delivered that day, to consider that this strong, independent-minded and isolated man might not be willing to undergo medical treatments that would shake his very identity?

George Alexopoulos thinks he has the answer: routine assessment of depression and suicidal ideation in primary care settings.

And Dr. Alexopoulos isn't the the only one who feels this way.



Primary health care providers are uniquely suited to screen depressed patients for suicidal ideation. Often these vulnerable people are reticent to seek services from a mental health clinician for a psychiatric condition that could lead them to consider suicide. New collaborative care models for depression management in the primary care setting show promise for lifting symptoms and may help prevent suicide in those vulnerable to self-harm.

The U.S. Preventative Services Task Force (USPSTF), an independent panel of experts in primary care and prevention that develops recommendations for clinical preventive services, recommends screening adults for depression in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment and follow-up. USPSTF is part of the Agency for Health Care Policy and Research within the U.S. Department of Health and Human Services.

“Routine assessment of suicidal ideation in depressed patients is necessary as these patients will rarely explicitly inform their physicians about suicidal thoughts or plans,” notes Alexopoulos, Professor of Psychiatry at Weill Medical College of Cornell University.

Yet depression is inadequately treated in primary care settings, with more than 40 percent of depressed primary care patients receiving no antidepressant treatment, regardless

of age and medical comorbidity. Of those who do receive antidepressants, insufficient dosages, inadequate treatment time, and poor treatment adherence by patients can compromise the care of depressed patients from primary care practitioners.

These physicians are in a unique role to recognize signs for suicide. Moreover, they are also able to address the depression, addictive disorders or other underlying conditions that could predispose vulnerable individuals to self-destructive thoughts and acts. Yet many PCPs are reticent to diagnose mental illness. The reasons are many: insufficient time to spend with patients; inadequate training, discomfort or personal biases about mental disorders; fear of reprisal or litigation. When differences between doctor and patient exist in ethnicity, culture or language, there is chance for misinterpretation on both sides of the discussion.

Too often these doctors will refer a patient to a psychiatrist or other mental health specialist. But the likelihood that a patient referred for psychiatric care will actually seek it out is not good, as research shows that the majority—more than 80 percent—of depressed primary care patients prefer to be treated by their PCP instead of a mental health specialist.

One answer to manage depression in primary care? A collaborative team approach that includes co-locating a psychiatric social worker, psychologist or psychiatric nurse in a primary care setting, with off-site support from a psychiatrist. This care manager offers symptom assessment, guideline-driven antidepressant treatment and treatment adherence support. Yet despite demonstrated successes, these collaborative care models are not yet widely used by PCPs.

“There is no evidence that physician inquiries about suicidal ideation can provoke a suicide attempt,” stresses Alexopoulos. “And early detection of suicidal ideation may prevent completion of suicide. So treatment of patients at risk for suicide is not only feasible but effective in primary care.” **A**

“There is no evidence that physician inquiries about suicidal ideation can provoke a suicide attempt.”

—GEORGE S. ALEXOPOULOS, MD, Weill Medical College of Cornell University

Suicides triple in wake of Katrina

The emotional effects of seeing homes, neighborhoods and lives destroyed continue to plague residents of the Gulf Coast more than a year after the devastation of Hurricane Katrina.

At the tip of this emotional iceberg? Suicides, which have tripled in Orleans Parish, according to a Nov. 9, 2006, report by *The Associated Press*.

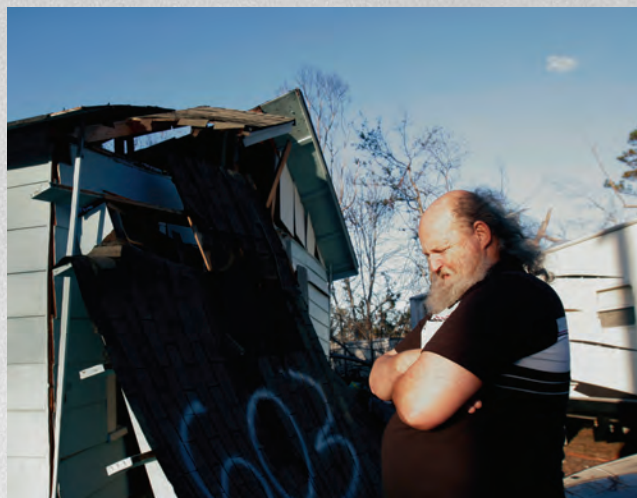
Additionally, involuntary psychiatric commitments have risen, and increased calls to law enforcement for domestic violence, drunkenness and fights continue to strain local service providers. Many of these providers themselves—police officers, social workers, community mental health clinicians and others—are susceptible to their own personal fatigue and fallout from the storm.

This crisis in mental health care has also strained the city's few operating hospitals, reduced to just two of 11 hospitals pre-Katrina. One of them, Jefferson Parish Medical Center, typically had seen, on average, one patient in a psychiatric crisis daily before the storm; today staff sees about 12 people a day, emergency room physician Dr. Richard Manthey reported to AP on Nov. 8, 2006.

The psychological effects of Hurricane Katrina were spotlighted at the 22nd Annual Rosalynn Carter Symposium on Mental Health Policy, Nov. 8 and 9, 2006, in Atlanta. Rescue workers and survivors in attendance described a bleak overview of the long-term psychological fallout from Katrina.

Mental health effects from the unprecedented storm that claimed thousands of lives was twofold: it triggered anxiety and depressive disorders in people—including rescue workers—who may have never faced a mental health issue. The storm also crippled mental health service delivery to those with chronic pre-existing mental illnesses.

Findings shared at the Carter symposium are underscored in a federally funded study released Aug. 28, 2006, in the *Bulletin of the World Health Organization*, which shows the prevalence of mental disorders roughly doubled in the months after the storm. Children can be particularly impacted, according to Jim Yancey, executive director of the Jackson County Community Services



© 2006 Jodi Hilton/CORBIS Used with permission

Residents of the battered Gulf Coast suffered incredible losses in the wake of Hurricane Katrina. Here displaced resident Arvis Cuevas waits for a demolition crew to remove the remains of his home in Pass Christian, Miss., when he was photographed in Jan. 2006. "I'd love to keep this place because it was my mama's and we've had it for sixty years," said Cuevas, living on disability since an industrial accident. Nearly five months after Katrina hit the area, Cuevas and his family were still living in a FEMA trailer next to their battered home.

Coalition in Jackson, Miss. Difficulties concentrating on schoolwork, residing in FEMA trailers, symptoms of depression such as irritability, trouble sleeping and behavioral and mood swings are some of what Yancey has observed. As for adults, they're experiencing domestic and marital problems—and if they seek counseling, can face significant delays due to backlogs from insufficient number of counseling services providers.

"The impact of Hurricane Katrina on victims was unprecedented for our nation," says Dr. Thomas Bornemann, director of The Carter Center Mental Health Program. "People suffered multiple traumas not only from injury and loss of possessions, but from the perception that agencies and authorities were unable or unwilling to help them."

Bornemann adds that gathering officials and experts at The Carter Center will help define effective practices and policies to address these needs in the future by improving disaster planning, preparedness and response as they relate to mental health.

CALENDAR

2007 National Multicultural Conference and Summit

American Psychological Association

Jan. 24-26, 2007

Seattle
multiculturalsummit.org



National Health Policy Conference

AcademyHealth

Feb. 12-13, 2007

Washington, D.C.
academyhealth.org



AAGP Annual Meeting

American Association of Geriatric Psychiatry

March 1-4, 2007

New Orleans
aagpmeeting.org

2007 Military Suicide Prevention Conference

United States Department of Defense

March 5-8, 2007

Hollywood, Fla.
www.ha.osd.mil/2007mspc



31st Annual CONTACT USA

University of Illinois Chicago

March 16-18, 2007

Chicago
uic.edu/orgs/convening



Depression on College Campuses

University of Michigan Depression Center

March 19-20, 2007

Ann Arbor
med.umich.edu/depression

37th Annual NCCBH Conference

National Council for Community Behavioral Health care

March 26-28, 2007

Las Vegas
nccbh.org



40th Annual AAS Conference

American Association of Suicidology

April 11-14, 2007

New Orleans
suicidology.org



11th Annual SPAN USA

National Awareness Event

Suicide Prevention Action Network

July 19-21, 2007

Washington, D.C.
spanusa.org

HE MAY NOT ASK FOR **HELP...**
HE MAY ACCEPT IT IF YOU
ASK THE RIGHT QUESTIONS.

LEARN HOW
QPR ON SITE OR ONLINE

ADVANCED TRAINING FOR PROFESSIONALS ON SITE AND ONLINE

QPR
For Suicide Prevention

 **EASTERN**
WASHINGTON UNIVERSITY

 **Devereux**

ONLINE
Call 1-800-331-9959
www.ewu.edu/qpr

ON SITE
Call 1-888-726-7926
www.qprinstitute.com

RECENT RELEVANT RESEARCH

Antidepressant aversion suggests physician-patient communication is key

Although depression is widespread in the elderly, drug treatment for the disease is either absent or, at best, inadequate. This incongruence is even more perplexing when one considers 40 percent of the elderly take at least five medications a week, according to David Bates, Harvard Medical School's associate professor of medicine. Researchers at the University of Pennsylvania may have found root causes when analyzing data on older patients' aversion to antidepressants. A significant portion of the sample, 42 out of 68 patients, identified concerns about chemical dependence, prior bad experiences with depressive medication, and more revealing, "resistance to viewing depressive symptoms as a medical illness." These findings may go a long way in improving patient-provider communication on treating depression in elderly populations.

Older Patients' Aversion to Antidepressants: A Qualitative Study. J. L. Givens, C. J. Datto, K. Ruckdeschel, K. Knott, C. Zubritsky, D. W. Oslin, S. Nyshadham, P. Vanguri, F. K. Barg. *J Gen Intern Med.* 2006 Feb. 21(2):146-51.



Control, struggle, connectedness are key themes

People who attempt suicide can have diverse and complex experiences. That makes managing risk in these vulnerable individuals a challenge. Better understanding of these experiences may help others predict, prevent and manage risk for suicide. With this in mind, researchers considered the subjective experience of older people who had recently attempted suicide through explor-



ing their understanding of the pathway to and from their attempt within the context of aging. Three broad themes emerged. First was struggle, as in both before and after the attempt, and in relation to aging. The second theme was control—trying to maintain control over life and trying to regain it after the attempt. A third theme was visibility, with participants feeling invisible or disconnected from others.

Interestingly, some of the participants construed risk factors for suicide (as identified in the literature) as not relevant to their suicide attempt. This supports the need for broad public education on risk factors for suicide so those at risk—and those in contact with them—will understand the relevance of these factors as indicators of potential for suicide.

Giving up or Finding a Solution? The Experience of Attempted Suicide in Later Life. L. Crocker, L. Clare, K. Evans. *Aging Ment Health.* 2006 Nov; 10(6):638-47.



Homecare patients vulnerable to suicide, underserved for prevention

Visiting nurses, home health aides and others interacting with medically ill home health care patients play a key role in suicide prevention in this underserved, high-risk population. Severity of depression, medical comorbidity, functional status and social support were considered by this research team in 539 participants age 65 and older who were newly initiated to home care for skilled nursing services. Participants were classified as having no suicidal ideation in the past month, passive ideation, active ideation or active ideation with poor impulse control or suicide plan. Results showed high prevalence, persistence and incidence of suicidal ideation in this vulnerable population. Yet factors associated with their suicidal ideation—both psychosocial and clinical—are potentially modifiable. Therefore, targeting "gatekeepers" for homecare patients, and arming them with interventions for suicide prevention may be key to addressing suicide in this high-risk group.

Suicidal Ideation Among Elderly Homecare Patients. P. J. Raue, B. S. Meyers, J. L. Rowe, M. Heo, M. L. Bruce. *Int J Geriatr Psychiatry.* 2006 Sep 5 (in press at publication time).



Phone follow-up may deter attempts

Can a simple phone call to those who attempt suicide decrease the likelihood of a reattempt? That's the question researchers posed in this randomized controlled study of 605 people discharged from emergency care after attempting the act. The result: calling vulnerable individuals one month after their suicide

attempt bodes well for them. Patients contacted by phone one month after discharge from an emergency room for deliberate self-poisoning were less likely to report having reattempted suicide than those contacted three months after discharge. During calls, patients were asked about success of recommended treatment or to adjust treatment; control patients received usual treatment, typically referral back to their general practitioner. This study suggests that contacting attempters one month after attempt may indeed help reduce further attempts over the course of one year post-attempt.

Effects of Telephone Contact on Further Suicide Attempts in Patients Discharged from an Emergency Department: Randomised Controlled Study. G. Vaiva, F. Ducrocq, P. Meyer, D. Mathieu, A. Philippe, C. Libersa, M. Goudemand. *BMJ*. 2006 May 27; 332(7552):1241-5.



Suicidal attempts among blacks

Little is known about lifetime prevalence of suicidal ideation among blacks, including age of onset of these thoughts and subsequent plans and attempts. The research is simply not there, making it difficult for professionals to effectively screen blacks vulnerable to suicide. With this study, researchers have added to the sparse knowledge about suicide among blacks in the U.S., and have begun to document the burden of nonfatal suicidality among this population, notably Caribbean black men and individuals making planned attempts. The study showed that greatest danger of progressing from suicidal ideation to planning or actually attempting occurred within one year after onset of suicidal ideation. Blacks at highest risk for suicide attempts? Those in younger birth cohorts who were less educated, residents of the Midwest, and had one or more DSM-IV disorders. Next steps, according to the research team, is to investigate the transition from suicidal planning to actual attempt. This, they say, is vital to improve the efficacy of health care professionals' ability to screen blacks at risk for suicide.

Prevalence of and Risk Factors for Lifetime Suicide Attempts Among Blacks in the United States. S. Joe, R.E. Baser, G. Breeden, H.W. Neighbors, J.S. Jackson. *JAMA*. 2006 Nov 1; 296(17):2112-23.



Old age and depression.



They don't have to go together.

The elderly have the highest rate of suicide in our country – nearly 50 percent greater than the national rate of 11.0 per 100,000 people. The Cornell Institute of Geriatric Psychiatry is responding, breaking new ground in understanding geriatric psychiatric disorders, educating and training future behavioral health care professionals, and providing specialized care to older adults.

The Institute of Geriatric Psychiatry at Weill Medical College of Cornell University is a leader in the study of geriatric depression, spearheading groundbreaking research that will further our understanding of the mind, our treatment of mental illness – and our ability to prevent suicide.

Research • Training • Clinical Care

CORNELL
UNIVERSITY
Joan and Sanford I. Weill Medical College

*A world-renowned center of excellence in both brain-based
and psychologically-based psychiatry*

21 Bloomingdale Road
White Plains, NY 10605
(914) 997-4331

www.nycornell.org/psychiatry/geriatrics

SPRC SUICIDE PREVENTION RESOURCE CENTER

**Your source for the best of science,
skills and practice.**

Visit www.sprc.org for:

- ◆ Suicide prevention information customized for a multitude of professions and audiences
- ◆ Specific pages for each of the fifty states, including plans, contacts, data and events
- ◆ Presentations from SPRC bi-regional conferences
- ◆ Our publications, including “After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances”
- ◆ The latest news headlines, research summaries and funding opportunities

www.sprc.org ◆ 1-877-GET-SPRC ◆ info@sprc.org

SPRC is supported by a grant (1 U79 SM55029-01) from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS).



Overview

Advancing Suicide Prevention® (ISSN 1554-4508) is a strategic health policy magazine for professionals in all arenas impacting suicide prevention or whose work places them in contact with suicidal individuals. These include professionals in health care, social and human services, policy development, advocacy, education, research, legal and law enforcement, corrections, crisis intervention, pastoral and bereavement counseling. The magazine is owned by Point de Vue Communications Inc. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without prior written consent of the publisher.

Circulation

20,000 core base, controlled

Advertising

Closing date is approximately 60 days before the month of publication. Please call for exact deadline. For rate card and other information visit advancingsp.com or call 920-457-4033.

Sponsorships

Sponsorships of special supplements, inserts and more are available. Call 920-457-4033 for more information.

Subscription Services

Subscribe online
advancingsp.org

Orders, inquiries and address changes

Advancing Suicide Prevention

Phone: 920-457-4033

Fax: 920-457-4011

Email: info@advancingsp.org

Address: *Advancing Suicide Prevention*

P.O. Box 625
Sheboygan, WI 53081

Annual rates

US \$47.00

Canada \$67.00

International \$75.00

Payments accepted

VISA, MasterCard

Checks in U.S. dollars payable to
Point de Vue Communications Inc.

Article Reprints and Permissions

Contact Customer Service Department at Point de Vue Communications to order reprints or to obtain permissions to copy, quote or translate *Advancing Suicide Prevention* articles. Reprints are available in hard copy, as electronic downloads with permission to print, and in customized versions.

For information or to order

Customer Service Department
Point de Vue Communications Inc.

629 North 8th Street, Suite 203

Sheboygan, WI 53081-4502

Phone: 920-457-4033

(8 a.m.–5 p.m. CST weekdays)

Fax: 920-457-4011

Email: info@advancingsp.org

Reprint Prices

1–9 copies \$7.00 each

10–49 \$6.50

50–79 \$6.00

80–99 \$5.50

100–499 \$5.00

(Minimum order \$50. Discounts apply to multiple copies of the same article.)

Custom and Quantity Orders

For quantity estimates or quotes on customized reprints, call 920-457-4033, fax 920-457-4011 or email info@advancingsp.org.

Privacy Statement

Advancing Suicide Prevention makes reasonable efforts to ensure that privacy issues are handled responsibly.

Disclaimer

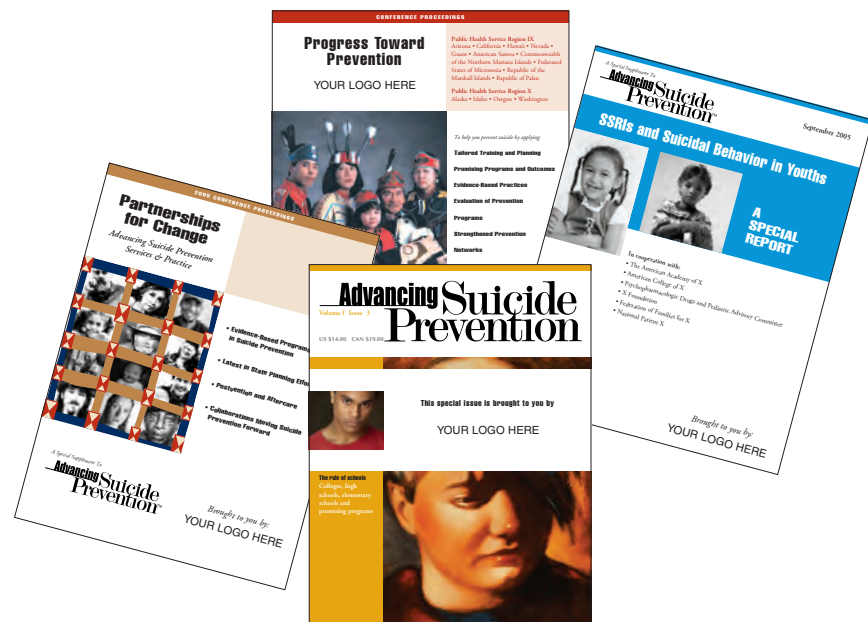
Opinions, when presented in the pages of *Advancing Suicide Prevention*, are those of the person being quoted and do not necessarily reflect the views of sponsors, advertisers, editorial advisory board or publisher. Although great care has been taken in compiling and checking the information in this publication to ensure accuracy, Point de Vue Communications Inc. and its servants or agents shall not be responsible or in any way liable for the continued currency of the information or for any errors, omissions or inaccuracies in this magazine, whether arising from negligence or otherwise or for any consequences arising therefrom. Also Point de Vue Communications Inc. and its servants or agents shall not be responsible or in any way liable for advertiser-generated inaccuracies, nor should advertiser presence be construed as endorsement by Point de Vue Communications Inc. and its servants or agents. Individuals should consult with their own health care providers on issues related to their specific situations. This magazine is not a substitute for such consultation. The *Advancing Suicide Prevention* editorial advisory board provides insight and other editorial support. In no way are they responsible for the views presented in *Advancing Suicide Prevention*.

Copyright © 2007 Point de Vue Communications Inc.
All rights reserved.

POSTMASTER

Send domestic address changes, orders and inquiries to *Advancing Suicide Prevention*, Subscription Services, P.O. Box 625, Sheboygan, WI 53081. Standard postage paid at Random Lake, Wis. and additional mailing offices. Printed in the U.S.A. *Advancing Suicide Prevention* (ISSN 1554-4508) is published by Point de Vue Communications Inc., 629 North 8th Street, Suite 203, Sheboygan, WI 53081-4502.

Partner with us to advance suicide prevention in our communities, states and nation



BE A SPONSOR OR COSPONSOR OF

>> **Special Supplements**

>> **Inserts**

>> **Bonus Editions**

>> **Content or Column**

OR ADVERTISE YOUR

◆ Crisis Services and Networks ◆ Books, Journals, Websites and Newsletters ◆ Testing and Assessment Instruments ◆ Organizations, Foundations, Corporations and Associations ◆ Conferences, Symposia and Workshops ◆ Resource Centers, Education and Training Courses ◆ University Graduate Programs and Announcements ◆ Awards Programs and Collaborative Partnerships

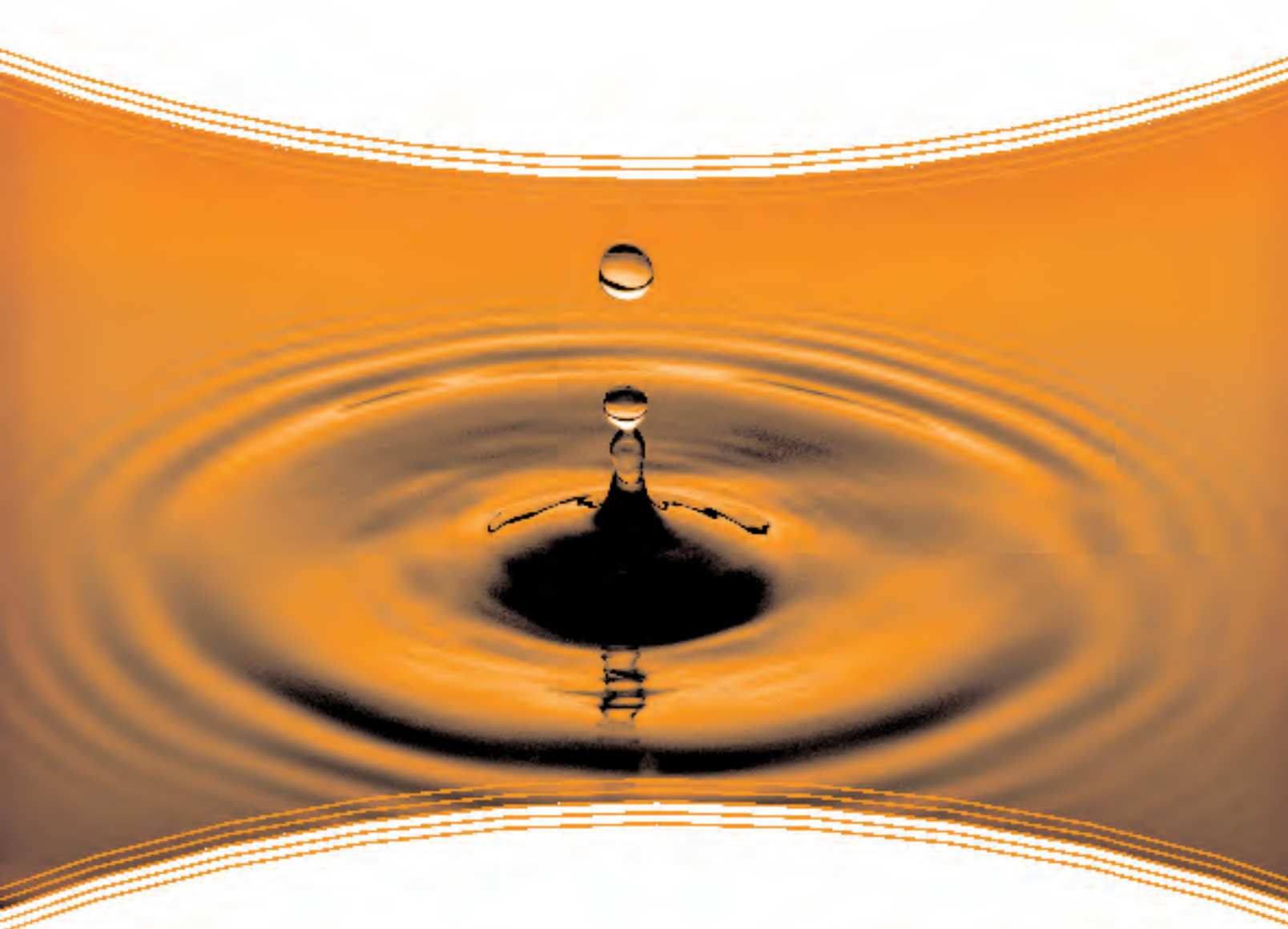
**For more information contact ASP at
920-457-4033 or info@advancingsp.org**



A firefighter buries his head in his hands after working all night at the site of the World Trade Center disaster, New York City, September 12, 2001

© Yoni Brook/CORBIS Used with permission

They work at the edge of life and death, firefighters along with others exposed to traumatic stress, among them soldiers and military veterans, paramedics and police officers. And if they are disabled by duty-related trauma, often they do not get help. Instead of acknowledging feelings, asking for help or seeking appropriate treatment, they may turn to alcohol or drugs. They may become frustrated, discouraged, angry or irritable. Some may immerse themselves in work or hobbies, or engage in reckless behavior. A key to helping these high-risk populations say experts? Assessing where potentially suicidal individuals may be found—courts, chemical dependency treatment settings, workplaces, prisons, churches—and aggressively expanding the spectrum of care to include these sites that are well beyond the traditional health care delivery system, yet critical to saving lives.



A suicide may be a personal act,
BUT WE ALL FEEL ITS EFFECTS.

In the United States, we lose 87 people a day to suicide. For every suicide at least six people will be left to make sense of it. At least six people will grapple with feelings of loss, despair, and guilt.

Each year, over 180,000 individuals become suicide survivors. Suicide impacts families, communities, and society as a whole. That's why suicide is a public health problem. **That's why we all need to be part of the solution.**

OPENING MINDS. CHANGING POLICY. SAVING LIVES.



SUICIDE PREVENTION ACTION NETWORK USA

A close-up portrait of Melvin Martin, a man with dark hair and glasses, wearing a blue button-down shirt under a dark jacket. He is looking directly at the camera with a slight smile.

**“I felt such an utter and
all pervasive sense
of hopelessness.”**

—Melvin Martin,
Marketing Executive
Member of the Oglala
Lakota Nation

Real Men. Real Depression.

“When I was 19 years old and in the Army in Germany...I felt such an utter and all pervasive sense of hopelessness that it took all the energy I could generate just to get out of bed. Often I'd just lie there. I didn't want to go through another day of the same thing. It was a sadness so deep that even now, 30 years later, it's indescribable.” Depression is a real disease that can be successfully treated. For information, call 1-866-615-6464, visit www.nimh.nih.gov, or contact your health care provider.

**It takes courage to ask
for help. Melvin did.**



NIMH
National Institute
of Mental Health

National Institutes of Health