SUICIDE IN ALABAMA

"Storm of the Mind"

Certified Public Manager® Program
CPM Solutions Alabama 2017

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at AUBURN MONTGOMERY

Solutions That Drive Success

TABLE OF CONTENTS

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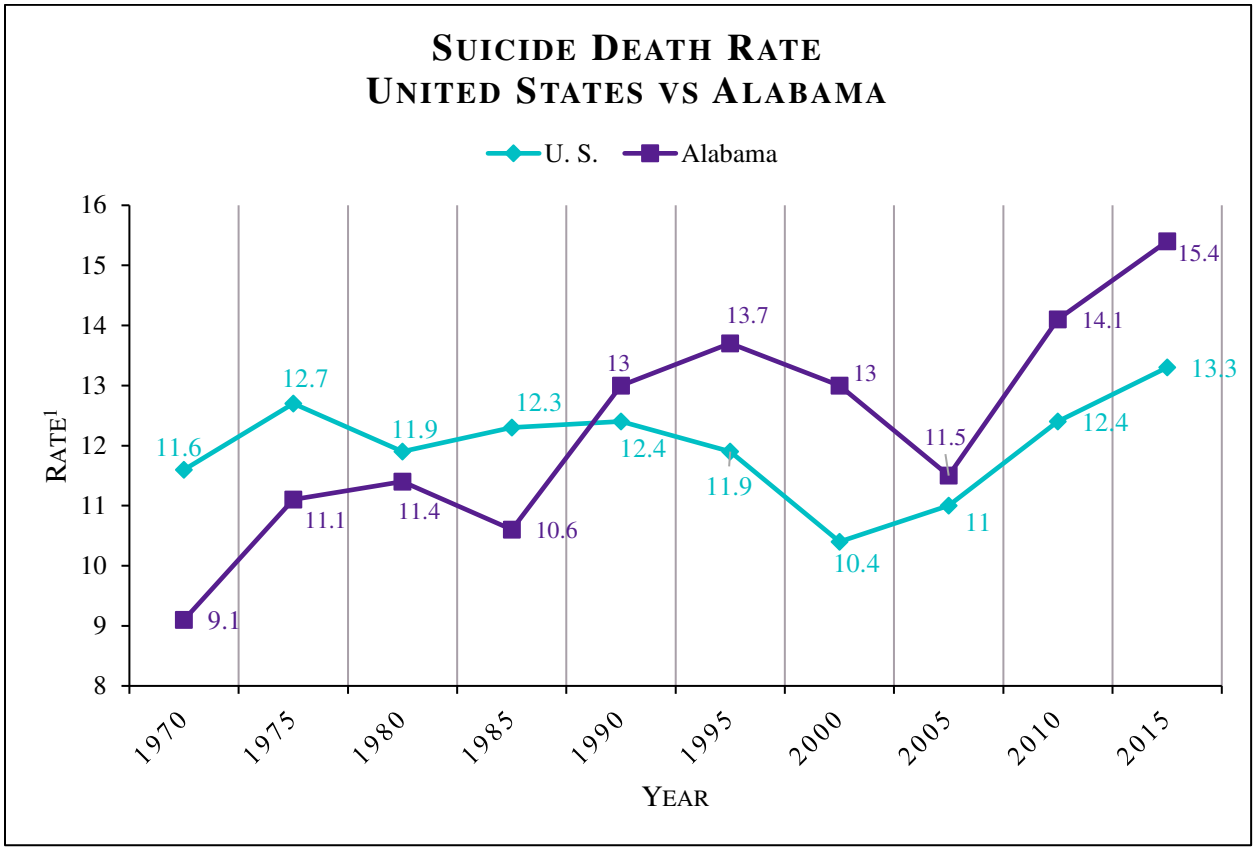
INTRODUCTION

Suicide was the second-leading cause of death for people ages 10 through 44 in the United States in 2014 and the tenth-leading cause overall, according to the Centers for Disease Control (CDC) (2017). Suicide rates in Alabama have increased over 45% in the 30 years from 1985 to 2015 (CHS 2017). In 2010 alone, completed suicides cost the State of Alabama $683 million (CDC 2017). It is estimated that 147 people are affected by each completed suicide, and six of those people experience a major life disruption by losing their loved one (Drapeau 2016). The CPM Solutions Suicide in Alabama team was tasked with assessing the problem of suicide in Alabama through researching statistics, interviewing subject matter experts, and identifying current resources available to make recommendations that could potentially reduce the number of suicides.

FINDINGS

Suicide Statistics

As shown below in Figure 1, Alabama's suicide rate has been higher than the national average since 1990. According to the latest data from the Centers of Disease Control and the Alabama Department of Public Health's (ADPH) Center for Health Statistics, the national suicide rate in 2015 was 13.3 per 100,000 while Alabama's was 15.4 (CDC 2017) (Shen[a] 2016).



[1]Rate is per 100,000 population in specified group.

Figure 1: Suicide Death Rates for the U.S. and Alabama, 1970-2015 (CDC and CHS)

The Alabama Center for Health Statistics (CHS), a division of the Alabama Department of Public Health, publishes the state's vital statistics annually, which includes birth, mortality,

marriage and divorce rates. As shown in Figure 2, Alabama's suicide rate has been almost twice the homicide rate since 2010 (CHS 2017).

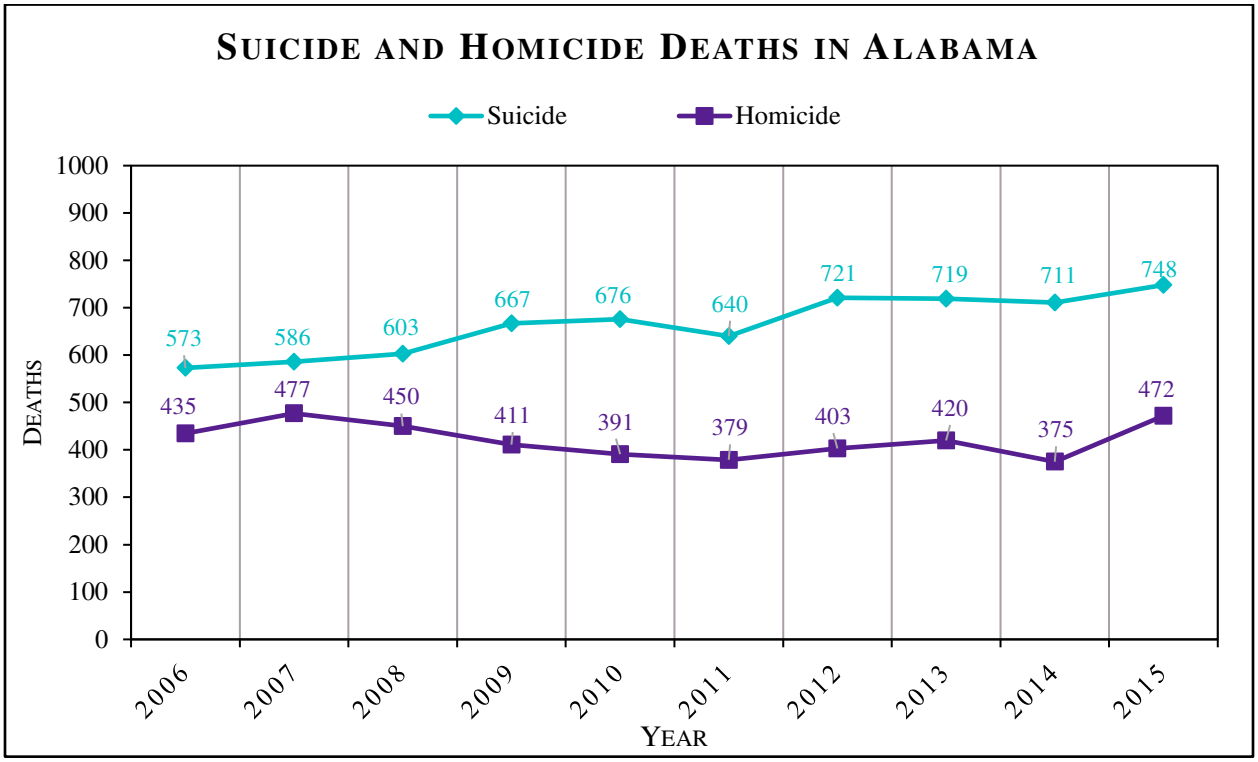
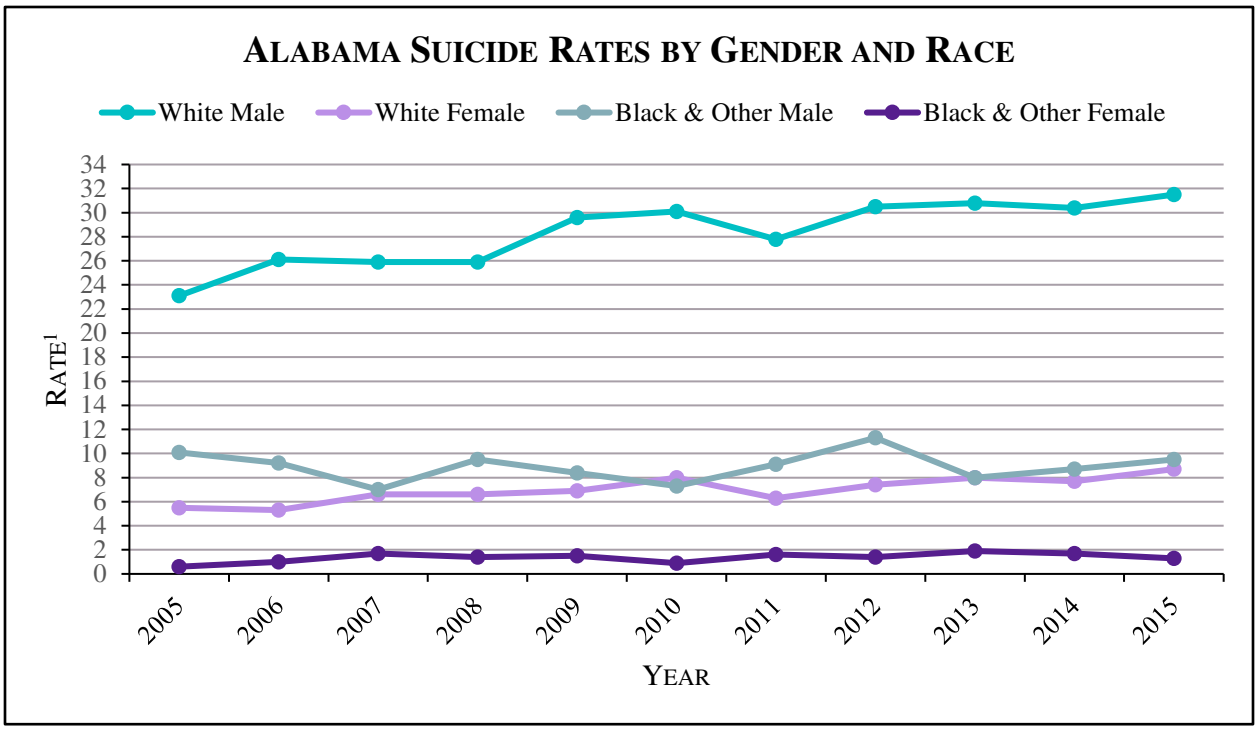


Figure 2: Comparison of Suicide and Homicide Deaths in Alabama (CHS)

Figure 3 on the following page shows the suicide rates by race, gender, and age. White males make up 70% of those that complete suicide, with an overall rate of 31.5 per 100,000 in 2015 (Shen[a] 2016). African-American women have the lowest suicide rate across all age groups. It is suggested that this is because individuals who have strong social support networks within their community, social circle, or religion have lower suicide rates. Individuals who have weak social support networks and more independent, self-reliant, or isolated lifestyles are more susceptible to suicidal tendencies (SPRC[c] 2013).



[1]Rate is per 100,000 population in specific group.

Figure 3: Suicide Rates in Alabama by Gender and Race, 2005-2015 (CHS)

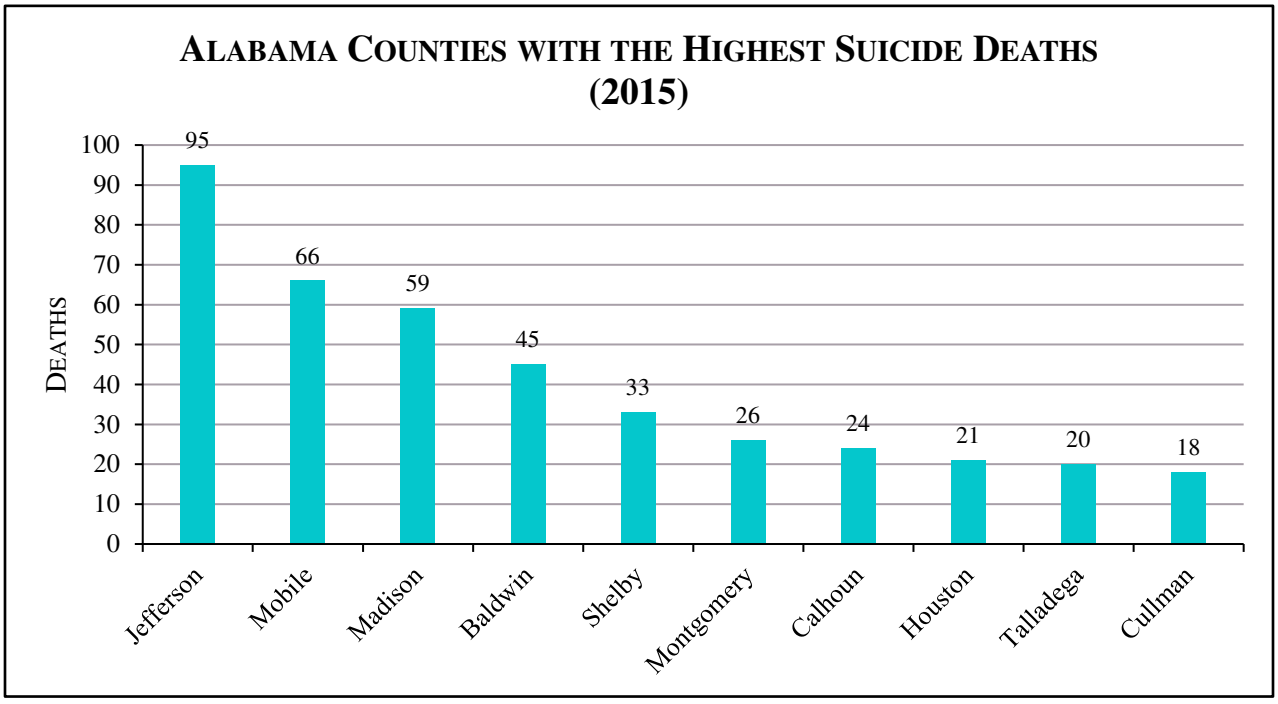
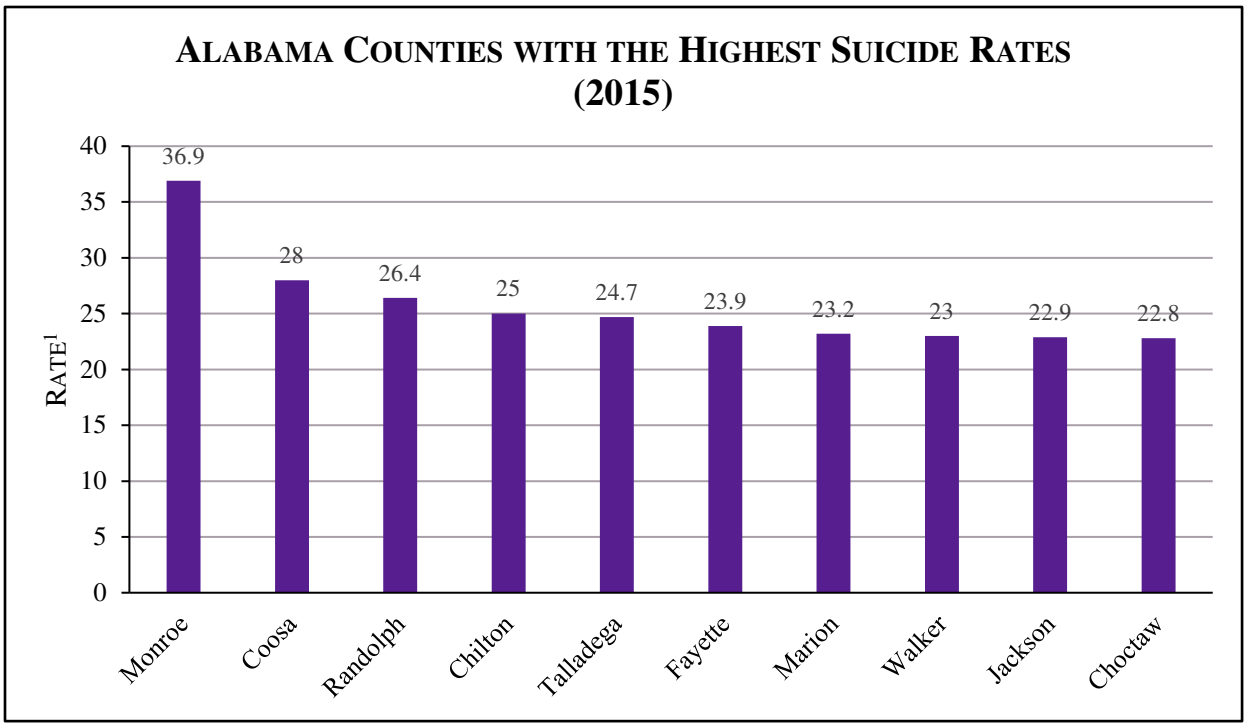


Figure 4: Top Ten Counties in Alabama with Highest Suicide Deaths in 2015 (CHS)



[1]Rate is per 100,000 population in specified county.

Figure 5: Top Ten Counties in Alabama with Highest Suicide Rates in 2015 (CHS)

Looking at Figure 4 on the previous page, geographically, the highest number of suicide deaths occur in more urban counties with the highest populations. As is the case here, the top five counties follow very closely with their respective population rankings. However, according to Figure 5 above, the highest rates of suicide occur in more rural counties that have an average population of about 36,000. Because these counties have such small populations, each completed suicide has a significant effect on the overall rate. Therefore, based on this data, it is difficult to conclude whether geography has a significant influence or not on a person completing suicide in Alabama.

Economic Impact

The emotional costs of suicide are immeasurable. Intangible/human costs for those left behind include pain, grief, suffering, and loss of quality of life. Suicides and suicide attempts

have a notable impact on the economy as well. According to the CDC, the total cost to American society in 2015 was $56.9 billion with each suicide having an average cost just under $1.3 million (2017). According to a study performed in 2015, the 2013 national cost of suicide and suicide attempts in the U.S. was $58.4 billion. This cost was solely based on reported numbers. However, this number could be as high as $93.5 billion due to expected under-reporting. This study took into account both direct costs (hospitalization, ambulance transport, follow-up care, medical examiner investigations, and more) and indirect cost (loss productivity, net present value of future salaries and fringe benefits), with indirect costs making up 97.1% of the total economic costs (Shepard, et al. 2015). The total direct and indirect costs of suicide in Alabama in 2010 is estimated to be just over $683 million, with an average cost of about $1 million per completed suicide (CDC 2017). These estimates are based on reported numbers and do not include the costs associated with suicide attempts. Therefore, the actual total cost would be much higher.

Links to Mental Illness and Substance Abuse

Of those who complete suicide, more than 90% have a diagnosable mental disorder. An estimated 3% to 20% of people diagnosed with bipolar disorder complete suicide. Suicide is the leading cause of premature death in those with schizophrenia with an estimated 6% to 15% of those diagnosed completing suicide. People with personality disorders are approximately three times as likely to complete suicide as those without those disorders. As many as 80% of those with Borderline Personality Disorder have suicidal behavior and approximately 4% to 9% complete suicide.

People who complete suicide are often experiencing undiagnosed, undertreated or untreated depression. Depression is the most prevalent risk factor for suicide. Suicide risk is

highest in individuals who feel hopeless about the future, those that have recently been discharged from a hospital, those with a family history of suicide, and those who have made prior suicide attempts (University of Washington 2017).

Though widespread, depression is an uncommon discussion topic. Like high blood pressure and heart disease, depression is a medical condition. However, many Americans do not see it as such. Research has shown that depression has a chemical and physical effect on the brain. Figure 6 shows two positron emission tomography (PET) scans, one of a healthy (not depressed) brain and the other of a depressed brain. The colors indicate the amount of activity that occurs in the brain with the lighter colors (orange, yellow, white) showing heightened activity and the darker colors (blue, black, purple) showing less activity (Mayo Foundation 2017). As you can see, the depressed brain scan shows significantly less activity than what would be considered "normal" levels.

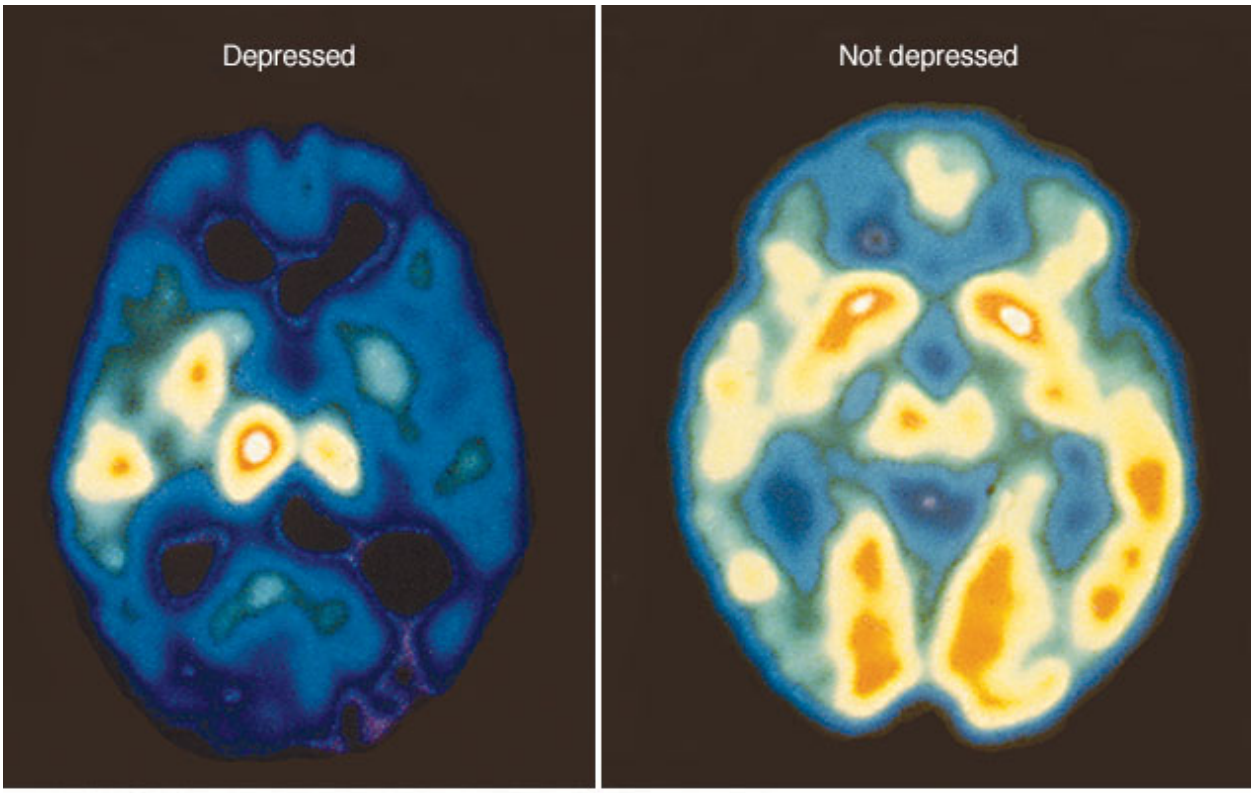


Figure 6: PET Scan of the Brain for Depression (Mayo Foundation)

While those suffering from depression and other mood disorders are at greatest risk for suicide, those abusing alcohol and drugs are a very close second. Individuals with substance abuse disorders are about six times more likely to complete suicide than the general population. Substance abuse not only increases a person's likelihood of completing suicide, but it can also be used as a means to carry out a suicide. Approximately one in three people who complete suicide were under the influence of drugs at the time, most often opiates or alcohol.

There are a few possible explanations for why suicide is so prevalent among those addicted to drugs or alcohol. When individuals are under the influence of drugs or alcohol, they typically become less inhibited and are more likely to take risks that they might not normally take. It is also true that many people abuse drugs or alcohol in an attempt to relieve symptoms of

depression, anxiety or other mental health conditions. The rate of major depression is two to four times higher among addicts than the general population.

Abusing drugs, especially alcohol or other sedatives, can trigger symptoms of depression, which in turn increases the risk of suicide. As the consequences addiction leaves behind add up, from legal problems and damaged relationships to financial ruin and loss of employment, it is easy to see how an addict could lose hope.

The suicide rate among those with untreated substance abuse disorders is thought to be as high as 45%, but only about 11% of addicts get treatment. Stigma often plays a role in keeping people from seeking help, and a lack of training in suicide prevention contributes to the problem once a person seeks treatment.

Very serious threats face patients with addictions and mental health disorders. Integrated dual diagnosis treatment for both substance abuse and co-occurring mental health disorders by a multidisciplinary team of professionals is crucial in preventing suicide (Ross 2014).

Stigma

There is a stigma surrounding mental illness and substance abuse that prevents them from being common topics of discussion. As a result, those who suffer from mental illnesses and substance abuse often do not seek the treatment needed, fearing that they will either be judged or not taken seriously and accused of "seeking attention." Untreated mental illness and substance abuse increase suicidal risk. For most people, suicide is not a typical topic of discussion even among close family members. There are several myths that exist surrounding the subject as well. For example (Crisis Center 2017):

MYTH: "A person who talks about dying by suicide won't do it."

FACT: About 80% of people who complete a suicide express their intentions to one and

often more than one person.

MYTH: "Talking about suicide to someone who is depressed may cause them to kill himself or herself."

FACT: Studies have shown that in the majority of cases, asking someone if they are thinking about suicide does not increase suicidal thoughts, but, in fact, may reduce suicidal ideation (Mathias, et al. 2012).

MYTH: "If a person shows improvement after a suicidal crisis, the risk has passed."

FACT: Most suicides occur within three months or so after the onset of improvement, when the person has the energy to act on intentions.

MYTH: "Suicide usually occurs without warning."

FACT: Many survivors of suicide have reported that they had thoughts of suicide long before their attempt. A person planning suicide usually gives clues about his or her intentions.

Risk Factors

As indicated by the information above, there are often signs that a person may be having thoughts of suicide. Part of the solution to lower Alabama's suicide rate is to know what risk factors and warning signs to look for in others and even ourselves. Risk factors are variables that may increase the potential for suicide and suicide ideation. Some risk factors to consider are (SPRC[b] 2017):

- Male gender
- Caucasian or American Indian/Native Alaskan race
- Bullying (adolescents)
- Substance abuse
- Mental illness
- Chronic or terminal health condition
- Recent loss of a loved one

- Recent loss of employment
- Divorce/domestic problems
- Family history of suicides and attempts
- Traumatic experience/abuse
- Post-traumatic stress disorder (PTSD)
- Traumatic brain injury

Part of the problem of this growing issue is that there is no "one-size fits all" solution. Each person has different thresholds and triggers. While everyone is different, it is common for multiple risk factors to be present. It is often the compounding of events or severity of the situation that "breaks" the individual (AAS 2017).

Warning Signs

In addition to noting risk factors, an individual may exhibit behavioral changes or warning signs that could indicate a risk for suicide. An individual may exhibit one or multiple warning signs. Some of the more common signs to look for include (SPRC[d] 2017):

- Social isolation/withdrawal from friends
- Missing classes, events, and work
- Reckless behaviors (drinking alcohol excessively, drug abuse)
- Drastic changes in behavior (impulsiveness, aggression, rage)
- Sleeping too much or too little
- Changes in eating habits
- Feeling hopeless, helpless, or worthless
- Making statements such as "Life is not worth living," "I'm finished," or "No one would care if I were gone."

- Giving away personal possessions
- Obtaining a lethal means (buying a gun, storing up medications)
- Sudden burst of energy after being very depressed

The last three signs listed above should be taken seriously. These may be indicators that the person has developed a plan to kill him/herself (ADPH 2017). While looking for these signals, also trust your "gut feeling" that may be indicating someone is at risk.

Legislative Opportunities to Prevent Suicide

Existing federal and state laws can have a major impact on suicide prevention. Federal legislation has furthered suicide prevention efforts among two important groups – youth and veterans. State laws can provide resources, encourage training, and help increase awareness and knowledge. Current legislative acts include:

Jason Flatt Act

The Jason Flatt Act requires that all certified public school personnel receive two hours of annual suicide awareness and prevention training. According to The Jason Foundation website, each day there is an average of over 5,240 suicide attempts by 7-12th graders, and four out of five teens who attempt suicide have given clear warning signs. Given this statistic, having teachers trained to recognize these signs is very important.

According to The Jason Foundation's website, Tennessee was the first state to pass this legislation in 2007. Now, nineteen states have passed the Jason Flatt Act, including Alabama where it was passed on May 10, 2016 (2017).

Matt Adler Act

The Matt Adler Suicide, Assessment, Treatment, and Management Act of 2012 was passed in Washington State. It requires continuing education on suicide assessment, treatment, and management for certain health professionals to obtain and maintain their license.

According to the Forefront Suicide Prevention website, Matt Adler died by suicide on February 18, 2011. He was a successful lawyer who suffered from depression after the downturn in the economy affected his law firm where he was a partner. He sought treatment for his problems, but according to the website, "The mental health professionals Matt was seeing were not prepared to manage or to treat his suicide risk. Knowing of Matt's suicidal intent, they had an obligation to act decisively, empathically, and collaboratively to ensure his safety."

It also states, "Most health care professionals receive little or no training in how to assess, manage and treat suicidal individuals. This lapse is a public safety issue – it contributed not only to Matt's suicide – it is a factor in many other tragic deaths by suicide." Multiple sources indicate that there is a problem due to the greatly increased rate of anti-depressant and anti-anxiety drug prescriptions. One of the problems is that patients are being prescribed psychiatric drugs by primary care doctors without proper diagnoses of depression or mental illness by psychiatrists (Forefront 2017). To date, the Matt Adler Act has not been passed in Alabama.

Garrett Lee Smith Memorial Act – Federal

The Garrett Lee Smith Memorial Act was passed October 21, 2004, with $82 million in initial funding. It has been renewed each year with about $30 million in funding. The Act provides grants for prevention programs by states on college campuses and Indian reservations. Alabama has received two grants: one for the Alabama Department of Public Health, Alabama

Youth Suicide Prevention Program, and the other for the Alabama State University Suicide Prevention Grant (SPRC[a] 2017). Other colleges in the State could also apply for a grant to start this type of program on their campuses (Silberner 2016). A copy of the bill is available at: https://www.gpo.gov/fdsys/pkg/PLAW-108publ355/pdf/PLAW-108publ355.pdf.

Clay Hunt Act – Federal

The Clay Hunt Act was signed into law on February 15, 2015 by President Obama and is aimed at reducing suicide among veterans. The Act is named after Clay Hunt who died by suicide in 2011 after a lengthy struggle with the Veterans Affairs (VA) over benefits and ineffective treatment. His PTSD prevented him from holding a job, but the VA awarded him only 30% disability. Scheduling treatment took months, and the "counseling" he received was simply medication. He moved back to Houston to be near his family but had to wait months to see a psychiatrist at the Houston VA medical center. He completed suicide two weeks after his appointment. Five weeks later and 18 months after filing an appeal, the VA finally revised his disability rating to 100%. He was open about having PTSD, and he actively sought treatment, but the VA did not meet his needs (IAVA 2017).

Under the law, the Department of Veterans Affairs' suicide prevention and mental health treatment programs are now subject to outside evaluations and yearly reports to Congress. The Department is required to set up an interactive website detailing their various resources. They must offer incentives to recruit and retain mental health professionals, and veterans will have an extra year to obtain health care through the department without first proving service related disability (Congressional Research Service 2014).

According to a 2012 report by the VA, 22 veterans commit suicide every day and the law seeks to make it easier for the veterans to receive the health care they need. The new

requirements for outside evaluations and accountability reports to Congress are meant to ensure a better quality of care and reduced wait times (Kemp and Bossarte 2012). A copy of the bill is available at https://www.gpo.gov/fdsys/pkg/PLAW-114publ2/pdf/PLAW-114publ2.pdf.

RECOMMENDATIONS

The Suicide in Alabama team has determined that a two-sided approach may be most effective at providing a solution to Alabama's growing suicide rate: a community-focused approach and an individual-focused approach.

Community-Focused Solutions

Collectively as a community, we should:

1. Increase access to mental health care by:
    a. increasing capacity for in-patient treatment at publicly-funded mental health facilities;
    b. providing additional resources for community mental health centers;
    c. ensuring that health insurance policies provide same-level coverage for mental health treatment; and
    d. recruiting more mental health practitioners to the state;
2. Practice providing psychotherapy along with the prescription of psychiatric medications; and,
3. Support suicide prevention and awareness programs in communities.

Increase Access to Mental Health Care

Alabama is facing many barriers in reducing the rate of suicide. One of the most daunting is the current state of mental health care. According to data regarding access to mental health care in the US, Alabama ranks 50th out of the 50 states plus Washington, D.C. This rating is based on nine measures, which include (MHA 2017):

1. Adults with any mental illness who did not receive treatment
2. Adults with any mental illness reporting unmet need
3. Adults with any mental illness who are uninsured
4. Adults with disability who could not see a doctor due to costs
5. Youth with Major Depressive Episode who did not receive mental health services
6. Youth with severe Major Depressive Episode who received some consistent treatment
7. Children with private insurance that did not cover mental or emotional problems
8. Students identified with emotional disturbance for an Individualized Education Program
9. Mental Health workforce availability

Increase capacity for in-patient treatment at publicly-funded mental health facilities

Contributing to this crisis has been the closing of Alabama Psychiatric Services, a large, state-wide mental health service provider for over 30 years, in February of 2015. Decreased funding from Blue Cross Blue Shield of Alabama and changes to how the company covers behavioral health services were cited as the reasons for its closing. This closure was estimated to have impacted 28,000 patients throughout Alabama. The loss of a large service provider placed added strain on the services offered by state-operated mental health facilities (Alexander 2015).

Provide additional resources for community mental health centers

The influx of new patients has left community mental health centers struggling to meet the needs of individuals in crisis promptly. Many individuals receive their care through nonprofit agencies and private practitioners, who also have long waiting lists. They are also burdened by slow reimbursements from Medicare, Medicaid, and insurance companies. Often, it costs the provider more to treat the patient than will be covered in reimbursements. Unfair reimbursement

practices have forced practitioners out of the business of treating those with mental illnesses who are covered by government-administered plans and managed care insurance (Marullo 2015). Simply put, there are just not enough treatment facilities and mental health providers to address the needs of Alabamians.

Why is this important? Beyond the economics of health and mental health care, is the human cost of inadequate care. Timely access to care is crucial. With much discussion of late regarding the crisis in Alabama schools, prisons, Medicaid and so on, we must address the crisis in mental health care in Alabama.

Ensure that health insurance policies provide same-level coverage for mental health treatment

We must address the inadequacy of public funds required to meet the treatment needs of Alabama's uninsured and underinsured citizens with psychiatric illnesses and psychological disorders. We must insist that insurance companies provide the same level of care for patients with mental health disorders that they provide to patients with other medical problems.

Recruit more mental health practitioners to the state

According to an article by Suzanne Koven, an overall shortage of psychiatrists is partially to blame for inadequate mental health care. Some of the reasons cited for the lack of psychiatrists are as follows:

- Fewer medical students are going into psychiatry because psychiatrists earn among the lowest salaries of all physicians.
- Those that do go into psychiatry often do not accept insurance, thus requiring patients to pay out of pocket.
- Since some health insurance policies do not adequately cover specialized mental-health care, they look for help from primary care doctors who are covered.

- Some people do not want the stigma of seeing a psychiatrist.

Research is needed for the above problems to figure out a way to overcome them, which may include legislation for better insurance coverage for psychiatry and regulations on primary care doctors prescribing anti-depressants and anti-anxiety medications without a proper mental diagnosis (Koven 2013).

Practice Providing Psychotherapy Along with the Prescription of Psychiatric Medications

Another barrier seen across the United States is psychotherapy versus medications. Even though psychotherapy is known to be an effective treatment for psychological disorders, the average person seeking help tends to ask for and receive psychiatric drugs rather than psychotherapy. Antidepressants and anxiety medications are among the leading prescribed drugs in the US. Data indicates that up to 95% of federal dollars spent on mental health research goes to drugs, not psychotherapy, in clinical trials (Whitbourne 2015). More than a third of all mental-health care in the U.S. is now provided by primary-care doctors, nurse practitioners, pediatricians, and family practitioners, as opposed to psychiatrists and psychologists (Koven 2013). Implementing programs that include psychotherapy in hospital emergency departments and providing parity insurance coverage for mental health care could reduce the suicide rate by 10%. This would provide an estimated savings of $9.4 billion to the nation's economy (Shepard, et al. 2015).

Many individuals think nothing much about filling one of these prescriptions, without much or any consultation. However, there should be real concerns that these medications might fail to treat the psychological symptoms and possibly cause a host of adverse side effects.

Support Suicide Prevention and Awareness Programs in Communities

Communities should seek ways to conduct suicide prevention training and awareness events to help de-stigmatize suicide and give its members the tools to help those suffering from suicidal ideation. Organizations should apply for appropriate grants to help fund these trainings and events in attempts to reach the maximum number of people. One such grant available is provided by the Garrett Lee Smith Memorial Act mentioned earlier. Because this grant is specifically for universities and colleges, it is an excellent resource that can be used in targeting a particularly susceptible population, young adults.

The month of September is known as National Suicide Prevention Awareness Month, which helps promote resources and raise awareness around the issues of suicide prevention, how individuals can help others and how to talk about suicide without increasing the risk of harm. Multiple events across the U.S. are held throughout the month to encourage community participation, such as 5k walk/run events and rallies. September 10th is designated as World Suicide Prevention Day in order to encourage communities across the globe to reach out to those affected by suicide, raise awareness and connect individuals with suicidal ideation to treatment services. In addition, community members and organizations can help spread awareness and support by sharing images and graphics on their websites and social media accounts. Hashtags, such as #suicideprevention or #StigmaFree, can also help to connect people on social media.

In fighting for those living with mental illness, there is still much more that needs to be done and more ways to get involved such as volunteering at your local crisis center, taking the Stigma Free Pledge, and donating to support suicide prevention services (NAMI 2017).

Individual-Focused Solutions

Individual awareness is crucial in reducing the suicide rate in Alabama. The more knowledge you have, the more you may be able to help. To stop the increasing rate, and ideally decrease it, individuals must be educated to recognize the warning signs of suicide, know how to intervene, and know where to find help. Many of the steps recommended to intervene when someone may be at risk for suicide are analogous to those taken to help someone having a heart attack.

First, assess the risk factors. Second, observe the warning signs. Third, ask the individual if there is something wrong. Fourth, take action. Fifth, seek help. Finally, stay with the person until help arrives. In 1995, Paul Quinette, Ph.D. developed a plan for helping suicidal individuals: QUESTION, PERSUADE and REFER (QPR). Just like CPR (cardiopulmonary resuscitation) for heart attacks, QPR is a "chain of survival" intended to increase the chance of survival in the event of a crisis. CPR is commonplace in American society today. Many people have been trained to recognize the signs of a heart attack and how to perform the sequence of actions to help a victim survive. However, the converse of this is true with regard to suicide prevention and intervention (QPR Institute 2017).

The first step of the QPR chain of survival is "Question." This first step is probably the most crucial in preventing a person from harming him/herself, but it is also probably the most difficult. As mentioned before, openly discussing suicide and mental illness is, for the most part, foreign and uncomfortable for people. However, it is important that the American public understands the positive effect it can have on the suicide rate when people are open and upfront when talking about it. The most helpful way to approach the subject is to be direct and ask the question, "Are you thinking about killing yourself?" (Crear 2017). If asked indirectly, the person

may avert the answer to dispel any concern. For example, by just asking “Are you ok?”, the person is more likely to say that things are fine. Below is a table that lists what people should do to help.

What to Do	What to Say
Recognize your own feelings	"I'm really worried about you"
Avoid giving advice	"Tell me"
Show you aren't afraid of the topic	"I want you to live"
Build the relationship	"Seems like you're having a rough time"
Listen more than you talk	Nothing, just listen
Use supportive words and reflective listening	"It's ok to ask for help"
Let the person know you will help	"I want to help you"
Seek support from other professionals	"Who could help right now"

Figure 7: How to Help Someone in Suicidal Crisis (Bartlett 2017)

Once the suicide question has been asked, and a “yes” answer has been given, it then becomes an obligation to continue to the next step, “Persuade.” Research has shown that once a person has been questioned about suicide, they have a feeling of relief and not distress. The most effective way of persuading someone not to end their life is to listen. Give the person your undivided attention and do not interrupt them when they are speaking. Allow the person to say what is bothering them without judging or dismissing their issues (Quinnett 2013). Some important points include (Harrington 2004):

- Assume you are the only one who knows they are contemplating suicide;
- Do not say things like, “Everything is going to be ok.”; “You have so much to live for.”; “Suicide is selfish.”; “Suicide is a sin.”; “Suicide is no way to solve your problems.”;
- Do not use guilt as leverage;

- Do not dismiss their feelings or belittle their problems; and,
- Do not leave the person alone if the risk is imminent.

The goal of the persuasion step is getting the person to agree to get help. Have the person call 1-800-SUICIDE or 1-800-273-TALK to talk to someone who can link them with resources in their area. You may also find out if there is a family member or friend they would like for you to call to take them for intervention and treatment. It is also a good idea to get the person to promise not to hurt themselves and make a recommitment to living. Persuasion works best when you:

- Make statements that suicide is not a good solution and offer suggestions that better alternatives can be found;
- Focus on the solutions to the problems, not the suicide solution;
- Accept the reality of the person's pain, but then offer alternatives; and,
- Offer hope in any form and in any way.

If the person refuses to get help or will not make a commitment to go on living, then involuntary treatment may be necessary. At this time you can call 1-800-SUICIDE or 1-800-273-TALK, where you can learn access to involuntary treatment professionals who can make the determination for a possible detention in a hospital. Call 911 if the person is in severe crisis and imminent danger of self-harm. You should also reduce the risk of suicide by restricting access to the means of suicide, such as removing things like medications, guns, knives, or ropes from the person's environment. Finally, always remain with the person until help arrives.

If the evaluating professional believes the person is "a danger to self" and is not willing to accept an outpatient plan for treatment, then the person could be referred to a Probate Judge in Alabama. The judge may order the person into an involuntary, inpatient treatment facility. This

treatment is usually less than two weeks and consists of crisis resolution, counseling, and medications that have been agreed upon by the patient.

The last step in the QPR is "Referral." If the person has agreed to get help, it is best if a family member, friend or you will accompany them to a mental health provider or professional. If no one can escort the suicidal person, follow up with them to ensure they made and kept their appointment.

The QPR Institute offers training on how to become a Gatekeeper that can be completed online in only 60 minutes for a one-time cost of $29.95. This information can be found at www.qprinstitute.com (Quinnett 2013). Free QPR Gatekeeper training is also available to organizations from the Alabama Suicide Prevention and Resources Coalition. Information is available from https://www.asparc.org/qpr-training. Funding for the training is provided by Garrett Lee Smith Suicide Prevention grant (ASPARC 2014). Who are those that are in positions that would benefit with QPR training? Everyone! (Quinnett 2013)

CONCLUSION

Suicide is a problem that the citizens of Alabama cannot afford to ignore. Although there are significant barriers to reducing the suicide rate in our state, the solution begins with us – as individuals and as a community. The Suicide in Alabama team's determination is that providing information to educate individuals and communities and increasing access to care could have a positive impact in reducing the suicide rate in Alabama. As individuals, Alabamians need to learn to recognize the signs and symptoms in a person who is considering suicide and how to intervene and help that person get the help they need. As a community, Alabamians need to advocate for suicide prevention by improving access to mental health resources throughout the state of Alabama.

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APPENDIX

Additional Resources

AMERICAN FOUNDATION FOR Suicide Prevention

https://afsp.org/

http://www.suicidology.org/

Family Sunshine Center

http://familysunshine.org/

ALABAMA Mental Health | Courage Challenge Change

http://www.alabamamentalhealth.org/

NATIONAL SUICIDE PREVENTION LIFELINE™ 1-800-273-TALK (8255) suicidepreventionlifeline.org

https://suicidepreventionlifeline.org/

CRISIS CENTER Helping people in Crisis since 1970

http://crisiscenterbham.org/

CRISISSERVICES OF NORTH ALABAMA Responding to individuals and families in crisis.

http://www.csna.org/

Substance Abuse and Mental Health Services Administration SAMHSA

https://www.samhsa.gov/