Suicide in Washington's East Region

Data Center Report

Data is important for understanding the scope or magnitude of suicide. It can show rates, and also the distribution of suicidal behaviors among the population (e.g., in various age groups and racial or ethnic groups). Data can point to the factors that play a role in suicidal behavior.

Without data, it is difficult to know exactly what groups are at particular risk in a community and what a program or strategy should focus on to reduce suicides. Data can make a difference to decision makers, such as suicide prevention coordinators or policymakers, because it can be used to determine how to most effectively direct—or redirect—resources to the communities and populations that need them most.

East Region

Washington State has 39 counties. For the purposes of this report, staff more closely examined suicide in the east region of the state. The emergency medical services (EMS) system specific to this area is comprised of the following counties: Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, and Whitman. Spokane County is considered an urban county and the others are rural counties.

Suicide Data

Information about suicide in Washington's east region is presented using data from death certificates. Non-fatal suicide attempts are described using inpatient hospitalization data. This information provides an understanding of the more severe suicide attempts. There are more suicide attempts where people may be injured, but are treated in an emergency room, urgent care center, or healthcare provider's office. Information about these types of healthcare visits is not available for analysis.

Suicide is the seventh leading cause of death in the east region of Washington. It is the second leading cause of death among individuals 15-44 years of age.[i] Family and friends of people who die by suicide may experience feelings of shock, anger, or guilt about the suicide.[ii]

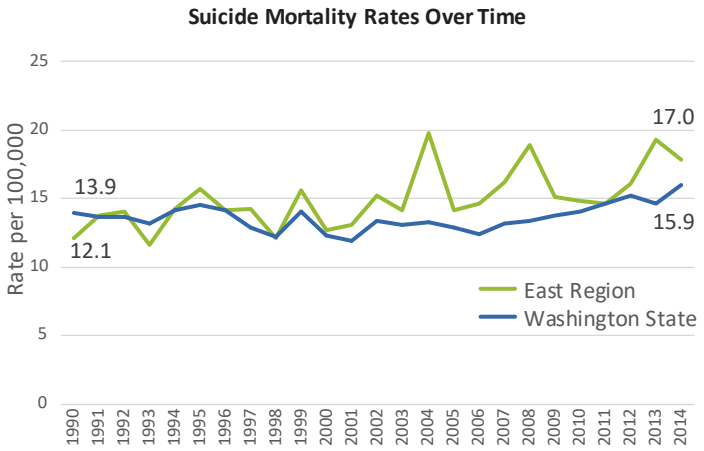
More people attempt suicide than die from suicide. Nationally, there are approximately 11 suicide attempts for every one death from suicide.[iii] People who survive a suicide attempt may then have a serious injury, such as a broken bone, traumatic brain injury, or organ damage.

Suicide affects people across the lifespan, all genders, and all race and ethnicities. While all groups are impacted, some people may be more at risk than other. Factors that increase the risk for suicide are below.[iv] If an individual has a risk factor, it does not mean they will attempt suicide, it only increases the likelihood that they may.

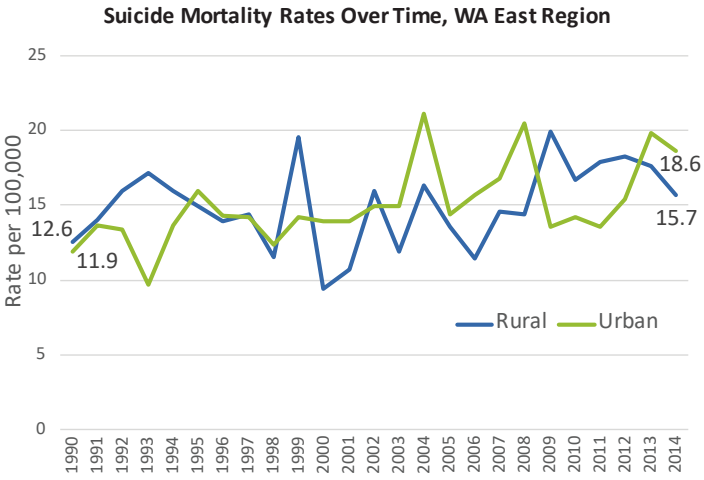
- Depression, other mental disorders, or substance abuse disorder
- A prior suicide attempt
- Family history of a mental disorder or substance abuse
- Family history of suicide
- Family violence, including physical or sexual abuse
- Having guns or other firearms in the home
- Incarceration, being in prison or jail
- Being exposed to others' suicidal behavior, such as that of family members, peers, or media figures.

Fatal Suicides

The east region in Washington had an increasing trend in suicide rates over the last 25 years. Statewide there was a decreasing trend from 1990-2006 and then an increasing trend from 2006-2014.



Over the last 25 years, the pattern of suicides in the east region was fairly variable – more so for rural counties than the urban county. The urban county demonstrated a significant increasing trend in the suicide death rate. There was no identified trend in rural suicide rates.

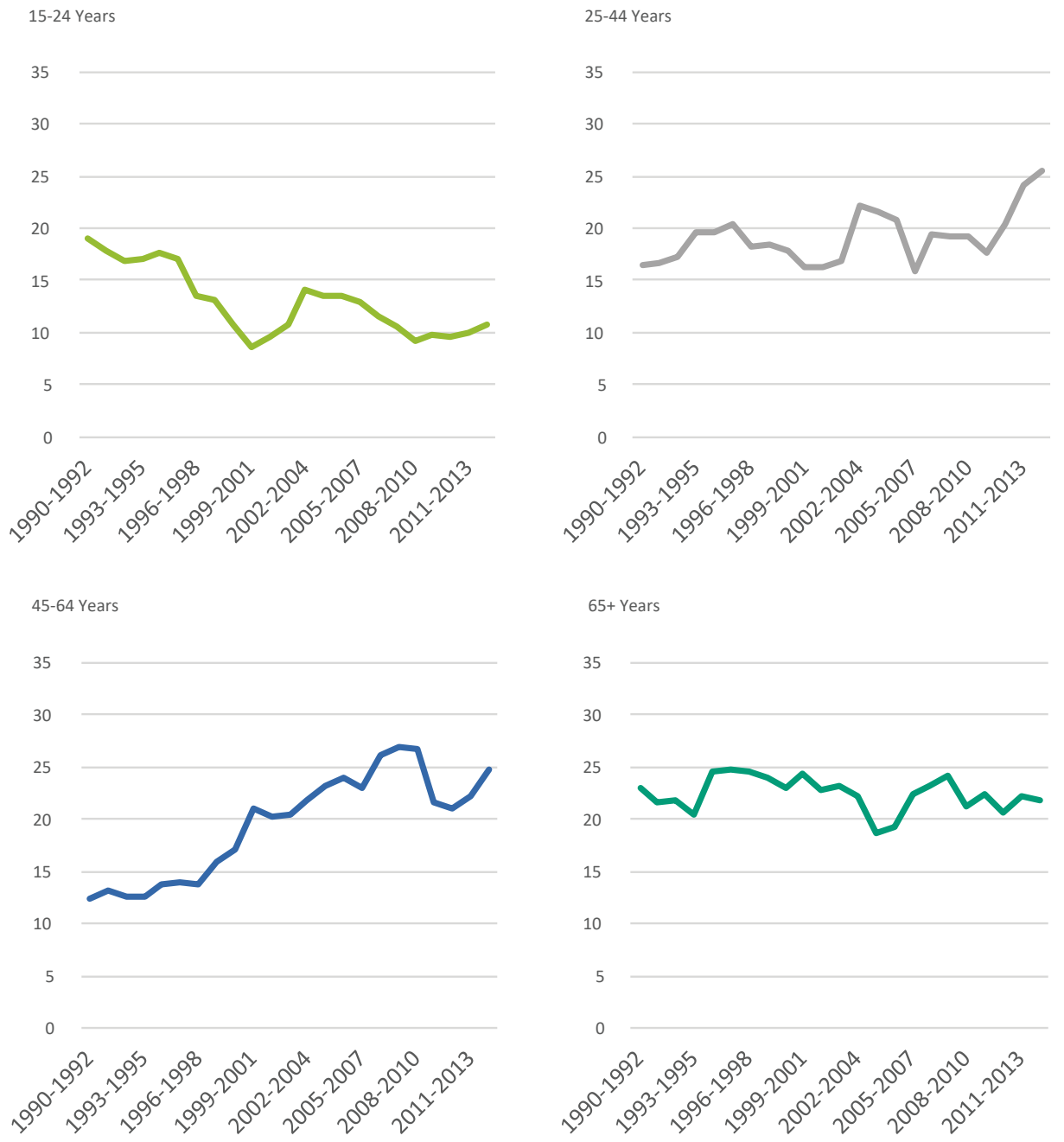


During 2010-2014, an average of 106 people died each year from suicide in the east region of Washington. The five-year suicide rate was significantly higher for the east region compared to Washington State. In the east region, there were differences in the suicide rate by demographics. Males had a significantly higher suicide rate than females. Generally, males tend to use more lethal means when attempting suicide, which is reflected in the higher suicide rate for males (also see method chart on page 5). Compared to individuals 25-44 years of age, those who were younger had lower suicide rates. Among seniors, individuals 75-84 years of age had the highest suicide rate. Compared to whites, Asians/ Pacific Islanders had a significantly lower suicide rate. There were no differences in the suicide rates among other races. Hispanics had a significantly lower suicide rate than non-Hispanics.

Suicide Rates by Demographics,WA East Region, 2010-2014 (n=530)

In the east region of Washington, the suicide rate had some statistically significant trends over time for different age groups. A three-year rolling rate was used to stabilize the rate. There were too few suicides among youth younger than 15 years of age for trend analysis. Individuals 15-24 years of age had a decreasing trend from 1997-2001. Individuals 45-64 years of age had an increasing trend from 1992-2009. There was no trend for individuals 25-44 years of age and among seniors, the rates were stable.

Suicide Mortality, 3 Year Rolling Rate per 100,000, WA East Region, 1990-2014

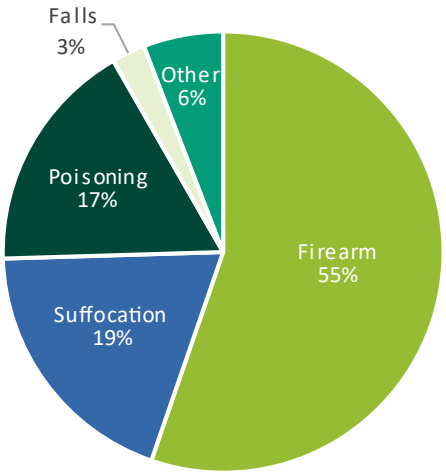


The most prevalent manner in which suicide occurred was the use of a firearm. More than half of suicides in the east region during 2010-2014 were due to a firearm. Among the firearm suicides, 39% used a handgun, 21% used a rifle or shotgun, and in 40% of the deaths, the type of firearm was not specified.

The second most prevalent manner was suffocation. This includes hanging, strangulation, and suffocation.

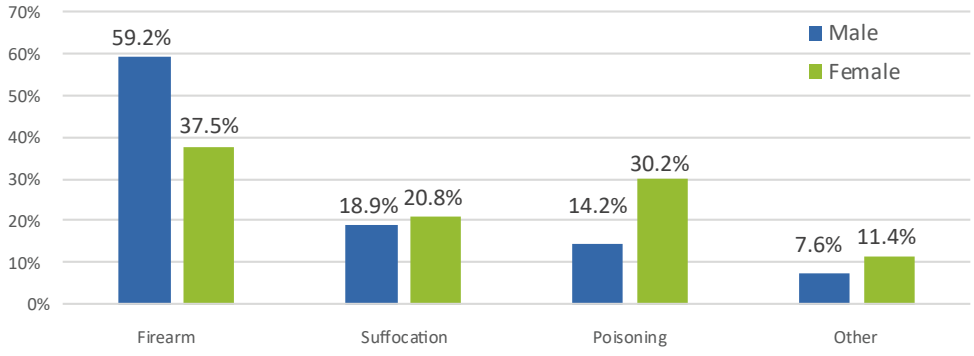
The third manner was poisoning. Among poisoning suicides, half were due to an unspecified drug or medication. One in five (21%) were from gasses or vapors. Eleven percent were from narcotics or hallucinogens. Another 12% were from sedative or hypnotic drugs.

Method of Suicide, WA East Region, 2010-2014



Males had a higher use of a firearm for dying by suicide than females. Females had a higher proportion of suicide by poisoning.

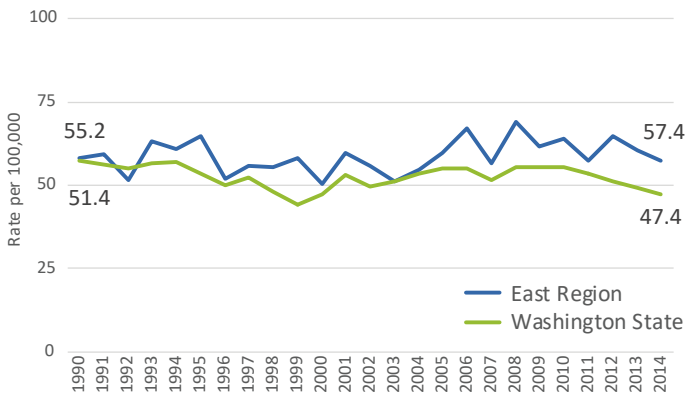
Suicide Method by Sex, WA East Region, 2010-2014



Non-Fatal Suicide Attempts

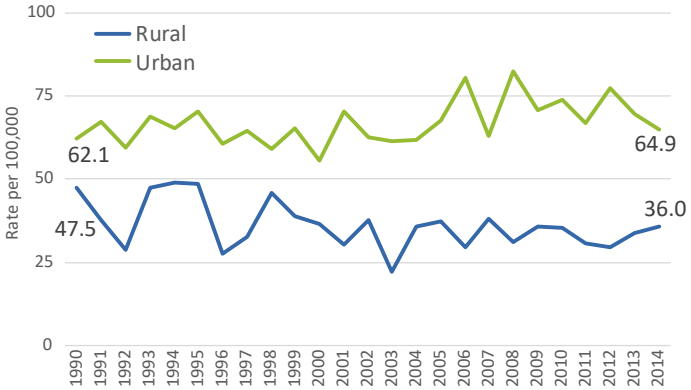
The rate of suicide attempts ending in a hospitalization varied from year to year in the east region of Washington over the last 25 years. Overall, the suicide attempt rate increased a small amount. This increase was statistically significant. Washington State had three significant trends during that time. The suicide attempt rate decreased from 1990-1999, increased from 1999-2009, and then decreased again from 2009-2014.

Non-Fatal Attempted Suicide Hospitalizations Over Time



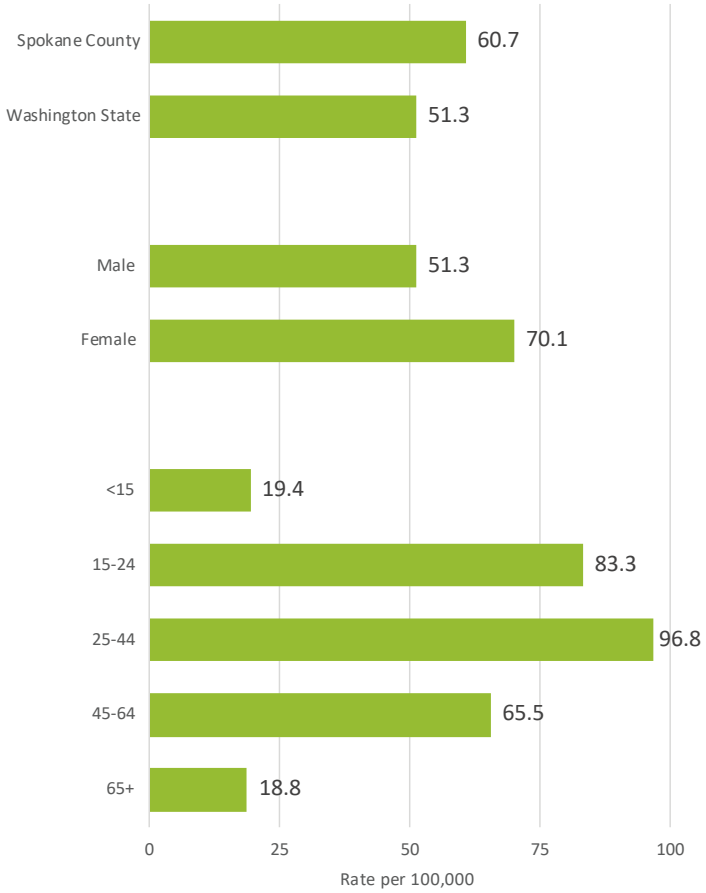
Over the last 25 years, the pattern of suicide attempts in the east region was fairly variable, in both rural counties and the urban county. The urban county demonstrated a significant increasing trend in the non-fatal suicide hospitalization rates from 1990-2014. The non-fatal suicide hospitalization rates in the rural counties had a significantly decreasing trend from 1990-2014.

Non-Fatal Attempted Suicide Hospitalizations Over Time, WA East Region



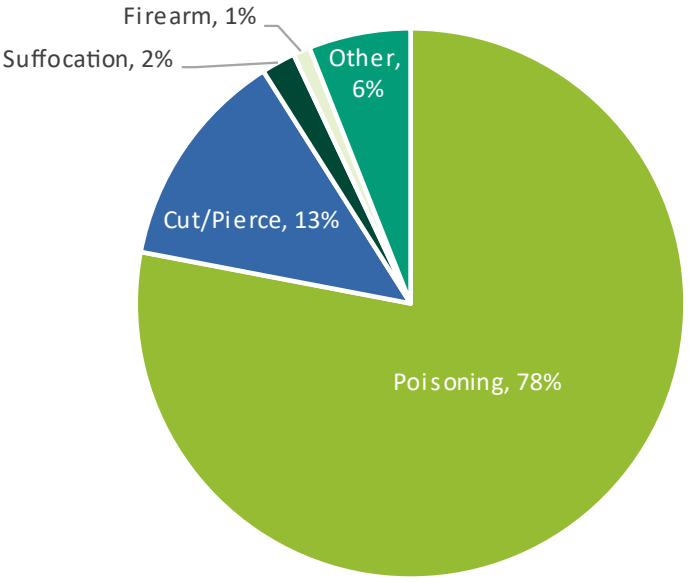
Approximately 390 residents in the east region of Washington were hospitalized annually from an attempted suicide. The 2010-2014 rate of hospitalization from non-fatal suicide attempts was significantly higher in the east region than in Washington State. Females had a significantly higher suicide attempt rate than males. Adults 25-44 years of age had the highest suicide attempt rate. The rate was significantly lower for all other age groups.

Attempted Suicide Hospitalization Rates by Demographics, WA East Region, 2010-2014 (n=1,951)



The majority of suicide attempts resulting in a hospitalization in the east region of Washington during 2010-2014 were from poisoning, followed by cutting or piercing injuries. The manner of suicide attempts was similar for males and females.

Method of Suicide Attempt Requiring Hospitalization, WA East Region, 2010 - 2014



Prevention

There are many best-practice interventions for suicide prevention. A listing of these can be found on the Suicide Prevention Resource Center's Best Practices Registry.[v] Many focus on education and training, such as Lifelines curriculum. This is a school-based curriculum to increase positive outcomes and prevent suicide. Sources of Strength is another youth program used in schools. This program trains youth as peer leaders with support from adults. There are one on one conversations, development of posters, classroom presentations, and individual and media messaging. Through this, the peer group norms are changed to reduce the acceptability of suicide as a response to distress and to increase the acceptability of seeking help, improving communication between youth and adults, and to develop healthy coping attitudes.

QPR gatekeeper training is another example of training to reduce suicide. It stands for Question, Persuade, and Refer. The program trains gatekeepers; someone who is in a position to recognize if someone is at risk of suicide and refer them to help. Gatekeepers are anyone who has regular interaction with others, such as parents, friends, neighbors, teachers, coaches, case workers, and police officers. Individuals of all ages can be impacted by QPR.

The Prevent Suicide Spokane Coalition is a grassroots group that focuses on best-practice interventions including training of professionals and community members in QPR, SafeTALK and Applied Suicide Intervention Skills Training (ASIST). SafeTALK and ASIST are both programs of Living Works, an international suicide prevention training organization. Other best practices addressed by this coalition are guidelines for responsible media reporting on suicide, www.reportingonsuicide.org, and reducing access to means of suicide.

Some interventions are based on medical treatment. Multisystemic Therapy provides psychiatric treatment in the home of a suicidal child. Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) reduces suicidal ideation and depression among seniors. It works with primary care physicians to recognize depression and suicidal ideation, uses a treatment algorithm, and is managed by using treatment specialists.

It is important to note that while some non-fatal suicide attempts result in hospitalization, some of the self-injurious behaviors may be perceived as a suicide attempt when in fact there was not a clear intent to die. Self-injury, also known as cutting or self-mutilation, occurs when someone intentionally and repeatedly harms herself/himself. The method most often used is cutting, but other common behaviors include burning, punching, and drinking something harmful, like bleach or detergent.[vi]

Self-injury is often thought to be directly linked with suicide because sometimes people who self-harm will later attempt suicide, but this is not always the case. Self-injury hospitalizations are often recorded as a non-fatal suicide attempt. However, from a prevention perspective it is important to identify the behavior and ask clearly about whether or not there is an intent to die or if the behavior is a way to cope with life. Information on treatment of self-injury is available from S.A.F.E. Alternatives®, http://selfinjury.com.

i Washington State Department of Health. Center for Health Statistics. 2014.

ii Centers for Disease Control and Prevention. *Understanding Suicide, Factsheet 2015*.
http://www.cdc.gov/violenceprevention/pdf/suicide_factsheet-a.pdf

iii Centers for Disease Control and Prevention.
Web-based Injury Statistics Query and Reporting System (WISQARS). 2014.
http://www.cdc.gov/injury/wisqars/

iv National Institute of Mental Health. *Suicide in America*. 2015.
http://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml

v Suicide Prevention Resource Center. www.sprc.org/

vi Mental Health America. http://www.mentalhealthamerica.net/self-injury

Suicide in Washington's East Region Report author:

Amy Riffe, MA, MPH, Epidemiologist

January 2017

Spokane Regional Health District - Data Center
1101 W. College Ave., Spokane, WA 99201
srhd.org | 509.323.2853

In partnership with