

Navigating Tough Conversations: Suicide Prevention and Employee Support Strategies

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No one cares how much you
know until they know how
much you care.



- Over 49,000 deaths per year
- Over 1.7 million attempts (2022) up from 1.3 million (pre-pandemic)
- 1 in 3 adolescents report ideation (post-pandemic)
- Men die by suicide 3.5x more often than females (80% of completed suicides are men)
- History of suicide attempt is one of the strongest risk factors for suicide.
 - 5% to 11% of hospital-treated attempters do go on to complete suicide, a far higher proportion than among the general public where annual suicide rates are about 1 in 10,000.

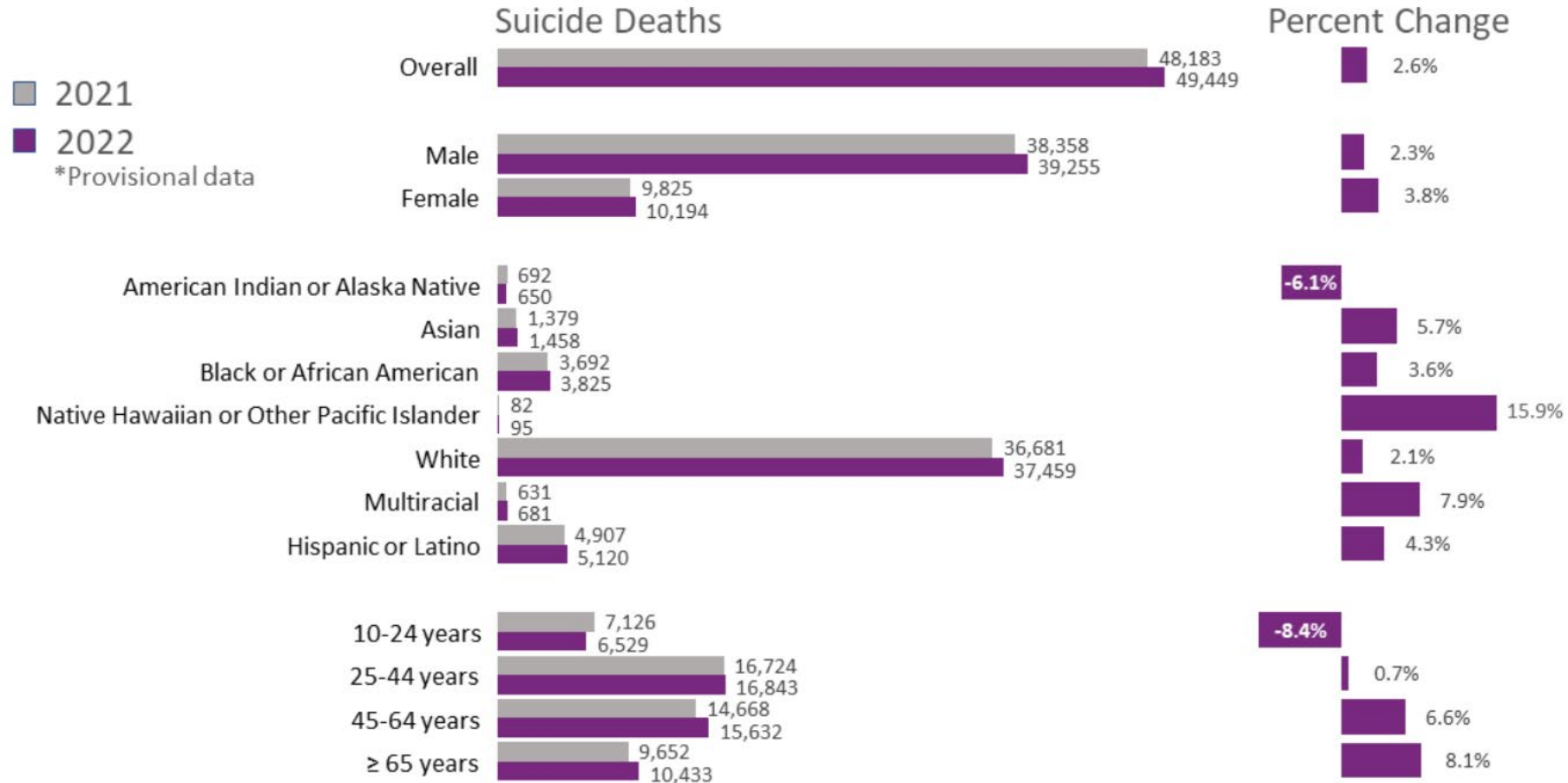
- 12.3 million adults think about suicide each year (up from 10 million pre-pandemic)
- 3.5 million made a plan up from 1.2 million
- Firearms most common method at 55%
- Over 1 million loss survivors each year
- Risk is highest in middle aged adults

- Nine out of ten people who attempt suicide and survive will NOT go on to die by suicide at a later date. This has been well-established in the suicidology literature.
- A literature review ([Owens 2002](#)) summarized 90 studies that have followed over time people who have made suicide attempts that resulted in medical care.
 - Approximately 7% (range: 5-11%) of attempters eventually died by suicide, approximately 23% reattempted nonfatally
 - 70% had no further attempts.

What does this tell us?

- 80% of people who die from suicide suffer from a mental health issue, usually mood (e.g., depression), substance use, PTSD, or impulse control disorders.
 - 20-40% engagement
 - Majority are not engaged in services
- Alcohol use and misuse are associated with approximately 25% to 50 of suicides.
- The combination is quite lethal.

Overall, the number of deaths by suicide **increased** 2.6% from 2021 to 2022*, but **decreased** among American Indian/Alaska Native people and Youth

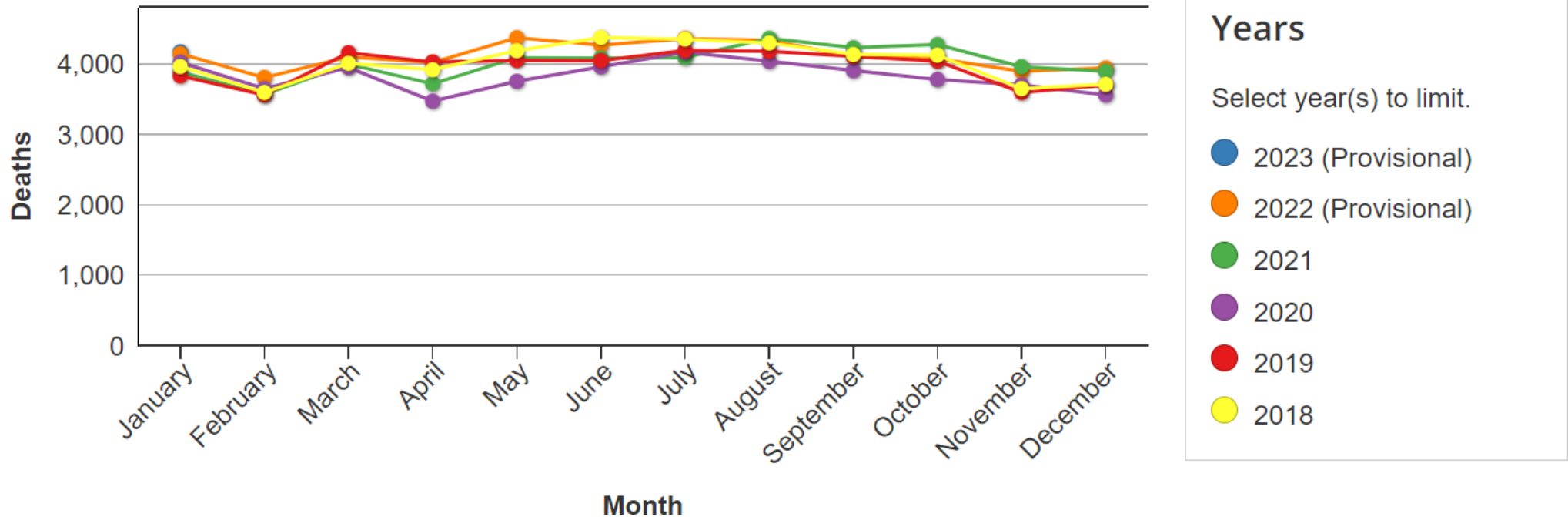


Provisional and Final Fatal Injury Data by Month, United States

Select Injury Type

Suicide

May, June, July “highest months.” SUMMER risk



The supreme myth: Only certain people can help prevent suicide. Therapists, psychologists, mental health professionals, etc.

**Fact: WE ARE ALL PART OF THE SOLUTION.
ALL HANDS ON DECK!**

Myth 1: Talking about suicide increases the chance a person will act on it.

Fact: Talking about suicide may reduce, rather than increase, suicidal ideation. It improves mental health-related outcomes and the likelihood that the person would seek treatment. Opening this conversation helps people find an alternative view of their existing circumstances. If someone is in crisis or depressed, asking if he or she is thinking about suicide can help, so don't hesitate to start the conversation.

Myth 2: People who talk about suicide are just seeking attention.

Fact: People who die from suicide have often told someone about not wanting to live anymore or they do not see the future. It's always important to take seriously anybody who talks about feeling suicidal. It's important to be kind and sensitive, and ask direct questions such as: “Are you thinking about hurting yourself?” “Are you thinking about suicide?” or “Do you have access to weapons or things that can be used as weapons to harm yourself?”

Myth 3: Suicide can't be prevented.

Fact: Suicide is preventable but unpredictable. Most people who contemplate suicide often experience intense emotional pain, hopelessness and have a negative view of life or their futures. Suicide is a product of genes, mental health illnesses, and environmental risk factors. Interventions targeted to treat psychiatric and substance use illnesses could save lives.

Myth 4: People who take their own lives are selfish, cowards, or weak.

Fact: People do not die of suicide by choice. Often, people who die of suicide experience significant emotional pain and find it difficult to consider different views or see a way out of their situation. Even though the reasons behind suicide are quite complex, frequently suicide is associated with psychiatric illnesses, such as depression, anxiety, bipolar disorder, schizophrenia, and substance use.

Myth 5: Teenagers and college students are the most at risk for suicide.

Fact: The suicide rate for this age group is below the national average, and suicide risk increases with age. The age group with the highest suicide rate in the U.S. is men and women between 45 and 64. Though particular groups may be at higher risk, suicide is a problem among all ages and groups.

Myth 6: Nothing can be done once a person decides to take their own life.

Facts: There are far ranging interventions that can prevent suicide. For example, safety plans and barriers to lethal means are effective interventions.

Myth 7: Talk therapy and medications don't work.

Fact: Treatment can and does work. One of the best ways to prevent suicide is by getting treatment for mental illnesses such as depression, bipolar illness, or substance abuse, and learning ways to cope with problems. Finding the best treatment can take some time, and the right treatment can greatly reduce the risk of suicide.

Myth 8: Suicide always occurs without warning.

Fact: There are almost always warning signs before a suicide attempt.

Here are a few common signs:

- Talking about suicide — making statements such as “I’m going to kill myself,” “I wish I were dead” or “I wish I hadn’t been born.”
- Getting the means to take your own life, such as buying a gun or stockpiling pills.
- Withdrawing from social contact and wanting to be left alone.
- Having mood swings, such as being emotionally high one day and deeply discouraged the next.
- Being preoccupied with death, dying, or violence.
- Feeling trapped or hopeless about a situation.

- Increasing use of alcohol or drugs.
- Changing normal routine, including eating or sleeping patterns.
- Doing risky or self-destructive things, such as using drugs or driving recklessly.
- Giving away belongings or getting affairs in order when there is no other logical explanation for doing this.
- Saying goodbye to people as if they won't be seen again.
- Developing personality changes or being severely anxious or agitated, particularly when experiencing some of the warning signs listed above.

**Individual/
Personal Level**

Social Level

**Contextual/Life
Environment**

- Previous suicidal behavior
- Gender (male)
- Mental illness
- Chronic pain or illness
- Immobility
- Alcohol or other substance abuse
- Low self-esteem
- Low sense of control over life circumstances
- Lack of meaning and purpose in life
- Poor coping skills
- Hopelessness
- Guilt and shame
- Feeling like a burden

- Abuse and violence
- Social isolation
- Family dispute, conflict, and dysfunction
- Separation
- Bereavement
- Significant loss
- Peer rejection
- Imprisonment
- Poor communication skills
- Family history of suicide or mental illness

- Access to lethal means
- Unemployment, economic insecurity
- Financial stress
- Neighborhood violence and crime
- Poverty
- School failure
- Social or cultural discrimination
- Homelessness
- Exposure to environmental stressors
- Lack of social support services
- Geographical isolation

Source: Tennessee Department of Mental Health

Behavioral		Physical
Talking about suicide	Sense of hopelessness	Withdrawal from friends, family, or society
Making a suicide plan	Feeling trapped (like there is no way out)	Ceasing activities that used to be important
Self-harming behavior	Withdrawing from friends and family	Giving away valued possessions
Prior suicide attempt/s	Ceasing activities that used to be important	Increased alcohol and/or drug use
Finalizing affairs, <i>e.g., making a will</i>	Giving away valued possessions	Uncharacteristic or impaired judgment or behavior, <i>e.g., risk taking</i>
Unexplained crying	Increased alcohol and/or drug use	
Uncharacteristic or impaired judgment or behavior, <i>e.g., risk taking</i>		

Best List: “Individual Factors” (DBT with Suicidal Adolescents)

- Male gender
- Advancing age
- Race (white more likely)
- Employment status (unemployed/retired)
- Marital status (single/divorced)
- Religion (Protestant over Catholic and Jewish; risk for Muslims unclear)
- Living alone
- Guns, medications (access to lethal means)
- Physical disease
- Feelings of hopelessness
- Recent MH hospitalization
- Financial difficulty
- Heavy gambling losses
- Talking about suicide
- Suicide of others

Suicide Risk in Specific Disorders

Condition	% Lifetime Risk
Prior Suicide Attempts	27.5%
Bipolar Disorder	15.5%
Major Depression	14.6%
Mixed Drug Abuse	14.7%
Dysthymia	8.6%
Obsessive-Compulsive	8.2%
Panic Disorder	7.2%
Schizophrenia	6.0%
Personality Disorder	5.1%
Alcohol Abuse	4.2%
General Population	0.72%

A.P.A Guidelines Part A pg. 16

- These populations are at higher risk than average for suicide:
 - Working age adults are the highest risk age group
 - Suicide is the second leading cause of death for men aged 25-44
 - American Indian and Alaska Native individuals have the highest rate of suicide
 - Survivors of suicide are four times more likely to die by suicide than the general population
 - Males complete suicide at a rate four times that of females, but females attempt more often
 - African American children under the age of 12 are more likely to die by suicide than white children
 - Suicide is the second leading cause of death for ages 10-24
- Other at-risk populations include those who:
 - Are in jail or prison
 - Suffer from chronic pain or illness
 - Have a family history of substance abuse, mental illness, suicide, or violence
 - Are in the LGBTQ+ community
 - Are members of the military or veterans



A video player showing a man with tattoos (Chester Bennington) laughing heartily while sitting at a table with a woman and a child. The man is wearing a dark tank top and has extensive tattoos on his arms. The woman is wearing a black t-shirt and glasses. The child is wearing a dark t-shirt. The background shows a living room with a brown leather sofa and a brick fireplace.

1:02

 Chester Bennington's Wife Shares Video of Him Laughing Hours Before...
Audacy · 4.5M views · 4 years ago

 Who died from Lincoln P... 1 key moment ▾

- “had a way of making anyone he spoke to feel heard, understood and significant. His aura and spirit were contagious and empowering. Often those types of people have so much pain and torture inside that the last thing they want is to contaminate or break the spirit of others... As real and transparent as our conversations would be, he was always the one projecting light on the shadows.”

Doesn't always look like a “depressed person.”



- “Hopefully his death serves as a wake-up call. Mental health is a real thing,” he said. “You never know what people are going through ... Money or fame doesn’t mean anything if you’re not happy inside.”
- “A lot of people, we go on and we don’t deal with what’s happening to us,” he continued. “Especially if you’re a performer like that. **You just start numbing yourself. You just become numb. He’s singing it. You just go and get bigger audiences and things like that and you move further away from yourself.**”



- “wife has said she thought her husband was ‘in a good place’ in the time leading up to his [suicide](#).”
- “He was a bright, loving soul with an angel's voice,” she finished, “And now he is pain-free singing his songs in all of our hearts. May God bless us all and help us turn to one another when we are in pain. Chester would've wanted us to do so.”



I'm tired of being what you want me to be
Feeling so faithless, lost under the surface
Don't know what you're expecting of me
Put under the pressure of walking in your shoes

Every step that I take is another mistake to you
(Caught in the undertow, just caught in the undertow)

I've become so numb
I can't feel you there
Become so tired
So much more aware
I'm becoming this
All I want to do
Is be more like me
And be less like you

“What I’ve Done” ...

In this farewell
There’s no blood, there’s no alibi
‘Cause I’ve drawn regret
From the truth of a thousand lies

So let mercy come and wash away

What I’ve done
I’ll face myself
To cross out what I’ve become
Erase myself
And let go of what I’ve done

- “I am now more educated about those signs, but they were definitely there: **the hopelessness, the change of behavior, isolation,**” Talinda Bennington told CNN during an interview with CNN’s Anderson Cooper during the CNN Town Hall, “Finding Hope: Battling America’s Suicide Crisis.”
- We avoid the conversation. Family, friends, co-workers. In “hindsight” there were signs.

- Hx of drug and alcohol misuse. In and out of recovery. Unsure of recurrence prior to suicide.
- Isolation
- Hopelessness
- Change of behavior

- Bennington, 41, was outspoken about his struggle with drugs and alcohol. Linkin Park had a string of hits in the late 1990s and early 2000s, and Bennington's vocals were one of the band's trademarks. Bennington was close friends with fellow rocker Chris Cornell, who killed himself in May.



The biggest barrier to suicide prevention is stigma, shame, and discomfort surrounding the topic.

THIS KEEPS US FROM ASKING: “Are you okay—are you REALLY OKAY?”

- Be aware of your beliefs
- Acknowledge your values, attitudes, and opinions
- Respect differences
- Be non-judgmental
- Your own history with suicide (family, friends, or professionally)
- Attitudes and outlook surrounding mental health
- Religious beliefs
- NOTHING CAN BE DONE!
- FEAR
- What if I make it worse? (YOU WON'T)

Do's and Don'ts in Suicide Prevention

DO'S	DON'TS
<ul style="list-style-type: none">• Remove opportunities• Receive and accept suicidal communication• Do intrude (get up in my business)• Prevent isolation and involve significant others• Transfer rather than refer• Follow-up• Always obtain consultation when unsure• Do know your own value system about suicide• Get precipitant (identify issues, concerns, and/or events that led up to the current crisis)• Use self as instrument of prevention	<ul style="list-style-type: none">• Do not worry about saying the wrong thing• Do not consider suicidal persons as special• Do not assume ability to solve problem(s)• Do not try to talk the person out of suicide• Do not engage in abstract discussion about suicide, death, dying• Do not be too accepting of suicide• Do not de-legitimize• Do not give cheap general reassurance• Do not lose confidence (may need more limited goals)

ASK

Do:

- Ask if s/he is thinking about suicide
- Actively listen
- Acknowledge talk, behavior and feelings

Don't:

- Debate whether suicide is right or wrong
- Discuss whether feelings are good or bad
- Lecture them on how they should feel

CARE

Do:

- Listen!
- Discuss/care about issues and troubles

Don't:

- Encourage him or her to do it as a test
- Act shocked at their desire to die
- Rush to try to “fix” or “cheer up” the person
- Judge or minimize

ESCORT

Do:

- Encourage the person to talk to supervisor or HR.
- GET TO EAP
- Take them to medical/emergency room/call 911.
- And do it NOW!
- If suicide risk is mild or moderate—coordinate psychiatric appointment/talk therapy

Don't:

- Leave them “on their own”
- Who are they going to call?
- Be sworn to secrecy

No one cares how much you
know until they know how
much you care.

There is always more to the story than meets the eye ...

- Be curious.
- Be open.
- **BE HUMAN.**



Photo by [Scott Walsh](#) on [Unsplash](#)

Getting Run over by a Bus Hurts


It hurts in more ways than you can imagine.


Thank you for your time!


Questions?


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