QUESTION, PERSUADE, REFER (QPR) SUICIDE PREVENTION TRAINING: ASK A QUESTION, SAVE A LIFE

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QUESTION, PERSUADE, REFER (QPR) SUICIDE PREVENTION TRAINING: ASK A QUESTION, SAVE A LIFE

Supreme Court of Kentucky Deputy Chief Justice Debra Hembree Lambert
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CONTENT WARNING: This article discusses suicide and suicidal ideation, and some people may find it disturbing. If you or someone you know is having thoughts of suicide, please contact your physician, go to your local ER, or call the Suicide and Crisis Prevention Lifeline at 988 or message the Crisis Text Line at 741741. Both programs provide free, confidential support 24/7.

"Suicide is not a blot on anyone's name; it is a tragedy."
Kay Redfield Jamison,
Night Falls Fast: Understanding Suicide

First Things First: The question you never ask:

"You're not thinking about *committing* suicide (or *hurting* yourself), are you?"

It's the wrong question using the wrong words and in the wrong form. When this form of the question is used, you're conveying to the distressed individual that you want or need them to answer "no." They're not invited to be truthful because you're leading them (as the good lawyer you are) into a negative answer. We must also be mindful of language. Words matter. Using the phrase "committed suicide" implies death by suicide is a sin or a crime, thereby enforcing the stigma. And finally, the individual who is in such emotional pain that they believe the only escape is death, does not believe killing themselves is "hurting" themselves but more like relieving themselves of the constant emotional torment. People who are having suicidal thoughts don't want to die, they just want the pain to stop. For more information on words and language to use when discussing suicide, *see* attached National Alliance on Mental Illness infographic as Appendix A-1 and Words Matter as A-2.

On average, people with depression go for 11 years before receiving treatment. (https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/). It is likely that lawyers go much longer without seeking help than the average person, since lawyers have a built-in resistance and there are significant barriers to treatment. We reckon that because we help others, we must be able to help ourselves, even though we're lawyers and not mental health professionals. We also misunderstand the role of the Kentucky Lawyer Assistance Program (KYLAP) and their rules of confidentiality when offering assistance.

I. LAWYERS' MENTAL HEALTH PROBLEMS: THE ROLE OF STRESS IN DEPRESSION

"Stress" may be defined as anything in our environment that knocks our bodies out of their homeostatic balance. The stress response is the physiological adaptations that ultimately reestablish balance. Recently, scientists have been focusing on the connection between stress and anxiety and the role they play in producing and maintaining depression. For a high-stress profession like practicing law, this link is alarming.

"If stress is chronic, repeated challenges may demand repeated bursts of vigilance. At some point the vigilance becomes overgeneralized leading us to conclude that we must always be on guard – even in the absence of stress. And thus the realm of anxiety is

entered." Dr. Robert Sapolsky, *Lawyers with Depression, The Stress Depression Connection*, May 11, 2008, www.lawyerswithdepression.com.

Is this familiar?

> *Stress went on too long in my own life as a litigator. I had, indeed, entered the realm of anxiety. For me, this anxiety felt like I had a coffee pot brewing twenty-four-seven in my stomach. I became hypervigilant, each of the files on my desk felt like ticking time-bombs about to go off. Over time, the litigation mountain became harder to climb as the anxiety persisted over a period of years.*
>
> Dan, *Lawyers with Depression*

If chronic stress is or seems to be insurmountable, it gives rise to helplessness. This helplessness may be so generalized that the person is unable to accomplish tasks they could actually master. Helplessness is a pillar of a depressive disorder. It becomes a major issue for lawyers because helplessness is unfamiliar and threatening when considering the work we do for clients. Nobody wants a helpless lawyer.

Studies are showing that the presence of co-morbid anxiety disorders and major depression is common, and according to some studies, as high as 60 percent. This may shed light on why the depression rates for lawyers are so much higher than other professions. We work in a chronically anxious and stressful state. *Lawyer with Depression, The Stress Depression Connection*, May 11, 2008, www.lawyerswithdepression.com.

Over time, this type of chronic anxiety causes the release of too much of the fight-or-flight hormones, cortisol, and adrenaline. Research is clear that prolonged release of cortisol damages areas of the brain that are implicated in depression, the hippocampus (involved in learning and memory), and the amygdala (involved in how we perceive fear). *Id.*

II. MANIFESTATION OF SEVERE DEPRESSION IN LAWYERS AND ETHICAL CONCERNS

For various reasons, there are very few studies of lawyer impairment and its impact on ethical breaches. First, much of lawyer impairment is hidden, and the client never knows there is an impairment or that there may be an ethical breach (*i.e.,* the client generally has no idea whether the lawyer is filing pleadings timely). Second, disciplinary counsels of most state boards don't typically keep records of the relationship of mental health impairment to ethical violations, and so it's not reported in any usable statistical form. There are, however, some general statistics. For example, a study of disciplinary cases in Ontario, Canada revealed that nearly 50 percent of lawyers facing serious disciplinary sanctions there have admitted to either alcohol, drug or psychiatric impairment. Legal Profession Assistance Conference, Addiction and Psychiatric Impairment of Lawyers and Judges; A Search for Meaningful Data, *Discipline Digest, LSUC, October 1992-October 1995*.

The American Bar Association's Commission on Lawyer Assistance Programs has suggested that as many as 90 percent of all serious trust fund (escrow) disciplinary matters involve severe mental health issues and/or substance use disorder, primarily alcoholism.

The areas in which Kentucky and other bar associations see the highest level of complaints are not coincidentally the three areas in which an attorney with severe depression or other impairment will have the greatest struggle. Refer to the identifying traits, *supra*. Specifically: communication, competency, and diligence.

A. Kentucky Supreme Court Rule 3.130(1.4) Communication

> (a) A lawyer shall:
>
> (1) promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(e), is required by these Rules;
>
> (2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;
>
> (3) keep the client reasonably informed about the status of the matter;
>
> (4) promptly comply with reasonable requests for information; and
>
> (5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by the Rules of Professional Conduct or other law.
>
> (b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

B. Kentucky Supreme Court Rule 3.130(1.1) Competence

> "A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness, and preparation reasonably necessary for the representation."
>
> Comments:
>
> **Thoroughness and Preparation**
>
> Competent handling of a particular matter includes inquiry into and analysis of the factual and legal elements of the problem, and use of methods and procedures meeting the standards of competent practitioners. It also includes adequate preparation. The required attention and preparation are determined in part by what is at stake; major litigation and complex transactions ordinarily require more elaborate treatment than matters of lesser complexity and consequence. An agreement between the lawyer and the client regarding the scope of the representation may limit the matters for which the lawyer is responsible. *See* Rule 1.2(c).

Maintaining Competence

To maintain the requisite knowledge and skill, a lawyer should engage in continuing study and education. If a system of peer review has been established, the lawyer should consider making use of it in appropriate circumstances.

C. Kentucky Supreme Court Rule 3.130(1.3) Diligence

"A lawyer shall act with reasonable diligence and promptness in representing a client."

Each of these requirements – communication, competence, and diligence – becomes harder and harder for the lawyer with depression to complete or maintain as the illness progresses. Hence, hopelessness begins to set in. The more difficult the circumstance, the more likely that attorney's thoughts may turn to suicide as an escape from the pain of living.

III. SUICIDE WITHIN THE PRACTICE OF LAW

As set forth herein, risk factors for suicide include depression, anxiety, substance use disorder, divorce, and stress. Lawyers experience ALL of these risk factors at a higher rate than the general population. Lawyers are also more likely to be perfectionists and competitive – personality traits which make a person considering suicide *less likely* to seek help. Larry Berman, Executive Director, American Association of Suicidology.

As stated by Robin Frazer Clark, 50th Georgia Bar President, in her President's Page of the *Georgia Bar Journal*, December 2012, "[F]ailure is not an option in a high-stakes profession such as ours. As a result, lawyers are three times as likely to suffer depression as any other profession."

A frequent progression of an untreated major depression is suicide. Lest there be any doubt, if left untreated, depression can be fatal. There have been several periods in recent history when there have been spates of Kentucky lawyers dying by suicide. Suicide clusters are a group of suicides or suicide attempts that occur closer together in time, space, or both than would normally be observed for a community.[1]

Sadly, these were deaths that were almost completely preventable had the signs been clear and recognized. Unfortunately, many times we, as lawyers, have gotten so good at hiding our true feelings and repressing our actual emotions (skills which are not only useful, but imperative if we are to be effective advocates for our clients), that it is nearly impossible – even for our loved ones – to understand or recognize the symptoms. No one is to blame. We only have an obligation to act when we know the signs of which to be aware. Acknowledging that we, as lawyers, may be masters of repressing our true feelings, means that we must be hyper-vigilant with our colleagues. After we have been educated, we are responsible. There is a duty to help your colleagues when you see the signs that may be preceding an attempted suicide. It's better to be safe than sorry. Better courage than regret.

[1] https://www.cdc.gov/mmwr/volumes/73/su/su7302a3.htm#%3A%7E%3Atext%3DSuicide%20clusters%20are%20a%20group%2Ccommunity%20(1%2C2)

Thoughts of death by suicide are not the problem. Death by suicide is the perceived *solution* to the *real* problem or problems. Death by suicide has been called "a permanent solution to a temporary problem." Our obligation is to try and recognize when someone is experiencing suicidal thoughts and guide them in the direction of *real solutions* and medical help. When the mental health issues that may lead to suicide are recognized early, experts agree that suicide is almost entirely preventable through medication and therapy.

> *It is tempting when looking at the life of anyone who has [died by] suicide to read into the decision to die a vastly complex web of reasons; and, of course, such complexity is warranted. No one illness or event causes suicide; and certainly no one knows all, or perhaps even most, of the motivations behind the killing of the self. But psychopathology is almost always there, and its deadliness is fierce. Love, success and friendship are not always enough to counter the pain and destructiveness of severe mental illness.*
>
> Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide*

IV. SUICIDE IS A SERIOUS PUBLIC HEALTH PROBLEM

The COVID-19 pandemic significantly increased rates of death by suicide.

Suicide rates increased approximately 36 percent between 2000-2022. Suicide was responsible for 49,476 deaths in 2022, which is about one death every 11 minutes. The number of people who think about or attempt suicide is even higher. In 2022, an estimated 13.2 million American adults seriously thought about suicide, 3.8 million planned a suicide attempt, and 1.6 million attempted suicide.[2]

Suicide is the eleventh leading cause of death among all Americans.[3] It's the second leading cause of death among Americans ages 10 to 14 and 25 to 34, and the third leading cause of death among Americans ages 15 to 24. It's the fifth leading cause of death for those 35 to 44.[4] There were nearly two times as many suicides (48,183) in the United States as there were homicides (26,031).[5]

Approximately 132 persons in the United States die by suicide every day.[6] This equates to 5.5 suicides each hour, or one suicide every minute.

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[2] https://www.cdc.gov/suicide/facts/index.html#%3A%7E%3Atext%3DSuicide%20is%20a%20serious%20public%2Cone%20death%20every%2011%20minutes.%26text%3DThe%20number%20of%20people%20who%2Cattempt%20suicide%20is%20even%20higher.

[3] Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports, *available at* https://wisqars.cdc.gov/lcd/?o=LCD&y1=2021&y2=2021&ct=12&cc=ALL&g=00&s=0&r=0&ry=0&e=0&ar=lcd1age&at=groups&ag=lcd1age&a1=0&a2=199.

[4] *Id.*

[5] *Id.*

[6] https://afsp.org/suicide-statistics/.

In Kentucky, the general population facts about suicides are:[7]

- In 2020, Kentucky lost at least twice as many citizens to suicide as to homicide.
- Kentucky's suicide death rate in 2022 was the 20th highest in the nation (17.9 deaths per 100,000).[8]
- Suicide is the second leading cause of death for Kentuckians 10 to 24 and 25 to 34 years old.
- Suicide is the fourth leading cause of death for adults 35 to 44 years old.
- Suicide is the eighth leading cause of death for those aged 55 to 64.
- Our elderly have a higher suicide rate than the national average.
- Sixty-five percent of all deaths by suicide in Kentucky were by firearms.[9]
- Two out of three Kentuckians (64 percent) know at least one person who has attempted or died by suicide.
- One out of three (33.8 percent) consider themselves to be a suicide survivor (someone who has lost a loved one or close friend to suicide).
- Experts believe most people facing suicide don't want to die, they just want to end their pain. When behaviors indicating suicidal thoughts are detected early, lives can be saved.
- Citations: https://afsp.org/suicide-statistics/ and www.kentuckysuicideprevention.org.

In 2022 in the United States, the suicide rate in the general population was 14.3 deaths per 100,000 deaths.[10] In Kentucky, the rate was 17.74 suicides per 100,000 deaths.[11] Kentucky's overall rate of suicide is 24 percent higher than the national average.

V. LAWYER STATISTICS VERSUS GENERAL POPULATION

As compared to 14 deaths by suicide for every 100,000 deaths in the general population, the national average rate *for lawyers* is 66 suicides per 100,000 deaths. Lawyers are more than *six times higher* than the general population, to die by suicide (National Institute of Mental Health). Prior studies indicate that between 10 and 12 percent of lawyers have contemplated suicide.[12]

In a 2015 ABA/Hazelden Betty Ford national study, 11.5 percent of the attorneys responding reported thoughts of suicide at some point during their career, 2.9 percent reported self-injurious behaviors, and 0.7 percent reported at least one prior suicide attempt.

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[7] *Id.*

[8] https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.

[9] https://afsp.org/suicide-statistics/.

[10] https://www.cdc.gov/nchs/data/vsrr/vsrr034.pdf.

[11] https://afsp.org/suicide-statistics/.

[12] Thiese, M.S., Allen, J.A., Knudson, M., Free, K. and Petersen, P., "Depressive symptoms and suicidal ideation among lawyers and other law professionals." *Journal of Occupational and Environmental Medicine*, 63(5), 2021, pp.381-386.

Male lawyers between the ages of 20 and 64 are more than twice as likely to die from suicide as men of the same age in other occupations. National Institute for Safety and Health Study.

Suicide was the third leading cause of death among lawyers insured by the Canadian Bar Insurance Association. (It's the tenth leading cause of death in the U.S. in general.) Canadian Bar Association Study.

Unfortunately, these shockingly high suicide numbers set forth above may inaccurately reflect the *real numbers* and real impact of U.S. suicides.[13] This is because suicide data is based on causes of death as reported on death certificates only. Given that many suicides are likely misreported – not as suicides, but as automobile accidents, hunting accidents, swimming accidents, or accidental alcohol or drug overdoses – the true suicide number is most likely significantly higher.[14]

"If they tell you that she died of sleeping pills, you must know that she died of a wasting grief, of a slow bleeding at the soul."
Clifford Odets

Not insignificantly, the current suicide rates fail to address the number of non-fatal suicide attempts. Since there is no standardized method of data collection among doctors or hospitals related to suicide attempts, there is no hard data to reflect these numbers. However, the American Association of Suicidology (2006) has estimated that at least **25 suicide attempts occur for each completed suicide.** In 2021, there were an estimated 1.7 million non-fatal suicide attempts.[15]

VI. RISK FACTORS FOR SUICIDE

A. Psychiatric Disorders

At least 90 percent of people who take their own lives have a diagnosable and treatable psychiatric illness – such as major depression, bipolar disorder, or some other depressive illness, including:

- Schizophrenia
- Substance use disorder (alcohol or other drugs), particularly when combined with depression
- Posttraumatic stress disorder, or some other anxiety disorder
- Bulimia or anorexia nervosa
- Personality disorders especially borderline or antisocial (lawyers are at a higher risk for antisocial behavior than the general population)

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[13] Granello, Darcy Haag, and Granello, Paul, *Suicide: An Essential Guide for Helping Professionals and Educators*, 2007, https://u.osu.edu/granello.2/files/2008/10/granello.pdf.

[14] Juhnke, Granello & Lebron-Striker, *Professional Counseling Digest*, 2007.

[15] https://afsp.org/suicide-statistics/.

B. Past History of Attempted Suicide

Between 20 and 50 percent of people who die by suicide had previously attempted suicide. Those who have made serious suicide attempts are at a much higher risk for a fatal suicide attempt.

C. Genetic Predisposition

Family history of suicide, suicide attempts, depression, or other psychiatric illness.

D. Neurotransmitters

A clear relationship has been demonstrated between low concentrations of the serotonin metabolite 5-hydroxyindoleactic acid (5-HIAA) in cerebrospinal fluid and an increased incidence of non-fatal and fatal suicide in psychiatric patients.

E. Impulsive Control Disorders

Individuals with impulsive control disorders are more apt to act on thoughts of suicide. This includes individuals with a diagnosis of oppositional defiant disorder, intermittent explosive disorder, and conduct disorder.

F. Demographics

1. Sex: Males are three to five times more likely to die by suicide than females.

2. Age: Elderly Caucasian males have the highest suicide rates.

VII. WARNING SIGNS OF A SUICIDE RISK

Suicide *can* be prevented. While some suicides occur without any outward warning, most people who are having thoughts of suicide do give advance warnings. You may be able to reduce the likelihood of suicide by loved ones by learning to recognize the signs of someone at risk, taking those signs seriously, and then knowing how to respond to them.

GENERAL WARNING SIGNS OF SUICIDE INCLUDE:

- Observable signs of serious depression:
  - Unrelenting low mood
  - Pessimism
  - Hopelessness
  - Desperation
  - Signs of Anxiety (including panic, insomnia, and agitation)
  - Withdrawal from usual activities or loved ones
  - Sleep problems (too much or too little)
- Increased alcohol and/or other drug use
- Recent impulsiveness and taking unnecessary risks, reckless behavior
- Threatening suicide or expressing a strong wish to die
- Making a plan:
  - Giving away prized possessions

- Sudden or impulsive purchase of a firearm
- Obtaining other means of killing oneself such as poisons or medications
- Unexpected rage or anger or any other dramatic mood change

Larry Berman, Executive Director, American Society of Suicidology, *supra*.

The emotional crisis that usually precedes a suicide attempt is often recognizable and treatable. Although most depressed people are not facing suicide, most people having suicidal thoughts are depressed. Serious depression can be manifested in obvious sadness, but often it is rather expressed as a loss of pleasure or withdrawal from activities that had been enjoyable. One can help prevent suicide through early recognition and treatment of depression and other psychiatric illnesses.

VIII. OTHER INDICATORS THAT SOMEONE MAY HAVE THOUGHTS OF SUICIDE

Most individuals facing suicide give some warning of their intentions. But there may be less obvious signs. The most effective way to prevent a friend or loved one from taking his or her life is to recognize the factors that put people at risk for suicide, take warning signs seriously, and know how to respond. Don't be afraid to talk about it. There is too much at stake to avoid these early warning signs.

Know the Facts:

A. PSYCHIATRIC DISORDERS

More than 90 percent of people who die by suicide are living with one or more psychiatric disorders, in particular:

- Major depression (especially when combined with a substance use disorder)
- Bipolar disorder
- Substance abuse and dependence (alcohol and other drugs)
- Process addictions (*e.g.,* gambling disorder)
- Schizophrenia
- Post-traumatic stress disorder (PTSD)
- Eating disorders
- Personality disorders

Depression and the other mental disorders that may lead to suicide are – in most cases – both recognizable and treatable.

The core symptoms of major depression are a "down" or depressed mood most of the day or a loss of interest or pleasure in activities that were previously enjoyed for at least two weeks, as well as:

- Changes in sleeping patterns (sleeping more or less)
- Change in appetite or weight (both weight gain and weight loss)
- Intense anxiety, agitation, restlessness or being slowed down
- Fatigue or loss of energy
- Decreased concentration, indecisiveness or poorer memory

- Feelings of hopelessness, worthlessness, self-reproach or excessive or inappropriate guilt
- Recurrent thoughts of death or suicide

B. PAST SUICIDE ATTEMPTS

Between 25 and 50 percent of people who die by suicide had previously attempted suicide. Those who have made suicide attempts are at higher risk for a fatal suicide attempt.

1. Availability of means.

   In the presence of depression and other risk factors, ready access to guns and other weapons, medications or other methods of self-harm increases suicide risk.

2. Recognize the imminent dangers.

   a. The signs that most directly warn of suicide include:

      i. Threatening to hurt or kill oneself.

      ii. Looking for or obtaining the means to die by suicide (weapons, pills, or other means).

      iii. Talking or writing about death, dying or suicide (look at Facebook posts).

      iv. Has made plans or preparations for a potentially fatal attempt.

   b. Other warning signs include expressions or other indications of certain intense feelings in addition to depression, in particular:

      i. Insomnia.

      ii. Intense anxiety, usually exhibited as psychic pain or internal tension, as well as panic attacks.

      iii. Feeling desperate or trapped – like there's no way out.

      iv. Feeling hopeless.

      v. Feeling there's no reason or purpose to live.

      vi. Rage or anger.

   c. Certain behaviors can also serve as warning signs, particularly when they are not characteristic of the person's normal behavior. These include:

      i. Acting reckless or engaging in risky activities.

ii. Engaging in violent or self-destructive behavior.

iii. Increasing alcohol or drug use.

iv. Withdrawing from friends or family.

3. Take it seriously.

   a. Fifty to 75 percent of all suicides give some warning of their intentions to a friend or family member.

   b. Imminent signs must be taken seriously.

4. Be willing to listen.

   a. Start by telling the person you are concerned and give them examples of why.

   b. If they're depressed, don't be afraid to ask whether they're having thoughts of suicide or if they have a particular plan or method in mind.

   c. Ask if they have a therapist and/or are taking medication.

   d. Do not attempt to argue someone out of suicide. Rather, let the person know you care, that they're not alone, that thoughts of suicide are temporary, and that depression can be treated. Avoid the temptation to say, "You have so much to live for," or "Your suicide will hurt your family."

5. Seek professional help.

   a. Be actively involved in encouraging the person to see a physician or mental health professional immediately.

   b. Individuals facing suicide often don't believe they can be helped, so you may have to provide more encouragement.

   c. Help the person find a knowledgeable mental health professional or a reputable treatment facility and take them to the treatment.

IX. WHAT IS A SUICIDE CRISIS?

A "suicide crisis" is a time-limited occurrence signaling *immediate* danger of suicide. This indicates a suicide attempt is more likely than in a "suicide risk," (discussed above), which is the broader term that includes the above factors such as age and sex, psychiatric diagnosis, past suicide attempts, and traits like impulsivity.

The signs of crisis (again, ***immediate danger***) are:

A. Precipitating Event

A recent event that is particularly distressing such as loss of a loved one or career failure. Sometimes the individual's own behavior precipitates the event: for example, a man's abusive behavior while drinking causes his wife to leave him.

B. Intense Affective State in Addition to Depression

Desperation (anguish plus urgency regarding need for relief), rage, psychic pain or inner tension, anxiety, guilt, hopelessness, acute sense of abandonment.

C. Changes in Behavior

1. **Speech** suggesting the individual is close to suicide. Such speech may be indirect. Be alert to such statements as, "My family would be better off without me." "I feel like I'm in a hole and I can't get out of it." Sometimes people facing suicide talk as if they are saying goodbye or going away.

2. **Actions** ranging from buying a gun to suddenly putting one's affairs in order.

3. **Deterioration in functioning** at work or socially, increasing use of alcohol, other self-destructive behavior, loss of control, rage explosions.

X. WHAT TO DO IN AN ACUTE CRISIS

- If a friend or loved one is threatening, talking about, or making plans for suicide, it is an acute crisis.
- Do not leave the person alone.
- Remove all alcohol from the person or the home.
- Remove from the vicinity any firearms, drugs or sharp objects that could be used for self-harm.
- Take the person to an emergency room or walk-in clinic at a psychiatric hospital.
- If a psychiatric facility is unavailable, go to your nearest hospital or clinic.

If the above options are unavailable, call the **Suicide and Crisis Lifeline at 988**.

Follow-up on Treatment

- Individuals facing suicide are often hesitant to seek help and may need your continuing support to pursue treatment after an initial contact.

- If medication is prescribed, make sure your friend or loved one is taking it exactly as prescribed. Be aware of possible side effects and be sure to notify the physician if the person seems to be getting worse. In today's world, there are almost always alternative medications that can be prescribed.

- Frequently, the first medication doesn't work. It takes time and persistence to find the right medication(s) and therapist for the individual person. Encourage the individual to "keep trying." Encourage them to explore DNA testing that is

becoming common that indicates classes of drugs that are more likely to provide relief for persons living with depression.

XI. CONCLUSION – IN A NUTSHELL

What to Do if You Notice Someone (of any age) Exhibiting Signs of Suicide Risk:

A. Open a dialogue. Asking questions will help you to determine if your client or colleague is in immediate danger. Always take thoughts of, or plans for, suicide seriously.

AGAIN: The question you NEVER ask:

"You're not thinking about suicide (or harming yourself), are you?"

This question tells the person you want them to say "No." It's the wrong form.

1. Be direct. Talk openly and matter-of-factly about suicide. Ask, "Do you ever feel so badly that you think about death by suicide?" or "Do you have a plan to take your life?"

2. Be willing to listen. Allow expressions of feelings.

3. Be non-judgmental. Don't debate whether suicide is right or wrong, or whether feelings are good or bad. Lecturing (for example, on the value of life) or being shocked will put distance between you.

4. Be available. Show interest and support.

5. Offer hope that alternatives are available.

6. Take action.

B. Do not leave the person alone, if you think they might harm him or herself, until the next steps are accomplished.

C. Let them know you are going to do what you can to help them.

D. While they are with you, call the Suicide and Crisis Lifeline at 988 to be connected to the nearest available crisis center for a referral to local mental health resources.

E. If the person at risk is a colleague, you should similarly call the Suicide and Crisis Lifeline at 988 and also refer the colleague to KYLAP at 1-502-226-9373 for resources.

XII. QPR TRAINING

QPR stands for QUESTION, PERSUADE AND REFER – Three simple steps that anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to

recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. Each year thousands of Americans, like you, are saying "Yes" to saving the life of a friend, colleague, sibling, or neighbor. QPR can be learned in our Gatekeeper course in as little as one hour. The cost is $29.95. The cost is inconsequential when compared to having the training that could help you save a life.

In one hour, you can become a Gatekeeper.

According to the Surgeon General's National Strategy for Suicide Prevention (2001), a gatekeeper is someone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide. Gatekeepers include parents, friends, neighbors, teachers, ministers, doctors, nurses, office supervisors, squad leaders, foremen, police officers, advisors, caseworkers, firefighters, and many others who are strategically positioned to recognize and refer someone at risk of suicide.

As a QPR-trained Gatekeeper you will learn to:

- Recognize the warning signs of suicide
- Know how to offer hope

www.QPRInstitute.com

Your Language Matters

The words you use matter. You can break down negative stereotypes and give people hope by choosing **words that are more relatable and promote understanding**. This simple but caring approach may help people feel more comfortable and willing to **talk openly about mental health** and to reach out for support early.

Tips for Talking About Mental Health

CONSIDER

SAYING

- Mental health condition
- The weather is unpredictable
- My daughter has schizophrenia
- Person with a mental health condition
- Lives with, has or experiences

INSTEAD OF

- Brain disorder or brain disease
- The weather is bipolar
- My daughter is schizophrenic
- Consumer, client or patient
- Suffers from, afflicted with or mentally ill

Tips for Talking About Suicide

CONSIDER

SAYING

- Suicide attempt/ attempted suicide
- Died by suicide/ suicide death
- Took their own life
- Died as the result of self-inflicted injury
- Disclosed

INSTEAD OF

- Failed suicide or unsuccessful attempt
- Successful or completed suicide
- Committed suicide
- Chose to kill him/herself
- Threatened

When talking about suicide, consider other meanings your words may have. For example, “committed suicide” implies that suicide is a crime. You can help **eliminate the misunderstanding and stigma** that prevent people from speaking up and getting support by **choosing words that are clearer and more neutral**.

Words matter.

Learning how to talk about suicide in a hopeful, respectful way has the power to save lives.

01 / Language Guidelines

The topic of suicide should be approached with care and compassion. Whether we are engaging in a dialogue, talking to someone with lived experience or writing about the issue in a professional setting, being mindful of our language is not just about being politically correct. It's about saving lives.

As our knowledge and understanding of suicide evolves, the way we talk about it must evolve as well. To help you be more conscious of your own language decisions, this guide will show you how to avoid reinforcing the stigma that prevents people from seeking help when they need it most.

While there are specific terms and phrases to avoid when speaking about suicide and mental illness, the general rules below can help you choose your words more carefully.

Avoid:

- Anything that reinforces stereotypes, prejudice or discrimination against people with mental illness and suicidal ideation
- Anything that implies mental illness makes people more creative, fragile or violent
- Anything that refers to or defines people by their diagnosis

Choosing our words carefully is about more than avoiding stigmatizing terms. The language we use can also have a positive effect, which makes choosing the right words just as important as avoiding the wrong ones.

- Be direct. We know that talking to someone about suicide won't cause or increase suicidal thoughts, or cause the person to act on them. It can help them feel less isolated and scared.
- Be hopeful. People can and do get better.
- Encourage people to seek help.

02 / Language Guidelines

INSTEAD OF THIS...	...SAY THIS	WHY
commit/committed suicide	died by suicide / death by suicide / lost their life to suicide	"commit" implies suicide is a sin or crime, reinforcing the stigma that it's a selfish act and personal choice using neutral phrasing like "died by suicide" helps strip away the shame/blame element
successful/unsuccessful suicide completed/failed suicide	died by suicide / survived a suicide attempt / lived through a suicide attempt fatal suicidal behaviour / non-fatal suicidal behaviour fatal suicide attempt / non-fatal suicide attempt	the notion of a "successful" suicide is inappropriate because it frames a very tragic outcome as an achievement or something positive to be matter-of-fact, a suicide attempt is either fatal or not
epidemic, skyrocketing	rising, increasing	words like "epidemic" can spark panic, making suicide seem inevitable or more common than it actually is by using purely quantitative, less emotionally charged terms like "rising", we can avoid instilling a sense of doom or hopelessness
<Name> is suicidal	<Name> is facing suicide / is thinking of suicide / has suffered through suicidal thoughts / has experienced suicidal thoughts	we don't want to define someone by their experience with suicide; they are more than their suicidal thoughts
He's suicidal They're a schizophrenic She's bipolar The mentally ill <Substance> addicts	he is facing suicide / thinking of suicide / experiencing suicidal thoughts they have schizophrenia / are living with schizophrenia people with mental illness people addicted to <substance>, people with addiction	putting the condition before the person reduces someone's identity to their diagnosis—people aren't their illness; they *have* an illness people-first language shows respect for the individual, reinforcing the fact that their condition does not define them

These recommendations have been informed by the Canadian Psychiatric Association's *Media Guidelines for Reporting on Suicide.*

Together, we can change the way the world perceives and treats people facing suicide.

The unfortunate reality is that many stigmatizing phrases and ways of talking about suicide have been ingrained into our vocabulary. Even the most dedicated supporters of the mental health movement may find themselves slipping up from time to time, and that's okay. This does not make you a bad person—it makes you human.

If you catch yourself using problematic language about suicide or mental illness, correct yourself out loud. By letting those around you know why your words were harmful, you can turn the conversation into a positive learning experience for everyone involved. If we all put in this effort, we will see a fundamental shift in the way society addresses these issues.

APPENDIX B
KENTUCKY – SUICIDE RESOURCES AND SUPPORT GROUPS

Kentucky Suicide Prevention Group: **www.kentuckysuicideprevention.org**
Kentucky Suicide Prevention Group
1603 Vivian Lane
Louisville, KY 40205
TELEPHONE: (502) 931-3999

Beck Whipple, MSW
State Suicide Prevention Coordinator
Kentucky Dept for Behavioral Health, Developmental and Intellectual Disabilities
275 East Main Street
Frankfort KY 40601
Email: Beck.Whipple@ky.gov
TELEPHONE: (502) 782-4548

There is also a growing number of teens and young adults who attempt suicide. To address these issues, here are some frequently asked questions. Many of these questions came from young teens struggling to understand the suicide attempts of friends, and trying to learn how they can help.

1. What percentage of college students who kill themselves are male? Why do you think more/less boys than girls kill themselves?

Seventy-five to 80 percent are boys although more girls attempt suicide. Boys are more involved than girls in all forms of aggressive and violent behavior.

2. I've heard that suicides are more frequent around the holidays. Is this true, and if so, how much do they increase at that time?

Suicides are not more frequent during the holidays. It appears that the rates are the highest in April, and the summer months, June and July.

3. It is often said that a person facing suicide goes through a period where he seeks help from other people. Does this then mean that it could be ultimately the fault of other people (because they don't appear concerned enough) that one decides to kill themselves?

Not a fair conclusion, although it could be a contributing factor in some cases particularly with elderly, terminally ill people.

4. What is the biggest cause of suicide among college students?

Ninety-five percent are experiencing mental illness, usually depression. If experiencing depression, the co-occurrence of substance use disorder, anxiety, impulsivity, rage, hopelessness, and desperation increase the risk.

5. Apart from talking to a person facing suicide and encouraging them to go for counseling, what else can we do to prevent this?

Going with someone to the counselor often helps. If the person won't listen to you, you may need to talk to someone who might influence them. Saving a life is more important than violating a confidence.

6. People often get uncomfortable when one discloses something as intimate and frightening as having suicidal thoughts. What do you think can be done to reduce this stigma, either of people thinking of suicide, or of depressive patients? Can people actually "change" their minds and accept someone who is having thoughts of suicide?

As people recognize that suicidal behavior is the result of a medical condition, not a sign of weakness or character defect, it will change.

7. What is the most frequent method of suicide? Is the most frequent method different for men and women?

Fifty-two percent of all people who kill themselves do so with a firearm, accounting for almost 17,000 deaths each year in the U.S. Use of a firearm is the number one method in those aged 35 and up.