WHY? WHY? WHY? WHY? WHY? WHY?
WHY? WHY? WHY? WHY? WHY? WHY?
WHY? WHY? WHY? WHY? WHY? WHY?
WHY? WHY? WHY? HOW? WHY? WHY?
WHY? WHY? WHY? WHY? WHY? WHY?
WHY? WHY? WHY? WHY? WHY? WHY?
WHY? WHY? WHY? WHY? WHY? WHY?
WHY? WHY? WHY? WHY? WHY? WHY?
WHY? WHY? WHY? WHY? WHY? WHY?
WHY? WHY? WHY? WHY? WHY? WHY?

Means Matter

Suicide, Guns & Public Health

A Suicide

A 20-year old with a drug problem moved back in with his parents after his girlfriend broke up with him. When he stopped going to work, his parents contacted a mental health center and urged him to see a counselor. He refused. He called his girlfriend hoping to get back together, but she wouldn't speak to him. He felt desperate. He went to his father's gun cabinet, removed a loaded gun, and shot himself in the head. He died within seconds.

A Life Saved

A 20-year old with a drug problem moved back in with his parents after his girlfriend broke up with him. When he stopped going to work, his parents contacted a mental health center and urged him to see a counselor. He refused. He called his girlfriend hoping to get back together, but she wouldn't speak to him. He felt desperate. He went to his father's gun cabinet, but the guns were gone. He found a razor and cut his wrists. His parents found him an hour later and brought him to the hospital where he was treated and agreed to get help.

The Difference?

In both scenarios the parents contacted a mental health center, concerned that their son might be suicidal. They got good information about ways to help him through this difficult period.

However, the clinician in the second story also asked the parents about guns in the home and advised them, as a precaution, to temporarily remove any or lock them very securely. The second family avoided a tragedy because the clinician had been trained to screen for access to lethal means of suicide.

WHO?
WHEN?
WHERE?
WHY?
HOW?

Suicide

is a major problem in the United States.

While progress is being made, the sad reality is that every year over 30,000 Americans, including many young people, take their own lives.

The loss is unacceptable and preventable.

Of course, suicide is a complicated issue, one that confuses and leaves many overwhelmed. Although we need more answers,

there is much we can do to save lives today.

Efforts to prevent suicide generally focus on the *why*.

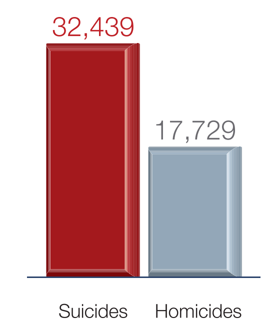
We provide support and care to those who are suicidal – trying to help resolve the problems that led to their hopelessness. This is a valuable and humane response. But as we understand more about *who* attempts suicide and *when* and *where* and *why*, it becomes increasingly clear that *how* they attempt—the means they use—plays a crucial role in whether they live or die.

Who is most affected by suicide?

Suicide hurts all of us–parents, children, siblings, friends, lovers and spouses. The loss for society is psychological and financial. Understanding suicide requires looking at all of the factors that underlie this complex and intensely emotional issue and applying logic and reason, even in the face of sadness and despair.

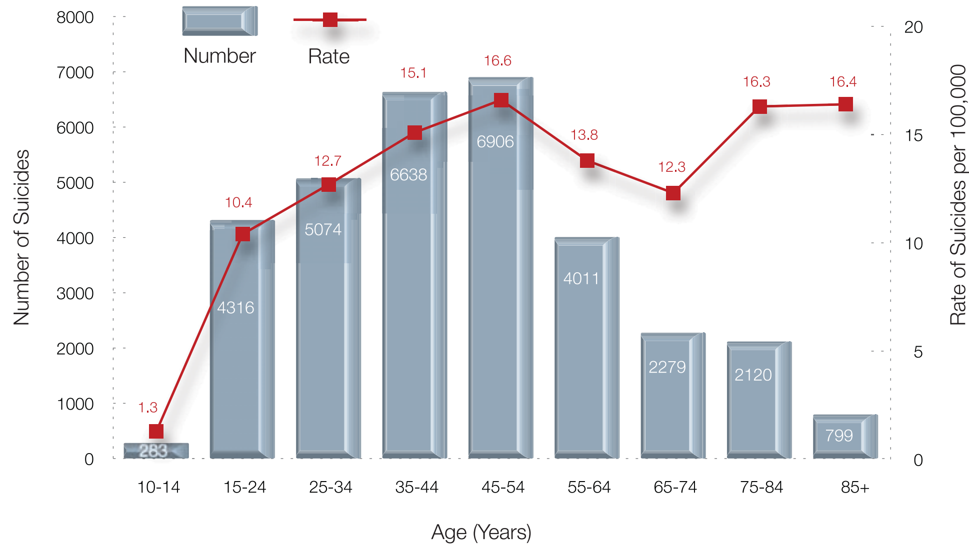
Suicide is the 11th leading cause of death in the U.S. and the fourth leading cause for males under 65.[1] For each death, about 45 people attempt and survive.[2] Those who die are more likely to be male, older, and to use more lethal methods.[3,4]

Suicide and Homicide, 2004[1]



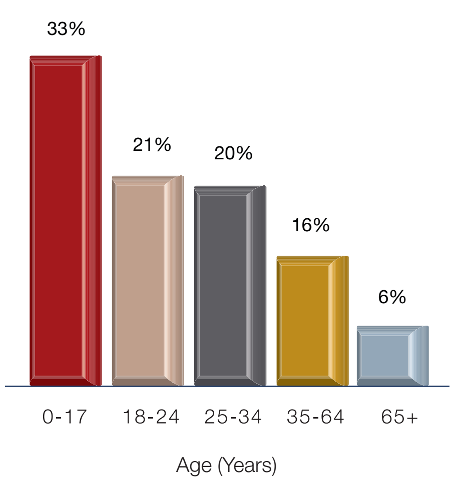
Suicides outnumbered homicides almost two–to–one in 2004.

Suicides by Age, 2004[1]



When do people take their lives?

Percentage of Suicides with a Crisis on the Day of Suicide (by age)[5]



A study of people who nearly died in a suicide attempt asked:[6]

"How much time passed between the time you decided to complete suicide and when you actually attempted suicide?"

- 24% said less than five minutes
- Another 47% said an hour or less

Although some people who die by suicide plan their act carefully, many don't. In fact, many take their lives within 24 hours of a crisis– like an argument with a family member or a relationship break-up.

One third of youths who died by suicide had faced a crisis within 24 hours, according to the police or medical examiner investigation report.[5]

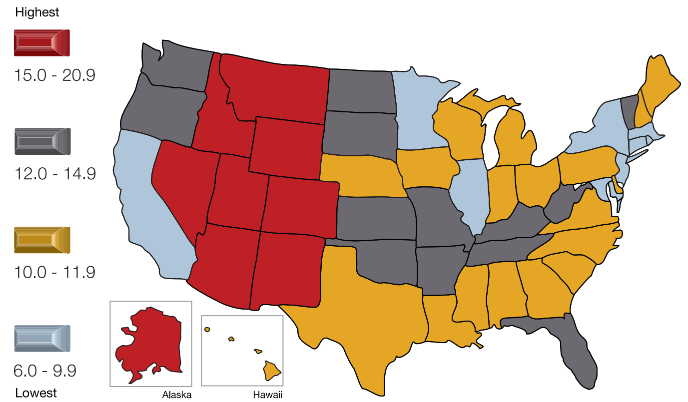
Where do suicides occur?

About three-quarters of suicide incidents occur at home. Most (85%) die at the scene and never make it to the hospital.[5]

Suicide rates are highest in rural areas, in the west (excluding California) and, to a lesser extent, in parts of the south and northern New England.[7]

Suicide Rates by State, 2000-2004[1]

(Age-adjusted rates per 100,000 population)



Why do people take their lives?

Many factors lead individuals to try to end their lives. Drug and alcohol dependence and abuse, depression and certain other mental illnesses, impulsiveness and aggressiveness, family history of suicide, parental psychopathology, previous attempts, and recent losses or setbacks (like a relationship break-up, arrest, or job problem) are risk factors for suicide deaths and attempts.[8,9] Cultural factors also play a role. Feeling hopeless is probably the most common theme.

Suicide attempts (whether fatal or nonfatal) rarely occur "out of the blue." Attempters typically face multiple problems–some long term, some short term. The moment when they take action, however, is often during a brief period of heightened vulnerability.

One of the most powerful risk factors for suicide deaths is the ready availability of highly lethal methods. In the U.S., that means guns.

The focus of suicide prevention has traditionally been on *why* people take their lives.

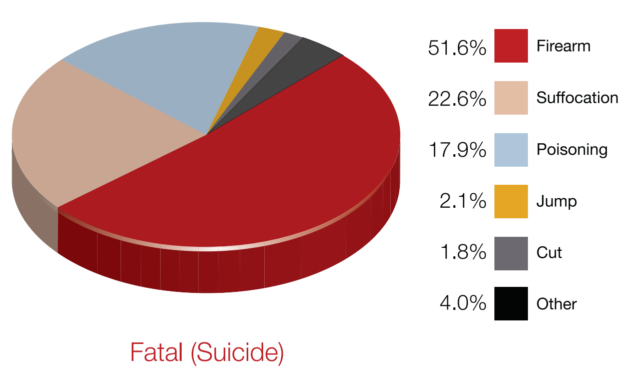
The *why* of suicide is important, but a growing body of research indicates that *how* they attempt is also important. Reducing access to lethal means is an effective way to increase the odds that a suicide attempt will end in care, not in death.

The *means matter* when it comes to suicide prevention.

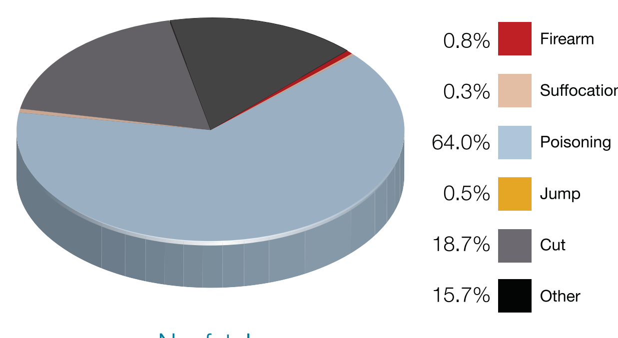
How do people most commonly complete suicide?

- More use a firearm than every other method combined.[1]
- Most nonfatal attempts are overdoses, followed by cutting. Less than 1% use a gun.[1]

Methods of Self-Harm, 2004[1]



Fatal (Suicide)



Nonfatal

How do we know firearms are a risk factor for suicide?

- All U.S. studies that have compared individuals who have died by suicide with "matched controls" (demographically similar people who did not die by suicide) have found that a gun in the home increases the risk of suicide.[e.g.10–14]
- This is true for people of all ages, but particularly for youths. It is true both for those with psychopathology and without.

How do states compare?

Studies that compare states with high and low gun ownership levels find that where there are more guns, there are more suicides.

Suicides in States with the Highest and Lowest Gun Ownership Levels, 2000-2002[7]

	High–Gun States*	Low–Gun States**
Population	**39 Million**	**40 Million**
% Of Adults With A Gun At Home	**47%**	**15%**
Male		
Firearm Suicide	8,489	2,430
Non-Firearm Suicide	3,572	4,007
Total Suicide	12,061	6,437
Female		
Firearm Suicide	1,260	176
Non-Firearm Suicide	1,488	1,439
Total Suicide	2,748	1,615

*WY, SD, AK, WV, MT, AR, MS, ID, ND, AL, KY, WI, LA, TN, UT

** HI, MA, RI, NJ, CT, NY

How do guns differ from other means?

Guns are more lethal. They're quick. And they're irreversible. Once the trigger is pulled, death usually follows within minutes.

Attempters who take pills or inhale car exhaust have some time to reconsider mid-attempt and stop or be rescued before it's too late. The method itself may fail. Even many of those who use hanging can stop mid-attempt.[15]

Won't an attempter just substitute another method if no gun is available?

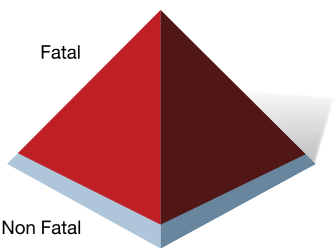
Often yes. But any method they substitute will be less likely to kill them—in some cases a lot less likely. Some attempters will die—particularly those who are very purposeful and determined, but more will live than if they had used a gun.

Will they go on to die by suicide later?

90% of those who attempt suicide and survive —even those making very serious attempts like jumping in front of a train—do not go on to die by suicide later.[16] Some 20–25% make another nonfatal attempt, but very few die by suicide, even 10–20 years later.

85%

of firearm suicide attempts are fatal.[1]



90%

of survivors of near-lethal suicide attempts do not commit suicide thereafter.[16]

How do young suicide victims get a gun?

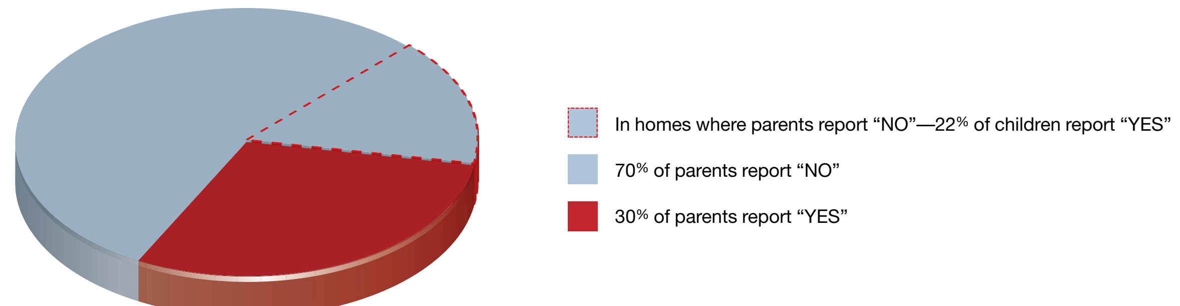
Among the most tragic suicides are those by young people. Too often youths use their parents' guns. Parents may believe that their guns are adequately "hidden" or that their kids would never use them in a suicide attempt. But data show parents routinely underestimate youths' ability to find and handle guns at home.

Among gun-owning households, the risk of youth suicide is lower in those storing all guns locked and unloaded than in those storing guns less securely.[17]

85%

of youths under 18 who died by firearm suicide used a family member's gun, usually a parent's.[5]

Responses to the Question: "Has Your Child Handled Your Gun in Your Home?"[18]



How do we keep our families safe?

Recommendations for families

Weigh the pros and cons.

Some families have decided that having guns at home, especially with kids present, is too great a risk and choose to dispose of their guns. Storing guns for sport or hunting in a location away from the home is another option.

Temporarily remove guns.

There may be times when it makes sense to temporarily remove guns from the home. If a family member is going through a difficult time—such as dealing with depression, a drug or alcohol problem, a difficult divorce, an arrest, etc.—temporarily having someone else hold the guns could prevent a suicide and save a life.

Store guns securely.

Families who choose to keep guns at home can make sure they are properly stored. Store guns locked and unloaded with ammunition locked separately. A securely locked cabinet or safe or case provides good protection. Make sure it truly can't be opened by an unauthorized person (e.g., no glass fronts, no flimsy locks). Trigger locks also provide added safety.

How do we keep our communities safe?

Recommendations for state suicide prevention groups

Train providers.

Train mental health and medical providers on how to talk with suicidal and at-risk patients and their families about reducing access to guns at home. Most currently do not.[19] The Suicide Prevention Partnership is funding CALM trainings (Counseling on Access to Lethal Means) in New Hampshire for mental health providers and is expanding the program to primary care and emergency department providers. Other states are beginning to follow suit.

Change policy.

Encourage professional groups (like your state social workers association and state hospital association) to add a "means matter" policy to their current suicide prevention protocols to ensure that all suicidal or at-risk patients and their families are counseled about reducing access to guns at home.

Expand options.

Work with local police and other public safety groups to expand options for families who want to permanently or temporarily remove their guns. Many police departments currently have no policy or protocols in place to dispose of or store weapons and aren't able to help families. Work with them to explore some feasible options.

Suicide is a national tragedy. With hundreds of thousands of Americans attempting suicide each year, and over 30,000 dying, the problem calls out for solutions.

There are many ways to help, but one step is clear. Reducing a suicidal person's access to lethal means helps save lives, particularly among impulsive attempters. Firearms are the most lethal and most common suicide method. Suicide attempts with a firearm are almost always fatal, while those with other methods are less likely to kill. And nine out of ten people who survive an attempt do not go on to die by suicide later.

By working with family members and care providers to reduce a suicidal person's access to guns, we help ensure that more people get a second chance at life.

www.meansmatter.org

Sources cited:

[1]Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS). Available at: www.cdc.gov/ncipc/wisqars

[2]Kessler RC, Berglund P, Borges G, Nock M, Wang PS. Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *JAMA*. 2005;293(20):2487-95.

[3]Vyrostek SB, Annest JL, Ryan GW. Surveillance for fatal and nonfatal injuries—United States, 2001. *MMWR*. 2004; 53(SS07):1-57.

[4]Miller M, Azrael D, Hemenway D. The epidemiology of case fatality rates for suicide in the northeast. *Ann Emergency Med*. 2004;43(6):723-30.

[5]Harvard Injury Control Research Center, National Violent Injury Statistics System (NVISS). 2001 suicide data summary. Available at: http://www.hsph.harvard.edu/hicrc/nviss/documents/Suicide%20Summary%202001.pdf

[6]Simon, T.R., Swann, A.C., Powell, K.E., Potter, L.B., Kresnow, M., and O'Carroll, P.W. Characteristics of Impulsive Suicide Attempts and Attempters. *SLTB*. 2001;32(supp):49-59.

[7]Miller M, Lippmann S, Azrael D, Hemenway D. Household firearm ownership and rates of suicide across the 50 US States. *Journal of Trauma*. 2007;62(4):1029-35.

[8]Krug EG, Dahlberg LL, Ziwi AB, Lozano R (eds). *World Report on Violence and Health*. WHO:Geneva, 2002.

[9]Gould MS, Greenberg T, Velting DM, Shaffer D. Youth suicide risk and preventive interventions: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry*. 2003;42(4):386-405.

[10]Brent DA. Firearms and suicide. *Ann NY Acad Sci*. 2001; 932:225-39.
And see: http://www.suicidereferencelibrary.com/test4~id~513.php

[11]Brent DA, Perper JA, Moritz G, Baugher M, Schweers J, Roth C. Firearms and adolescent suicide. A community case-control study. *Am J of Diseases of Children*. 1993;147(10):1066-71.

[12]Conwell Y, Duberstein PR, Connor K, Eberly S, Cox C, Caine ED. Access to firearms and risk for suicide in middle-aged and older adults. *Am J Geriatr Psychiatry*. 2002;10(4):407-16.

[13]Kung HC, Pearson JL, Liu X. Risk factors for male and female suicide decedents ages 15-64 in the US. Results from the 1993 National Mortality Followback Survey. *Soc Psychiatry Psychiatr Epidemiol*. 2003;38(8):419-26.

[14]Miller M, Hemenway D. Firearm prevalence and the risk of suicide: A review. *Harvard Health Policy Review*. 2001; 2 (2):29-37. http://www.hcs.harvard.edu/~epihc/currentissue/Fall2001/miller4.htm

[15]Bennewith O, Gunnell D, Kapur N, Turnbull P, Simkin S, Sutton L, Hawton K. Suicide by hanging: multicentre study based on coroners' records in England. *Br J Psychiatry*. 2005;186:260-1.

[16]Owens D, Horrocks J & House A. *Br J Psychiatry*. 2002;181:193-99.

[17]Grossman DC, Mueller BA, Riedy C, et al. Gun storage practices and risk of youth suicide and unintentional firearm injuries. *JAMA*. 2005;293(6):707-14.

[18]Baxley F, Miller M. Parental misperceptions about children and firearms. *Arch Pediatr Adolesc Med*. 2006;160(5):542-7.

[19]Grossman J, Dontes A, Kruesi M, Pennington J, Fendrich M. Emergency nurses' responses to a survey about means restriction: an adolescent suicide prevention strategy. *J Am Psych Nurse*. 2003;9:77-85.

www.meansmatter.org

Harvard Injury Control Research Center
Harvard School of Public Health

Kresge Building, 3rd Floor
677 Huntington Ave.
Boston, MA 02115

Office: 617•432•3420
Fax: 617•432•3699
Email: hicrc@hsph.harvard.edu

Funding provided by The Joyce Foundation and the David Bohnett Foundation.
Design: Better World Advertising [www.socialmarketing.com]