THE BURDEN OF SUICIDE IN WISCONSIN

2007–2011 | Released 2014

A joint report by the Wisconsin Department of Health Services, the Injury Research Center at the Medical College of Wisconsin, and Mental Health America of Wisconsin

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SXLFLGH UHPDLQV D VLJQLÀFDQW SXEOLF KHDOWK SUREOHP LQ :LVFRQV
DUH ERWK HFRQRPLF DQG HPRWLRQDO 6XLFLGDO EHKDYLRU LPSRVHV
the families of decedents and results in lost productivity in the workforce. Moreover, the pain and
VX•HULQJ HQGXUHG E\ IULHQGV IDPLOLHV DQG FRPPXQLWLHV D•HFWHG E

The intention of this report is to provide an overview of the burden of suicide in Wisconsin using available data to community members and leaders, health professionals, and other suicide prevention stakeholders at the local and state levels. In addition, this report includes themes for prevention that are based on the analysis of suicide data, which will be incorporated into Wisconsin's suicide prevention strategy. It is beyond the scope of this report to examine the complex relationships between the data presented.

:KDW \RX ZLOO ÀQG LQ WKLV UHSRUW

The Burden of Suicide in Wisconsin ZDV ÀUVW UHOHDVHG LQ FRYHULQJ GDWD IURP illustrate a clearer picture of the incidence and characteristics of suicidal behavior in Wisconsin. This 2014 report includes updated data from the Wisconsin Violent Death Reporting System (WVDRS), inpatient hospitalization records, and emergency department records in order to examine the extent of suicide deaths and attempts in Wisconsin from 2007–2011. In addition, results of the 2013 Youth Risk Behavior Survey, administered by the Wisconsin Department of Public Instruction, and 2012 Behavioral Risk Factor Survey, administered by the Wisconsin Department of Health Services, provide insight into the prevalence of suicidal thoughts, behaviors, and associated risk factors among Wisconsin teens and adults. This report only includes data representing Wisconsin residents above the age of 10 in accordance ZLWK WKH GHÀQLWLRQ XVHG E\ ERWK WKH :RUOG +HDOWK 2UJDQL]DWLRQ and Prevention. Data in this report are not directly comparable to those published in the 2008 report. Readers interested in comparing data from 2007–2011 to data from earlier years can utilize the Wisconsin Interactive Statistics on Health (WISH) website. A tutorial for using this tool can be accessed through the Wisconsin Department of Health Services' Injury and Violence Prevention Program website: www.dhs.wisconsin.gov/health/injuryprevention/

7KH ÀUVW VHFWLRQ RI WKLV UHSRUW DGGUHVVHV WKH TXHVWKLV p°€0`LÓa

Key Findings 2007–2011

The suicide rate in Wisconsin remained generally constant from 2007–2011 but increased over the eight-year period from 2004–2011. From 2007–2011, there

a greater proportion of the total. The total costs associated with emergency department visits due to VHOI LQÁLFWHG LQMXULHV LQ :LVFRQVLQ GXULQJ [2] ZDV DSSU representing a greater proportion of the total. (See Appendix, Table 1).

While the FRVWV RI VXLFLGH WR VRFLHW\ are great, the costs to communities, families, and in JUHDWHU)RU HPSOR\HUV DQG FRPPXQLWLHV VXLFLGH UHVXOWV L contribution of the individual to the community's vitality and well-being. Communities struggle with the pain and confusion of losing friends, neighbors, coworkers, young people, and other community members to suicide.

Perhaps the JUHDWHVW FRVW RI DOO LV WKH PHQWDO DQG HPRWLRQDO IDPLOLHV of those who die by suicide. Family survivors of suicide often experience feelings of severe guilt and self-blame in addition to the feelings of profound loss associated with the death of a loved one 0F1LHO +DWFKHU 5HXELQ :KLOH WKLV UHSRUW VHHNV WR in Wisconsin, a more personal understanding comes from hearing the stories of those who have lost someone to suicide or struggled with suicide themselves. In the following piece, Heidi Bryan, a member of the National Action Alliance for Suicide Prevention: Suicide Attempt Survivor Taskforce and resident of Wisconsin, shares how suicide has impacted her life:

> "On January 7, 1995, my life and world changed forever. That was the day my older brother killed himself. My belief system, my faith, and my foundation cracked and tumbled down inside of me. I was devastated. All I could think about was how his wife, children, and friends must feel.
>
> It was then I realized that suicide was no longer an option.
>
> I struggled with suicidal thoughts since childhood and halted an attempt when I realized I would be found in time and would survive. When my brother died, I had a plan, a back-up plan, and a back-up plan to the back-up plan — I was not going to survive. But now I had to live because I knew that whatever my brother was WKLQNLQJ EHIRUH KH NLOOHG KLPVHOI [3] OLNH ZH·G EH EHWWHU suicidality talking to him and it was not the truth.
>
> If it applied to him, then it had to apply to me. This realization forced me to get help and stick with it until I found the proper professional help. I learned that for me, I have to treat my suicidality like a chronic disease. , KDYH D VDIHW\ SODQ WKDW FKDQJHV DV , FKDQJH 0RVW LPSRU when I start feeling overwhelmed or suicidal. There's something almost magical about verbalizing it without fear of being judged or fear of reprisal — it takes away the power and intensity of the thoughts and feelings DQG OHVVHQV P\ SDLQ 7KHQ ,·P DEOH WR VHH RXWVLGH P\VHOI Life may not always be easy or fun but no matter what kind of day I have, I'm glad I'm alive"

+HLGL·V OLYHG H[SHULHQFH H[HPSOLÀHV WKH WUXQFDWHG FRQFHSWXDOL]DWLRQ 0RVW story also demonstrates that getting help is possible and that suicide can be prevented.

3UHYHQWDELOLW\ RI 6XLFLGH DQG D 3XEOLF +HDOWK $S

One way to conceptualize how and why suicide can be prevented is to utilize the social-ecological model. The social-ecological model emphasizes that risk and protective factors at the individual, relationship, FRPPXQLW\ DQG VRFLHW\ OHYHOV DOO LQÁXHQFH WKH OLNHOLKRR Prevention further supports this conceptualization:

> "Suicide prevention is not exclusively a mental health issue. It is a health issue WKDW PXVW EH DGGUHVVHG DW PDQ\ OHYHOV E\ GL•HUHQW coordinated and synergistic way."

Thus, this report examines individual, relationship, community, and societal level factors that are important for developing suicide prevention strategies in Wisconsin beginning on page 30.

In order to prevent suicide, we must gain a better understanding of suicidal behavior: What is its LQFLGHQFH" :KHUH GRHV LW WDNH SODFH" :KR LV DWWHFWHG" +RZ GRHV L in hand, we can identify important risk and protective factors and begin to form a comprehensive prevention plan around them. Throughout this section, we examine characteristics of suicides, attempts, and related behaviors as well as highlight important results in order to develop an understanding of potential risk and protective factors.

:KDW LV WKH ,QFLGHQFH RI 6XLFLGDO %HKDYLRU"

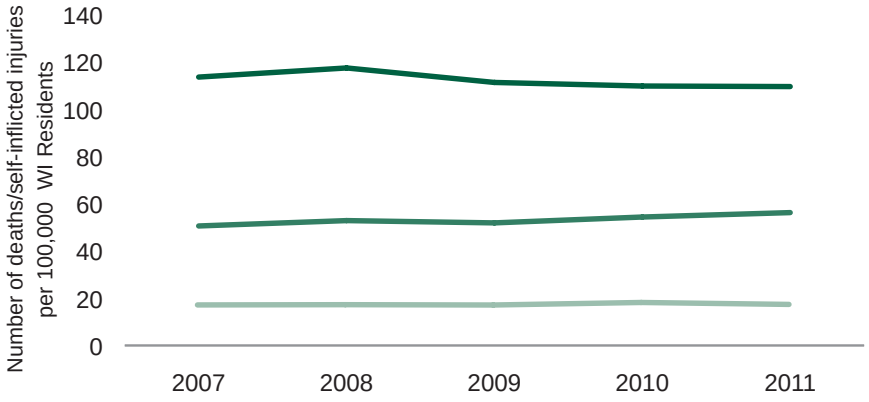
To understand the incidence of suicidal behavior in Wisconsin, we can look at suicides, hospitalizations DQG HPHUJHQF\ GHSDUWPHQW YLVLWV GXH WR VHOI LQÁLFWHG LQMXU\ D Wisconsin Violent Death Reporting System (WVDRS) captures important information about suicides, while inpatient hospitalizations and emergency department visits due to self-injury serve as indicators of suicide attempts. Although data on adult suicidal thoughts and behaviors is limited, a survey of Wisconsin high school students, the 2013 Youth Risk Behavior Survey, examines the prevalence of suicidal thoughts, behaviors, and related risk factors among youth.

'XULQJ WR RXW RI HYHU\ :LVFRQVLQ UHVLGHQWV DJHG DQ
More than 14 died by suicide.
0RUH WKDQ ZHUH KRVSLWDOL]HG IRU LQSDWLHQW FDUH GXH WR V
More than 53 visited the emergency department due to VHOI LQÁLFWHG LQMXU\

In 2013, DPRQJ :LVFRQVLQ KLJK VFKRRO VWXGHQWV RXW RI . VHULRXVO\ FR

7KH GL•HUHQFH EHWZHHQ WKH GHDWK UDWH DQG WKH VHOI LQÁLFWHG LQ burden of suicide in Wisconsin is much greater than death statistics alone might suggest. The high proportion of high school students who report considering suicide further emphasizes this point.

As Figure 2 shows, the UDWH RI VXLFLGH LQ :LVFRQVLQ GXULQJ 2007–2011 KDQJH VXEVWDQ The UDWH RI HPHUJHQF\ GHSDUWPHQW YLVLWV IRU VHOI LQÁLFWHG LQMXU\ LQSDWLHQW KRVSLWDOL]DWLRQV IRU VHOI LQÁLFWHG LQMXU\ GHFOLQHG slightly (see Appendix Table 2 for data).



There were many more hospitalizations and emergency department visits due to self-LQÀLFWHG LQMXU\ WKDQ suicides in Wisconsin during 2007–2011.

)LJXUH 5DWHV RI VXLFLGH LQSDWLHQW KRVSLWDOL]DWLRQV DQG HPHUJHQF\ GH
:LVFRQVLQ UHVLGHQWV E\ DJH ±

Sex

6XLFLGDO EHKDYLRUV D•HFW PDOHV DQG IHPDOHV GL•HUHQWO\ 3U
DQG VRFLDOO\ GHULYHG GL•HUHQFHV EHWZHHQ VH[HV FRQWULEXW
self-injury.

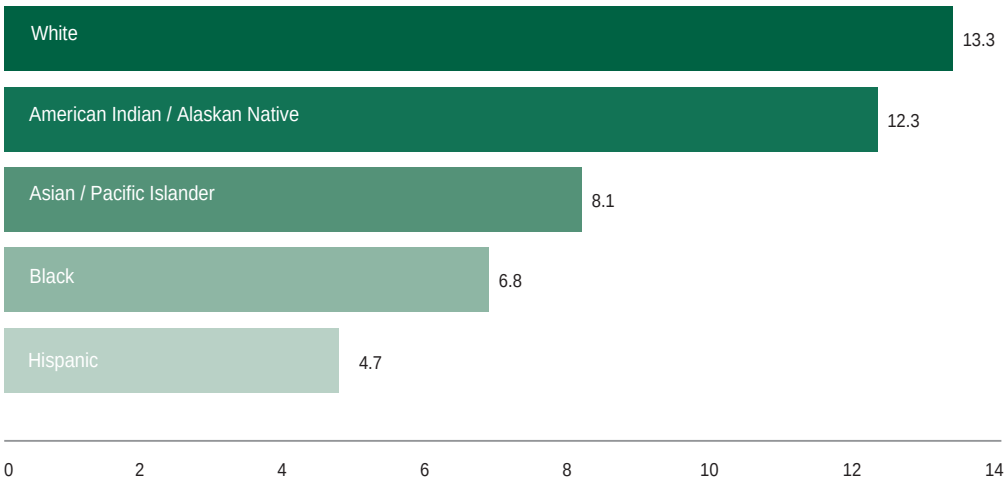
From 2007–2011, QHDUO\ RXW RI SHUVRQV ZKR GLHG E\ VXLFLGH LQ :LV
approximately RXW RI SDWLHQWV KRVSLWDOL]HG IRU VHOI LQMXU\ ZHU
Tables 7 and 8 for numbers and rates of self-injury by sex each year from 2007–2011).

7DEOH $ 1XPEHU UDWH SHU :LVFRQVLQ UHVLGHQWV DQG SHUFHQW RI VXLF
HPHUJHQF\ GHSDUWPHQW YLVLWV IRU VHOI LQMXU\ E\ VH[±

5DWHV RI VXLFLGH DPRQJ IHPDOHV ZHUH ORZHU WKDQ UDWHV RI V
IURP ² 7KH VPDOOHVW GL•HUHQFH EHWZHHQ VH[HV RFFXUUHG
GL•HUHQFH RFFXUUHG DPRQJ SHRSOH DJHG 7KH IHPDOH VXLFLG
10–14 and highest among adults aged 45–54. The male suicide rate was lowest among children aged
² DQG KLJKHVW DPRQJ WKH HOGHUO\ DJHG ZLWK D QR
7 and Appendix, Table 9 for number of suicides in each age group by sex).

)LJXUH 6XLFLGH UDWHV SHU :LVFRQVLQ UHVLGHQWV E\ DJH DQG VH[±

'L•HUHQFHV EHWZHHQ PDOHV DQG IHPDOHV UHJDUGLQJ VXLFLGH DQG VHO
IDFWRUV &RPSDUHG WR IHPDOHV PDOHV· JUHDWHU WHQGHQF\ WR XVH KL
may help explain their higher rates of death but lower rates of hospitalization for self-injury (Bossarte,

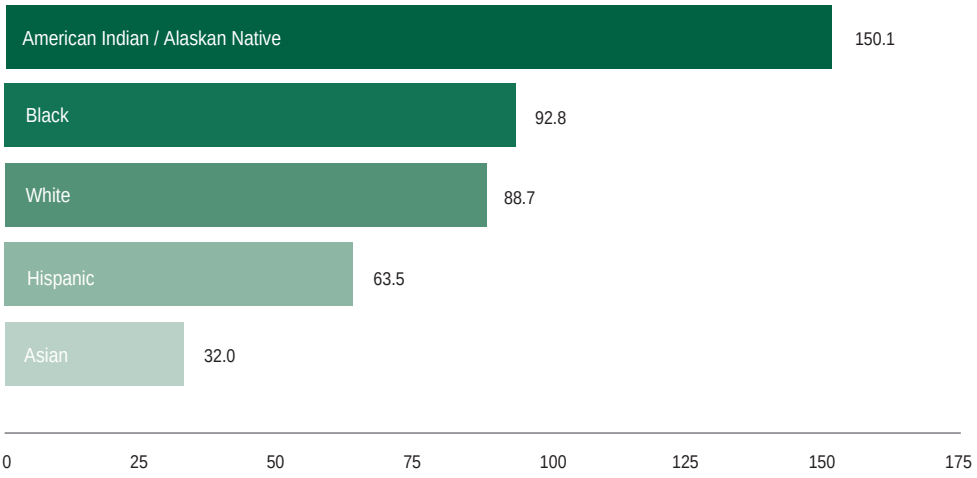


Whites and American Indians had the highest suicide rates in Wisconsin during 2007–2011.

)LJXUH 6XLFLGH UDWHV SHU :LVFRQVLQ UHVLGHQWV E\ UDFH HWKQLFLW\

,QSDWLHQW KRVSLWDOL]DWLRQ GDWD IURP GHPRQVWUDWH PLQRULW\ EDFNJURXQGV H[SHULHQFHG JUHDWHU UDWHV RI LQSDWL

Indian / Alaskan Natives had the highest rates of inpatient hospitalizations for self-injury followed by Blacks, Whites, and Hispanics of any race (Figure 9, Appendix Table 11) 3HUVRQV RI $VLDQ 3D Islander descent had the lowest rates of hospitalization for self-injury.

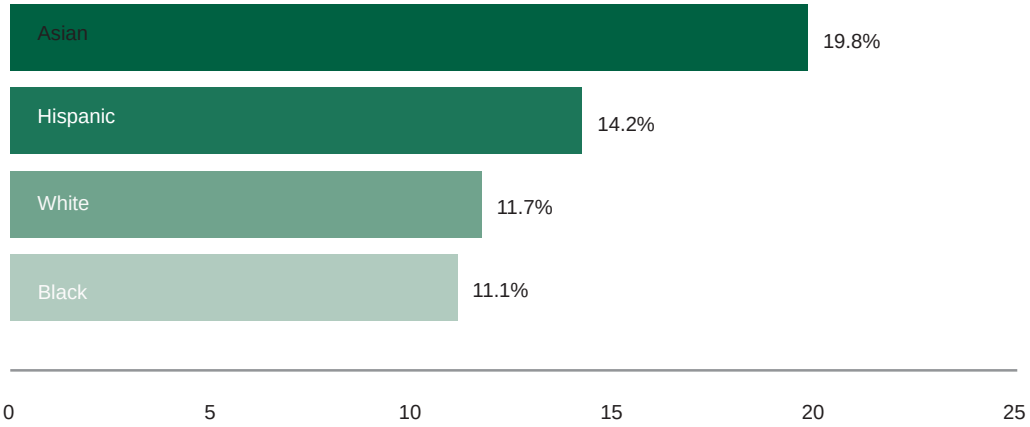


American Indians and Blacks had the highest rates of inpatient hospitalizations in Wisconsin during 2007–2011.

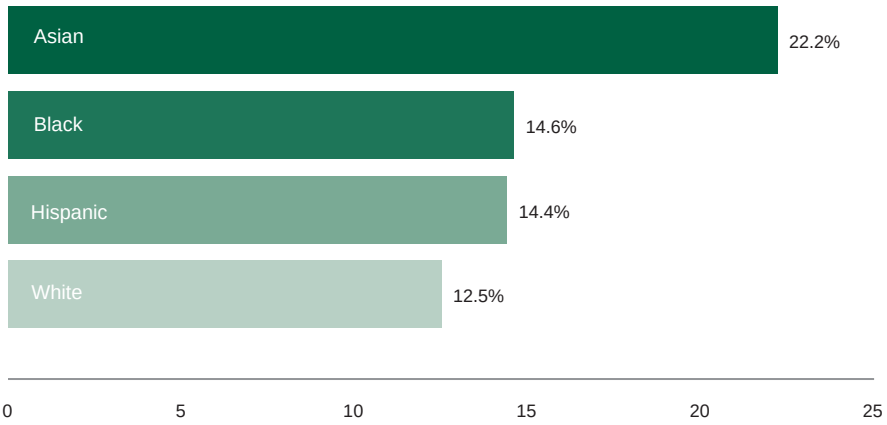
,QSDWLHQW KRVSLWDOL]DWLRQV GXH WR VHOI LQÀLFWHG LQMXU\ SHU SRSXOD

)LJXUH 5DWHV RI LQSDWLHQW KRVSLWDOL]DWLRQ GXH WR VHOI LQÀLFWHG LQMXU\ SHU :LVFRQVLQ UHVLGHQWV E\ UDFH HWKQLFLW\

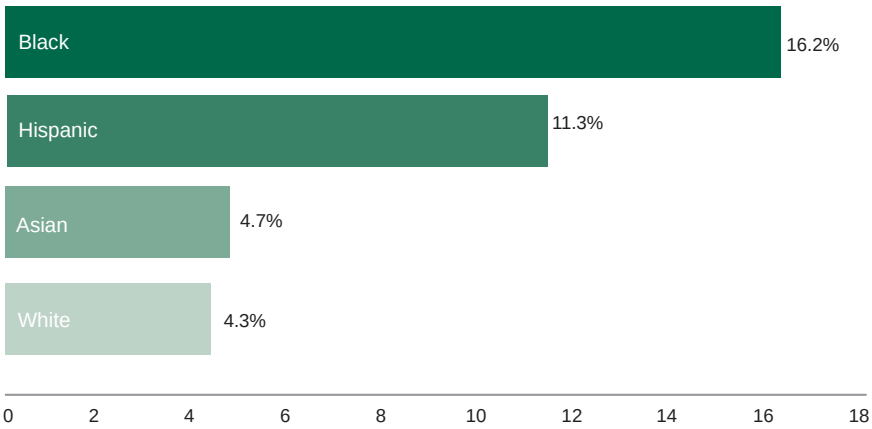
YRBS data from 2013 suggest a JUHDWHU SUHYDOHQFH RI VXLFLGDO WKRXJKWV :LVFRQVLQ KLJK VFKRRO VWXGHQWV RI HWKQLFLW\ (see Figures 10-12). In 2013, PLQRU a greater proportion of Asian students reported seriously considering suicide and making a suicide plan compared to Hispanic, Black, or White students. The proportion of students who reported attempting suicide was greatest among Blacks, followed by Hispanics, Asians, and Whites, respectively.



Percent who responded "Yes."



Non-White students were more likely to respond that they had seriously considered attempting suicide in the past 12 months.

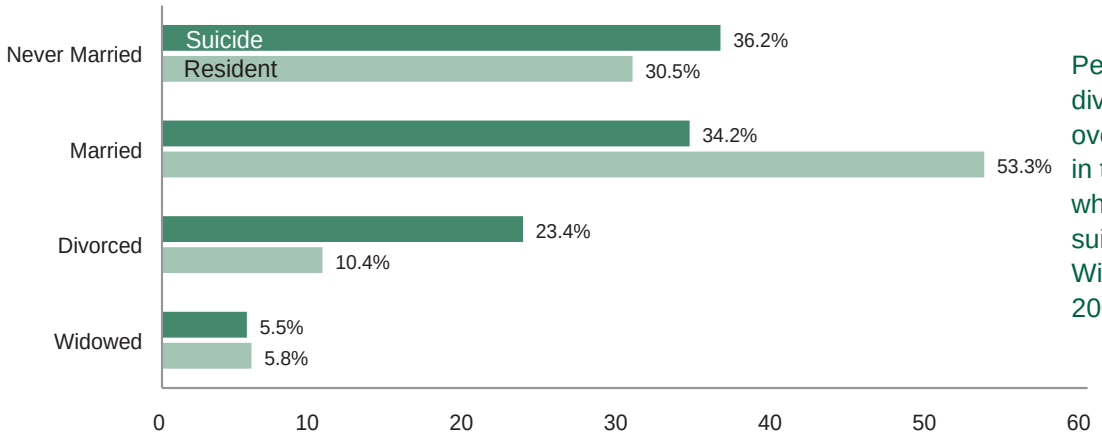


Non-White students were more likely to respond that they had attempted suicide in the past 12 months.

Marital Status

National research suggests that married persons are less likely to die by suicide than never married, widowed, or divorced persons (Kposowa, 2001). Wisconsin data demonstrate the occurrence of this trend DW WKH VWDWH OHYHO DQG KHOS GLUHFW VXLFLGH SUHYHQWLRQ H•RUWV of suicide, such as divorced people.

From 2007–2011, SHRSOH ZKR QHYHU PDUULHG FRQVWLWXWHG WKH ODUJHVW SUF suicide, followed by married, divorced, and widowed people, respectively (see Figure 14 and Appendix, Table 13). In order to compare the proportion of those who were married, never married, widowed and divorced and died by suicide to the proportion of all Wisconsin residents in each category, American Community Survey estimates from 2008–2012 are used (see Figure 13). The higher percentage of Wisconsin residents who were married relative to the lower percentage of those who died by suicide and were married indicates that married people are underrepresented among suicide decedents. Conversely, while GLYRUFHG SHRSOH DFFRXQWHG IRU RQO\ RI :LVFRQVLQ UHVLGHQW DFFRXQWHG IRU RI VXLFLGH GHFHGHQWV GXULQJ ² LQGLFDWLQ married people also appear over-represented among suicide decedents while widowed people appear neither overrepresented nor under-represented.



People who divorced were over-represented in the population who died by suicide in Wisconsin during 2007–2011.

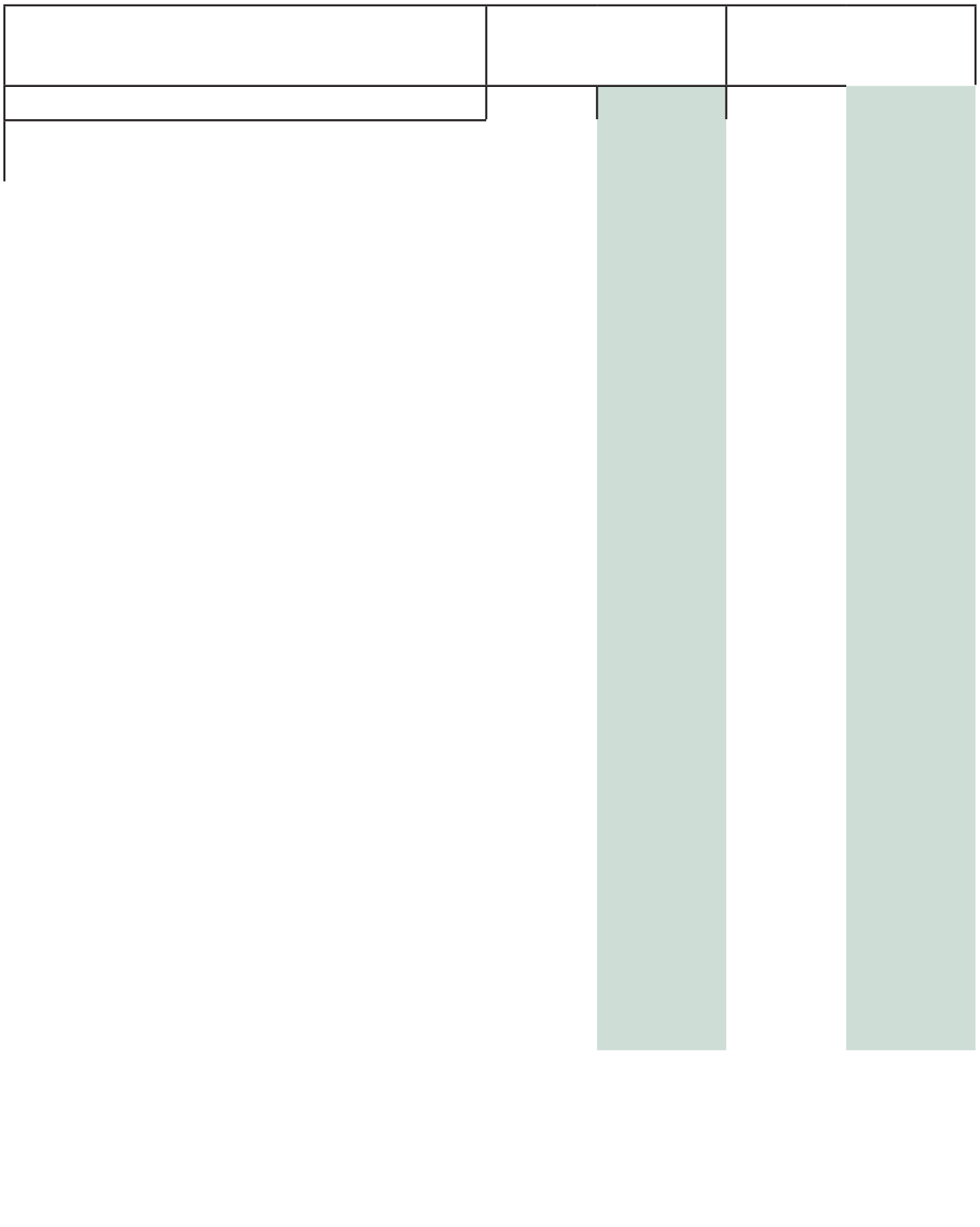
)LJXUH 'LVWULEXWLRQ RI PDULWDO VWDWXV :LVFRQVLQ UHVLGHQWV FRPSDUHG WR :LVFR

Divergent explanations of this phenomenon relate to the emotional toll of relationship breakdown and the possibility that psychologically healthy people are more likely to get married and remain married than people with diminished mental or emotional health (Wyder, Ward, & De Leo, 2009). The lower UDWH RI VXLFLGH DPRQJ PDUULHG SHRSOH PD\ DOVR UHÁHFW WKH SRVLW intimate partners and / or family members (Kposowa, 2001). These data suggest that marital status may play an important role in suicide prevention among Wisconsin residents.

Sexual Orientation

While a great deal of research suggests that sexual orientation and gender identity play an important role in suicide risk, related data are very limited in Wisconsin because information regarding sexual orientation and gender identity is not routinely collected by law enforcement, coroner / medical examiner, or state vital records systems.

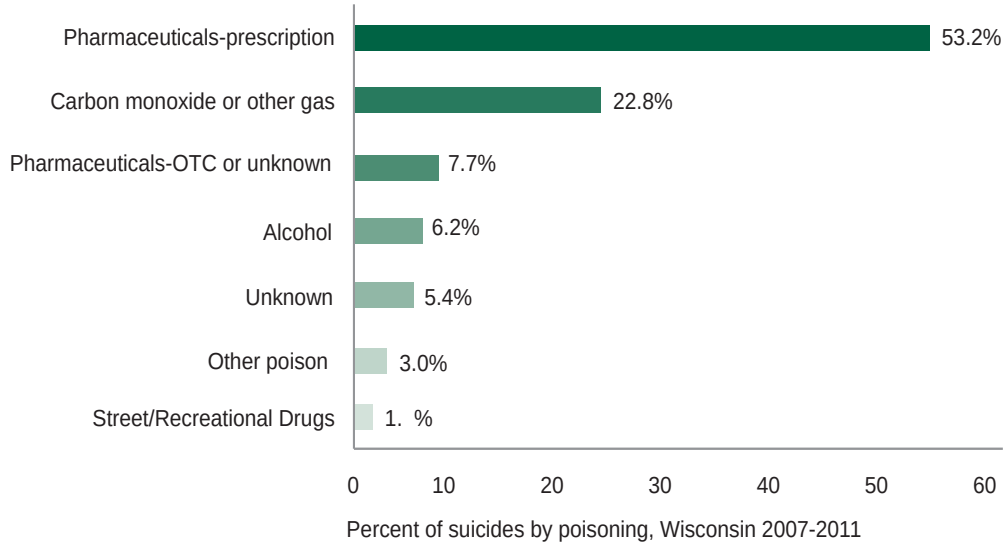
7DEOH % 3HUFHQWDJH RI UHVSRQGHQWV E\ VH[XDO LGHQWLW\ VHOHFWHG TXHVWLRQV IURP



7KH ODUJH SHUFHQWDJH RI SHUVRQV ZLWK YHWHUDQ VWDWXV ZKR GLHG E
of evidence indicating that veterans constitute a high-risk group for suicide (Braswell & Kushner, 2012).
In particular, older veterans bear a substantial portion of the burden of suicide in Wisconsin. Given that
PRVW YHWHUDQV DUH PDOHV IDFWRUV WKDW LQFUHDVH WKH ULVN RI VXL
those particular to military experience, further exacerbating suicide risk for many veterans.

Conclusion

%DVHG RQ DYDLODEOH :LVFRQVLQ GDWD WKH EXUGHQ RI VXLFLGH GLVSU
adults and elderly males, Whites and American Indian / Alaskan natives, people who did not graduate
high school, and divorcees. Veterans are also over-represented in the population of suicide decendents.
6XLFLGDO WKRXJKWV DQG DWWHPSWV DSSHDU WR PRVW D•HFW WHHQV DQ
of racial and ethnic minorities, and LGB youth. Stakeholders in suicide prevention should use this
information to target populations with contextually appropriate prevention strategies. Improvements
in data collection systems and methodology are needed in order to better examine the roles of race,
ethnicity, sexual orientation, and gender identity in suicide risk.



Over half of suicides by poisoning in Wisconsin during 2007–2011 involved prescription drugs.

)LJXUH $JHQWV LGHQWL¿HG LQ VXLFLGH E\ SRLVRQLQJ :LVFRQVLQ ±

After prescription drugs, the next three leading agents involved in suicide poisoning deaths were carbon monoxide (22.8%), over-the-counter pharmaceuticals (7.4%), and alcohol (6.2%). Illicit drugs were implicated in 1.8% of suicides by poisoning.

Alcohol and/or drug use with suicide

Drugs are often involved in suicides even when they are not the means of death. Alcohol and drug abuse are second only to depression and other mental health disorders as the most common risk factors for suicide (SAMSHA, 2008). The use of alcohol and drugs by an individual under psychological duress PD\ SURYH GLVLQKLELWLQJ +X•RUG &KHUSLWHO %RUJHV :L of depression and hopelessness, impair problem-solving abilities, and increase aggression (Conner & Chiapella, 2004). Alcohol and drug abuse may also be associated with suicide through shared risk factors such as depression, impulsivity, or a tendency to pursue thrill-seeking / life-threatening behaviors (Goldston, 2004).

During 2007–2011, of the over 2,000 suicides that received testing and had conclusive results for drugs (See Appendix, Table 22):

37% were positive for alcohol

32% were positive for anti-depressants

19% were positive for opiates

8% were positive for marijuana

5% were positive for cocaine

3% were positive for amphetamines

50% were positive for other drugs

&DVH IDWDOLW\ RI PHDQV RI VXLFLGH

7KH VHOHFWLRQ RI D JLYHQ PHDQV IRU D VXLFLGDO ZKHWKHU RU QRW WKH PHDQV EH D\ EH LQÁ
expressed as a case-fatality rate. The case-fatality rate for suicide indicates the likelihood that a certain method will result in death. A higher case-fatality rate indicates greater lethality.

Overall, ÀUHDUPV KDG WKH KLJKHVW FDVH IDWDOLW\ UDWH (92.2%; see Figure 19), followed DQG KDQJLQJ VWUDQJXODWLRQ VX•RFDWLRQ 7KH FDVH IDWDOLW\ U

)LJXUH &DVH IDWDOLW\ UDWHV IRU PHDQV RI VXLFLGH :LVFRQVLQ ±

Conclusion

Overall, ÀUHDUPV KDQJLQJ VWUDQJXODWLRQ VX~RFDWLRQ DQG SRLVRQLQ DUH WKH PRVW FRPPRQO\ XVHG PHDQV RI VXLFLGH LQ :LVFRQVLQ
Firearms, hanging, strangulation, VX•RFDWLRQ DQG GURZQLQJ ZHUH WKH PRVW OHWKDO 'HPRJUDSKLF FKD LQÁXHQFH GHFHGHQWV· FKRLFH RI PHDQV DQG WKHLU OLNHOLKRRG RI VX highlight the importance of identifying persons at risk for suicide, improving access to mental and EHKDYLRUDO KHDOWK WUHDWPHQW DQG SURPRWLQJ VDIHW\ UHJDUGLQJ À :KLOH UHVWULFWLQJ VXLFLGDO LQGLYLGXDOV· DFFHVV WR OHWKDO PHDQ prevention strategies related to more common yet less lethal means are also important to reducing the broader burden of suicidal behavior.

Why Does Suicidal Behavior Occur in Wisconsin? – Associated Circumstances and Factors

Factors associated with suicide can be conceptualized from a social-ecological perspective. Research has shown that risk and protective factors at the individual, relationship, community, and societal levels FDQ DOO LQÁXHQFH WKH OLNHOLKRRG RI$WWHPSWLQJ DQG GHYHORSLQJ D VXLFLGDO OHYHO
illness, interpersonal problems, and life stressors are known risk factors for suicidal behavior (Fliege, Lee, Grimm, & Klapp, 2009). Substance abuse problems and prior suicide attempts have also been linked WR VXLFLGH +DZWRQ YDQ +HHULQJHQ 6WXGLHV IXUWKHU V
on suicidal behavior may vary by a person's age and sex (Hawton & van Heeringen, 2009). We must examine the role of these multi-level risk and protective factors in Wisconsin in order to inform our approaches to suicide prevention.

Individual Level Factors

WVDRS data reveal that poor mental health, substance abuse problems, and life stressors played a substantial role in suicidal behavior in Wisconsin. Results of the 2013 Youth Risk Behavior Survey (YRBS) and 2012 Behavioral Risk Factor Survey (BRFS) help us to better understand the prevalence of these individual-level risk factors in Wisconsin.

)LJXUH &LUFXPVWDQFHV DVVRFLDWHG ZLWK VXLFLGH GHFHGHQWV :LVFRQVLQ

Of all suicides occurring during 2007-2011, RI GHFHGHQWV KDG DQ LQGLFDWLRQ RI FXUUH PRRG DQG KDG DQ LQGLFDWLRQ RI D FXUUHQW PHQWDO KHDOWK SURE (see Figure 20 and Appendix, Table 23). The BRFS 2012 results indicate that RI :LVFRQVLQ DGXOWV UHSRUWHG IRXU RU P mental health days in the last month. Similarly, the YRBS 2013 results indicate that nearly RI :LVFRQVLQ KLJK VFKRRO VWXGHQWV UHSRUWHG WKDW WKHLU PHQWDO KH 30 days. Nearly 25% of Wisconsin high school students felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. These data demonstrate the role of mental health in suicidal behavior.

From 2007-2011, RI SHUVRQV ZKR GLHG E\ VXLFLGH KDG DQ alcohol problem, LQGLFDWLRQ RI D and about KDG DQ LQGLFDWLRQ RI RWKHU VXEVWDQFH SUREOHPV (see Figure 20 and Appendix, Table 23). The YRBS 2013 and the BRFS 2012 provide insight into the use of alcohol throughout Wisconsin. Approximately RI :LVFRQVLQ KLJK VFKRRO VWXGHQWV UHSRUWHG KDY RI DOFRKRO LQ WKH SDVW GD\V (YRBS, 2013), and nearly RI :LVFRQVLQ DGXOWV drinking ÀYH RU PRUH GULQNV IRU PHQ RU IRXU RU PRUH GULQNV IRU ZRPHQ in the past 30 days (BRFS, 2013). These data demonstrate the role of alcohol in suicidal behavior and VXJJHVW WKDW XQGHUDJH DQG XQKHDOWK\ DOFRKRO FRQVXPSWLRQ DUH

/LIH VWUHVVRUV, including experiencing a crisis during the previous two weeks, physical health SUREOHP DQG MRE SUREOHP ZHUH FLUFXPVWDQFHV (see Figure 20 and UURXQGLQJ Appendix, Table 23). The BRFS 2012 and YRBS 2013 results shed further light on the prevalence of physical health problems, indicating that RI :LVFRQVLQ DGXOWV DQG RI :LVFRQVLQ KL VWXGHQWV H[SHULHQFHG DW OHDVW IRXU RU PRUH GD\V GXULQJ WKH SDV was not good 7KH IUHTXHQF\ RI FULVHV SK\VLFDO KHDOWK SUREOHPV MRE SU as circumstances of suicide speaks to the need for suicide prevention programming in settings where individuals experiencing such stressors are likely to be found. Given the large number of Wisconsin residents who report poor physical health, the health care sector may be a critical area of focus for suicide prevention activities.

Prior suicide attempt is also an important factor surrounding suicide. In Wisconsin, RI DOO SHUVRQV ZKR GLHG E\ VXLFLGH KDG DQ LQGLFDWLRQ RI SULRU VXLFLGH DWWHPSW Related reports about the deaths indicated that RI GHFHGHQWV KDG GLVFORVHG LQWHQW WR GLH E\ VXLFLGH W YRBS 2013 results indicate that 12-13% of high school students reported having seriously considered attempting suicide in the past 12 months or having made a suicide plan.

Overall, these data demonstrate that mental health issues, substance use problems, life stressors, and suicide-related thoughts and behaviors are prominent among suicide decedents in Wisconsin and that many Wisconsin adolescents and adults experience these behaviors.

Relationship Level Factors

Relationship level factors, including intimate partner problems, other relationship problems, and the GHDWK RI D IULHQG RU IDPLO\ PHPEHU DUH IUHTXHQWO\ UHODWHG WR VX Appendix, Table 23).

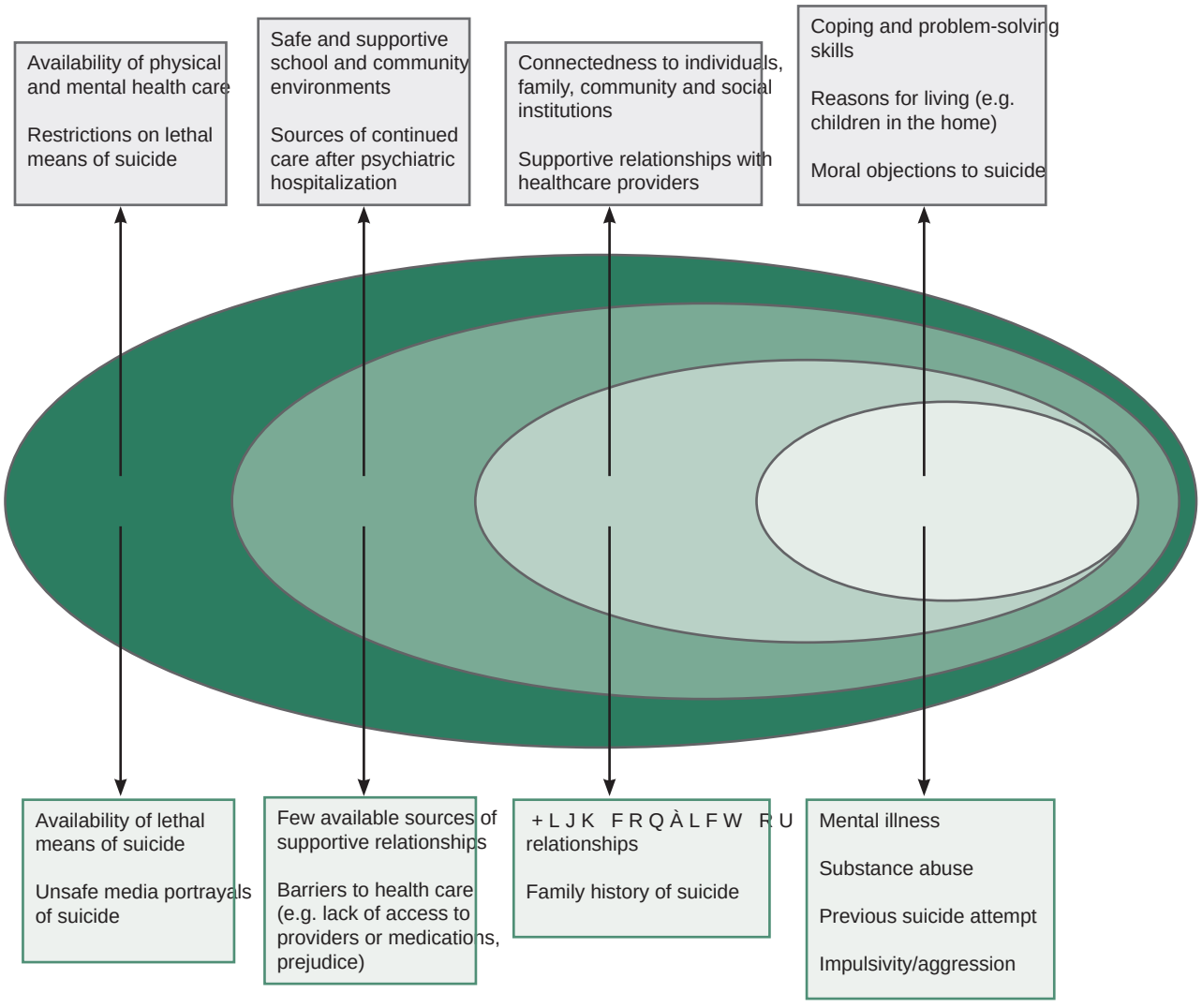
Social connectedness also varies across the state. The map below (see Figure 22) shows the percent of adults that perceive they have low social support based on data from the County Health Rankings (2005-2010).

)LJXUH 0DS RI FRXQW\ OHYHO SHUFHQWDJHV RI DGXOWV UHSRUWLQJ ORZ VRFLDO VXSSRU

Conclusion

,Q :KDW 'LUHFWLRQ 'RHV RXU 'DWD 3RLQW 8V"

The 2014 Burden of Suicide report examines the incidence of suicide and self-injury, the populations PRVW D•HFWHG E\ VXLFLGDO EHKDYLRU DQG WKH SULPDU\ ULVN FLUFXPVWÀQGLQJV IURP WKH UHSRUW GHPRQVWUDWH ULVN IDFWRUV DW HDF



At the individual level, Wisconsin data show that males, Whites and American Indian / Alaskan Natives, middle aged, and elderly adults have the highest suicide rates. People with low educational attainment and veterans are also over-represented in the population of suicide decedents. Physical and mental health problems, substance abuse problems and job problems were cited in a high proportion

f Men

- Man Therapy – an interactive mental health campaign targeting working-age men (25-54) that employs humor to cut through stigma and tackle issues like depression, divorce, and anxiety. www.mantherapy.org

f Adolescents / Teens / Young Adults

- American Indian Life Skills Development / Zuni Life Skills Development – a school-based suicide prevention curriculum designed to reduce suicide risk and improve protective factors among American Indian adolescents 14-19 years old. www.nrepp.samhsa.gov/ViewIntervention.aspx?id=81
- Coping and Support Training (CAST) – a high school-based suicide prevention program targeting youth 14-19 years old. CAST delivers life-skills training and social support in a small-group format. www.nrepp.samhsa.gov/ViewIntervention.aspx?id=51
- Kognito At-Risk for College Students – a 30-minute, online, interactive training simulation that prepares college students and student leaders, including resident assistants, to provide support to peers who are exhibiting signs of psychological distress such as depression, anxiety, substance use, and suicidal ideation. www.nrepp.samhsa.gov/ViewIntervention.aspx?id=303
- Kognito At-Risk for High School Educators – a one-hour, online, interactive gatekeeper training program that prepares high school teachers and other school personnel to identify, approach, and refer students who are exhibiting signs of psychological distress such as depression, anxiety, substance abuse, and suicidal ideation. www.nrepp.samhsa.gov/ViewIntervention.aspx?id=317
- Peer Assistance and Leadership (PAL) – a peer-helping program that seeks to build resiliency in youth by pairing youth with peer helpers who receive training and support from teachers participating in the program. The peer-based assistance provided through PAL is designed to help youth avoid risk factors for substance use as well as other problems, such as low achievement in school, dropout, absenteeism, violence, teen pregnancy, and suicide. www.nrepp.samhsa.gov/yo308 socialSt

o

ƒ Behavioral Health / Substance Use

- Community Trials Intervention to Reduce High-Risk Drinking – a multi-component, community-

Primary Data Sources

Suicide data source

Death information for this report was obtained from the Wisconsin Violent Death Reporting System (WVDRS; 2007-2011). WVDRS data are maintained at the Wisconsin Department of Health Services.

This system provides comprehensive data on all violent deaths in Wisconsin, including suicides. Cases DUH LQLWLDWHG WKURXJK D GHDWK FHUWLÀFDWH ,QIRUPDWLRQ R examiner records, police records, and crime lab records. WVDRS is funded by the Centers for Disease Control and Prevention (CDC) and is part of the National Violent Death Reporting System (NVDRS). More information about NVDRS may be obtained at www.cdc.gov/violencePrevention/NVDRS/index.html

6HOI LQMXU\ GDWD VRXUFHV

Inpatient hospitalization and emergency department visits data on self-injury, which were used as DQ LQGLFDWLRQ RI VXLFLGH DWWHPSWV ZHUH REWDLQHG IURP WK Public Health, Wisconsin Department of Health Services, with data collected by the Wisconsin Hospital Association Information Center. Psychiatric hospitals are not included in these data sources. The Wisconsin Interactive Statistics on Health (WISH) was used to obtain cost information for inpatient hospitalizations and emergency department visits.

6LPSOH TXHULHV PD\ EH SHUIRUPHG RQ :9'56 LQSDWLHQW GDWD YLVLW GDWD YLD WKH :LVFRQVLQ ,QWHUDFWLYH 6WDWLVWLFV RQ + www.dhs.wisconsin.gov/wish/.

<RXWK 5LVN %HKDYLRU 6XUYHLOODQFH 6XUYH\ <5%6

The Youth Risk Behavior Surveillance Survey monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including: (1) behaviors that contribute to unintentional injuries and violence; (2) sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; (3) alcohol and other drug use, WREDFFR XVH XQKHDOWK\ GLHWDU\ EHKDYLRUV DQG <5%6 FROOHF this information through a national school-based survey conducted by the CDC and state, territorial, tribal, and local survey conducted by state, territorial, and local education and health agencies and tribal governments. This report contains data from the 2013 version of the YRBS. More information can be obtained at www.cdc.gov/HealthyYouth/yrbs/index.htm.

%HKDYLRUDO 5LVN)DFWRU 6XUYHLOODQFH 6XUYH\ %5)6

BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. adult residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS collects data in all 50 states as well as the District of Columbia and three U.S. territories. This report contains data from the 2012 version of the BRFS. More information can be obtained at www.cdc.gov/brfss/index.htm.

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%LUNHWW 0 (VSHODJH ' / .RHQLJ % /%* DQG TXHVWLRQV VWXG
H•HFWV RI KRPRSKRELF EXOO\LQJ DQG VFKRRO FOLPDWH RQ QHJDWLY
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7DEOH 1XPEHU DQG DJH DGMXVWHG UDWHV SHU SRSXODWLRQ RI VXLFLGHV LQSDWLHQW KRVSLWDO]DWLRQ UHVLGHQWV DJHG DQG RYHU ±

	708	14.27	716	14.38	710	14.24	764	15.31	723	14.49
	5598	113.42	5801	117.28	5491					

7DEOH ,QSDWLHQW KRVSLWDOL]DWLRQV GXH WR VHOI LQÀLFWHG LQMXU\ E\ DJH

7DEOH 6XLFLGHV E\ DJH :LVFRQVLQ

						$JH 6SHFL¿F
	X	X	6	5	7	1.3
	95	74	97	101	111	12.0
	109	111	94	117	118	15.2
	142	141	141	114	110	17.3
	177	171	163	183	176	19.9
	89	124	107	136	109	16.7
	46	48	51	47	41	11.9
	36	31	34	41	37	13.9
	10	14	17	19	14	12.5
	708	716	710	763	723	
	12.4	12.5	12.4	13.3	12.6	

$Q ; LQGLFDWHV D QXPEHU OHVV WKDQ DQG LV XVHG WR SURWHFW WKH

7DEOH ,QSDWLHQW KRVSLWDOL]DWLRQV GXH WR VHOI LQÀLFWHG LQMXU\ E\ VH[:LVFRQVL

7DEOH 6XLFLGHV E\ YHWHUDQ VWDWXV :LVFRQVLQ

	579	577	570	594	599
	127	131	134	168	120
	X	8	6	X	X
	708	716	710	763	723

7DEOH 6XLFLGHV E\ VH[DQG PHWKRG XVHG :LVFRQVLQ

	1459	51.4%	184	23.6%	1643	45.4%
	59	2.1%	17	2.2%	76	2.1%
	382	13.4%	323	41.4%	705	19.5%
	712	25.1%	191	24.5%	903	24.9%
	45	1.6%	15	1.9%	60	1.7%
	31	1.1%	15	1.9%	46	1.3%
	8	0.3%	X	0.3%	10	0.3%
	23	0.8%	X	0.5%	27	0.7%
	19	0.7%	8	1.0%	27	0.7%
	9	0.3%	X	0.1%	10	0.3%
	93					

7DEOH 6XLFLGHV E\ DJH DQG PHWKRG XVHG :LVFRQVLQ

7DEOH 7R[LFRORJ\ WHVWLQJ DQG UHVXOWV DVVRFLDWHG ZLWK VXLFLGHV :LVFRQ

THE BURDEN OF SUICIDE IN WISCONSIN

2007–2011 | Released 2014

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