Suicide in the United States is a major public health issue resulting in tens of thousands of deaths and life-threatening and debilitating injuries annually. The increase in suicide attempts and deaths affects all trauma care providers. The American Trauma Society (ATS) recommends a call to action from the trauma and healthcare community in order to destigmatize, improve screening, promote healthcare and public education, and develop research and effective prevention strategies aimed at combating this public health problem. Recent increases in suicide and suicide attempts in children and in health care professionals are especially concerning and warrant additional prevention efforts.

Suicide as an Increasing Public Health Problem

Suicide in the United States in both the adult and pediatric population is a major public health problem resulting in tens of thousands of deaths and life-threatening and debilitating injuries annually. According to the Centers for Disease Control and Prevention (CDC), 47,173 people in the United States died as a result of suicide in 2017; (1) this is equivalent to one death every twelve minutes. Suicide has risen to the 10th leading cause of death nationwide and has prompted increased discussions regarding this growing public health concern. (1) It is alarming to note that suicide is the second leading cause of death in those between the ages of 10-34, 4th between the ages of 35-54, and 8th between the 55-64 age range. (1) Further analysis reveals that firearms are the leading means in all age groups, with the exception of those aged 10-14 who predominantly utilize suffocation or hanging. (1) Populations identified at increased risk of suicide include, but are not limited to: American Indian/Alaska Native, non-Hispanic White, Veterans, and sexual minority youth. (2) The National Institute of Mental Health reports that in 2016, 9.8 million of those 18 and older had serious suicidal thoughts, and 1.3 million had attempted suicide within the preceding year. (3)

According the CDC, since 2007 the suicide rate in children has more than doubled, while at the same time, vehicle fatalities have decreased by fifty eight percent. (4) In addition to the increased
rate of suicide deaths, the age of children attempting and completing suicides is now reported to be as young as five years old. Suicide has now become the second leading cause of death among children and adolescents aged 10-19 years old. (5) It is reported that every five days, one child under the age of 13 years die of suicide. (6) According to the Pediatric Health Information System Database, between 2008-2015, 115,800 suicide attempts or suicidal ideations were documented in the United States in the pediatric population. (7) Males are three times more likely to attempt suicide and be successful than females. Although firearm violence is a national crisis in the United States, hangings, strangulation and suffocation accounts for approximately 70% of the suicide deaths in children ages 5-15 years old. Reports show that 47% of children's reasons for completing or attempting suicide are due to relationship problems (family or friends), 35% are due to problems at school and 18% are due to recent trauma or tragedy. (8)

While most health-care providers focus on patient care, it is important to note that health-care workers are particularly vulnerable to suicide ideation and a high incidence of suicide.

**Nursing:** Nurse suicides have been found to be significantly higher than the general population for both females [11.97/100,000 vs 7.58/100,000 (p < 0.001)] and males [39.8/100,000 28.2/100,000 (p < 0.001)]; furthermore, benzodiazepines and opioids are most commonly used substances in nurse suicide. (9)

**Public Safety:** A 2013 study of 4022 Emergency Medical Service (EMS) personnel from all 50 US States showed that, among respondents, the EMS profession had a 37% suicide contemplation rate vs. 3.7% of the CDC National Average (9). Furthermore, EMS personnel surveyed had a 6.6% attempted suicide rate vs. 0.5% of the CDC National Average. (10) In 2017 suicide in firefighters and police officers outpaced Line of Duty Deaths (LODD) with 103 reported firefighter and 140 police officers suicides compared to 93 firefighter and 129 police officer LODD; the number of reported suicides is likely higher due to the culture of silence typically surrounding such cases. (11)

**Physicians:** Physicians have a significantly higher risk of dying from suicide than the general public, and among medical students, suicide is second only to traumatic injury as the most common cause of death. Physician suicide completion rate is estimated to range from 1.4-2.3 times the rate achieved in the general population. (12) Although female physicians attempt suicide less often than their counterparts in the general population, their completion rate equals that of male physicians and, thus, far exceeds that of the general population (2.5-4 times the rate by some estimates). (12)

**ATS believes that trauma centers, trauma care providers and EMS organizations have the ability and the responsibility to contribute to solutions that address the increasing rate of suicide in the United States and that trauma centers, trauma care providers and EMS organizations should:**
• Work to decrease the stigma of mental health disease by developing a better understanding of mental health and actively discussing it amongst themselves and their patients.

• Screen for suicidality starting at the age of 5.

• Increase their knowledge of suicide risk factors and protective factors.

• Actively participate in the screening of all injured patients for suicidality and for Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD).

• Contribute to the development of systems to screen for suicidality, ASD and PTSD.

• Prioritize the psychosocial care of the patient and the care providers including active participation of psychological care providers on the trauma care team during trauma resuscitations and during recovery.

• Develop easily referenced psychological resources to refer patients and families when needed.

Disclaimer: The ATS membership supported the development of this policy which was subsequently approved by the ATS Board of Directors. While our recommendations are evidence-based they are non-binding. Any given healthcare entity, facility, or trauma center must interpret the issue within the current context of their capabilities and may therefore vary in their capacity to adopt aspects or recommendations of any ATS Position Statement.

References


