

SUICIDE PREVENTION REVIEW and REQUEST

This is my nineteenth and final column on Suicide Prevention for the NH NASW News. It will be a brief summary of some of the issues previous columns have touched on related to suicide prevention. My interest in writing a column was to share information with you, my colleagues, as way of extending our collective knowledge and suicide prevention efforts. At the outset I certainly never envisioned that it would go on for almost 5 years!

So my request is, won't you please consider writing one article on a trend you see in your work, or a topic you are passionate about or have developed expertise in? Maybe it is something you want to learn more about – the process of gathering material and writing many of the articles I wrote furthered my own knowledge and understanding. It doesn't have to be a scholarly or academic article. Who knows maybe you will like doing it and then write several! Our field is so broad and the expertise of Social Workers in New Hampshire is so rich and deep if we took a little bit of time to share it with each other it would enhance our profession and the lives of our clients. Step up! I hope to see some new articles in the months to come.

Suicide is the second leading cause of death in NH between the ages of 15-34 and the fourth leading cause of death ages 35-54. We know that some groups are at higher risk: men die at a rate four times higher than women but women attempt suicide three times more than men. Native Americans, veterans, military, and older adults all have high rates of suicide, but the highest rates are among middle aged white males. Suicide rates tend to be higher in rural areas than in urban areas. This is true across the US as well as in NH where our more rural counties have higher suicide rates than our urban counties. We also know that we have to be careful when talking about suicide data and clarifying what we know from research. For example we know that Lesbian and Gay youth have higher rates of suicide attempts but at this point there is no evidence that they die by suicide more than the general population. Research is still lacking in the area of bisexual and transgender youth and gay and lesbian adults.

Despite what we read in the media, attributing causal factors to suicide is problematic. Suicide is a highly complex issue and typically involves multiple compounding risk factors which may be triggered by an event (eg. a break up in a relationship) but is not caused per se by that event. Simplistic explanations in the media are often inaccurate – for instance stating a foreclosure as the cause of a suicide, most people who go through foreclosure don't die by suicide, or focusing on deployment as the cause of military suicides when half of the current military suicides have never deployed. Research demonstrates that how media reports on suicide (sensational, graphic details, simplistic explanations, high prominence) may contribute to increased suicides for individuals who may already be at risk. Thus, having people who talk with media use Safe Messaging guidelines and having media follow media recommendations for reporting on suicide is an evidence based prevention strategy. The presence of the internet and “new media” also presents new challenges and opportunities for suicide prevention, intervention and response after a suicide death.

An evidenced based practice which most Social Workers can utilize is restricting access to lethal means. Talking with an individual who is contemplating suicide about the method they are considering, and then working with them and family/friends to restrict access can save lives. This should be a standard component of any risk assessment or safety planning.

Speaking of safety planning, research does not indicate that the process of “contracting for safety” is an effective suicide prevention strategy. Additionally, “safety contracts” do not in any way minimize civil liability for a law suit either. If a safety contract is utilized, it should only be done as part of a comprehensive risk assessment and safety plan. Safety plans should actively include the individual and when possible members of their family or natural support system.

Since having known someone who dies by suicide is itself one of the highest risk factors for suicide, taking steps to reduce risk and promote healing after a suicide are important prevention strategies. This includes working with those who are bereaved by suicide to provide them with a variety of supports. People who are seriously impacted by a suicide death go beyond immediate family and can include friends and colleagues as well as first responders. Communities can also be profoundly impacted by a suicide death and can benefit from a planned and integrated response by key service providers. Clinicians and treatment providers who lose a client to suicide may experience symptoms which rise to the level of Post Traumatic Stress Disorder and can benefit from immediate and extended support.

As a public health issue suicide prevention is still in its infancy. It is only ten years since the US first adopted a National Strategy for Suicide Prevention and only five years since NH adopted a state strategy. By comparison to other public health issues, suicide prevention has not yet had the “star power” that generates political will and financial commitment from both the public and private side. Additionally, positive gains that have been made on the suicide prevention side have been mitigated by repeated funding cuts to mental health services at both the federal and state levels as well as a lack of integration between primary health care and mental health care. Implementation of the affordable care act will dramatically increase access to mental health care for many high risk individuals and is likely to make improvements in integration of services as well. Additionally, suicide prevention efforts continue to gain a great deal of momentum locally and nationally.

It is everyone’s responsibility to prevent suicide. Warning signs include: talking about death or dying, isolation, anger/rage, hopelessness, increased use of alcohol or other drugs and mood changes. If you are worried about someone you think is at risk of suicide call the National Suicide Prevention Lifeline 1-800-273-TALK (8255).

This is the final article in a series for the NH NASW newsletter on suicide prevention. Previous articles include: Suicide as a Public Health Issue, Suicide Prevention In NH, Survivors of Suicide Loss, No Harm Contracts, Military/Veterans and Suicide, Restricting Access to Lethal Means, Suicide and Older Adults, Suicide Risk and LGBT Youth, Clinicians as Survivors of Suicide Loss, Suicide and the Economy, Media, New Media, Safe Messaging & Suicide Prevention, Ethics and Suicide Prevention, Suicide and Self Harm, Homicide/Suicide, Suicide Attempter Survivors and Bullying and Suicide. Previous articles can be viewed in the news and media section of the Connect Program website

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