Public Health Law Strategies for Suicide Prevention Using the Socioecological Model

Catherine Cerulli, Amy Winterfeld, Monica Younger, and Jill Krueger

Introduction

For a number of years, suicide has been considered an international public health problem. In 2017, nearly 45,000 people died from suicide in the United States. Since 1999, suicide rates have climbed more than 30 percent in half of the 50 states.[1] Despite initiatives which include Healthy People[2] recognition of suicide as a public health issue, various foundations' work, including but not limited to the American Foundation for Suicide Prevention,[3] and a national network of hotlines, managed by the Suicide Prevention Lifeline,[4] suicide rates have increased in the United States. Many suicide prevention efforts are focused on individuals, including identifying those at risk, providing access to mental health care, and thus improving mental health.

In 2013, suicide expert Dr. Eric Caine published an article in the *American Journal of Public Health* entitled "Forging an Agenda for Suicide Prevention in the United States."[5] Dr. Caine shifted the paradigm for suicide prevention from one focusing on individuals at risk to a continuum of approaches, across individuals' developmental stages and venues where they are.

> Suicide prevention must be transformed by integrating injury prevention and mental health perspectives to develop a mosaic of common risk public health interventions that address the diversity of populations and individuals whose mortality and morbidity contribute to the burdens of suicide and attempted suicide. Emphasizing distal preventive interventions, strategies must focus on people and places—and on related interpersonal factors and social contexts—to alter the life trajectories of people before they become suicidal...(p.1)[6]

As we consider suicide prevention across the socioecological model (SEM), (see Figure 1),[7] we must also consider law as a means to strengthen suicide prevention efforts at the individual, relationship, community,

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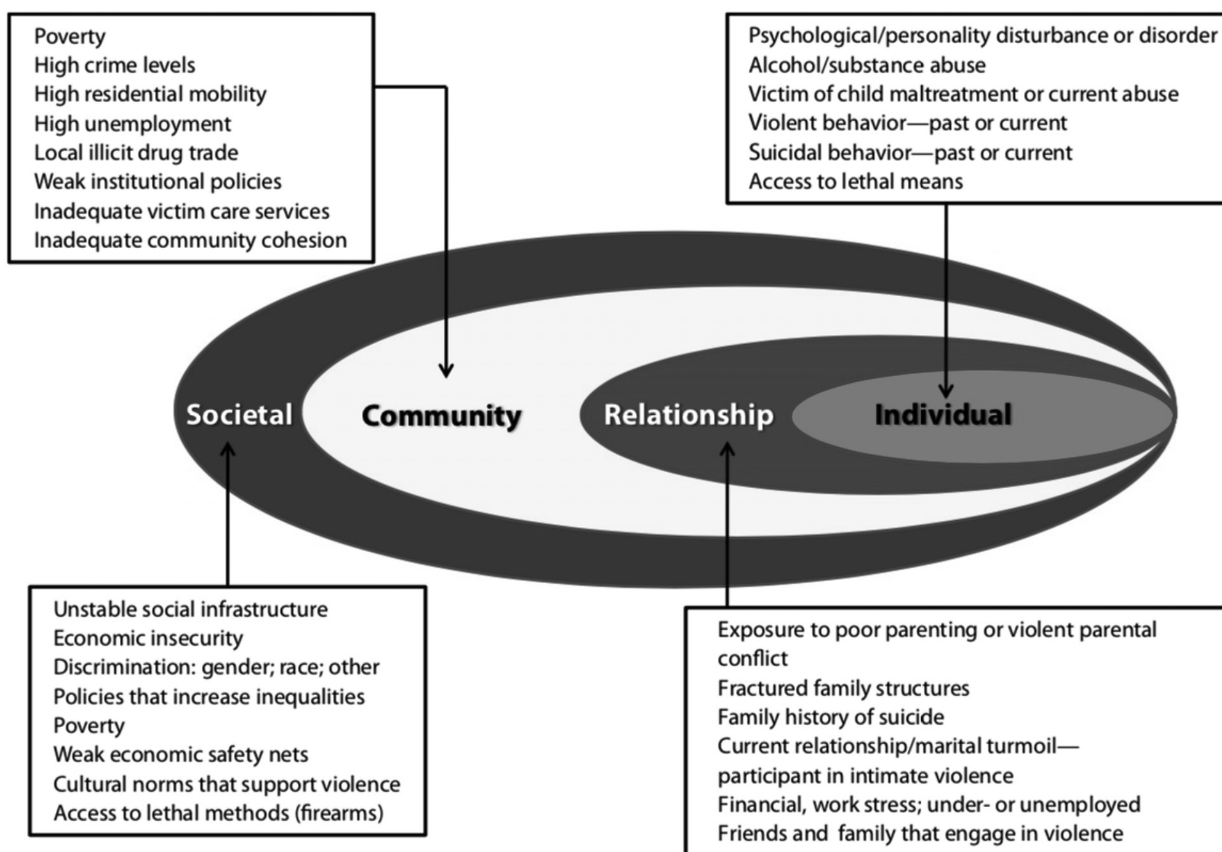
Figure 1



Source. Adapted from Butchart et al.[33]

and societal levels. Public health law strategies can complement the SEM suicide prevention approach.

This paper explores potential legal interventions across the spectrum of where people are as individuals, within their relationships, and at the community and societal levels, when they may be at risk for suicide.

Individual

Since 2005, the National Suicide Prevention Lifeline has been offering crisis intervention through 24/7 crisis lines for people in suicidal distress or loved ones inquiring how to help.[8] The federal government created the Lifeline for Vets which has answered over a quarter million calls over 21 years.[9] Nationally, Lifeline answered over 10 million calls, with approximately a quarter of those individuals expressing distress.[10] There has been an understanding that suicide risk includes more than depression and other mental health burdens. For many people who seek help on the crisis lines, suicidal thoughts and behaviors (STB) occur in the wake of life-altering events: e.g., divorce, custody disputes, bankruptcy, intimate partner violence, child abuse histories, and the death of a loved one[11] which involve people's relationships to others, including family members and colleagues. Given the service these crisis lines provide, perhaps more county, state, and federal lawmakers might consider legislation providing financial support for the services as well as evaluation strategies. As an example, Minnesota funded a statewide service called Text4Life.[12] Crisis lines require us to wait for someone to be at the state of needing a crisis line, what if people coming into courts and other settings for services identified at risk were then referred to a system of care prepared to holistically address their needs?

As people work to resolve these relationship issues, they often find themselves in contact with the court system — both civil and criminal, and other helping social service agencies, rather than the mental health system. In studies conducted in court settings, both victims and perpetrators of violence exhibit higher rates of STB.[13] It may be possible to create a mecha-

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nism for suicide prevention that utilizes medical-legal partnerships (MLPs) as an option to provide individuals at risk for STB with a therapeutic bond to begin reducing isolation and creating treatment plans. Such referrals could be bi-directional — referring people in the medical or mental health service side with STB who are facing legal difficulties to preventive legal counsel, and vice-versa.[14] One such example is explored.

Relationship Level

The University of Rochester Strong Memorial Hospital has implemented a MLP that may be a potential model program for suicide prevention. The program, Healing Through Education, Advocacy and Law (HEAL),[15] incorporates legal remedies at the relationship level. When a person is identified as having intimate partner violence or any interpersonal violence experiences, a HEAL professional can work with that patient. The team within this MLP includes social workers, doctors, lawyers, mental health providers, and domestic violence advocates. The HEAL Collaborative provides on-site safety planning, including protection orders, and integrated care. Cases have come into the HEAL clinic which involve patients experiencing STB. Quick action by the clinicians, trained on suicide prevention strategies, contributes to the prevention of suicides. In partnership with emergency personnel and quality community emergency mental health ambulatory care, a collaborative approach can work. While we have always treated individuals at risk for suicide through screening and assessment when they present in certain venues, we often focus on the symptoms and not the root cause. By having interdisciplinary teams and relationships built with people at risk, we do not ignore a patient's lived experiences. It is important for those patients living in current violent relationships, or who have histories resulting in trauma, that we consider STB where the patients present for care, including clinics that offer protection orders co-located with mental health treatment. For such integrated care to occur, institutions must be willing to consider suicide prevention initiatives beyond traditional screening and referral and offer new holistic approaches to care: multidisciplinary and integrated.

Community Level: Statewide Effort in Selected Colorado Communities

At the community level, we may consider an institution, county, or state as a community entity — using an approach to reducing STB. This varies from the societal level approaches, discussed below, which include public health campaigns. Here, we discuss a statewide effort in multiple Colorado communities that use legal leverage to implement suicide reduction strategies. Colorado, currently at 10th in the nation for suicide, is an example of a state that has been working on multiple levels to reduce suicide. In 2017, a record number of people died by suicide in Colorado — 1,175,[16] with men more likely to commit suicide than women by 3 to 1. Suicide is the leading cause of death in Colorado's 10-24 year-old age group. While targeted youth suicide prevention strategies were needed, so were public health awareness strategies. Concerned public health leaders came together and formed the Metro Public Health Behavioral Health Collaboration (Collaboration). Colorado mental health leaders, including the Collaboration, and advocates such as Mental Health Colorado, worked together in 2018 to successfully introduce legislation to try to stem the tide of suicide. In 2018, three proposed bills targeted youth suicide reduction. Although none of these legislative proposals passed, their introduction was an important step in moving suicide prevention out of the individual level of the SEM into the community level. The three bills[17] were: HB 18–1177, Youth Suicide Prevention proposing multiple approaches to prevent suicide among youth, SB 18-114, Suicide Prevention Enhance Student Life Skills to prevent youth suicide by strengthening life skills; and SB 18–153, Behavioral Health Care Related to Suicide Ideation. This bill would have required a study of best practices to address gaps in suicide and opiate prevention and to coordinate communication among multiple professionals.

At the 11th hour of Colorado's 2018 legislative session, a 4th bill, SB 18–272, was enacted creating the Crisis and Suicide Prevention Training Grant Program, for comprehensive suicide prevention strategies and training in schools. Importantly, a financial appropriation was included and grants are now being distributed by the Colorado Department of Public Health and Environment (CDPHE).

Societal Level

At the societal level, Colorado also provides important strategies for shifting to a culture of open conversation about mental health. The Collaboration developed a stigma reduction education campaign, Let's Talk CO, with support from the Colorado State Innovation Model (SIM), a governor's office initiative, funded by the Centers for Medicare & Medicaid Services (CMS).[18] The messaging is aimed at low-income Coloradans and their providers in federally qualified health centers and safety net clinics. The Collaboration reached out to partners like health systems, community mental health centers, and volunteer organizations to convene a group that could design a communication campaign with the local health departments in the seven-county metro Den-

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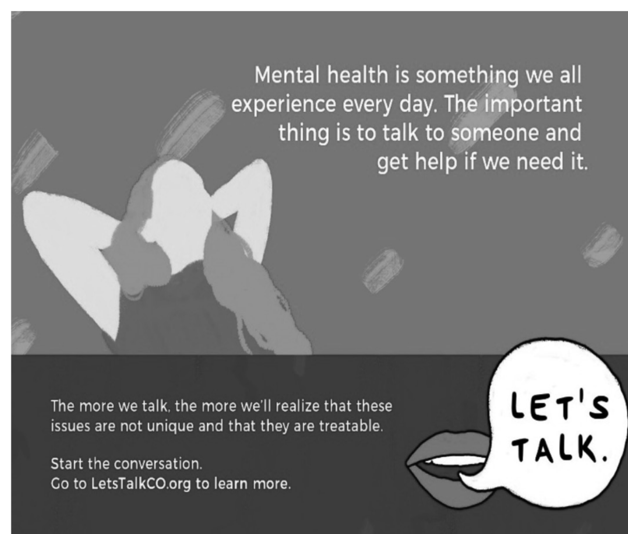
Figure 2



ver region. The campaign included phrases such as "Let's talk about our mental health"; "Mental health isn't just in our head"; and "Mental health is a big part of our health and well-being".

The Let's Talk CO Campaign (see Figure 2)[19] works by encouraging people to have the awkward conversation about mental health, emotions, and other life stressors. Let's Talk provides community members with links to providers and other community resources to address any mental health questions, issues, or ways to support the campaign. By providing tools to encourage conversations about mental health, the Let's Talk CO campaign may help support people at risk for suicide.[20] It teaches communication skills, and links people to resources that help them manage challenges with their relationships, jobs, health, or other concerns. Most importantly, Let's Talk CO aims to connect people at risk to crisis services and effective and coordinated mental and physical healthcare.

Most people who attempt or complete suicide do not have a current mental health diagnosis, and societal stigma deters those experiencing situational challenges from seeking help. Better understanding of mental health and well-being, and of skills and behaviors that contribute to well-being, changes the societal context of thinking about suicide.[21]

Discussion

Relationship level interventions laws at every level of government can help to increase self-management, relationship-building and conflict resolution skills across the life-span, as well as address stigma and discrimination related to mental health, particularly in the education and health sectors.[22]

Relationship level interventions, such as home visiting and other parenting programs, can nurture positive parenting skills and provide social connectedness and support for new parents and young children. At the community level, incorporating social and emotional learning in school benchmarks supports the development of resilience and coping skills that can help to navigate adverse childhood (and adult) experiences.[23] Legal strategies can support related professional development for teachers, so that they are trained in methods to incorporate practice in self-management, self-awareness, social awareness, relationship-building, and conflict resolution into academic instruction in the classroom.[24] Emerging laws requiring health education in schools to address mental health may normalize discussion of mental health and reduce stigma in the general population, particularly when implemented with fidelity to the literature analyzing effective approaches to stigma reduction.[25] Laws that require or encourage relevant continuing education among mental health and primary care providers can also lessen provider stigma, so that providers do not inadvertently convey negative or stereotypical messages and behaviors to current and potential patients and clients, as well as their family members and care-givers.[26]

Legal strategies increasingly acknowledge the role of social, cultural, and economic conditions in contributing to risk or protective factors for suicide, both in the population as a whole, as well as among specific populations such as communities of color and rural communities.[27] Innovative efforts to collect and assess data related to mental health and well-being provide rich information to guide future policy-making to reduce inequality, improve conflict resolution skills, and increase social connectedness, support, and cohesion.[28]

In conclusion, this brief report suggests a suicide prevention model that uses law and legal settings which span the Socioecological Model domains where suicide risk may be present in peoples' lives and relationships. Examples include screening court consumers facing life altering events, using court-based settings to link at-risk individuals with integrated care, such as Medical-Legal Partnerships and protection orders, and using legislation to authorize and fiscally support educational and stigma reduction campaigns. We must strive to reduce the burden of suicide. This approach to reduce the STB should be complemented with a broad approach to using public health laws to also prevent suicide risk factors in the first place, such as preventing violence before it happens. One such example can be seen in the CDC guide for violence prevention.[29] To move suicide prevention into a public

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health law approach would break down silos between various risk factors and create cohesive plans within institutions and governments seeking to improve the overall health of their communities.

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