The Integration of Public Health and Mental Health in Suicide Prevention

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As we begin a new year, I find myself thinking about what important new steps we in the field of suicide prevention can take to reduce the burden of suicidal behavior in our nation. Since 2001 when the National Strategy for Suicide Prevention was released, we have spoken about the importance of viewing suicide prevention through a public health lens, yet I’m not convinced we have truly applied the public health approach to the degree that we should. As a field, we still largely rely on mental health solutions to address suicide. I believe this is because we often hear that 90 percent of suicides are related to mental illness. Naturally, when presenting suicide in this manner, the solution appears to be quite evident…early intervention and treatment of those with mental disorders.

While the mental health lens is crucial and treatment is absolutely part of the solution, so too is the public health lens. In fact I would argue that it is the application of both, not either/or, that will lead to true reductions in suicidal behavior. It is my hope that in 2012 we will begin to integrate interventions and approaches from both mental health and public health that have the potential to measurably reduce suicidal behaviors and improve the quality of life for many. An example of what I mean can be found by examining the practice of training clinicians to screen for mental health concerns, especially in those who, through public health surveillance efforts, have been identified as being at increased risk. While it sounds fine as a stand-alone practice, if we don’t also train clinicians to go the extra step and inquire about access to lethal means for those at high risk in addition to providing treatment, we have failed to comprehensively address the patient’s environment and how it may influence their risk for suicide.

We need effective treatment for those who struggle with mental illness and substance use disorders but we also need comprehensive prevention efforts so many of these conditions do not occur in the first place or at the very least their impact can be minimized. As George Albee (an early prevention proponent) reminded us, no public health problem has ever been treated out of existence.

I worry that many of us speak to a public health approach to suicide prevention yet in reality we spend the majority of our days intervening in crisis cases. While I agree fully we must continue our efforts to identify and treat those at risk, we must also at the same time pursue upstream strategies and address environmental issues that may
contribute to eventual suicidal behavior. Health promotion, resiliency, life-skills training, and other prevention activities (including increasing connectedness or social support) could reduce the potential for future risk. We can continue to learn from a number of the model suicide prevention programs, like the US Air Force Suicide Prevention Program [1]. This model program embraces the public health approach, and in addition to offering mental health services and gatekeeper training, the program also changed the prevailing cultural norms and engaged the entire community in broad-based prevention efforts. The take-home message is that by applying a public health approach, it becomes evident that there are many opportunities to intervene at different points along the continuum that leads to suicide and suicidal behaviors. We can’t afford to sit back and assume that at-risk individuals will know when to come to us and ask for our help.

As January is the time for resolutions, I propose that as a field, we resolve to be bold in 2012, test new hypotheses and evaluate promising programs that have the real potential to move the needle, and make significant progress to reduce suicide, and suicidal behavior in our nation. We should look to bringing programs like the US Air Force program to scale and testing such models in new communities. Let’s not just look at applying a best practice, let’s look at the relationship of best practices to each other (synergistic effects) and to the environment where those who struggle may live, work, recreate and worship.

What will you do in 2012 to apply the public health approach to suicide prevention? Please share your thoughts below.

Best wishes for a safe and healthy 2012.

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