Suicide prevention policy: a framework for Minnesota

Nicholas Hable, MPH, University of Minnesota Medical School

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Abstract

Suicide rates have been steadily increasing for the last two decades in the United States, which is a trend that has also been observed in Minnesota. Suicide is now one of the leading causes of death for Minnesotans, and specific populations such as Native Americans, older adults, and white men living in rural areas have been disproportionately impacted. Interventions aimed at preventing suicide have historically focused on downstream interventions, but these often overlook the root causes of suicidal ideations. A new approach focused on creating a suicide prevention policy for the Minnesota Medical Association, the largest physician advocacy organization in Minnesota, is assessed and proposed in this issue brief. The framework for the policy was created through examination of the upstream, midstream, and downstream factors that impact suicide rates in Minnesota. As a result of this research, Minnesota Medical Association members and the Board of Trustees approved the proposed framework, formally adopting their first ever suicide prevention policy.

Problem

Suicide is a multifactorial and complex national public health crisis that has drastically worsened over the previous two decades despite an increased emphasis on suicide prevention initiatives.

Magnitude of the Problem

From 2000 to 2021, the national suicide rate increased by 36% [1]. In 2021 alone, over 12 million adults considered suicide, 3.5 million specifically planned out their suicide attempt, and over 1.5 million attempted to go through with their plan [2]. In Minnesota, suicide rates have been steadily rising for the past 20 years, and suicide is now the 8th leading cause of death [3]. In 2022, the suicide rate in Minnesota was reported as 14.3 per 100,000 individuals, which is higher than the reported rate of 13.9 in 2021 [4]. These are the second and third highest suicide rates reported in Minnesota in the last twenty years [4]. Suicide rates are disproportionately higher in specific populations, such as older individuals [3], white men aged 35-64 living in rural areas [5], and Native American individuals [3], with a noticeable disparity for Native American youth [5]. For Minnesotans who died by suicide from 2015 to 2020, firearms were used in 45% of the deaths, 30% of individuals had alcohol in their system at the time of death, and 55% of individuals had an ongoing mental health concern [5].

Issues

A comprehensive approach from organizations that are well-suited to address suicide prevention is often nonexistent. State and national health advocacy organizations should have suicide prevention policies in place that drive their institution's initiatives on suicide prevention. One such organization that could benefit from having a defined suicide prevention policy is the Minnesota Medical Association (MMA). The MMA, which has over 10,000 members, is the largest and oldest professional association for physicians in Minnesota [6]. The MMA focuses on advocacy for critical issues impacting healthcare in Minnesota but has never had a suicide prevention policy. The objective of this initiative is to review the structure of the recently created policy, which was officially adopted May 20, 2023, and discuss how this policy can benefit Minnesota physicians [7].

Main Issue

Suicide prevention has been predominately approached through downstream interventions, but this can be ineffective as they often do not address the root causes of suicidal ideations.

Main Policy Question

How can a large health advocacy organization create a policy that encompasses upstream, midstream, and downstream factors that are contributing to suicidal ideations in Minnesotans?

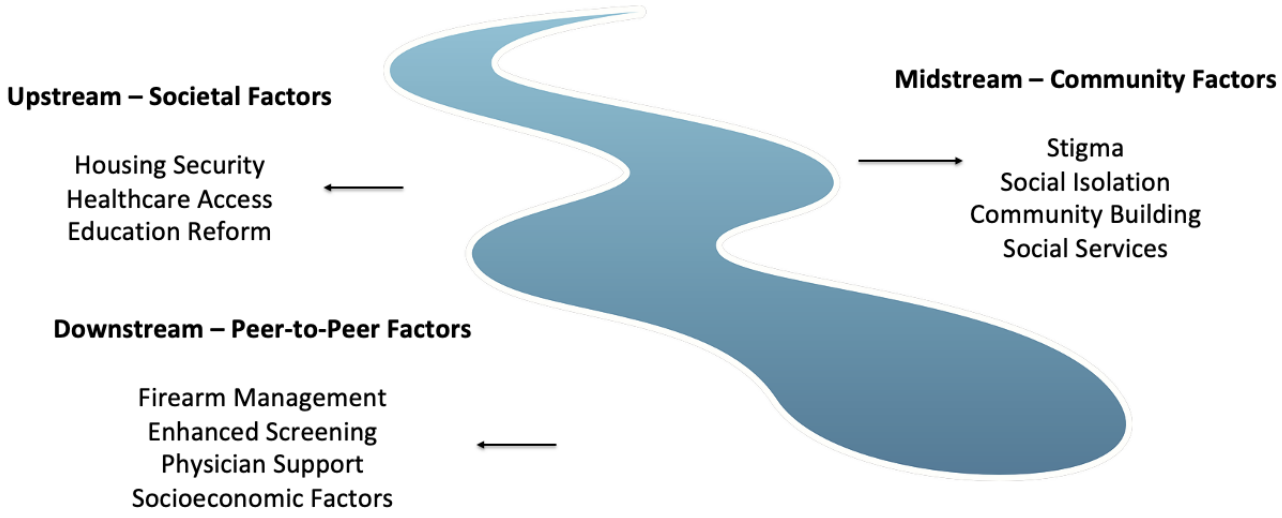

Figure 1. Suicide Prevention Policy Framework

Problem Trajectory

Rates of suicide have been steadily increasing over the past two decades, and these numbers are expected to continue rising. As seen in Figure 1, suicide prevention should be predicated on upstream factors that focus on society's role, midstream factors that focus on the community's role, and downstream factors that focus on a peer-to-peer approach, all while being culturally sensitive. These factors, as listed below, are the basis for the MMA's new suicide prevention policy, which is outlined in Figure 2.

Political, Social, and Economic Factors

Upstream Factors

Housing insecurity that leads to homelessness predisposes individuals to a higher risk of physical and mental health concerns [8]. This can in turn cause higher rates of suicidal ideations, as 40% of homeless youth have attempted suicide at least once in their lifetime [9]. Suicidal ideation has been estimated to be ten times higher in homeless individuals than in the general population [10]. Lack of access to timely and adequate healthcare services, especially in rural communities, also leads to increased rates of suicide [11, 12]. Individuals may not have the resources necessary for telehealth visits, which means they must wait long periods of time for in-person availability or travel far to see a healthcare provider [11, 12]. Shortcomings of current health screenings [13] and corresponding follow-up availability of mental health services [14] are also barriers that patients often face.

Midstream Factors

Stigma around discussing suicide is a major reason why many individuals do not seek care. This is often noticeable in Native American communities [14], which have the highest rate of suicide in Minnesota [15]. Social and cultural isolation, characterized by a loss of social support systems or ones' personal identity, are linked to higher suicide rates in young and older individuals [16, 17], as well as Native American communities [18], and may partially explain the recent increase in suicides for individuals aged 65 and older [3]. The difficulty of utilizing social services can also be a barrier for patients trying to access care when needed, which may result in individuals choosing not to seek help [19].

Downstream Factors

Firearms are one of the most common methods of suicide in Minnesota [5], especially for white males living in rural areas [5]. This is in part due to lack of safe storage [20] and a high prevalence of gun ownership [21]. A physician's time constraints and competing professional demands can be a barrier to identifying and treating suicidal ideation [22]. Physicians themselves are also at risk for suicide, as they tend to have a higher rate of suicide than the general population [23] due to stress, burnout, substance misuse, and a medical culture that praises stoicism [24]. Patient demographics and socioeconomic factors also significantly impact the rate of suicides, as seen with males in Minnesota having a suicide rate four times higher than females [15].

Suicide is a serious public health problem. In addition to the lost lives, there are long-lasting effects on families and communities. For the past 20 years, the number of suicides in Minnesota has steadily increased, mirroring patterns across the United States and contributing to a decline in average life expectancy. Suicide is also complex, with a plethora of psychiatric, cultural, and socioeconomic roots. Nearly half of all individuals that die by suicide are known to have visited with a healthcare provider in the four weeks prior to their death. The Minnesota Medical Association recognizes the increasingly important role that physicians have in relation to suicide prevention efforts. Physicians have the ability to advocate for societal change, raise awareness about suicide prevention, connect with their patients about their mental health, recognize signs of suicidal ideation, provide adequate resources, and facilitate appropriate next steps in order to reduce the rate of suicide in Minnesota.

(1) The MMA recognizes that mental health is a uniquely personal aspect of health. Real and perceived stigma deters many from discussing this with their physician. The Minnesota Medical Association will work to combat stigma regarding mental health conditions through the normalization of discussions around depression and suicide and screening of these issues.

(2) The Minnesota Medical Association recognizes that there are a variety of social drivers of health that increase the risk of suicide. Among others, these factors include housing insecurity, economic instability, stigma, and lack of access to mental health resources. The Minnesota Medical Association supports programs and policies that will work to address these social drivers of health with the goal of decreasing suicide risk.

(3) The Minnesota Medical Association recognizes that social isolation is a main driver for suicidal ideation. The Minnesota Medical Association encourages the development of programs and initiatives that aim to improve social support systems for individuals, families, and communities. The Minnesota Medical Association also supports the incorporation of anti-bullying messaging into schools, as being bullied and bullying are both linked with a higher risk of suicidal ideation.

(4) The Minnesota Medical Association recognizes the role that firearms play in suicide. White males and individuals in rural areas are most likely to die by suicide with a firearm, and more needs to be done to address the suicide risk among these, and other high-risk populations. The Minnesota Medical Association will educate physicians and disseminate tools that encourage conversations between physicians and patients that use a harm reduction approach, and that are tailored to each patient's needs. Some examples include information on how safely storing firearms and ammunition, and safe handling practices, can reduce suicides.

(5) The Minnesota Medical Association recognizes that silence and stigma about suicide exists among many racial and ethnic populations. The Minnesota Medical Association supports initiatives that aim to increase connectedness in one's community and family structure; promote culturally appropriate messaging about suicide; and provide individual, interpersonal, and community level approaches to addressing and preventing suicide among these populations.

(6) The Minnesota Medical Association recognizes the relationship between access to mental health resources and suicide outcomes. The Minnesota Medical Association supports and will advocate for strategies to improve access and availability of mental health resources such as increased funding for more mental health facilities and hospital beds; increasing the numbers of psychiatrists and other mental health professionals, with attention to the shortages that exist in rural and underserved areas. The MMA will also advocate for adequate coverage of mental health conditions by insurance providers. In addition, the Minnesota Medical Association also encourages the investigation of new models of healthcare delivery that aim to ease the burden on current healthcare providers and increase the availability of mental health care services.

(7) The Minnesota Medical Association recognizes that the ability to (1) screen for depression and suicide risk in a patient; and (2) address suicidal ideation, are critical skills for physicians. The Minnesota Medical Association will encourage Minnesota's medical schools and residency programs to incorporate suicide risk assessment and management into their curriculum. The Minnesota Medical Association will also encourage medical specialty societies to offer continuing medical education on assessing and managing suicide risk for their members. The Minnesota Medical Association will also continue to promote physician participation in evidence-based suicide prevention training programs such as Question-Persuade-Refer (QPR) and Counseling on Access to Lethal Means (CALM).

(8) The Minnesota Medical Association recognizes that compared to the general population, physicians are at a higher risk of suicide and suicidal ideation. Physician risk factors include burnout, unidentified or inadequately managed mental health conditions, stigma around mental health conditions, emotional distress, lack of personal support systems, and historic systemic deterrents (i.e., licensing and credentialing process) to seeking care. Through its wellbeing initiatives, the Minnesota Medical Association will continue to work to address the factors and stigma that are contributing to suicide – both among physicians and physicians-in-training.

Figure 2: Official MMA Suicide Prevention Policy

Previous Policies

Suicide prevention has support at every level, from initiatives like Zero Suicide [25] and the 988 lifeline [26], to being a key agenda item for former and current presidential administrations [27, 28]. The Minnesota Department of Health (MDH) has a state plan for suicide prevention that emphasizes improving infrastructure, increasing collaboration, and capacity building for local communities [29]. The newly adopted suicide prevention policy for the MMA directly aligns with the MDH's state plan, while calling attention to additional factors as mentioned above. This policy provides the framework for how the MMA can collaborate with other organizations, while also supporting and launching initiatives of their own that comprehensively address suicide prevention. An official policy also allows the MMA to voice support for initiatives that align with their stance. This can be a powerful advocacy tool, as an organization of 10,000+ physicians signaling support for suicide prevention strategies is likely to show the public the significance of and need for certain initiatives.

Pressure for Action

Nearly half of all individuals that die by suicide are known to have visited with a healthcare provider in the four weeks prior to their death [30]. As suicide rates continue to rise and disparities continue to worsen, physicians are uniquely

positioned to make a difference at every level that impacts suicide. This policy helps physicians further understand the intricacies of suicide, while providing opportunities for them to advocate for societal change, raise awareness around suicide prevention, connect with their patients about mental health, recognize signs of suicidal ideation, provide adequate resources, and facilitate next steps to reduce the rate of suicide in Minnesota. Additionally, future initiatives and educational campaigns that occur because of this policy will allow physicians to enhance their suicide prevention skillsets in ways that will positively impact themselves and their patients.

Author Contact Information

Nicholas Hable: hable016@umn.edu

References

[1] Facts About Suicide | Suicide | CDC. 2023. Available from: https://www.cdc.gov/suicide/facts/index.html

[2] Richesson D, Magas I, Brown S, Hoenig J. 2021 NSDUH Annual National Report | CBHSQ Data. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. Available from: https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report

[3] Gingerich SB, Roesler J, Carter T. Minnesota Suicide Mortality, Preliminary 2020 Report. Saint Paul, MN: Minnesota Department of Health, April 2021. Available from: https://www.health.state.mn.us/communities/suicide/documents/2020prelimsuicidedata.pdf

[4] Gingerich SB. Data Brief: Suicide Rate Increased in 2021, 2022. Saint Paul, MN: Minnesota Department of Health, May 2023. Available from: https://www.health.state.mn.us/communities/suicide/documents/2021suicidedatabrief.pdf

[5] Gingerich SB. Minnesota Violent Death Reporting System (MNVDRS). Saint, MN: Minnesota Department of Health, November 2022. Available from: https://www.health.state.mn.us/communities/injury/midas/mnvdrs.html

[6] Minnesota Medical Association. Available from: https://www.mnmed.org

[7] MMA Board Passes Policies on Firearm Safety and Suicide Prevention. Press Release. https://www.mnmed.org/news-and-publications/news/mma-board-passes-policies-firearm-safety-and-suicide-prevention

[8] Bird CE, Seeman T, Escarce JJ, Basurto-Dávila R, Finch BK, Dubowitz T, et al. Neighbourhood socioeconomic status and biological "wear and tear" in a nationally representative sample of US adults. J Epidemiol Community Health. 2010 Oct;64(10):860–5.

[9] Chavez L, Kelleher K, Bunger A, Brackenoff B, Famelia R, Ford J, et al. Housing First Combined with Suicide Treatment Education and Prevention (HOME + STEP): study protocol for a randomized controlled trial. BMC Public Health. 2021 Jun 12;21(1):1128.

[10] Patterson AA, Holden RR. Psychache and Suicide Ideation among Men Who Are Homeless: A Test of Shneidman's Model: Suicide Ideation among Homeless. Suicide and Life-Threatening Behavior. 2012 Apr;42(2):147–56.

[11] Ku BS, Li J, Lally C, Compton MT, Druss BG. Associations between mental health shortage areas and county-level suicide rates among adults aged 25 and older in the USA, 2010 to 2018. Gen Hosp Psychiatry. 2021; 70:44–50.

[12] Graves JM, Abshire DA, Amiri S, Mackelprang JL. Disparities in Technology and Broadband Internet Access Across Rurality: Implications for Health and Education. Family & Community Health [Internet]. 2021 Jul 14;Publish Ahead of Print. Available from: https://journals.lww.com/10.1097/FCH.0000000000000306

[13] Hogan MF, Grumet JG. Suicide Prevention: An Emerging Priority for Health Care. Health Affairs. 2016 Jun;35(6):1084–90.

[14] Suicidal Behavior in American Indian and Alaska Native Communities: A Health Equity Issue. CDC Public Health Grand Rounds, March 2019. Available from: https://www.cdc.gov/grand-rounds/pp/2019/20190319-preventing-suicide-behavior.pdf

[15] Gingerich SB, Roesler J, Carter T. Suicides in Minnesota Show Racial and Demographic Disparities, 2019 Report. Saint Paul, MN: Minnesota Department of Health, January 2021. Available from: https://www.health.state.mn.us/communities/suicide/documents/2019mnsuicidedata.pdf

[16] Niu L, Jia C, Ma Z, Wang G, Sun B, Zhang D, et al. Loneliness, hopelessness and suicide in later life: a case–control psychological autopsy study in rural China. Epidemiol Psychiatry Sci. 2020 Apr 24;29: e119.

[17] Bridge JA, Ruch DA, Sheftall AH, Hahm HC, O'Keefe VM, Fontanella CA, et al. Youth Suicide During the First Year of the COVID-19 Pandemic. Pediatrics. 2023 Feb 15;151(3): e2022058375.

[18] American Indian Suicide Rate Increases. National Indian Council on Aging (NICOA), September 2019. Available from: https://www.nicoa.org/national-american-indian-and-alaska-native-hope-for-life-day/

[19] Placzek H, Cruz S, Chapdelaine M, Carl M, Levin S, Hsu C. Intersecting systemic and personal barriers to accessing social services: qualitative interviews in northern California. BMC Public Health. 2021 Oct 24;21(1):1933.

[20] Shenassa ED. Safer storage of firearms at home and risk of suicide: a study of protective factors in a nationally

representative sample. Journal of Epidemiology & Community Health. 2004 Oct 1;58(10):841–8.

[21] Studdert DM, Zhang Y, Swanson SA, Prince L, Rodden JA, Holsinger EE, et al. Handgun Ownership and Suicide in California. New England Journal of Medicine. 2020 Jun 4;382(23):2220–9.

[22] Institute of Medicine (US) Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide; Goldsmith SK, Pellmar TC, Kleinman AM, et al., editors. Reducing Suicide: A National Imperative. Washington (DC): National Academies Press (US); 2002. 9, Barriers to Effective Treatment and Intervention. Available from: https://www.ncbi.nlm.nih.gov/books/NBK220944/

[23] Schernhammer ES, Colditz GA. Suicide Rates Among Physicians: A Quantitative and Gender Assessment (Meta-Analysis). AJP. 2004 Dec;161(12):2295–302.

[24] Kalmoe MC, Chapman MB, Gold JA, Giedinghagen AM. Physician Suicide: A Call to Action. Mo Med. 2019;116(3):211–6.

[25] Zero Suicide initiative. Available from: https://zerosuicide.edc.org

[26] 988 Lifeline initiative. Available from: https://988lifeline.org

[27] S.2661 - National Suicide Hotline Designation Act of 2020. https://www.congress.gov/bill/116th-congress/senate-bill/2661

[28] Fact Sheet: Biden-Harris Administration Actions to Prevent Suicide. The White House, September 2022. Available from: https://www.whitehouse.gov/briefing-room/statements-releases/2022/09/30/fact-sheet-biden-harris-administration-actions-to-prevent-suicide/

[29] Suicide Prevention Minnesota State Plan. Minnesota Department of Health April 2023. Available from: https://www.health.state.mn.us/communities/suicide/mnresponse/stateplan.html

[30] Ahmedani BK, Simon GE, Stewart C, Beck A, Waitzfelder BE, Rossom R, et al. Health Care Contacts in the Year Before Suicide Death. J Gen Intern Med. 2014 Jun;29(6):870–7.