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Suicide control in Charleston, South Carolina

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COUN 6785: Social Change in Action:

Prevention, Consultation, and Advocacy

Social Change Portfolio

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Contents

Below are the titles for each section of the Social Change Portfolio. To navigate directly to a particular section, hold down <ctrl> and click on the desired section below.

Please do not modify the content section, nor remove the hyperlinks.

[Please note that in brackets throughout this template you will see instructions about information to include in each section. Please delete the instructions that are found in brackets, including this message, and replace the bracketed instructions with the relevant content for each section].

OVERVIEW

Keywords: Suicide control in Charleston, South Carolina

[Insert title of your social change project here. For example: Teen Alcohol Use in Juneau, Alaska]

Goal Statement: To reduce the rate of suicide attempts in Charleston, SC.

Significant Findings: Suicide is a serious public health problem and is one of the leading causes of death in the United States. According to the Centers for Disease Control and Prevention (2021), 12.2 million Americans seriously thought about suicide and 1.2 million Americans attempted suicide in 2020. These numbers will only increase with Americas increase in mental health cases. There is not one single cause for suicide but occurs most often from undiagnosed and untreated depression. Stressors and health issues can converge with anxiety and substance problems creating an experience of hopelessness and despair (American Foundations for Suicide Prevention, 2022). In turn, suicidal ideations can percolate into the brain and poison the mind, causing one to question every single thing. Mental health professionals and advocates seek to remedy these statistics and rectify one of the leading mental health issues. This Social Change Portfolio focuses on suicide in Charleston, South Carolina, which has shown radical increase in suicide and attempted suicide rates since the past pandemic. Discussed are prevention strategies and advocacy in suicide prevention along with diversity within the suicidal population, theories of prevention, and information regarding a social and ecological suicide model.

Objectives/Strategies/Interventions/Next Steps: Some objectives to reduce the rate of suicide attempts are to strengthen access to mental health facilities and suicide care, along with creating protective environments. Some actions can include reducing provider shortages in marginalized and underserved areas and stronger coverage of mental health conditions in health insurance policies. Communities can promote connectedness by engaging in activities to promote suicide prevention. Many support suicide prevention by participating in 5K races/walk or by being apart of community organizations that work together to reduce stigma, and support others who struggle. Identifying at-risk individuals, supporting them, and teaching coping and problem solving skills are appropriate strategies for intervention.

INTRODUCTION

Suicide Control in Charleston, South Carolina

The COVID-19 pandemic created a disturbance within the Charleston community, causing a massive spike in suicide rates, as well as attempted suicide rates. The virus brought not only illness and death, but a change in how humans navigate the world. Children faced school closures, there was economic turmoil worldwide, healthcare workers were pushed to breaking points, various mandates were implemented, businesses closed resulting in many layoffs, and remote work became the new normal for many. These are just a few challenges the world faced during the pandemic and they are all variables associated with the recent increase in suicide rates in South Carolina. Although the pandemic exacerbated these rates, South Carolina and Charleston saw rising trends before then. This social change portfolio will bring to light

Charleston's suicide issue, as well as ways to execute prevention strategies. These individuals at risk for suicide are the target population I want to focus on for this social change portfolio.

PART 1: SCOPE AND CONSEQUENCES

[Insert Title of Social Change Project here]

This portfolio will focus on suicide rates and prevention in the Charleston area of South Carolina, as well as South Carolina as a whole. The state of South Carolina (SC) has seen a dramatic increase in suicide and attempted suicide rates. The Centers for Disease Control and Prevention (CDC) released a report analyzing suicide rates from 1999-2016 in SC. The state came in as the 10th worst state in the United States with an increase of 38%, surpassing the national average of 25.4% (PR Newswire, 2018). During the years 2014 through 2018, Charleston County has an age-adjusted rate of 14.3 with an average annual count of 57 (National Institute on Minority Health and Health Disparities). According to the Charleston County Coroner's Office-2020 Annual Report (2020) that number rose to 65 deaths by suicide. These rates did not see improvement by 2021; in fact, the unprecedented attack from COVID-19 created a riff in the entire human population. This resulted in a major loss via physical and mental illness. The Charleston Police Department released a report identifying a terrifying increase in suicide rates and attempts of 78% from 2020 to 2021 (O'Neal, 2021). This information delineates to Charleston's rising trend over the past two decades.

Consequences related to suicide in the Charleston community revolve around social effects, economic impacts, and the ramifications people closest to that person face. A 2020 incident report from the Medical University of South Carolina's (MUSC) Public Safety recorded

two suicides three days apart at one of the parking garages on campus (Jacobs, 2020). This type of information can generate a domino effect within the community. Suicide attempters can use these locations, especially knowing other people have done it. Regarding the fiscal consequences, there is a monumental economic toll suicide and suicide attempts have on society. The Centers for Disease Control and Prevention (CDC, 2019) indicated suicide and attempted suicides cost the nation $70 billion per year in lifetime medical and work-loss costs alone.

As there is a steady incline of suicide rates in Charleston, it has a direct impact on economy costs. There is not only the cost of the actual human, but funeral expenses, medical services, and emergency services are all involved. According to the ripple effect of suicide, those closest to the person who died are most greatly impacted (Sandler, 2018). Family, friends, co-workers, classmates, or anyone who regularly interacted with the person may experience tremendous grief, pain, depression, or even ideations of their own due to their overwhelming trauma. Charleston needs an act of social change in mental health and I hope to identify ways to implement this in this portfolio.

PART 2: SOCIAL-ECOLOGICAL MODEL

[Insert Title of Social Change Project here]

The Social-Ecological Model (SEM) is a creation used to further the understanding of the dynamic interrelations among four different levels. These levels include risk and protective factors at an individual, relationships, community, and societal grouping (CDC). This portion brings light to a SEM with a focus on suicide. It will explain what risk and protective factors each level encompasses in relation to suicide and suicidal ideations.

In regard to a Social-Ecological Suicide Model, individual risk factors can include their gender (transgender status), sexual orientation (lesbian, gay, bisexual), a family history of suicidal behavior, high risk profession (law enforcement or military), and firearm ownership. The United States is the country with the highest prevalence of civilian-owned firearms. The majority of firearms deaths are done with intention to self-harm, and half of suicide deaths involve the use of a firearm. Ownership of firearms is becoming a salient target for suicide prevention efforts (Martínez-Alés et el., 2021). Other factors include financial strain, job status (unemployed), incarceration, high stress/anxiety, race (American Indian and Alaskan Native are most susceptible), and age (middle aged and over the age of 85). In 2020, suicide rates were highest among adults aged 85 and older (American Foundation for Suicide Prevention [AFSP], 2022). Protective factors on the individual basis can be their heterosexual sexual orientation, religious or spiritual views (beliefs about suicide being wrong), their SSRI usage, and mood stabilizer treatment (Cramer & Kapusta, 2017).

A second level to the model looks at relationship risk and protective factors. Certain risk factors include family conflict and violence, family history of mental illness, and family history of suicide or suicide attempt. Other risk factors relating to the relationship component are its exposure to suicide, severing of romantic relationship, social isolation/withdrawal, and death of a loved one (Cramer & Kapusta, 2017). The aftermath of a loved one's suicide can take a painful toll on an individual and family. These family members and friends experience severe life disturbances, unbearable grief, and psychological suffering. Some have a high propensity for suicide themselves after such a traumatic event (Van Dongen, 1991). On the other hand, there are protective factors associated with relationships as well. Some of these include the presence

and use of social support, concerns suicide is harmful to family/children, sense of responsibility to family, healthy long-term marriages and relationships, children present in the home, and contact with caregivers. As a friend, co-worker, or family member, taking suicidal ideations seriously and showing support can let that person know they are not a burden, and they are able to open up to someone willing to listen. Relationship studies show how talking about suicide can help tremendously (Samaritans).

Moving forward, risk factors at a community level can also be present. Common factors include exposure to community violence, local suicide epidemic, and the ever present barriers to healthcare access. My community of Charleston, South Carolina has seen a large rise in suicide cases, as well as attempted suicide cases from the recent COVID-19 pandemic. However, protective factors are also seen at the community level. Crisis support lines, healthcare/mental healthcare access, community involvement, as well as school-based support and intervention programming all share an important role in a communities outcome (Cramer & Kapusta, 2017). Charleston, SC has multiple resources for those feeling suicidal. Development of outreach programs, such as the Speak Out Loud Project, which aims to provide an avenue for younger people to engage in peer-to-peer support and the Assessment/Mobile Crisis, a 24/7 psychiatric assessment team which directs individuals, when clinically appropriate, to appropriate treatment are assisting Charleston and it's members in fighting mental illness (Charleston Dorchester Mental Health Center).

Lastly, societal factors will play a role in the social-ecological suicide model. Societal risk factors for suicide include economic turmoil, seasonal variation, stigma surrounding mental health and treatment, living location, and poverty. As listed, these risk factors can be dependent

on where the individual lives. For example, a study found economic factors to play a part in influencing US suicide rates but not Taiwan suicide rates during the years 1952-1984. This was attributed to the differences in culture, in which being poor is not shameful in Taiwan, but has a greater effect in a consumer-oriented society such as the US (Mann & Metts, 2017). Protective factors include a healthy economy, living location (more restrictive firearms laws), and mental health funding (Cramer & Kapusta, 2017).

PART 3: THEORIES OF PREVENTION

[Insert Title of Social Change Project here]

The Theory of Planned Behavior and the Theory of Reasoned Action are two theories of prevention that will be addressed in this section. The two theories will be applied to suicidal ideations and action. These two theories dive into the relationship between behavior and beliefs, attitudes, and intentions. According to these models, behavioral intention is the most salient factor in determining behavior (National Cancer Institute, 2005). This behavioral intention is influenced by the attitude a person has toward performing a behavior, and by beliefs about whether individual's who are important to the person approve or disapprove of the behavior, which is considered the subjective norm. One construct that differs the two theories is the Theory of Planned Behavior's additional construct: perceived behavioral control. This poses the question of whether the individual believes they possess control over performing the behavior or not.

The Theory of Reasoned Action includes beliefs about social standards and motivation to comply with those norms, which affects subjective norms. Belief strength is the certainty with which the belief is held; belief evaluation is the extent to which the element is concluded to positive or negative. A normative belief is the perceived expectation of individuals of importance regarding the volitional behavior. Motivation to comply is real or imagined pressure one feels for their behavior to correspond with the perceived expectation of others (Hale, Householder, & Greene, 2002). Both theories include constructs that create an understanding that a causal chain of beliefs, attitudes, and intentions drives behavior (National Cancer Institute, 2005).

In accordance with these theories, the intention for an individual to engage in suicidal behavior is based on their attitude towards suicide, and the perceived control the individual feels like they possess over acting on it. The individual's beliefs about the act of suicide itself and the aftermath can influence the behavior. Individuals with strong religious beliefs can share negative feelings on suicidal behavior, as well as those individuals already seeking professional mental health assistance. Also, an individual would be less likely to complete the act of suicide if the belief evaluation would be thought of as negative. Individuals that value their friends and families feelings on suicide would feel more conviction not to complete the act (Hale, Householder, & Greene, 2002). In order to identify salient behavior, the counselor may conduct an open-ended elicitation interview. Included in these interviews are positive and negative feelings about performing the behavior, individuals or groups to whom they might listen who are in favor of or opposed to their performing the behavior, and situational barriers that make the behavior easy or difficult to perform (Montano & Kasprzyk, 2015).

An existing evidence-based programs for suicide is the Youth-Nominated Support Team-Version II Program to Prevent Adolescent Suicide. This program involves psychoeducational and social support for adolescents hospitalized in a psych unit. These adolescents have reported a recent suicide attempt or serious ideation of suicide (Social Programs that Work, 2018). "Caring adults," such as the adolescent's family, members from school, and/or community are nominated to serve as their support person post hospitalization. Psychoeducational courses are provided to learn about youth's problem list and treatment plan, as well as suicide warning signs, how to communicate with adolescents, and how to be promote positive behavioral choices (Social Programs that Work, 2018).

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

[Insert Title of Social Change Project here]

This section will focus on diversity and ethical considerations in dealings with suicide rates, specifically the stark disparities among American Indian and Alaska Native Youth. Among this group, suicide is a major health concern. The overall death rate from suicide is 20 percent higher as compared to the non-Hispanic white population. It is the second-leading cause of death for American Indian/Alaska Natives between the ages of ten and thirty-four (U.S. Department of Health and Human Services). Within the North American indigenous peoples, suicide has been linked to historical and intergenerational trauma (mass trauma resulting from colonization). This historical trauma has passed from generation to generation exposing psychological effects of forced relocation, assimilation, land dispossession, loss of spiritual practices, languages and

culture (FitzGerald et al., 2017). Losing connection to their land can result in a loss of cultural strength. This ethnic minority group often experiences negative social factors such as discrimination, bias, and low socioeconomic statuses. American Indians have also been shown to have the highest substance-related disorder rates than any other ethnic/minority group (Lee & Wong, 2020). All of these contribute and have been significantly associated with poor mental health.

American Indian/Alaska Native suicide is associated with cultural disruptions, disorganization, and a collective suffering. Contrary to this, lower suicide rates and increased well-being have been connected to community empowerment, connectedness, family cohesion, and cultural affinity among Native people (Wexler & Gone, 2012). Within this population, culture plays an integral role and incorporation of cultural sensitivities in counseling is extremely necessary. Family is also important within this population. Native individuals tend to lack the trust in nonnative individuals that lack the necessary local knowledge to most appropriately influence the social context of the individual (Wexler & Gone, 2012). Suicide prevention is best undertaken along with someone of importance to the individual. This is to be considered an ethical consideration as well. In connection with informed consent and confidentiality, which discusses rights and responsibilities of both the counselor and client, the counselor will need to adhere to the code of ethics in working with this population (American Counseling Association, 2014).

PART 5: ADVOCACY

[Insert Title of Social Change Project here]

This section will dive into advocacy and its role in the counseling field. Along with client advocacy, the Multicultural and Social Justice Counseling Competencies (MSJCC) will be identified specifically shedding light on its Counseling and Advocacy Interventions section. Barriers to addressing suicide at the institutional, community, and public policy levels will also be recognized. Lastly, advocacy action towards suicide prevention at all three levels will be mentioned.

Advocacy is not only an action to create environmental change on behalf of clients, but is known as a framework for counselors to help clarify how they may practice social justice (Murray & Crowe, 2016). The work counselors do with individuals one-on-one is not always enough. In order to make lasting differences in the lives of clients, counselors must challenge the social community and work to change it. Advocacy competence is the ability, understanding, and knowledge to implement advocacy appropriately and effectively (Toporek et al., 2009). In connection with advocacy competencies are the Multicultural and Social Justice Counselor Competencies (MSJCC). These competencies offer counselors a framework to integrate each one into all aspects of the counseling profession including counseling theories, practices, and research (Multicultural and Social Justice Counseling Competencies [MSJCC], 2015). The MSJCC has several components including counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions (MSJCC, 2015). However, this section will just focus on the counseling and advocacy interventions domain, specifically at the institutional, community, and public policy levels.

The institutional level may represent churches, school, prison facilities, and so forth. A common barrier to addressing suicide at this level, and every other level, is stigma and discrimination. These negative attitudes induces fear, rejection, and creates distance from people with mental illness. Stigma represents a major barrier to reducing suicide in which it prevents most individuals from seeking treatment resulting in increased suicide risk (Goldsmith, 2002). Detection of suicidality is another barrier to treatment. A study indicated less than 20% of adolescent suicide attempters were asked about suicidal behavior by their care provider despite the fact the strongest predictor of suicide is a previous suicide attempt (Slap et al., 1992). Financial barriers are other common deterrents to mental health treatment. Lack of health insurance coverage and health care costs are two big concerns for individuals looking to receive mental health care. Programs offering free services to suicidal youth and adolescents can still incur challenges such as lack of transportation or parent's unwillingness to seek treatment for their child (Crepeau-Hobson & Estes, 2019).

The unspoken norms, values, and regulations embedded in society are what represent the community level of counseling and advocacy interventions. As aforementioned, barriers to health care access are abundant. Rural areas as well as low socioeconomic communities have an increased need for mental health and suicide prevention, but have trouble gaining reasonable access. Cultural and religious beliefs about suicide within the community may play a role in suicide prevention. Stigma and discrimination creates a distance between mentally ill individuals in communities. Many do not find suicide or suicidal ideation acceptable/normal behavior. Evading individuals experiencing mental instability can create a larger presence of

suicide as well as suicide clusters. These clusters are considered suicidal events happening in greater-than-expected numbers close together in time or geography (CDC, 2021).

The public policy level envelopes the local, state, and federal laws and policies that regulate or influence client human growth and development (MSJCC). Usually, the viability of the mental health profession and its ability to provide elemental and effective services are directly affected by regulations and legislations (Heinowitz et al., 2012). Also on a public legislative level, better access to mental health care needs to be improved. Even the insured individuals may or may not gain access to mental health coverage, resulting in lack of treatment.

Advocacy measures are fortunately formed to support suicide prevention on each level of institutional, community, and public policy. At this latter level of public policy there is an overall objective to reduce the national rate. Annual state legislative recommendations are made in order assist in suicide prevention. An article from Healthy People (2014) mentions the Colorado General Assembly creating the statue, Suicide Prevention Commission. This was created due to Colorado's increased suicide rate. Advocacy for funding for suicide prevention programs and education can be applied at an institutional level. Many students do not seek out treatment and school staff may not have the education to detect suicidal behavior. This may be one of the most feasible avenues of suicide rate reduction in schools.

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