WLG 405

Preventing Suicide in our WV Communities

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Educational Objectives

- Participants will learn the prevalence of suicide in West Virginia.
- Participants will learn how stigma can prevent people from seeking help.
- Participants will learn how to help friends and families who are contemplating suicide.

Mental health is a real issue for families across the United States, including our own West Virginia families. Mountaineers are often known for determination and willpower. Many West Virginians take pride in meeting challenges with the determination to overcome and persevere. While the likelihood of experiencing a mental health issue is similar to urban areas, (approximately one in five adults experience mental health disorders), rural families do not have the same access to care. Across America, rural communities have 20% fewer primary care providers, 28% of rural homes lack access to broadband services, and 65% of rural counties do not have psychiatrist services.

These disparities are causing a mental health emergency in rural America. Mental health and substance use disorders are the most significant risk factors for suicidal behaviors. While rural life is often thought of as a more laid back and simpler way of life, suicide rates among people living in rural areas are 64% higher compared to people living in larger urban areas. In West Virginia one person dies by suicide every 22 hours. Suicide is the second leading cause of death for West Virginia residents, ages 10-34. In 2020, the suicide rate in West Virginia was 27% higher than the national rate.

Stigma

In addition to a lack of basic services, many rural families report a fear of being negatively judged by family, friends and community members for appearing weak or not being able to deal with life's challenges. This contributes to a false belief that mental health issues are not a valid health concern. This stigma that is often associated with mental health remains one of the largest barriers to treatment for many individuals in rural communities.

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As we learn more about the prevalence of mental health issues in our communities, we recognize how much our words matter to combat stigma. One of the best ways to begin helping our friends and family members is to be conscious of language and encourage others to talk openly and honestly about mental health. Try to respond to misconceptions or negative comments by sharing facts and experiences.

While the suggestions below are not an exhaustive list when dealing with stigma, common words to watch include:

Commonly Used Terms	A Less Stigmatizing Choice	Why it Matters
The mentally ill	People with mental illness, people with lived experience of mental illness	The less stigmatizing choices all use person-first language which emphasizes the person's humanity rather than the issue or diagnosis. The preferred terms emphasize that the person *has* a problem rather than *is* the problem. Terms that are less stigmatizing avoid negative thoughts or associations.
Schizophrenic	They have a mental illness, they have schizophrenia	
Addict, user, junkie, drug or substance abuser	Person with substance use disorder, patient	
Alcoholic, drunk	Person with alcohol use disorder	
Former addict, reformed addict	Person in recovery, person who formerly used drugs	
Habit	Substance use disorder or drug addiction	"Habit" undermines the seriousness of the disease and inaccurately implies that a person with a substance use disorder is choosing to use or can choose to stop.
Clean or dirty	Testing positive or testing negative	It's important to use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. Use of such terms may evoke negative thoughts or feelings and can cause people to associate substance use disorder with filth.
Commit/committed suicide	Died by suicide, lost his/her life to suicide	"Commit" implies suicide is a sin or crime, reinforcing the stigma that it's a selfish act and personal choice.
Low functioning	They have a tough time taking care of themself, they are still early in their recovery journey, they have a tough time learning new things	Less stigmatizing language speaks directly to a person's individual experience.

Understanding Suicide

In its simplest terms, suicide is a solution to a problem. However, suicide is extremely complex and often the most difficult human behavior to understand. Still, it is important to remember suicidal people are just like us; they have problems, we have problems. The difference is, for that moment, individuals contemplating suicide believe they are facing a problem that has no other solution than death.

Research shows that suicide is rarely an impulsive act. Most people will think about suicide for days, months, or years before acting. It is imperative to learn common warning signs, or clues of suicide. While this is not an inclusive list, common things to watch for include:

Talking about:

- Wanting to die
- Great guilt or shame
- Being a burden to others

Feelings:

- Empty, hopeless, trapped, or having no reason to live
- Extremely sad, more anxious, agitated, or full of rage
- Unbearable emotional or physical pain

Changing behavior:

- Planning or researching ways to die
- Withdrawing from friends, giving away important items
- Taking dangerous risks
- Extreme mood swings
- Sudden interest, or disinterest in religion

Changes in situation:

- Loss of any important relationship (spouse, child, friend, pet)
- Diagnosis of terminal medical condition
- Fear of loss of freedom
- Loss of financial security

Suicide is preventable and help is available. You can act if you see any of the warning signs or think someone is at risk of harming themselves.

Start the conversation

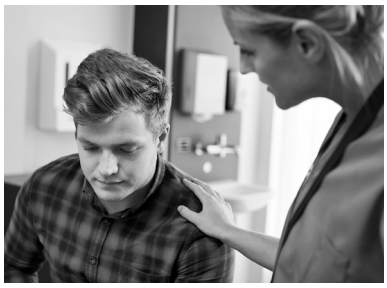
It will feel uncomfortable, but research shows the best response is to ask if they are thinking about suicide. A common myth about suicide is that talking about it will place the thought in someone's head. However, talking about suicide can help reduce suicidal thoughts. Having someone to talk to can ease their burden of carrying the issue alone and bring them relief.

Once you start the conversation, listen and let them know you care. After the question has been asked, your role is to listen first. Advice tends to be easy, quick, cheap and wrong. Practicing active listening takes time, patience, and courage, but it is always right. To be a better listener:

- Give your full attention
- **Do not** interrupt. Speak only when the other person has finished
- **Do not** rush to judgement or condemnation
- Tame your own fear so you can focus on the other person
- Ask open ended questions that encourage the person to keep talking

Once they have had the time to talk to you about the issue, you can start looking for additional help that is more skilled at dealing with individuals having suicidal thoughts.

Refer to a mental health professional



Connecting an individual to a mental health professional can be a challenge for many rural communities. It is important to do homework and know the names and numbers of where to refer a person for help. If you do not know anyone to call, call your own family doctor or dial **988** for the **National Suicide Crisis Lifeline**.

Use these guidelines for an effective referral:

- The best referrals are when you personally make an appointment and take the person you are worried about to a mental health provider
- The next best referral is when the person agrees to see a professional and you help them make the appointment. Then demonstrating concern by following up to learn they kept the appointment.
- The third best referral is getting the person to agree to accept help, even in the future, and providing them with specific referral information.

For those living and working in our rural communities, mental issues can have a detrimental effect on their overall health and impacts all aspects of how they live their lives. Having tools and resources to combat these issues is critical. If you or a loved one feel that you need someone to talk to, you can use one of the free, confidential resources listed below.

WVU Extension offers a community suicide prevention training. If your club, or other community group, would be interested in hosting a training, contact Ami Cook at *ami.cook@mail.wvu.edu* or David Roberts at *david.roberts@mail.wvu.edu*.

National Suicide and Crisis Lifeline
Phone: 988
988lifeline.org
The lifeline provides 24/7 free and confidential support for people in distress, prevention and crisis resources for you or your loved ones.

Crisis Text Line
Text HOME to 741741
crisistextline.org
The Crisis Text Line is free, 24/7 support from anywhere in the U.S. where a live, trained counselor can receive and respond to texts.

Rural Health Information Hub
Phone: 1-800-270-1898
https://www.ruralhealthinfo.org/topics/mental-health
The Rural Health Information Hub is a guide to improving health for rural residents – providing access to current and reliable resources and tools to address rural health needs.

West Virginia Hotlines and Resources

West Virginia Suicide and Crisis Line
Phone: 1-844-HELP4WV/1-844-435-7498
24-hour crisis line

West Virginia Family Resource Network
Phone 304-845-3300
http://wvfrn.org/
The West Virginia Family Resource Networks respond to the needs and opportunities of the Community in each of West Virginia's 55 counties.

Resources

https://www.nimh.nih.gov/health/publications/warning-signs-of-suicide
https://www.ruralminds.org/serving-rural-america
https://mhanational.org/sites/default/files/2022-10/Rural-MH-Crisis-Fact-Sheet.pdf
https://aws-fetch.s3.amazonaws.com/state-fact-sheets/2020/2020-state-fact-sheets-west-virginia.pdf
http://www.wvdhhr.org/bph/hsc/pubs/briefs/013/brief013.pdf
https://www.tn.gov/behavioral-health/stigma.html
http://wvfrn.org/

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