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POLICY SERIES

Youth Suicide Is Increasing: Modest Actions Taken Now Can Save Lives

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Dear Reader,

Now is the time to solve the growing behavioral health needs in our country by advancing public policies that transform the delivery of mental health and substance use disorder services and address outdated funding mechanisms.

This paper is part of Think Bigger Do Good, a series of papers launched in 2017 through the support and leadership of the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation. While the paper topics continue to evolve, our goal to develop a policy agenda to improve health outcomes for all remains constant.

In partnership with national experts in behavioral health, including our editors, Howard Goldman and Constance Gartner, we identified seven critical topics for this third series of papers. Each paper identifies the problem and provides clear, actionable solutions.

We hope you join us in advocating for stronger behavioral health policies by sharing this paper with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters. To learn more about Think Bigger Do Good and to access the other papers in the series, visit **www.thinkbiggerdogood.org**.

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Youth Suicide Is Increasing: Modest Actions Taken Now Can Save Lives

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Introduction

Suicide is the second leading cause of death among young people ages 10 to 24, and rates are rising, as they are for the entire population. Each year, about one in six high school students reports thinking of suicide[1]. More than 150,000 young people are treated in emergency departments annually after engaging in self-harm[2]. The "collateral damage" of youth suicide is extensive. Family and friends are often greatly affected by grief and guilt, and the effects frequently last for years.

Rarely, but even more traumatically, youth suicide can snowball within schools and communities into "suicide clusters," in which a single death becomes a kind of contagion fed by relationships and communication, including social media, and leads to others. Although such clusters are rare, they occur most frequently among young people, accounting for an estimated 100 to 200 deaths annually in this group[3]. These events are devastating for communities.

In a previous publication for this policy series, I discussed recommendations to reduce suicide across the life span[4]. There has been promising action on several of these recommendations, including accreditation standards with a stronger focus on suicide prevention issued by The Joint Commission and passage of the National Suicide Hotline Improvement Act of 2018. Now it is time to consider steps to decrease youth suicide. The burden of mortality and morbidity (e.g., residual trauma and increased risk for survivors) is high. The gap between what we know and what we do is large—and it is growing, because much more is being discovered about what works. The current level of effort nationally is very small. The only national youth suicide prevention program (created via the Garrett Lee Smith Memorial Act of 2004) has demonstrated its impact, but the program is modest and provides only time-limited support to selected communities. In addition, institutions that are critical to youth suicide prevention (e.g., schools and healthcare systems) have not yet broadly embraced the mission. The uneven adoption of effective suicide prevention methods, especially by schools, is particularly concerning given the impact of youth suicide clusters and the fact that suicidal impulses can trigger mass violence.

Although the risk of any individual suicide by a young person is low, the risk and the potential impact are increased by a "neighborhood" death, whether that neighborhood is defined geographically or by social media boundaries. Thus, the need to act on youth suicide is great. The opportunities are salient because of suicide's impact, because available tools are significantly improved, and because of several timely national policy opportunities.

Action is needed at the national level and in states and communities. Nationally, increasing concern about youth suicide as well as data showing both the effectiveness and the limited scope of the Garrett Lee Smith Memorial Suicide Prevention Program suggest that the program should be expanded. An ongoing effort is needed, rather than a program that provides time-limited discretionary grants in an unpredictable manner. In addition, as youth suicide rates increase, programs that address school safety and mental health needs must address suicide prevention more explicitly, as highlighted in national suicide prevention recommendations for school systems[5].

This policy paper focuses on policy advocacy for national action on youth suicide. Although compelling efforts have been implemented in the private sector, a full inventory is beyond the scope of this paper, and recommendations emphasize actions that could be undertaken by the government.

Patterns and Challenges

Thomas Joiner's interpersonal theory of suicide[6] has been influential in changing thinking about suicide and its prevention and helps frame policy choices. Joiner theorized that suicidal thoughts and the desire for suicide are influenced by isolation ("thwarted belongingness") and by perceptions that one is a burden to others. He suggested that thoughts of or even the desire for suicide are not sufficient to result in suicide; one must acquire the capability to kill oneself—both by overcoming one's natural fear of death and by acquiring the means to do so.

Research by Millner and colleagues[7] explored Joiner's ideas via in-depth interviews with individuals who had attempted suicide. Results showed that the median time between initial thoughts of suicide and the attempt was long (about 2 years), suggesting that acquiring the capability for suicide is often a lengthy process. This finding also suggests that a long window for productive intervention may often exist—if, and only if, individuals are identified during this period. However, Millner and colleagues found great variability in the "pathways" by which people progressed toward an attempt.

These patterns are even more variable with young people. Teenagers are sensitive to social influence, so "shaming" on social media may result in dangerous pressures on vulnerable youth. Media coverage that sensationalizes suicide or discusses methods of self-harm can make suicide seem more attractive and feasible, and can reduce normal inhibitions against self-harm. Impulsiveness is also a notable developmental challenge for teens, and thus they may be much more likely to progress quickly from thoughts of suicide to an attempt. These factors suggest that approaches to reduce youth suicide must be even more sensitive to social networks than in efforts with adults.

Patterns Specific to Youth Suicide

As noted, suicide is the second leading cause of death among young people ages 10–24. Suicide claimed more than 6,000 young lives in the United States in 2016—more than three times as many lives as lost to cancer in this age group and more than 25 times as many as lost to flu and pneumonia. The rate and number of youth suicides—as with suicide deaths generally—have both increased considerably since 2003, following a period of decline after 1990.

The number of suicide deaths among young people only partly illustrates the scope of the problem of self-harm, although the impact of youth suicide on families and the years of life lost are substantial. For every youth suicide death, there are about 25 suicide attempts serious enough to require medical attention. These attempts are also costly and traumatic, and a past suicide attempt increases future risk. This pattern of many nonfatal attempts is true for all age groups, but it is more pronounced for young people. A key issue is the means of self-harm that is used. Attempts with a gun are likely to be fatal, and the lethality of attempts is much greater for individuals with access to a gun (e.g., veterans, police officers, and older men). Therefore, access to firearms is a key suicide prevention issue when young people with their more impulsive mindset are exposed to loss or trauma, such as a suicide in their school.

Prevention efforts should consider several groups of youth who are at elevated risk of suicide. Considering Joiner's framework, it is likely that the vulnerability of some youth is affected by stigma that reinforces perceptions of being unwanted. For example, sexual minority youth have elevated rates of self-harm and suicide; these patterns are strongest among transgender youth, for whom stigma is powerful. American Indian/Alaska Native youth have the highest rates of suicide among ethnic groups, perhaps driven by historical trauma and loss of cultural identity. For these minority groups, addressing the underlying conditions of discrimination is a challenging but important task. Intervention efforts must also be culturally appropriate, because cultural issues can be the drivers of suicidal thinking and of isolation. Similarly, suicide rates are elevated for youth in the foster care and juvenile justice systems, where many have been exposed to some precursors of suicidal thinking (e.g., trauma) and where stigma and social isolation may also increase risk. This paper does not include specific recommendations for subpopulations of youth at elevated risk. However, an increased focus on identifying suicide risk (such as in healthcare and mental health settings) and providing effective treatment and support is needed.

Current Efforts to Prevent Youth Suicide: Status and Recommended Actions

Suicide prevention is a relatively young field. The first National Strategy for Suicide Prevention, developed by the Center for Mental Health Services and the Office of the Surgeon General, was published in 2001. It emphasized applying public health methods to the problem (e.g., surveillance, community-wide efforts, developing awareness, and improving access to mental health care). As noted previously, the first national program targeting youth suicide was created by the Garrett Lee Smith Memorial Act, passed in 2004. The legislation was championed by U.S. Senator Gordon Smith, who lost his son to suicide. Currently funded at about $40M per year and administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Garrett Lee Smith (GLS) Memorial Suicide Prevention Program provides grants to states and tribal nations and also smaller grants for campus suicide prevention. The grants emphasize the community-wide approaches championed in the national strategy and more recently also require healthcare and behavioral healthcare systems to develop suicide prevention competencies or "suicide care" competencies. Both community-wide and healthcare strategies are necessary for suicide prevention for youth as well as adults. In the previous publication for this policy series, I emphasized the need to expand a focus on suicide prevention in health and behavioral health systems[4]. The GLS grant program does this effectively, but its impact is limited to the states and regions that receive grants.

The impact and effectiveness of the GLS grant program have been evaluated several times. Walrath and colleagues[6] reported that the program reduced suicide in communities where grant-funded efforts were present, but only for the target population. Effects were not sustained beyond the grant period. A more recent evaluation of the GLS grant program had somewhat similar results; effects continued beyond the grant period but faded after two years[7]. It appears that the infrastructure for youth suicide prevention in a community must be sustained to be effective.

ACTION RECOMMENDATION

Congress should expand the Garrett Lee Smith Memorial Suicide Prevention Program to provide ongoing grant support to states, retain the competitive grant program for colleges and universities, and ensure a continued focus on tribal communities.

The other national prevention efforts are modest programs that cover the entire age span. The National Suicide Prevention Lifeline (Lifeline) is a network of more than 160 crisis call centers coordinated by a national office that sets standards for the local centers and provides training, support, and evaluation. The Lifeline, launched in 2002 and reached via 1-800-273-TALK, has seen steady growth and now handles more than 2 million calls a year. A recent evaluation of the program showed that callers value its services, and many credit calls with averting suicide[8]. However, funding is inadequate at about $6M per year. Insufficient capacity to keep up with increasing call volume, which spiked after the deaths of Kate Spade and Anthony Bourdain, led to a small one-time funding increase in 2018. Federal funding is used for infrastructure and training but does not address costs of the roughly 160 local centers that answer the calls. As a result, there is turnover in participating centers, long waiting times can occur, and capacity in many states is not adequate to ensure that calls are answered in that state. The backup centers in other states that answer many calls lack quality information on resources in the caller's community.

Strengthening the nation's crisis line infrastructure is being considered as a result of the National Suicide Hotline Improvement Act, passed in 2018. The legislation requires SAMHSA, the Department of Veterans Affairs (VA), and the Federal Communications Commission (FCC) to report on the effectiveness of the Lifeline and on the feasibility of assigning a national three-digit number (a "911 for the brain") for the Lifeline. As of early 2019, SAMHSA and the VA have completed reports, and the FCC must integrate its findings and report to Congress this year. Although many technical issues must be addressed, the suicide prevention field is united in the belief that a three-digit national number would have great benefits in terms of visibility and reduced stigma.

ACTION RECOMMENDATION

A national three-digit number (a "911 for the brain") should be dedicated to suicide prevention and mental health crises.

A national effort to improve timeliness and stability of the Lifeline while also addressing mental health crisis calls will require a stronger local call center infrastructure that allows calls to be answered in the state where they originate. Lifeline personnel who answer calls locally have better knowledge of available resources, which leads to better referrals and follow-up. Improvements made in crisis call lines for veterans show these better outcomes.

Currently, via a "press 2" option, Lifeline callers who are veterans are transferred to the Veterans Crisis Line (VCL) operated by the VA. The VCL has been adequately funded and significantly improved. It now includes three call centers staffed 24/7, robust text and chat programs, and connections to suicide prevention coordinators located at every VA medical center. Results include dramatic improvements in waiting times, fewer missed calls, and thousands of "rescues"—in which local safety personnel were dispatched to locations where callers acknowledged a suicide attempt was imminent or in progress.

ACTION RECOMMENDATION

The improvements made to the Veterans Crisis Line and call centers should be applied to the National Suicide Prevention Lifeline. Congress should appropriate the modest increases in federal funding to cover all call center costs.

Adequate funding could also expand the responsibilities undertaken by crisis call centers. Personnel could make follow-up calls to individuals at high risk, such as those recently discharged from inpatient units or from emergency departments. There is considerable evidence that supportive "caring contacts," such as those made after inpatient discharge, can reduce suicide attempts and death. This is important because rates of suicide in the days and weeks after a discharge from acute care are the highest measured for any population. However, follow-up support is not yet provided in most healthcare settings. The responsibility of the inpatient unit ends with discharge. For various reasons, including reluctance to accept post-hospital care, only about half of individuals discharged from inpatient psychiatric care receive any outpatient care within the first week post-discharge—the most critical period for suicide prevention. Some participating Lifeline centers offer a program of follow-up calls, but funding for such calls is minimal.

ACTION RECOMMENDATION

With the strong evidence supporting caring contacts and the reality of a fragmented and poorly resourced mental health system making follow-up care difficult to receive, improved funding for the Lifeline and for crisis care is needed and should be used to make caring contacts more widely available.

Other national suicide prevention resources that include a focus on youth are at the Centers for Disease Control and Prevention (CDC) and the Suicide Prevention Resource Center (SPRC) funded by SAMHSA. The CDC, consistent with its mission, promotes public health approaches to suicide prevention. It provides guidance to states and communities but does not have the resources to fund suicide prevention activities. Of particular relevance are SAMHSA's recommendations specific to youth, and in particular its guidance to schools and school districts about suicide prevention (e.g. Preventing Suicide: A Toolkit for High Schools). Such guidance is important because schools are the major institution for all children and because student safety and well-being are a concern and, at least implicitly, a responsibility of schools. The complexity of children's needs has grown and addressing them presents an almost insurmountable challenge for schools. Therefore, the best available advice for schools on suicide prevention is a significant resource.

Broader application of national guidance on school suicide prevention would be strengthened if this message was backed by funding directed to schools. Indeed, a key and relevant resource that SAMHSA provides to schools should—but does not currently—require attention to suicide prevention. The Safe Schools/Healthy Students (SS/HS) initiative is a robust national grant program launched in 1999 after a series of school shootings that called school safety into question. The program emphasizes comprehensive prevention-oriented approaches to targeting healthy development, preventing behavioral health problems, improving school safety, and promoting collaborative local action. There is no prohibition against including suicide prevention in SS/HS activities. However, school violence is often seen as a problem of violence toward others not toward oneself, and SS/HS programs include no explicit requirement to address suicide.
For several reasons, the SS/HS program should require explicit attention to suicide prevention in its school violence prevention efforts. Schools are integral to youth suicide prevention because they are the single institution in which virtually all young people participate. In addition, suicide is devastating for school communities, and effective school suicide prevention practices exist.
Although prevention experts, such as SAMHSA and SPRC, advocate school suicide prevention efforts, there has been no explicit national mandate or funding to address the problem.

A more explicit focus on suicide prevention by schools is necessary. These actions could include education and awareness programs, such as Signs of Suicide (SOS) for middle and high schools[10], and crisis intervention/postvention efforts, in which schools have access to same day/next day mental health support after a traumatic event, such as the death of a student or teacher.

In addition, recent research has drawn a tighter link between suicide and other violence. Joiner[11] has suggested that most if not all mass shootings have elements of suicide. Therefore, preventing the most egregious acts of school violence requires attention to suicide, and evidence-based prevention programs that are known to help prevent suicide, such as Sources of Strength (**sourcesofstrength.org**) and the Good Behavior Game (**goodbehaviorgame.org**), are consistent with the SS/HS framework.

Finally, suicide clusters, in which a single death leads to others in a community, represent a particularly urgent kind of preventable school-related violence.

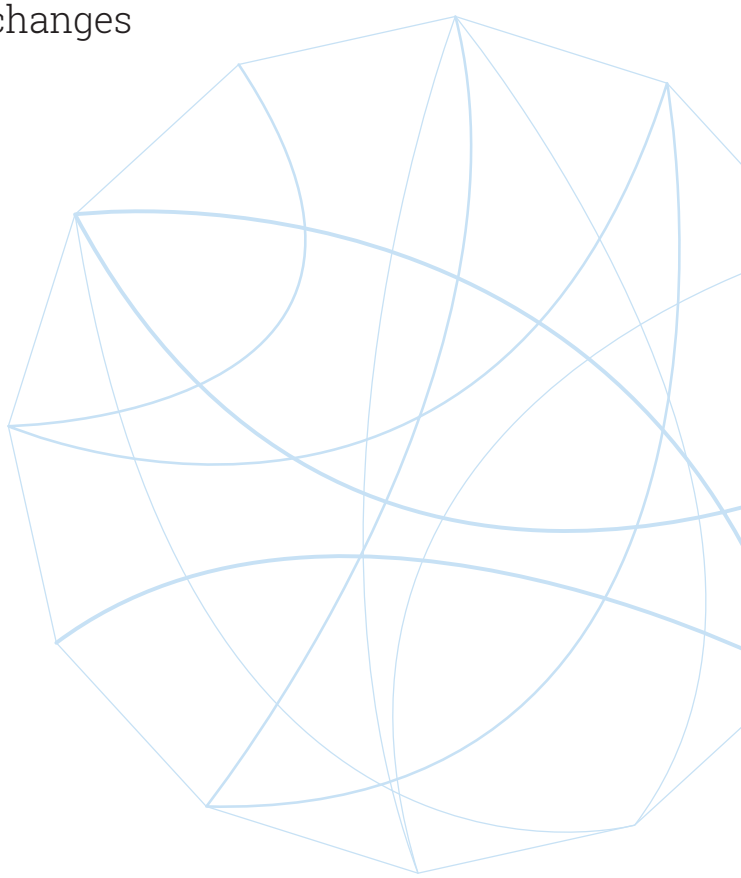
ACTION RECOMMENDATION

SAMHSA should revise grant requirements for the Safe Schools/Healthy Students program to make suicide prevention activities, including readiness to prevent suicide clusters, an explicit and required element of the program.

Conclusion

The knowledge needed to prevent youth suicide has evolved, and at the same time rates of death have increased. Applying new knowledge can reverse the trajectory of increased deaths among young people.

Because of growing concern, action now appears possible. We should seize the moment to make these modest changes that can save young lives.



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