Reversing the Rising Tide of Suicide
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The National Conference of State Legislatures is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation’s 50 states, its commonwealths and territories.

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Introduction

Suicide is a prominent and growing health concern in the United States. According to the Centers for Disease Control and Prevention (CDC), suicide was the 10th leading cause of death in the United States in 2018, accounting for over 48,000 deaths. Suicide deaths have increased in nearly every state between 1999 and 2016 and have increased by more than 30% in half of all states.

For every suicide death, there are more than 200 people who consider suicide—more than 10 million Americans in 2018. Of these 10 million who considered suicide, more than 3.3 million would go on to make a suicide plan and more than 1.4 million made a suicide attempt.

Suicide deaths and suicide attempts have tremendous implications beyond the individual. Family, friends and coworkers of the deceased can struggle with grief, anxiety and guilt. Beyond the human toll, suicides and suicide attempts cost the nation almost $70 billion per year in lifetime medical and work-loss costs.

Suicide is a preventable cause of death and states, local governments and the federal government are implementing a variety of strategies to reverse its escalation.

Risk Factors for Suicide

There is no one cause of suicide. According to the American Foundation for Suicide Prevention, suicide “most often occurs when stressors and health issues converge to create an experience of hopelessness and despair.”

There are many factors that may influence an individual’s risk of suicide. Recent research has found a strong correlation between childhood traumatic events, known as adverse childhood experiences (ACEs) and an adult’s risk of suicidal thoughts and behavior. Other risk factors can include a personal or family history of mental illness, including alcohol and substance abuse, or suicide attempts. Physical illnesses, especially chronic conditions, can also influence an individual’s risk of suicide. In at least one study, 85% of people who died by suicide had contact with a health care provider in the four weeks prior to their death. However, researchers maintain it is important to note that more than half of people who die by suicide have no known mental health condition at the time of their death.
Adverse Childhood Experiences and Risk of Suicide

Adverse childhood experiences (ACEs) encompass potentially traumatic events that occur before the age of 18. Experiences such as violence, abuse, and growing up in a family with mental health or substance abuse problems can affect people throughout their lifetime. Toxic stress, or chronic stress sustained by a child over time without adequate adult support, can alter brain development and affect how the body responds to stress. The first ACEs study, conducted from 1995 to 1997, and decades of research since, have linked certain childhood experiences to lifelong negative health and social outcomes, including asthma, substance use disorder, mental illnesses such as depression and suicide, and other issues. Often, these experiences are repeated through generations.

ACEs can describe physical, emotional and sexual abuse, household challenges of parental separation, household substance abuse, parental incarceration, violence and untreated mental illness in a parent. In 2019, CDC published a report noting a link between childhood adversity and at least five of the 10 leading causes of death, including suicide. The study found 61% of U.S. adults reported having at least one ACE and 16% had four or more. These findings highlight the potential of preventing ACEs as a strategy for addressing the opioid overdose crisis, reducing the prevalence of suicide and preventing leading causes of death in the United States.

Fortunately, certain protective factors can help mitigate the long-term effects of ACEs. Factors such as strong family bonds cultivate resilience that can help protect children from the detrimental effects of adverse experiences. Safe, stable and nurturing relationships and communities help build resilience, prevent violence, improve mental health and support health across one’s life span. Efforts that focus on building healthy families early in a child’s life are cited as significant means of preventing ACEs and reducing their damaging effects.

Since 2015, at least 30 states and Washington, D.C., have enacted bills related to ACEs. They focus on topics such as childhood trauma, child adversity and toxic stress. Many of these bills address workforce training on trauma-informed practices or how to identify ACEs, behavioral health supports for children, or creating a new task force or fund to address childhood adversity. Some relate directly to suicide prevention. For instance, Iowa enacted SB 18-2113 to require school districts to train employees to identify ACEs and adopt protocols for suicide prevention and strategies to mitigate toxic stress. Texas lawmakers enacted SB 19-11 to establish the Texas Child Mental Health Care Consortium. This bill requires a trauma-informed care policy in education, including a mental health and suicide prevention curriculum, and allocation of funds for prevention and treatment programs that address ACEs. Washington passed SB 19-6259 amending the Indian Behavioral Health System, requiring funds to be used on programs that address the ongoing suicide and addiction crisis among Native Americans and Alaska Natives in recognition of higher rates of exposure to ACEs.

Explore other policies related to ACEs and suicide prevention in NCSL’s Injury Prevention Database.
Who Dies by Suicide in the U.S.?

Suicide affects people of all ages, races, religions and geographic locations across the United States. However, deaths by suicide and suicidal ideation affect some populations more than others and risk factors for suicide are not spread evenly across the country.

While many people associate suicide deaths with younger Americans and death by suicide in this age group is of great concern, middle-aged men make up the largest number of suicides. Men are between 3.5 and 4.5 times more likely to die by suicide than women, a trend that holds up in all age groups except the youngest, ages 10 to 14. Women, however, are 1.5 times more likely to consider suicide than men.

Suicide is the second-leading cause of death for people 15 to 24 years old and the fourth-leading cause among people ages 35 to 44. However, suicide accounts for less than 15 deaths per 100,000 people among 15- to 24-year-olds and 18.2 deaths per 100,000 among 35- to 44-year-olds.

Suicide deaths in the United States

By age and gender, per 100,000 people.

Rural and remote communities, which may experience both harsher economic conditions and less access to mental health care, also experience higher rates of suicide than urban areas. Certain professions, like veterans, first responders and health care providers, are also more likely to die by suicide. According to the CDC, other major occupational groups at higher risk of suicide include construction and extraction (miners, forestry workers, etc.), transportation and material moving (trucking), and health care support. Sexual minorities, especially LGBTQ+ youth, are particularly vulnerable to suicide, with 29% of LGB youth reporting a suicide attempt in the prior year compared to 6% of heterosexual youth, according to the CDC in 2015. Research has also demonstrated that 25% to 30% of transgender adolescents attempt suicide at least once in their lifetimes. American Indian and Alaska Native communities experience the highest rates of suicide.
State Strategies

While suicide is a complex and growing problem among the states, suicide is preventable and there are evidence-based policy options lawmakers can consider.

Crisis Hotlines and Apps

Crisis “hotlines” or “lifelines” are phone numbers that people considering suicide or self-harm can contact to speak to a trained intervention specialist about their situation. Traditionally, individuals using these hotlines would call and speak to a live person, usually a trained volunteer. Increasingly, hotlines enable users to text with the person on the other end of the line. Texting can feel more comfortable for many people afraid to open up about their mental health struggles or for youth who are more comfortable with texting than speaking on the phone.

The National Suicide Prevention Lifeline (1-800-273-8255) provides free and confidential emotional support to people in suicidal crisis or emotional distress across the United States. The lifeline comprises a national network of over 150 local crisis centers that respond directly to local calls. Because local crisis centers answer calls, backups and longer wait times can occur if a crisis call center does not have the resources to meet local demand.

State legislatures have expanded on the work of the national lifeline and created tailored lifelines for their communities. Colorado’s SB 07-197 created the state’s Safe2Tell program, which initially allowed students, parents and other members of the education community to anonymously report threats and instances of bullying by calling the toll-free number. Colorado’s SB 12-79 revised the program and expanded the list of reportable concerns to include suicide and allowed students to make reports by phone, the program’s website and the program’s app. Today, most of the reports received by the hotline are concerns about suicide. Utah’s SB 15-175 created the statewide mental health crisis line known as SafeUT. The program anonymously connects youth with licensed clinicians 24/7 through the program’s app. If counselors deem users to be at risk of immediate harm to themselves or others, they can track the user’s cell phone location and notify local responders trained to intervene in crisis situations.

Gatekeeper Training

Learning to identify the signs that someone may be experiencing a mental health crisis and the strategies to intervene can help prevent suicide and connect those with unmet mental health needs to the appropriate care. This can be especially true with professionals who work in close contact with at-risk individuals, such as teachers, and with professionals who are part of high-risk groups, such as first responders.

There are a number of nationally recognized “gatekeeper” training models that states have implemented to prevent suicide. Mental Health First Aid is an eight-hour course that teaches people how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training provides the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. Different iterations of the training program are designed for teachers, first responders, veterans and other professionals who work with vulnerable populations.

More than 20 states have considered or adopted Mental Health First Aid training requirements for various professions, including educators, first responders, corrections officers, school administrators and health care professionals. Maine’s HB 17-929 requires all teachers in secondary education to undergo the training while Florida’s SB 17-2500 provides an appropriation to local mental health agencies to provide training services.

Applied Suicide Intervention Skills Training (ASIST) is another program that helps hotline counselors, emergency workers and other gatekeepers identify and connect with suicidal people and connect them to available resources. One study of 1,410 suicidal individuals who called 17 lifeline centers found that callers who spoke with ASIST-trained counselors were significantly more likely to feel less depressed, less suicidal and
more hopeful by the end of their call. Counselors trained in ASIST were also more skilled at keeping callers on the phone longer and establishing a connection with them.

The Zero Suicide framework is a systemwide, organizational commitment to safer suicide care in health and behavioral health care systems. The model recognizes that people at risk of suicide often fall between the cracks in the health care system. About 85% of people who die by suicide sought some form of health care in the four weeks prior to their death and up to 45% of individuals who die by suicide visited their primary care physician within a month of their death. Training providers to identify, intervene and successfully connect patients with appropriate suicide prevention care is a central tenet of the Zero Suicide framework. Beyond gatekeeper training, the framework also stresses the importance of continued health care quality improvement around suicide prevention, follow-up for patients considering or at risk of suicide, and counseling that encompasses access to lethal means.

Colorado’s SB 16-147 requires the Office of Suicide Prevention to create and implement a Zero Suicide plan involving health care providers from across the health care system. This plan improves training for health care providers, emergency first responders and other stakeholders on identifying individuals at risk for suicide and connecting them to the appropriate care. Louisiana’s HB 18-148 established the state’s Zero Suicide Initiative, which focuses on training health care providers to identify suicide risk factors early. The bill requires the state health department’s Office of Behavioral Health to use existing data to identify priority groups of patients, improve the quality of care for people considering suicide and provide a basis for measuring progress.

Addressing Specific Risk Groups

Some groups and professions are more at risk of attempting suicide than other populations. Stigma, lack of culturally appropriate care and exposure to traumatic events can make these populations, such as veterans, workers in construction and mining, first responders and sexual minority youth, more vulnerable to suicidal thoughts. Some states have taken legislative action to specifically address these groups and the special challenges they face.
■ VETERANS

There is a higher rate of death from suicide among veterans than in the general population. Over 6,000 veterans die by suicide each year and the suicide rate among male veterans is 1.3 times higher than non-veteran males and 2.2 times higher among female veterans than non-veteran females.

While the federal government handles many mental health needs among veterans through the Department of Veterans Affairs, many states have taken action on their own to address suicide in this vulnerable population. For instance, Washington’s HB 15-1424 requires all medical health professionals to undergo suicide prevention training specific to veterans and HB 18-6514 requires higher education professionals to receive training for identifying and intervening with student veterans at risk of suicide. Texas’ SB 17-27 established a trauma-affected veterans clinical care and research center at The University of Texas Health Science Center at San Antonio. West Virginia’s SB 20-289 created the state’s “Green Alert” program for missing veterans. It provides law enforcement with additional tools to help respond to at-risk veterans’ disappearances, emphasizing the risk of suicide for veterans with a service-related condition.

■ FIRST RESPONDERS

According to a 2018 white paper published by the Ruderman Family Foundation, there were at least 103 deaths by suicide among firefighters and emergency medical service (EMS) providers in 2017. The report concluded that deaths in the line of duty occurred less frequently than deaths by suicide, with 93 reported deaths in line of duty in 2017.

Among law enforcement, the same paper found 108 suicides in 2016 and 140 suicides in 2017. There were 129 deaths in the line of duty in 2017. For every reported suicide, the researchers believe there are an additional 25 suicide attempts. The same researchers also believe only 40% of suicides in these populations are reported. Accordingly, the actual number of first responders who died by suicide in 2017 is likely much higher.

Illinois’ SB 19-730 created the First Responders Suicide Prevention Act, requiring training programs to recognize signs of suicide and offer appropriate solutions for intervention. The bill relies on peer counseling services, or the service of other first responders to help support suicide prevention efforts. While the bill requires all first responders to receive suicide prevention training at least every three years, it also allows for certain first responders to be designated as peer supports to help connect other first responders experiencing suicidal thoughts to the appropriate care. Kentucky’s HB 18-68 requires the Department of Criminal Justice Training of the Justice and Public Safety Cabinet to develop a law enforcement wellness program. The program must use seminar-based peer support and counseling services designed to reduce negative mental and behavioral health outcomes and be offered twice a year.

■ OTHER PROFESSIONS

Other professions, including workers in industries like construction, extraction and other labor-intensive professions, face higher suicide rates than other groups. Professional associations for these groups cite stigma, chronic pain, substance use and a large number of veterans working in these professions as reasons for this disparity.

The Construction Industry Alliance for Suicide Prevention (CIASP) recommends employers make suicide safety a priority by providing training to identify and help those at risk. It advises raising awareness about the suicide crisis in construction and normalizing conversations about suicide and mental health to ultimately decreasing the risks associated with suicide in construction. CIASP has a number of resources for employers to improve their suicide prevention protocols and change company culture around discussing mental illness.

■ LGBTQ+ YOUTH

Sexual minorities, especially LGBTQ+ youth, are particularly vulnerable to suicide, with 29% of LGB youth reporting a suicide attempt in the prior year compared to 6% of heterosexual youth, according to the CDC in 2015. Another study shows that lesbian, gay and bisexual youth who come from rejecting families are 8.4 times more likely than their peers to attempt suicide. The study also reported that parental support of
transgender children was significantly associated with higher life satisfaction, lower perceived burden of being transgender and fewer depressive symptoms.

Promoting positive, connected environments for LGBTQ+ youth is one potential pathway for states to address suicide in this community. For instance, data show that the rate of suicidal thoughts was cut in half for lesbian, gay and bisexual students in schools with gay-straight alliances.

California enacted AB 18-2246, requiring school districts to create comprehensive suicide prevention plans for all students, including specific protocols for preventing suicide among LGBTQ+ students. In school districts with a suicide prevention policy enacted prior to AB 2246, only 3% contained language related to LGBTQ+ youth. By contrast, more than 90% of policies enacted post-AB 2246 address the needs of LGBTQ+ youth. Other states have addressed LGBTQ+ youth suicide by adding sexual orientation to existing anti-bullying statutes. Anti-bullying laws that explicitly protect youth based on sexual orientation are associated with fewer suicide attempts among all youth, according to the University of California, Los Angeles School of Law’s Williams Institute. Arkansas’s SB 11-892 clarifies the state’s existing anti-bullying statutes and prohibits bullying on the basis of sexual orientation and made certain requirements of school anti-bullying programs.

Other states have acted to ban conversion therapy among LGBTQ+ youth. Conversion or “reparative” therapy attempts to alter an individual’s sexual orientation or gender identity and research has demonstrated a link between conversion therapy and increased rates of depression and thoughts of self-harm. Twenty states have banned conversion therapy for youth, including Utah, which banned the practice through changes to its professional licensing rules. The Virginia General Assembly passed SB 20-245 to ban the practice.
Addressing Lethal Means

Whether or not a person dies of a suicide attempt may largely depend on the method used. Decreasing access to highly lethal means of suicide—including dangerous medications, firearms, and barrierless bridges and other high places—can be an effective strategy to prevent suicide for people at high risk. Individuals taking dangerous medications and firearm owners are not necessarily at higher risk of suicide attempts than others. However, they are more likely to die as a result of a suicide attempt because of their access to a highly lethal means of suicide.

States have employed counseling on access to lethal means (CALM) as a tool. Training on CALM provides health care providers and other professionals with knowledge about how to counsel people at risk for suicide and their families on how to safely store and restrict access to dangerous medications, firearms and other lethal means. North Carolina’s HB 19-75 provides grants through the state’s department of education for CALM trainings. Washington’s HB 19-2411 expands the types of health providers required to undergo suicide prevention training, including access to lethal means training, to include marriage therapists, certain social workers and other mental health care providers.

States have also partnered with firearm owners, retailers and local public health agencies on initiatives like the Gun Shop Project. This project is a partnership between various stakeholders, including public health agencies, firearm owners and retailers. It provides firearm retailers and firing ranges with suicide prevention materials tailored to their customers and encourages them to allow firearm owners at risk of suicide to safely store their firearms at their facilities while seeking treatment. The project currently has participating programs in 21 states. Vermont’s SB 15-141 directs the state’s department of health to administer such a partnership and to report to the legislature on the partnership’s activities and successes.

States have also sought to create barriers over bridges and other high places where suicides and suicide attempts are common. California’s AB 13-755, for instance, requires any new bridge replacement project to include a report on the history of documented suicides and demonstrate that a suicide barrier was considered during the project’s planning process.

Federal Resources

The CDC provides an overview of suicide prevention and prevention resources. Resources include CDC’s Vital Signs report from 2018 on suicide prevention that highlights key considerations for policymakers at the state and local levels. The CDC also provides a technical package with a comprehensive overview of suicide in the United States. It highlights a select group of strategies based on the best available evidence to help communities and states sharpen their focus on priorities with the greatest potential to reduce suicide. These include:

- **Connect patients with mental health care.** Strategies that increase access to care, including covering mental health services under insurance plans and working to address provider shortages in underserved areas, can address underlying mental health problems contributing to suicidality.

- **Strengthen economic stability.** Suicide rates increase during times of economic hardship and decrease in better economic climates. Financial strain caused by uncertain employment situations or job loss can influence suicide risk or exacerbate existing risk factors. Providing unemployment benefits and other forms of temporary assistance can help alleviate the stress and uncertainty of economic hardship. Efforts to stimulate job growth in rural and other economically distressed communities can help provide relief as well.

- **Promote connected environments.** Increasing social connectedness may protect against suicidal behaviors by decreasing isolation, encouraging coping behaviors and increasing a sense of belonging. Connectedness may also increase people’s access to formal supports and resources. Studies have shown that participants in community engagement activities, such as religious activities or volunteer activities, report lower levels of stress (a suicide risk factor), and higher levels of physical activity (a protective factor).

- **Additional strategies.** These include teaching coping and problem-solving skills, identifying and supporting people at high risk, creating protective environments, lessening harms and preventing future risk.
**Suicide Prevention in the Age of COVID-19**

The ongoing COVID-19 pandemic has renewed conversations about mental health and suicide prevention as the U.S. tumbles toward a recession and millions of Americans have lost their jobs. Although the response to the novel coronavirus has largely centered on preventing transmission of the virus and treating the ill, people’s anxiety around COVID-19 extends beyond fearing for their own physical health and the health of their loved ones. The pandemic has amplified feelings of isolation and loneliness for millions of Americans, especially older adults and others at heightened risk. Millions more have found themselves suddenly without a job or working reduced hours, increasing anxiety about financial security. Almost half of all Americans in a March poll reported that the virus had affected their mental health.

In response, states and the federal government have taken actions to increase access to mental health care during the crisis through telehealth. By increasing access to mental health care through virtual platforms, states are attempting to meet the increased demand for mental health services while maintaining social distancing. The government board tasked with regulating Florida's mental health providers released a new rule allowing certain interns to provide telepsychiatry services, increasing the number of providers. Kentucky's legislature passed SB 150, allowing the state's licensing boards to permit certain out-of-state licensed providers to offer telehealth services in the state and expediting certification of in-state providers as a response to the pandemic. Minnesota lawmakers introduced House File 4490 which would appropriate $90,000 annually to improve mental health services and outreach for rural Minnesotans.

The federal government also loosened some restrictions on telehealth to support state flexibility. The U.S. Department of Health and Human Services issued a “notification of enforcement discretion” on certain HIPAA (privacy law) requirements. It allows health care providers to communicate and provide treatment using certain non-public-facing virtual platforms that may not otherwise meet privacy requirements under federal law. The Centers for Medicare and Medicaid issued guidance allowing everyone covered by Medicare to access mental health care through telehealth regardless of their geographic location or whether they are a new or existing patient with the provider from whom they are seeking services.

The Substance Abuse and Mental Health Services Administration (SAMHSA), housed within the U.S. Department of Health and Human Services, leads public health efforts to advance the behavioral health of the nation and improve the lives of people living with mental and substance use disorders. SAMHSA administers and evaluates several state grant programs, including Grants to Implement the National Strategy for Suicide Prevention, Grants to Implement Zero Suicide in Health Systems and the Garrett Lee Smith grants for campus, state and tribal suicide prevention programs.

The U.S. Department of Veterans Affairs maintains a webpage dedicated to veteran suicide, offering online training to identify at-risk veterans as well as resources for veterans considering suicide to connect with care. The webpage is part of the department’s broader campaign to promote mental health resources for veterans and their families.

The Veterans Crisis Line is a dedicated hotline for veterans, staffed by people trained specifically to provide care for veterans experiencing mental health crises. Since its launch in 2007, the crisis line has received almost 4 million calls. Veterans also have the option of chatting online or texting with a trained responder.
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