The Our American States podcast—produced by the National Conference of State Legislatures—is where you hear compelling conversations that tell the story of America's state legislatures, the people in them, and the policies, process and politics that shape them.

You can subscribe through iTunes, Google Play or Spotify.

COVID-19: States, the CDC and Suicide Prevention | June 15, 2020 | OAS Episode 97

Ed: Hello and welcome to "Our American States," a podcast from the National Conference of State Legislatures. This podcast is all about legislatures: the people in them, the policies, process and politics that shape them. I'm your host, Ed Smith.

This podcast is one in a series NCSL is producing to focus on how states are responding to the coronavirus pandemic. You can find links to podcasts, webinars and other resources at www.ncsl.org/coronavirus.

Our topic today is a sobering one, suicide. The rate of suicide in the U.S. is one of the highest among wealthy nations. Nearly 50,000 people took their own lives in the U.S. in 2018. The Covid-19 pandemic has increased concern among experts that the nation may face an increase in suicides as people struggle during the crisis.

Our first guest today is Charlie Severance-Medaris, a policy expert on the topic at NCSL. Charlie will provide an overview of suicide in the U.S.

Our second guest is Dr. Alex Crosby, Chief Medical Officer in the Division of Injury Prevention at the Centers for Disease Control and Prevention. He has expertise and long experience in dealing with the public health aspects of suicide and suicide prevention.

Charlie, welcome to "Our American States."

Charlie: It's good to be here, Ed.

Time Marker (TM): 01:36

Ed: So, Charlie, we know that suicide has been a growing public health concern well before Covid-19. What kind of trends were we seeing then?

Charlie: What we've really seen across the United States is that suicide rates have risen significantly over the last two decades. Between 1999 and 2016, the CDC has reported that overall, in the U.S., suicide rates have risen nearly 30%. But in half of all states, we've seen increases greater than 30%. We've actually seen an increase in deaths by suicide in every state except for one.

Rates of suicide have also increased among all age groups under age 75 among both men and women and all racial and ethnic groups. In addition to deaths by suicide, we've seen emergency

department visits for self-harm increase by 42%. Overall, in the U.S., suicide is the tenth leading cause of death, accounting for nearly 50,000 deaths in 2018, and it is one of only three leading causes of death that are increasing.

To focus on that death figure for a little bit longer, researchers estimate that also means that in 2018, roughly 10 million Americans seriously thought about suicide, nearly 3 million made a plan, and more than 1 million attempted suicide.

TM: 02:48

Ed: Well, I have to say that's kind of shocking. What are some of the reasons that experts see for this increase?

Charlie: Unfortunately, we don't have a perfectly clear answer to that question. But one thing that researchers and public health officials find important to emphasize is that suicide is rarely caused by any single factor. Rather, it's determined by multiple factors. So, it's not likely that any one trend or risk factor is particularly to blame for the increases we've seen.

However, we have seen some other trends that might inform what we are seeing with suicide. For instance, among youth we've seen evidence of increased rates of mental health issues like major depressive disorder. Mental health issues are a risk factor for suicide, but it's important to note that roughly half of all people who die by suicide have no known mental health condition at the time of their death.

The rate of youth private health insurance that does not cover mental health services has also doubled between 2012 and 2019, and 10 million adults have reported they have unmet mental health needs.

It's also important to note over the same period that we have seen an increase in opioid-related drug overdose deaths, and we do know that increased substance use by an individual is a risk factor for suicide. In 2018, the number of drug overdose deaths was four times higher than it was in 1999. Nearly 70% of the 67,000 deaths in 2018 involved an opioid.

Another factor some researchers point to, though it doesn't necessarily explain all of the increases we've seen, is the 2008 financial recession, especially among people with no known mental health condition. Financial stress that can come with unemployment or underemployment or an unstable job market is a major risk factor for suicide.

Nationally, we've seen a recovery from that recession, but that doesn't necessarily mean that the recovery has been even in every community or that financial stresses that existed before the recession haven't been solved.

Researchers also point to a growing sense of isolation among Americans that has been increasing since the early 2000s. Right now, with Covid-19, I think a lot of the discussion, and I think that Dr. Crosby will be able to speak to this later, is around the social isolation as well as the risks of so many people out of work or working reduced hours, and the steps that policymakers can take to provide economic support.

TM: 05:09

Ed: You talked a little bit about the financial issues, the mental health issues as risk factors. What else? What other risk factors are there out there?

Charlie: As I've mentioned, there are many factors that may influence an individual's risk of suicide. These can include a personal or family history of mental illness, including alcohol and substance abuse or other suicide attempts. But risk factors can also include physical illnesses, especially chronic conditions.

Recent research has found a strong correlation between childhood traumatic events, what public health officials refer to as adverse childhood experiences or ACES, and an adult's risk of suicidal thoughts and behavior.

Prolonged periods of stress such as those caused by bullying, harassment, stressful work environments and relationship problems are environmental factors that may contribute to suicide or a suicide attempt. And even more acute, short-term stressors like a recent breakup, a death in the family, a sudden loss of job or another source of stress can also underlie suicidal thoughts.

Having easy access to a highly lethal means of suicide such as a dangerous medication or a firearm can also increase someone's risk of dying in a suicide attempt.

On an individual level, someone considering suicide may express feelings of hopelessness or worthlessness, and they may speak about being a burden to others or being in unbearable pain, either emotional or physical pain. These folks may speak openly about wanting to kill or harm themselves, even if that might just take the form of a passing comment or a joke.

There are also nonverbal signs including isolating or withdrawing from normal activities, sleeping too much or too little, increasing use of substances like alcohol, or becoming increasingly aggressive, agitated or anxious.

TM: 06:55

Ed: So, Charlie, I know the conventional wisdom is it's young people who are most at risk of taking their own lives. But I also have read that that's not necessarily the case. Can you talk a little bit about who is most at risk?

Charlie: Certainly, many people associate suicide deaths with younger people, and suicide is still a major concern for young people. However, the largest numbers of suicide are among middle-aged men. Men are between three and a half and four and a half times more likely to die by suicide than women. However, it's worth noting that women are one and a half times more likely to consider suicide than men, and that difference in death rates is largely attributable to men having easier access to one of those highly lethal means of suicide we talked about earlier.

As I mentioned, suicide is still a major concern for younger folks. It is the second leading cause of death for people 15 to 24 years of age after unintentional injury. This concern is especially true for sexual minorities like LGBT youth who are particularly vulnerable to suicide.

According to a 2015 survey, 29% of lesbian, gay and bisexual youth reported a suicide attempt in the year prior, as opposed to just 6% of heterosexual youth. Research has also demonstrated that 25 to 30% of transgender adolescents attempt suicide at least once in their lifetimes.

Rural and remote communities, which may experience both harsher economic conditions and less access to mental health care, also see higher rates of suicide than urban areas. American Indian and Alaskan native communities have the highest rates of suicide among all racial and ethnic groups, with that remoteness and lack of access to care, especially culturally relevant care being potential contributors to suicide in those communities.

Certain professions like veterans, first responders and healthcare providers, are also more likely to die by suicide, as are construction and extraction workers and people working in the transportation industry.

TM: 08:52

Ed: Well, Charlie, I know part of your job is to keep an eye on legislative policy around the country, and I doubt states have done anything quite recently as they've dealt with the pandemic. But what have states done to try to prevent suicide? Are there any success stories out there?

Charlie: The good news, certainly, is that suicide is preventable, and states are taking a variety of approaches to suicide prevention. Legislatively, one of the most common approaches we've seen is what is referred to as gatekeeper training, or simply training people who interact with high-risk populations to identify signs that a person might be considering suicide or experiencing a mental health crisis, and how to successfully intervene with that person.

One of these models is called Mental Health First-Aid. It's an eight-hour course that teaches individuals how to identify, understand and respond to signs of a mental health crisis. More than 20 states require certain professions to undergo this kind of training, including educators and others who work with youth.

Illinois has used gatekeeper training to address suicide among first responders through its First Responders Prevention Act. This bill requires all first responders to receive some gatekeeper training and creates peer support specialist roles within individual agencies to provide each first responder with a trained colleague they can turn to with a mental health issue.

Other states have looked to use gatekeeper training within the medical field. The zero-suicide framework is a system-wide organizational commitment to safer suicide care and health and behavioral healthcare systems. One important statistic: about 85% of people who die by suicide sought some form of healthcare in the month prior to their deaths, and up to 45% of individuals who die by suicide visited their primary care physician within a month of their death.

The zero-suicide framework recognizes that training providers to identify and intervene with a person who might be thinking about killing themselves, along every step of that patient's course of care, can prevent suicide.

As a legislative example, Louisiana established the state's zero suicide initiative, which focuses on healthcare provider training for early identification of suicide risk factors. The bill requires the Department of Health to examine and coordinate the use of existing data to identify groups of patients and approve the quality of care for people who may be considering suicide.

Other states have looked to expand or innovate their crisis hotlines. Utah created a 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 the user to be at risk of immediate harm to themselves or others, the counselor can engage the user's cellphone location to notify local responders trained to intervene in crisis situations.

During the first 14 months of use, the SafeUT app had nearly 1,500 tips about people considering taking their own lives, and clinicians working for the app exchanged more than 22,000 text chats with students or their parents about a variety of issues including bullying, suicide, self-harm and other threats.

States are also looking to expand access to mental health services. One of the ways they're doing this is by working to ensure that individuals with private insurance are able to access mental healthcare services.

Insurance parity, or the idea that insurers need to provide the same level of coverage for mental health services as they do for physical health services, is already mandated by federal law, but enforcement of this mandate is left up to the states.

In 2018, Colorado created the Office of the Ombudsmen at the Colorado Department of Human Services, which identifies, tracks and reports complaints or violations by insurers and assists consumers in appealing benefits decisions when they feel they've been wrongly denied care.

For those of you interested in learning more about how state legislatures are addressing suicide prevention, please keep your eyes peeled for NCSL's policy brief on suicide prevention. That will be published later this summer where we'll dig a little deeper into these strategies and explore other steps state legislatures have taken.

Ed: To see that report Charlie mentioned, check in with www.ncsl.org. Charlie, thanks for taking the time to fill us in on this critical issue. I'll be right back with Dr. Alex Crosby.

MUSIC

Ed: I'm back with Dr. Alex Crosby of the CDC. Dr. Crosby, welcome to "Our American States."

Dr. C: Thank you very much for the invitation. Glad to be here.

TM: 13:29

Ed: Charlie shared with us how suicide is a major health concern. Could you tell us how the CDC is working with states on reducing the number of deaths by suicide?

Dr. C: There are several ways that CDC is working with states and communities to address suicidal behavior. One was CDC released a technical package, which highlighted strategies that had the best available evidence for suicide prevention, and that's all a technical package was is it just brings together a number of different programs and describes them.

The other thing that CDC did is it produced some violence prevention implementation guidance, so not only the what in terms of suicide prevention programs, but then the how. So, how do you take those programs and actually put them into place?

Another thing that the CDC has done is to help support comprehensive suicide prevention planning, as well as implementation by some funding that CDC is just putting out this year for several states to actually put in comprehensive suicide prevention within their states.

And then, additionally, CDC is also supporting surveillance or data collection so that states can really assess what the problem is, the scope of the problem, the magnitude of the problem, what are the patterns of suicide, as well as nonfatal suicidal behavior in their state through mortality data, what's happening with their death certificate data, especially utilizing the national violent death reporting system along with some support of emergency department data through syndromic surveillance that will give them more real-time information.

TM: 15:20

Ed: There's been a lot of reporting on the increased number of calls to mental health hotlines during the pandemic. Does that translate to increasing the risk factors for suicide? Is there any data at this point showing a change in the rates of suicide attempts or deaths by suicide?

Dr. C: Calls to crisis hotlines give us an indication and those who are monitoring them, as well as those that are responders or operating or administering those lines, that there are people that are having trouble, that are in distress, and need some health. And so, the positive aspect is they are trying; they are reaching out and trying to get some help.

There's some very little preliminary data, one information that came from Colorado, that was showing an increase in the calls to the crisis hotline, but their initial data looking at deaths due to suicide was showing that it had actually decreased over the first few months of this year. So, while it looks like, at least with the Colorado example, crisis line calls have gone up, it looks like suicide deaths have declined.

TM: 16:30

Ed: We know that doctors, even before Covid-19, were at an elevated risk of suicide. How has the pandemic affected this?

Dr. C: That is information right now that we are still compiling. There have definitely been some observations that healthcare providers, primary care providers including physicians, are under added stress during this period. We don't have any good numbers on rates; that does take a little bit more time to try to look at rates by occupation. But there have been some efforts to try to support those groups, first responders, as well as other primary care providers like nurses, like physicians, like those that are working in hospitals, therapists, etc., respiratory therapists.

So, there have been some efforts to try to support those groups, but the data on actual rates is still being compiled and analyzed.

TM: 17:25

Ed: More broadly, what are some of the challenges you see in addressing suicide in this age of social distancing? What strategies do you think will be important to consider to prevent deaths?

Dr. C: One of the challenges is that many suicide prevention programs have been designed and tested for an in-person setting. So, it may be somebody who is training the trainer, that's in a room, that's training people so that they can recognize and refer people that might be at risk for suicidal behavior.

Well, given what's now in terms of people sheltering in place and in terms of not being able to actually do a lot of in-person meetings and training, is that now prevention program developers as well as administrators are now trying to transition some of those programs from in-person to more digital or electronic delivery, including things like telehealth. But we've got to do more evaluation to see how well do those work once you've made those adaptations to those programs. So, those are some of the challenges.

Some of the strategies that seem to be most important for the current situation have to do with things like economic supports, given what has been happening in terms of the number of people that have now started filing for employment. There have been previous studies that have shown that as unemployment goes up, there's a slight lag period, but then suicides also start to go up.

So, economic support, and there are programs that have shown that they're effective in terms of supporting people economically, those are some important programs that would be worthwhile during this time period.

Increasing safe social connections is another one in terms of trying to make sure that people have their strong social network, that network of friends and family that support them when they run into stressors or are having a difficult time, somebody that can be looking out for them, along with improving crisis services, which is also important, as we have just mentioned that calls to crisis lines are increasing.

And so, trying to make sure that those crisis lines have available capacity, have the right number in terms of human resources as well as capacity electronically to handle that kind of thing. So, including things like social media – can we use social media in terms of applications, apps, as well as other kinds of social media platforms, which might also be useful.

TM: 20:02

Ed: You mentioned the issue of financial stress. Can you talk a little about what was learned during the financial crisis of 2008 and how that affected suicide rates?

Dr. C: There did seem to be some associated increases in suicide, and this was not just in the United States, but around the world. As many people may recall, there was a global recession in terms

of many countries around the world saw unemployment go up and many also saw their suicide rates go up.

There were some countries that responded very well to try to increase support for those that might be at risk for suicide, and there was something that was learned in terms of what kind of programs looked like that were going to be the most effective in terms of putting the right kinds of resources in place for those that might be at risk.

And so, we're trying to make sure that those vulnerable communities have access to those programs, and the gaps of who is being reached and identified, that those gaps are also being addressed.

TM: 21:11

Ed: You mentioned earlier that social connectedness is important to prevent people from feeling isolated. How do we do that as we continue to use social distancing as a tool to control the pandemic?

Dr. C: There is definitely a challenge there. Many of those in public health, especially those that deal primarily with respiratory diseases and are experts in virology, have really been talking about things like social distancing, but really kind of translating that into a physical distance when they talk about staying six feet away from people and wearing masks, that you're trying to prevent the spread of that virus from one person to the next.

And really, when we're trying to look at things like how we can keep social connection, that we're really not necessarily talking about a physical distance, but how can we make sure that those social connections are still in place. Can we reach out to people either via telephone, via a text, via some sort of social media platforms?

So, those kinds of things that we're encouraging, whether those are electronic or phone contact to try to make sure that people stay in contact with their friends and their family and their loved ones to make sure that things are happening and that they're making sure that they're checking in on: How are you doing? How are people feeling? And those kinds of things.

TM: 22:32

Ed: Dr. Crosby, before we wrap up, is there anything else you'd like to share with our listeners?

Dr. C: I think that one of the messages that's important for legislators and decision makers and policymakers is that we are facing a difficult situation, not only here in the United States, but around the world. But there are some strategies that have hope and healing incorporated into those strategies.

One of the things in terms of looking at some of the theoretical basis for why people are at risk for suicide have to do with hopelessness and feeling like they're a burden. Well, there are ways in which some of the programs that have been designed and developed actually address some of those things.

So, we believe that there are ways of trying to reach those populations that are vulnerable and try to be able to counteract what might be going on in some of our other stressors in our society with some of those things that are protective.

So, we believe that we can make a difference and not necessarily see a great increase in suicidal behavior, but actually be able to help people that need help at the right time.

Ed: Well, Doctor, thank you so much for your time and sharing your expertise on this crucial topic. Stay safe and take care.

And that concludes this edition of our podcast. We encourage you to review and rate our episodes on iTunes, Google Play or Spotify. You may also go to Google Play, iTunes or Spotify to have these episodes downloaded directly to your mobile device when a new episode is ready. For the National Conference of State Legislatures, this is Ed Smith. Thanks for listening and being part of "Our American States."

MUSIC