

Decades of National Suicide Prevention Policies Haven't Slowed the Deaths

Federal officials have launched three suicide prevention strategies over the past two decades, but suicide rates have increased most years.

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If you or someone you know may be experiencing a mental health crisis, contact the 988 Suicide & Crisis Lifeline by dialing or texting “988.”

When Pooja Mehta’s younger brother, Raj, died by suicide at 19 in March 2020, she felt “blindsided.”

Raj’s last text message was to his college lab partner about how to divide homework questions.

“You don’t say you’re going to take questions 1 through 15 if you’re planning to be dead one hour later,” said Mehta, 29, a mental health and suicide prevention advocate in Arlington, Virginia. She had been trained in [Mental Health First Aid](#) — a nationwide program that teaches how to identify, understand, and respond to signs of mental illness — yet she said her brother showed no signs of trouble.

Mehta said some people blamed her for Raj’s death because the two were living together during the COVID-19 pandemic while Raj was attending classes online. Others said her training should have helped her recognize he was struggling.

But, Mehta said, “we act like we know everything there is to know about suicide prevention. We’ve done a really good job at developing solutions for a part of the problem, but we really don’t know enough.”

Raj’s death came in the midst of decades of unsuccessful attempts to tamp down suicide rates nationwide.

During the past two decades federal officials have launched three national suicide prevention strategies, including one announced in April.

The first strategy, announced in 2001, focused on addressing risk factors for suicide and leaned on a few common interventions.

The next strategy called for developing and implementing standardized protocols to identify and treat people at risk for suicide with follow-up care and the support needed to continue treatment.

The latest strategy builds on previous ones and includes a federal action plan calling for implementation of 200 measures over the next three years, including prioritizing populations disproportionately affected by suicide, such as Black youth and Native Americans and Alaska Natives.

Despite those evolving strategies, from 2001 through 2021 suicide rates [increased most years](#), according to the Centers for Disease Control and Prevention. [Provisional data for 2022](#), the most recent numbers available, shows deaths by suicide grew an additional 3% over the previous year. CDC officials project the final number of suicides in 2022 will be higher.

In the past two decades, suicide rates in [rural states](#) such as Alaska, Montana, North Dakota, and Wyoming [have been about double](#) those in urban areas, according to the CDC.

Despite those persistently disappointing numbers, mental health experts contend the national strategies aren't the problem. Instead, they argue, the policies — for many reasons — simply aren't being funded, adopted, and used. That slow uptake was compounded by the covid-19 pandemic, which had a broad, negative impact on mental health.

A chorus of national experts and government officials agree the strategies simply haven't been embraced widely, but said even basic tracking of deaths by suicide isn't universal.

Surveillance data is commonly used to drive health care quality improvement and has been helpful in addressing cancer and heart disease. Yet, it hasn't been used in the study of behavioral health issues such as suicide, said Michael Schoenbaum, a senior adviser for mental health services, epidemiology, and economics at the National Institute of Mental Health.

"We think about treating behavioral health problems just differently than we think about physical health problems," Schoenbaum said.

Without accurate statistics, researchers can't figure out who dies most often by suicide, what prevention strategies are working, and where prevention money is needed most.

Many states and territories don't allow medical records to be linked to death certificates, Schoenbaum said, but [NIMH is collaborating](#) with a handful of other organizations to document this data for the first time in a public report and database due out by the end of the year.

Further hobbling the strategies is the fact that federal and local funding ebbs and flows and some suicide prevention efforts don't work in some states and localities because of the challenging geography, said Jane Pearson, special adviser on suicide research to the NIMH director.

Wyoming, where a few hundred thousand residents are spread across sprawling, rugged

landscape, consistently ranks among the states with the highest suicide rates.

State officials have worked for many years to address the state's suicide problem, said Kim Deti, a spokesperson for the Wyoming Department of Health.

But deploying services, like mobile crisis units, a core element of the latest national strategy, is difficult in a big, sparsely populated state.

"The work is not stopping but some strategies that make sense in some geographic areas of the country may not make sense for a state with our characteristics," she said.

Lack of implementation isn't only a state and local government problem. Despite evidence that screening patients for suicidal thoughts during medical visits [helps head off catastrophe](#), health professionals are not mandated to do so.

Many doctors find suicide screening daunting because they have limited time and insufficient training and because they aren't comfortable discussing suicide, said Janet Lee, an adolescent medicine specialist and associate professor of pediatrics at the Lewis Katz School of Medicine at Temple University.

"I think it is really scary and kind of astounding to think if something is a matter of life and death how somebody can't ask about it," she said.

The use of other measures has also been inconsistent. Crisis intervention services are core to the national strategies, yet many states haven't built standardized systems.

Besides being fragmented, crisis systems, such as mobile crisis units, can vary from state to state and county to county. Some mobile crisis units use telehealth, some operate 24 hours a day and others 9 to 5, and some use local law enforcement for responses instead of mental health workers.

Similarly, the fledgling 988 Suicide & Crisis Lifeline faces similar, serious problems.

Only 23% of Americans are familiar with 988 and there's a significant knowledge gap about the situations people should call 988 for, according to a [recent poll](#) conducted by the National Alliance on Mental Illness and Ipsos.

Most states, territories, and tribes have also not yet permanently funded 988, which was launched nationwide in July 2022 and [has received](#) about \$1.5 billion in federal funding, according to the Substance Abuse and Mental Health Services Administration.

Anita Everett, director of the Center for Mental Health Services within SAMHSA, said her agency is running an awareness campaign to promote the system.

Some states, including Colorado, are taking other steps. There, state officials installed financial incentives for implementing suicide prevention efforts, among other patient safety measures, through the state's Hospital Quality Incentive Payment Program. The program hands out about

\$150 million a year to hospitals for good performance. In the last year, 66 hospitals improved their care for patients experiencing suicidality, according to Lena Heilmann, director of the Office of Suicide Prevention at the Colorado Department of Public Health and Environment.

Experts hope other states will follow Colorado's lead.

And despite the slow movement, Mehta sees bright spots in the latest strategy and action plan.

Although it is too late to save Raj, "addressing the social drivers of mental health and suicide and investing in spaces for people to go to get help well before a crisis gives me hope," Mehta said.

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