

Suicide During the Pandemic

Talking Points

What We Know

Suicide is multi-faceted, and research tells us that no one ends their own life for a single reason. While the COVID-19 pandemic and its ramifications do not cause suicide, for some people, these pandemic-related experiences may contribute to their risk.

- Just like there are many factors that can have a positive or negative effect on our health in other areas (like stress and exercise on cardiac health), the contributors to suicide are multi-dimensional.
- A person who attempts suicide or dies by suicide likely has individual risk factors and life stressors at play.
- The interaction between risk factors and life stressors is dynamic and intersects with environmental factors.

Risk factors and stressors that are more common during the pandemic that can precipitate suicidal behavior include:

- Anxiety, uncertainty, fears
- Depression
- Physical and social isolation
- Economic stress and unemployment
- Increased substance use (rise in alcohol sales & opioid overdoses during the pandemic)
- Loss and grief on many levels
- Physical illness and pain
- Access to lethal means (firearm purchases rose during the pandemic)
- Suicidal ideation
- Barriers to accessing healthcare
- Sensationalized and other unsafe media reporting on suicide

Protective factors also play a powerful role in mitigating against suicide risk, especially during times of increased stress, including:

- Access to healthcare, including virtual access to telehealth services and effective mental health care
- Open, honest dialogue and supportive conversations about mental health and suicide
- Social connectedness
- Limiting access to lethal means, including efforts to make home and work environments as safe as possible
- Safe media reporting on suicide that promotes mental health resources
- Assistance with basic needs such as food, housing, and finances, especially but not exclusively for those whose circumstances have been impacted by COVID-19

Suicide Death Data

- **Provisional 2020 suicide death data** from the CDC show that deaths by suicide in the U.S. declined from 47,511 to 44,834 (5.6%) between 2019 and 2020. Suicide reportedly moved from the tenth to the eleventh leading cause of death as COVID-19 became the third leading cause of death in 2020.
- Historically, suicide rates have initially gone down during some periods of wartime and other disasters and have shown mixed results during or after previous epidemics. Provisional 2020 data appear consistent with this trend. It is possible, though not pre-determined, that we could experience an increase in suicide risk as the immediate COVID-19 threat lessens and in the aftermath period if community cohesion diminishes and if less attention is paid to intentional social connections, proactive resilience and mental health self-care, and the importance at key times of engaging in mental health treatment and crisis care. Helping those who are struggling with basic needs can also mitigate suicide risk.
- **Several states** have reported 2020 mortality data, including Maryland, Connecticut, Florida, Massachusetts, Utah, New Jersey, and Hawaii. Early data from all reporting states show that overall suicide rates declined or saw no change in 2020 compared with the previous year.
- While provisional 2020 mortality data show a declining rate of suicide for the overall U.S. population, we do not yet have the full picture as to how this translates to geographic areas within states or specific populations.
- The pandemic has had a disproportionate impact on certain populations; there are concerning signals of increasing suicide rates in some non-White populations during the pandemic, e.g., in Maryland and Connecticut.
- A 2021 **CDC report** looked at trends in emergency department (ED) visits for suspected suicide attempts by age group and sex during three time periods during the COVID-19 pandemic. During February-March 2021, when compared to the same time period in 2019, there was a 39% increase in ED visits for suspected suicide related concerns among youth aged 12-17 years. The increase for females aged 12-17 years was 51% and for males aged 12-17 years the increase was 4%. Young people aged 18-24 years did not see a similar increase as adolescents. These are not mortality data, but rather ED presentations for “suspected suicide attempts” meaning

likely self-harm (some of which is non-suicidal), suicidal ideation and suicide attempts. Important to note that suicidal behavior is generally more prevalent among girls than boys, while boys suicide death rates are higher than girls. Presenting to the ED for suicidal concerns could be reflective of both higher rates of distress among the 12–17 year-old girl population but also could also be a measure of increased help seeking behavior.

- It will take more time until data and research are available to understand the entire impact of COVID-19 on suicide. Research shows there can be a time lag in the manifestation of distress, even months after the acuity of a traumatic or stressful period.

What Needs to Be Done During and Beyond the Pandemic

We cannot let up on our efforts to reduce suicide risk, increase protective factors, and implement evidence-based suicide prevention strategies. We need lawmakers to help us bring the following efforts to scale:

- Invest in crisis support systems, including the National Suicide Prevention Lifeline at the national level and 988 implementation at the state level, which includes local crisis call centers, mobile crisis services, trained peer specialists, substance use/detox treatment centers, crisis stabilization and receiving centers, and other wraparound behavioral health services.
 - Calls to the National Suicide Prevention Lifeline (1-800-273-8255) had a 6% increase in contact volume in July 2020 compared to the same time period in 2019.
 - Implementation of 988 will likely increase calls to the Lifeline network dramatically as that number goes live nationwide in July 2022 and efforts begin to promote the new number.
- Train all healthcare workers in suicide assessment and prevention, including Emergency Department personnel and primary care and behavioral health professionals.
- Train youth workers, parents, educators, first responders, corrections personnel, and workplaces in suicide prevention.
- Address mental health workforce shortages, particularly in underserved areas and in communities disproportionately impacted by the pandemic.
- Expand access to telehealth services and require parity in insurance coverage and reimbursement rates for telehealth and in-person services.
- Ensure existing mental health parity laws are upheld and empower state regulators to enforce said laws and require regular reporting from insurers.
- Promote public messages that convey accurate, safe information about suicide and suicide prevention
- Increase and expand internet and broadband access for the U.S. population for greater access to telemental health services.
- Invest in suicide prevention programs at the community level (i.e. schools, workplaces)

We must all take care in our messaging to avoid implying that an increase in suicide rates is an inevitable outcome of the COVID-19 pandemic. Early data does not support this and messaging like this can increase risk of contagion.

- Contagion is of particular concern with young people at risk for suicide. Much media coverage has focused attention on increased suicidal ideation and attempts among young people during the pandemic, and many have attributed this to quarantining/remote learning. The truth is a more complex mixture of contributors are likely at play, such as mental and physical health concerns, social disruption, trauma, parental anxiety, substance use, and access to lethal means.
- It is important to note that increases in suicidal thoughts and self-harm do not necessarily translate into increased suicide death rates, although they are a sign of distress and warrant serious concern and a need for action. Help seeking has been shown to reduce suicide risk.
- Continued isolation, the loss of loved ones, family strife, and economic hardship can and do impact children's mental health.
- While there are no concrete data demonstrating causation between remote learning and children's mental health or suicide, there are steps parents, teachers, and other caring adults can take to protect youth mental health, including:
 - Take care of your own mental health
 - Have honest, candid, supportive conversations with children
 - Stick to routines as much as possible
 - Ensure children get physical exercise and spend time outdoors
 - Enlist the help of a mental health professional when needed.

Suicide is not a simple issue to solve and there is no singular approach, but we can all play a role in prevention by:

- Taking care of our own and others' mental health – learn how to have a #RealConvo at afsp.org/realconvo and how to help someone who is struggling at afsp.org/get-help
- Educating one another on mental health and suicide – learn about suicide risk factors and warning signs at afsp.org/signs
- Providing resources for our communities, and prioritizing those communities with pre-existing health and economic disparities and who have been disproportionately impacted by the pandemic, including:
 - People with serious mental illnesses
 - Black, Latinx, American Indian, Alaska Native, Asian American, Pacific Islander, and other BIPOC communities
 - Older adults

- Frontline workers, including healthcare professionals and other essential workers
- LGBTQ individuals
- Servicemembers, Veterans, and their families
- Individuals who lack basic needs such as food, housing, and financial security
- Supporting and investing in strategies like those mentioned above and those included in AFSP's Federal and State Public Policy Priorities, see afsp.org/priorities