MENTAL HEALTH POLICY IN THE UNITED STATES

THE CRISIS OF SUICIDE IN AMERICA*

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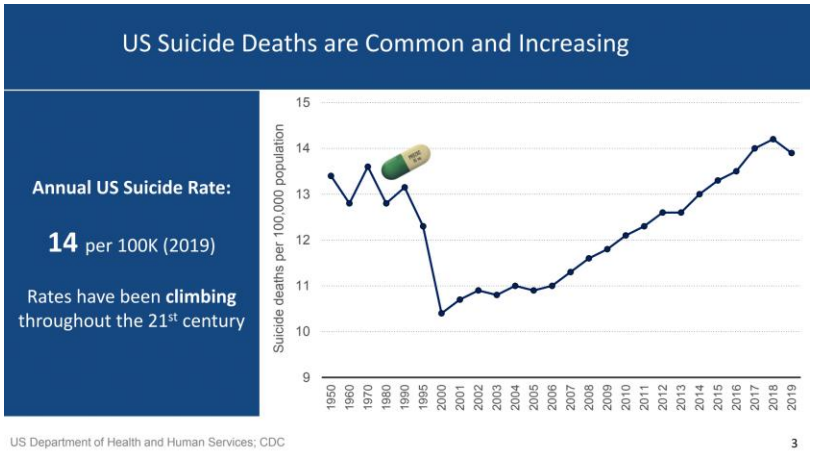
Abstract: This lecture provides an overview of the "crisis" of suicide in America. The suicide rate has grown about 34% since the beginning of the 21st century after more than a decade of decline at the end of the 20th century. The reasons for the rise of suicide in this century (and its decline in the first year of the pandemic) are matters of debate. It is widely agreed that there are many risk factors, but none of them taken alone or in combination make it possible to predict and avert suicide. Most notable are mental illness and/or substance misuse and the common use of guns in completed suicides. There are clinical and sociological perspectives on the reasons for rising suicide rates. Clinically the focus is on the inadequacy of identification and treatment of mental illness. Sociologically, the recent focus is on "deaths of despair", i.e., deaths of working age men with limited education and poor job prospects as well as on the Durkheimian view that high rates of suicide are linked to social "anomie". This lecture provides an overview of these perspectives. It also includes an overview of policy changes that have been proposed to reduce the incidence of suicide in America including improved screening, increased treatment, and addressing sources of social isolation, hopelessness, and loss of a sense of meaning.

Over the first two decades of the 21st century, suicide rates in the United States have risen by about 34%,[1] an alarmingly high increase. It is all the more alarming because in the last decade of the 20th century suicide rates declined by nearly 15%.



* Much of this lecture is taken from Nestadt, P and Friedman, M (2020) "The Crisis of Suicide in America".

Something has happened in the beginning of the 21st century to fuel an epidemic of suicide. What? And what can be done about it?

Strange to say, so far the suicide rate in America has declined during the pandemic despite the expectation that it would rise.[2] Perhaps there is something about human experience during the pandemic that can shed light on both the rise and fall of suicide rates.

First some background information about suicide in 2020[3]:

- Suicide was the 12th leading cause of death in the United States. It was the second leading cause of death for Americans under 45. The rate of suicide is higher but a less significant cause of death for people over 45, who are increasingly likely to die of other causes as they age.

- While females attempted suicide far more often than males, males were more than 3 times as likely to complete suicide. This may be because males tend to use guns to take their own lives. Women are more likely to use less lethal means.

- The highest rate of suicide is among males 75+. But the rate for that age group has gone down since the turn of the century, while the rate for working aged men has gone significantly up.

- Suicide is more common among White people than people of color, except for Native Americans, who have the highest rate of suicide and the highest increase in rate in this century. Although rates of suicide have increased among Blacks, Hispanics, and Asians, all together they completed suicide at less than half the rate of Whites.

- Suicide is more common, and rising faster, in rural than in urban or suburban areas.

- Guns were the most common means of suicide (just over 50%), especially among older men in rural areas. Hanging and drug overdoses are the next most common but are comparatively infrequent.

- There are many risk factors for suicide.[4] They include:

    - Mental and substance use disorders
    - Serious physical health conditions including pain
    - Traumatic brain injury
    - Recent diagnosis of dementia
    - Access to lethal means including firearms and drugs

- Prolonged stress, such as harassment, bullying, relationship problems or unemployment
- Stressful life events, such as rejection, divorce, financial crisis, and other life transitions or loss
- Exposure to another person's suicide, or to graphic or sensationalized accounts of suicide
- Previous suicide attempts
- Family history of suicide
- Childhood abuse, neglect, or trauma

The more risk factors, the greater the risk, but **completed suicides are statistically rare even among people with several risk factors**.

According to Thomas Joiner's interpersonal theory of suicide, the two critical factors are (1) a **lack of "belongingness"** and (2) a **sense of "burdensomeness."**[5] He notes that there is a kind of physical and social "taboo" about suicide. Camus noted something similar in *The Myth of Sisyphus* when he commented that whatever the mind thinks about whether life is worth living, "The body wants to live." [6] The vast majority of people are suicide resistant, as it were. How, Joiner asks, do those who take their own lives get past that very powerful resistance? His answer is that they are people who don't feel that they belong, that they have a worthwhile place in their world. They feel alone and adrift. And they feel, Joiner says, that they are an undeserving burden on the people who would have better lives without them. (Note that this is a very different theory of suicide than early psychodynamic theory that saw it as an act of anger or vengeance against people who would be sorry when the suicidal person was gone.)

Why are suicide rates rising? What can be done about it?

There are two broad, but not mutually exclusive, perspectives regarding rising suicide rates—clinical and sociological.

The clinical perspective on suicide is based on the fact that 80-90% of the people who complete suicide suffer from a mental illness, usually an affective disorder, especially major depression.[7] There are also high rates of suicide among people with schizophrenia (especially during and just after their first psychotic break),[8] substance dependence (especially alcohol or opioids),[9] or PTSD (especially veterans).[10]

There is widespread agreement among mental health providers and advocates that rising suicide rates somehow reflect failures of the American behavioral health system and that greater access to treatment would help.

Some make the broad claim that rising suicide rates are the outcome of deinstitutionalization, i.e., of reducing psychiatric hospital beds without providing adequate alternatives in the community. The problem with this

claim is that suicide rates declined in the United States during the peak years of deinstitutionalization. That notwithstanding, some argue that the reduction of psychiatric hospital beds has reached a **tipping point** and that now more are needed.[11]

Another line of thought concludes that rates of suicide declined when anti-depressants were introduced and that rates of suicide increased when a warning was issued about potentially deadly side-effects of anti-depressants. The problem with this point of view is that overall the use of antidepressants has increased while suicide rates have been rising.[12]

Does that mean that treatment does not reduce the risk of suicide? No one that I know of believes that. They believe that treatment helps people who are at real risk of suicide—people with serious mental and/or substance use disorders, but that treatment of people without serious conditions has no impact on suicide rates. Anti-depressants, they argue, are increasingly being used by people with mild forms of mental illness or no diagnosable mental illness, just some emotional distress. Advocates of this perspective call for more targeted use of anti-depressants.

Many behavioral health advocates are skeptical about claims that more targeted use of medications or the creation of more hospital beds will bring down suicide rates. But, as I've said, virtually all mental health advocates agree that tremendous improvements in the nation's mental health system are needed. For example, there has been strong support for improving the nation's crisis services and for the recent creation of a 988 number for psychiatric crisis intervention. And there is also strong support for enhancing access to quality behavioral health services.

There is also widespread agreement that identification of suicide risk needs to improve. Considerable attention focuses on primary care physicians because 45-70% of people who take their own lives have been to the doctor within thirty days of their suicides.[13] Would more screening by physicians make a difference? There is some debate about the value of screening specifically for suicide risk because these screening instruments reveal suicidal ideation but not the likelihood of completing suicide. Because of the relative rarity of completed suicide, these screens are plagued by false positive indications of suicide risk, as well as unacceptable levels of even more tragic false negatives. Still, there is general agreement that screening for depression and substance abuse could be helpful.[14] (Failure to screen, of course, does not explain the rise in suicide rates since doctors were certainly not screening for suicide when suicide rates were lower.)

Suicide prevention advocates also call for better training of behavioral health professionals and other health and human service providers not only in identification of suicide risk but also in management of risk. Traditional

efforts of distinguish between serious suicide risk and suicidal thoughts that are not likely to result in attempts focused on questions such as whether the person had a plan and access to the means to complete suicide. That is important, but it now appears that a great many suicides are impulsive.[15] So, now there is increasing attention to developing a safety plan that helps a person considering suicide not to attempt it if the impulse becomes strong.[16] Very importantly, this involves limiting access to the means of suicide, especially guns, which are used in over 50% of suicides in the United States.[17] Training in this shift in orientation about people with suicidal ideation could make a difference.

Clinicians, of course, have a responsibility to take protective action if a patient is a clear and present danger to self or others. What they should do depends on the circumstances, and legal requirements vary from state-to-state. Call 911, call 988, call a mobile crisis team, make a report of dangerousness to a local authority, call for removal of weapons from the home, begin an inpatient or outpatient commitment procedure? It is not clear that behavioral health and other health and human services professionals working in community settings are well-informed about what actions to take, or even the extent of their legal authority or obligations.

The sociological perspective on suicide has a long history going back to Emile Durkheim, who studied suicide rates at the end of the 19th century.[18] He identified a number of sociological factors that increase the risk of suicide, most famously "anomie" ("social instability resulting from a breakdown of standards and values").[19]

Social determinants of mental and substance use disorders and of suicide have become an increasing focus of concern in recent years. For example, considerable attention has been paid the ease of access to guns in the United States and to the apparent link between economic circumstances and suicide rates.

There is strong evidence that states without meaningful gun control laws have higher rates of suicide than states with such laws even after controlling for important differences such as rurality and race.[20] This leads most behavioral health professionals to call for strong gun control measures.

There is also historical evidence that suicide rates rise and fall with the economy. But in the United States the current rise in suicide rates does not seem to be closely linked to the economy. Yes, suicide rates went up during the great recession that began in 2008, but they continued to go up as the economy grew stronger. In addition, in the European Union, suicide rates have trended down since the turn of the century even though the vicissitudes of their economies have paralleled those in the United States.

Anne Case and Angus Deaton have developed an interesting theory that links economic factors to what they call "deaths of despair." The link, they say, and the reason for the declining life expectancy in the United States even before the pandemic, is not between suicide and the overall economy. Declining life expectancy prior to the pandemic, they say, is focused on a particular subpopulation that has rising rates of suicide, drug overdose deaths, and alcohol-related deaths. This subpopulation consists of White working age men with no more than a high school education—a subpopulation that is increasingly closed out of upward mobility or even economic stability in America. In their most recent book, Case and Deaton link rising deaths of despair with failures of capitalism and call for progressive social change in America.[21]

Case and Deaton have been criticized for failing to identify people of color and women as part of the population in despair in America, and there have been increases in suicide and overdose rates among Blacks since there original report. But it seems to me that you have to have had hope to lose hope. It may be that people of color, especially Blacks, never had much hope of sharing in the American dream. In addition, there may be strengths in communities of color that protect against suicide such as the Black churches, which are strong forces for faith and social connection.

There are other theories of social causes of suicide. For example, in a remarkable article tracing suicide rates for 100 years, Julie Phillips[22] notes that the rise of suicide in America has taken place especially among the Baby Boom generation. Raised with a promise of happiness, this generation may be more vulnerable to disappointments. Other possibilities include a growing sense of disconnectedness and dislocation in a society marred by vast economic, racial, and political divides. Or perhaps a loss of traditional values and sources of meaning as reflected in the decline of participation in religious institutions is driving a lost sense of belonging. Or perhaps it is changes in family culture--fewer marriages, more mobility, less acceptance of a responsibility to care for one's own. Or perhaps it is the significant rise in social isolation. Or maybe despair about the state of the world and the future of the human species. It will certainly be interesting to see whether suicide rates ultimately rise during and after the pandemic, which brings its own set of anxieties, new levels of isolation, economic turmoil and unemployment, an increased rate of gun ownership, and grief both for lost ways of life and more concretely for lost loved ones. Those factors suggest an increase in suicide, but so far suicide rates are down a bit. Maybe rallying together during tough times is a protective factor for suicide. Or maybe facing death increases appreciation of life.

What To Do?

Clinical Improvements: Suicide prevention has become a major mental health policy goal. Although it is not clear what is driving the increase in the suicide rate, there is widespread agreement that reducing the incidence of suicide requires improvements in both the physical and behavioral health systems. This would include:

- Improvements in response to psychiatric crisis such as the new 988 number to call instead of 911
- Improving identification and treatment of mental and substance use disorders in primary health care
- Improving the response to demoralizing health conditions
- Improving pain management using non-opioid interventions
- Improving integration of the physical and behavioral health care
- Increasing capacity, access, and quality in the behavioral health system
- Increasing the use of safety plans for people considering suicide—including safe storage or removal of guns
- Increasing early intervention for people experiencing their first psychotic break
- Enhancing outreach to populations at high risk of attempting or completing suicide
- Increasing public education to combat stigma, to increase public understanding of behavioral health, and to increase knowledge of how to get help.

In order to achieve these improvements in the health and behavioral health systems, a number of major initiatives and models have emerged such as "Zero Suicide".[23]

Societal Interventions: Given the social factors at play in the rise of suicide, it is important to work towards social change as well as clinical improvements. A public health approach, intervening at the population level, is vital.

Perhaps most importantly this includes efforts to:

- Reduce access to guns
- Reduce social isolation
- Encourage family and community responsibility with increased family support and the development of disability-friendly communities
- Address poverty, disparity, and racism
- Address economic structures that result in disconnection from opportunity
- Improve access to care
- Address social divides that result in disconnection
- Address the human need for values and meaning.

Whether approached from a clinical or a sociological perspective, the effort to reduce the frequency of suicide in America is daunting. There are changes currently underway in response to crisis that hopefully will help, but substantial expansion and improvement of mental health services is an enormous challenge. And addressing the possible social roots of suicide seems to require fundamental—even revolutionary—social change. Is this a matter for mental health policy makers or is it too far beyond their core responsibilities? Is it possible to make changes in the American society at this time of angry social division that will build hope, connection, and meaning? These are critical questions for mental health advocates and policy makers.

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[8] Suicide in Schizophrenia: An Educational Overview - PMC (nih.gov)

[9] Addiction and Suicide - Addiction Center

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[11] Increase in US Suicide Rates and the Critical Decline in Psychiatric Beds (eurekamag.com)

[12] Antidepressant class, age, and the risk of deliberate self-harm: a propensity score matched cohort study of SSRI and SNRI users in the USA - PubMed (nih.gov)

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