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Social Policy Report Q&A: Preventing Adolescent Suicide: Recommendations for Policymakers, Practitioners, Program Developers, and Researchers

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Preventing adolescent suicide: Recommendations for policymakers, practitioners, program developers, and researchers

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According to the Centers for Disease Control and Prevention, adolescent suicides have tragically been rising for over a decade and the COVID-19 pandemic's toll on activities, social connections, and deaths have made these trends increasingly visible.

A new *Social Policy Report* (*SPR*) from the Steinhardt School of Culture, Education and Human Development at New York University led by Pamela Morris-Perez with co-authors Rachel Abenavoli, Adam Benzekri, Sarah Rosenbach-Jordan and Gianna Rose Boccieri reviews evidence for suicide prevention strategies designed to address these rising trends. Please refer to the end of the release for a selection of some of the suicide prevention strategies recommended for policymakers, practitioners, program developers, and researchers.

The Society for Research in Child Development (SRCD) had the opportunity to chat with Dr. Morris-Perez about her team's strategic vision and their recommendations to help reduce the rates of adolescent suicide.

SRCD: Please explain your overall strategic vision for adolescent suicide prevention.

Dr. Morris-Perez: We don't believe a single strategy alone will move the needle in reducing adolescent suicides; rather, a combination of strategies, along with mental health treatment, might be able to finally turn the tide on the rising rates of adolescent suicide. In our report, we argue for the effectiveness of a *layered* approach to adolescent suicide prevention, drawing from what has been called a "Swiss cheese model." This model recognizes that each setting has gaps but their layering can support more teens than when each exists on its own. Such a strategy would focus on the places where adolescents already are (such as pediatrician's offices and schools). Our vision is that the adults and peers in those places would know how to recognize the signs of suicidal thinking in young people and how to ask about it, respond to it, and link adolescents to care. Moreover, adolescents' homes and neighborhoods would help keep young people safe.

And all of this would occur in a world in which adolescents feel accepted and hopeful about the future.

SRCD: Which adolescent groups are most at risk for suicide fatalities and how do you recommend providing them with the support they need?

Dr. Morris-Perez: First, I want to clarify that there is a distinction between those groups at highest risk for suicide *fatalities* and those groups who are at highest risk for suicidal *thoughts* and *attempts*. For example, girls are much more likely than boys to think about suicide, but boys are much more likely than girls to die by suicide because boys typically use more lethal means than girls. That said, Indigenous adolescents, boys, and adolescents in rural communities are some of the groups most at risk for dying by suicide. And those most at risk for suicidal thoughts and attempts are Indigenous and multiracial adolescents, girls, and LGBTQ+ adolescents. Note that LGBTQ+ identity is not collected routinely on death certificates, representing a major gap in our data.

Even so, we believe that an effective way to support these highest risk groups of adolescents is to support all adolescents, with *universal* prevention strategies, such as restricting access to methods by which a young person can take their life, screening all youth in pediatrics and emergency departments as part of routine care, and implementing community-wide suicide awareness and prevention programs and youth-focused programs in schools. Suicide prevention has been largely dominated by a high-risk strategy, focusing on clinical care, but a sizeable number of adolescents experience suicidal thinking and even die by suicide who are not in mental health care. Therefore, we need to pair clinical approaches with programs in spaces that all young people can access.

SRCD: How can policymakers and practitioners create a protective environment by reducing lethal means?

Dr. Morris-Perez: This is one of the areas where the research is really clear: if we reduce adolescents' access to the methods by which they can take their lives, we will save lives. We can do so through firearm regulation and safe firearm storage programs; we can build barriers and nettings on buildings and bridges where young people are likely to take their life (as was done recently at the Golden Gate Bridge after an inordinate delay); we can distribute lockboxes for medications and restrict the size of lethal over-the-counter medications. These approaches work because most individuals who are considering suicide do not find a different method if we block access to the one they planned to use.

SRCD: How can policymakers, practitioners and researchers help create accepting environments by implementing policies and practices affirming LGBTQ+ youth?

Dr. Morris-Perez: Studies find that LGBTQ+-accepting policies can reduce adolescent suicide rates, and, perhaps surprisingly, not just for LGBTQ+ youth. We saw this perhaps most clearly when states implemented same-sex marriage laws before federal protections; doing so reduced suicide rates for all adolescents, and especially so for LGBTQ+ adolescents. Given the evidence, we suggest that state-level policymakers and school administrators protect and implement strategies that treat LGBTQ+ youth equally and affirm LGBTQ+ identities. This includes maintaining those same-sex marriage laws, but also creating safe spaces in schools like Gender and Sexuality Alliance clubs and fighting anti-LGBTQ+ legislation like those that limit access to medical care or participation in sports.

SRCD: How can schools make a difference?

Dr. Morris-Perez: You know, it's interesting: the most common way that schools address suicide prevention is to train teachers and other adults to recognize the signs of suicide in their students and refer students to care. But we know from research that those programs only make adults more knowledgeable; they don't typically increase student help-seeking, which is what we really need to encourage in order to help link students to care. It turns out that the most effective programs are focused on adolescents, leveraging friend networks and changing norms around talking about suicide and help-seeking. And this makes sense, since adolescents are often the first to recognize suicidal signs in their friends but don't always know what actions to take next. We thus urge state and federal Departments of Education to support the implementation and funding of youth-focused programs in schools, and that school personnel be considered part of the suicide prevention network.

SRCD: What are your recommendations for changing or strengthening data systems to help with suicide prevention strategies?

Dr. Morris-Perez: Well, there are a few challenges with our data systems. First, suicide-related mortality data is affected by what we call lack of burden of proof standards - that is, the evidence needed to label a death a suicide is different across the U.S. Gender identity beyond male and female and sexual orientation are also not systematically recorded on death certificates. Standardization and training would help us understand trends and rates in suicide fatalities better than we do now. But second, and perhaps even more importantly, we are stymied in this area by not having the kinds of multi-level data that exist in fields like education.

Administrative, real-time data across national, state, and school-district levels could help us understand how factors like neighborhood income inequity or school characteristics contribute to trends in suicide, and identify policy and programmatic levers for altering them. These data would perhaps lead to new solutions for adolescent suicide prevention.

SRCD: What next generation of suicide prevention programs need to be developed?

Dr. Morris-Perez: Existing school-based strategies typically focus on recognizing suicidal signs and connecting adolescents to care, with relative inattention to supporting adolescent needs for identity (who they are), purpose (their place in the world), belonging/connectedness, and hope in the future. New programs should be developed that support these basic developmental needs that would help adolescents not just be identified and connected to care, but to "find a life worth living."

Preventing Adolescent Suicide: Recommendations

Select recommendations for policymakers and practitioners include the following:

- Restrict access to lethal means including firearms, medications, and bridges/buildings.
- Include suicide screenings as part of routine medical care.
- Fund and implement youth focused school-based suicide prevention programs.

Select recommendations for program developers include the following:

- Develop programs for unique needs of high-risk groups (e.g., Indigenous, multi-racial, LGBTQ+, and rural adolescents).
- Involve youth in designing programs and prevention activities.
- Develop programs that support adolescent needs for identity, meaning-making, belonging/connectedness, and hope for the future.

Select recommendations for researchers include the following:

- Study differences in implementation of crisis services across states to guide best practices and identify gaps in program design and delivery.
- Study promising efforts to support schools after a suicide loss.
- Build data systems for real-time analysis of suicide fatalities, thoughts, behaviors, and relevant characteristics of areas where suicides have decreased.

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Summarized from *Social Policy Report*, “Preventing Adolescent Suicide: Recommendations for Policymakers, Practitioners, Program Developers, and Researchers,” by Morris-Perez, P., Abenavoli, R., Benzekri, A., Rosenbach-Jordan, S., Boccieri, G.R. (New York University).