Suicide is always personally tragic, and its impact can be far-reaching. Because suicide affects not only individuals but families, communities, and society at large, suicide is a significant public health issue. In 2020, suicide caused 45,979 deaths in the United States, according to the Centers for Disease Control and Prevention (CDC). Suicide ranked among the top nine causes of death for people ages 10–64. Among people ages 10 to 34, suicide was the second leading cause of death. These figures express the worst outcomes of a much larger story. In 2020, an estimated 1.2 million Americans attempted suicide, 3.2 million planned a suicide attempt, and 12.2 million had serious suicidal thoughts.

“Suicide is a public health crisis that affects all ages, races, genders, sexual orientations, religions, and communities,” says Daniel J. Reidenberg, PsyD, FAPA, executive director of Suicide Awareness Voices of Education (SAVE). “We have somebody dying by suicide every 11 minutes in this country. Somebody attempts to take their own life every 28 seconds. Suicide is more prominent than homicides or car accident fatalities. There are more deaths by suicide every year than by breast cancer. There are tragically too many deaths by suicide in our country.”

Unpack Suicide Stigma
As a public health issue, a mosaic of contemporary concerns influences suicide’s stark reality:

- Social isolation
- Economic and family stressors
- New or worsening mental health symptoms
- Disruptions to work and school caused by the COVID-19 pandemic

Evidence also suggests that childhood trauma or maltreatment, such as physical, sexual, and emotional abuse and neglect, is associated with an increased risk for suicidality (i.e., suicide or suicidal thoughts, plans, or actions) in adults.

For many reasons, suicide presents mental health advocates with a formidable public health challenge. Efforts to effectively meet this societal challenge invariably entail a comprehensive approach that engages mental health experts, primary care providers, social workers, educators, youth advocates, those with lived experience, and family and community resources.

“We have to address suicide prevention using a population health approach,” says Sandra J. Gonzalez, PhD, MSW, assistant
A professor in the family and community medicine department at Baylor College of Medicine in Houston, Texas. “Historically, we focused largely on individual factors rather than considering suicide in the context of families, communities, and even our broader society. But we know that contextual factors, such as the social determinants of health, have to be addressed. In many cases, individuals who attempt or complete suicide are also plagued by interpersonal or job-related stressors, financial worries, or community violence, just to name a few factors. This is why one of the public health strategies that can be used is to offer suicide prevention training on a wide scale.”

A variety of evidence-based programs, such as Question, Persuade, and Refer (QPR) and Mental Health First Aid, offer suicide prevention training to interested people, reports Dr. Gonzalez. The QPR Institute’s training course provides brief instruction to laypersons and professionals on recognizing warning signs for suicide and referring people for help. Similarly, Mental Health First Aid, sponsored by the National Council for Mental Wellbeing, offers instruction on identifying and assisting people experiencing mental health, substance use, and suicidal crises. Program participants come from all backgrounds, including adults, teens, caregivers, school faculty, emergency medical services personnel, military veterans, and law enforcement.

Admittedly, suicide can be a difficult or uncomfortable topic for people. “We still have stigma and discrimination around the issue of suicide,” acknowledges Dr. Reidenberg. “The topic scares people. They don’t want to think about it, talk about it, or want to believe it could happen to someone they know or someone they care about or love. While people are talking about suicide more than in the past, many people are still afraid of the topic. They also [may] shun those that have lost someone to suicide. This [attitude] complicates the public health crisis as well.”
workers, and other health care practitioners. Primary care providers also play a key role in reducing suicide risks.

“About one-third of those who die by suicide had contact with the primary care system in the month before they died,” remarks Anthony R. Pisani, PhD, associate professor of psychiatry and pediatrics at the University of Rochester Center for the Study and Prevention of Suicide and founder of SafeSide Prevention. “That differs by age group with a greater percentage of older Americans and a smaller percentage of adolescents seen in primary care in the month before they died. As we know, screening for depression—and increasingly for suicide risk—is becoming more common in primary care. But with increased screening, there is also more need for primary care professionals to be prepared to respond if there is a positive screen for suicide risk. Screening helps only if the response is [proficient], and people are glad they shared with their primary care team.”

This fact speaks to the opportunities in primary care to identify and offer treatment to at-risk patients and also to the need to improve the ability to do so in a timely and effective manner. “Primary care is a key setting for suicide prevention, but there are challenges,” says Dr. Pisani. “The biggest challenge primary care offices face is time. There are a lot of competing demands. However, there are ways within the demands and constraints of primary care for professionals across roles and disciplines to really help.”

As the main entry point into the health care system, Dr. Pisani suggests primary care providers recognize they can play an expanded role in suicide prevention. “I prefer not to refer to primary care providers as ‘gatekeepers’ as if their only job is to identify somebody and try to get them to a referral,” he says. “Referrals are important, but they’re not the only help primary care professionals can offer.”

Accordingly, Dr. Pisani identifies four core tasks in suicide prevention:
1. Making a connection with the individual
2. Assessing and understanding suicide concerns
3. Responding to the person, learning what is driving their concerns, and making plans with them
4. Extending their care beyond the individual to a broader support network, including mental health specialists for continuing care

“The first task is to connect with people, which means, when asking someone directly about suicide, making sure they feel you really want to know and are able to handle their response,” says Dr. Pisani. “Most primary care providers have strong basic connection skills, but when suicide comes up, there’s so much anxiety around the topic that it can be hard to stay connected. Suicide can make anybody feel unskilled. We don’t want anything to happen to the person. And beyond this primary concern for the person’s life, most of us worry about ourselves and may wonder, 'If something does happen, will I be blamed or sued?’”

To address these challenges, SafeSide Prevention offers video-based training modules that primary care, behavioral health, and youth services teams work together—providing opportunities to not only build skills but also have team discussions about challenges specific to the setting and population they serve.

“Screening tools are helpful in primary care, but they need skillful follow-up,” adds Dr. Pisani. “Understanding the context and understanding whether suicidal thoughts have been occurring for a long time or are new is [vital]. While most primary care professionals are not going to conduct a full risk assessment, it is important for them to understand what goes into one and be conversant in understanding models for suicide risk.”

Beyond referrals, even a primary care physician’s simple initiative could sometimes make a difference to a patient in crisis. “We have a member of our team, a middle-aged man who was very close to taking his own life,” recalls Dr. Pisani. “But he revealed this to his primary care provider, and she
responded beautifully. One of the things that she did was make a series of appointments with him in a relatively short period. It’s often not feasible for providers to have very long, extended visits with people. But having multiple short visits sometimes is possible, and in this case, it was probably lifesaving.”

**Screening Recommendations**

The U.S. Preventive Services Task Force (USPSTF) recommends screening for early detection and treatment of mental health and substance use disorders in the primary care setting. Unfortunately, behavioral health screening rates in community-based physician practices are low.

“The most important thing we can do now is implement the universal use of screening tools,” says Dr. Gonzalez. “Family medicine and primary care settings that follow the USPSTF should be aware that depression screening is a grade B recommendation for all adults 18 years of age and older and adolescents aged 12 to 17.”

The USPSTF assigns one of five letter grade recommendations (A, B, C, D, or I) to clinical preventive services, with grades A and B being the highest level of recommendation, based on reviews of available evidence. The grade B recommendation indicates high certainty of a moderate or substantial patient benefit in providing a clinical service.

As Dr. Gonzalez explains, a useful starting point in screening for depression and other mental or behavioral health disorders is the multiple-choice Patient Health Questionnaire (PHQ). The PHQ includes an initial prescreen (or PHQ-2) with two questions about how often the person has experienced a depressed mood and or anhedonia, the loss of pleasure in things they once enjoyed, over the past two weeks. This initial screening can be followed as needed by the PHQ-9, a longer instrument that looks at the severity of depression symptoms. The PHQ-9, in particular, includes a question about thoughts of suicide.

“The PHQ-9 can be self-administered by the patient, or it can be administered by a medical assistant,” says Dr. Gonzalez. “For medical assistants, [the PHQ-9] can be instrumental in making sure all eligible patients receive screening and in working with their clinician to make sure further assessment is done in those patients that screen positive. They can also assist with the important task of follow-up.”

When identifying mental health problems at the primary-care level, an interdisciplinary collaboration among providers is integral to the patient’s ongoing care and treatment, explains Dr. Gonzalez. Indeed, collaboration can be especially critical for patients with risk factors for suicide.

“As a mental health professional, my first charge is to assess the degree of imminent risk in a patient,” explains Dr. Gonzalez. “I want to make sure that I know where the patient is at and that I can match them with the appropriate level of care. Then I’ll continue to monitor that patient’s symptoms, work with their care team, which may include their primary care clinician or psychiatrist, and then assess that risk throughout the course of treatment.”

With her experience working in family medicine settings, Dr. Gonzalez recognizes the value of close collaboration among providers. “Besides routine screening, I’ve found that interprofessional collaboration is vital to both identifying and providing care for people with mental health conditions,” she observes. “If you’re fortunate in your practice to have an interprofessional or interdisciplinary group, a warm handoff will go a long way to demonstrate to the patient that they have a team of clinicians who are really committed to [the patient’s] overall well-being.”

When a primary care or family medicine clinic does not have a mental health professional on-site, Dr. Gonzalez recommends the practice take steps to develop relationships with local professionals who can serve as referrals. “When we are talking about referral sources, I would add that it’s also important to understand what those referral sources are doing in terms of their trauma-informed care approach,” says Dr. Gonzalez. “For example, we know there is a relationship between adverse childhood experiences, or ACEs, and trauma and the risk for suicide. For this reason, I always like to know a little about their approach to trauma-informed care.”

**Bolster Early Detection**

For many individuals struggling alone with feelings of hopelessness or suicidal thoughts, early detection can be vital in steering them into treatment and recovery. This may be especially true for young people with depression and substance use disorders.

“We know that both depression and substance use disorders often occur together and are highly correlated with death by suicide,” says Dr. Gonzalez. “One of the reasons alcohol intoxication, in particular, is such a big risk factor is [that] it decreases inhibitions, increases impulsivity, and affects judgment. In addition to that, substance use also increases depressed moods. That is why it’s so important, particularly when we’re talking about youth and young people, that we detect mental health and substance use disorders as early as possible and provide timely treatment.”

Unfortunately, the stigma surrounding...
suicide and mental health issues can hinder timely, professional treatment. “When it comes to mental health, we have seen some improvements in reducing stigma,” says Dr. Gonzalez. “But there’s still a lot of self-stigma that serves as a really significant barrier to help-seeking behavior. If we’re talking about both mental health and substance use disorders, we know … that stigma is even greater [with substance use]. So, tip No. 1 would be to encourage folks to be willing to talk about this. We should also be willing to use clear language [and] to not be afraid that if we ask the question, ‘Are you thinking about killing yourself?’ that [doing so] is going to put the idea into that person’s mind. We need to be able to have those open conversations.”

In terms of lessening stigma, health care teams should also be sensitive to how they refer to patients with a mental health diagnosis, advises Dr. Gonzalez: “We need to think about how our language affects our interactions with others. The use of person-first language is really important, for example. We don’t [say] ‘schizophrenic people’ or that a person is bipolar; we talk about a person living with schizophrenia, a person with depression, or a person with a substance use disorder.”

Medical assistants working in mental and behavioral health settings should make it a priority to support a clinic environment in which patients feel comfortable opening up and discussing their mental health challenges without shame or judgment. “Unfortunately, we still see a stigma surrounding mental health,” says Lindsay Vander Male, CMA (AAMA), a staff member at Spectrum Health Medical Group Psychiatry and Behavioral Medicine in Grand Rapids, Michigan. “A lot of people don’t even come forward for help because of the stigma and anxiety surrounding what people might think of them. But the further we can go in getting stigma about mental health care out of our lives, the more we talk openly about these issues without having it be hushed or embarrassing. I believe it will make a huge difference.”

Vander Male also encourages medical staff to understand patients’ perspectives on their mental health experiences. “As a liaison between the patient and the [physician], we’re asking questions and collecting information,” she says. “We’re kind of that front line for the provider, so we’re in a position in which we might pick up on nonverbal cues that the provider should know about. That’s why trust is so important. You want to be able to build rapport and trust with the patient, so they feel they can talk to you. It’s especially important to be empathetic to the patient and to have some knowledge of the difference between empathy versus sympathy. Even if someone calls on the phone in crisis, you want to interact with them in a way where they feel they made the right decision calling your office—where they say to themselves, ‘I know I can get help here.’”

Education on mental health issues is key, adds Summer Bickford, CMA (AAMA), who works in rapid response services for a community mental health center in Manchester, New Hampshire. “As a medical assistant, the first, most important thing always is to educate yourself on suicide, substance use, schizophrenia, bipolar disorder, or other conditions,” says Bickford. “The more education you can absorb on these conditions, the more comfortable and confident you will feel in helping someone who is asking for help. It’s also important for us to understand what people are going through. At the end of the day, we go home, but for people who are suffering, that is just their constant. While it’s important to be able to identify and understand the warning signs of suicide, you also have to be perceived as a compassionate, trustworthy person for someone to feel like they can open up about their mental health.”

Look Closely: Vision for the Future Notably, the CDC reports the suicide rate increased by 30% between 2000–2018. Yet, for complex reasons, the stressors associated with the COVID-19 pandemic have not led to an overall increase in the suicide rate. “Based on the latest data from the CDC, overall suicide rates have decreased by 3% from 2019 to 2020,” says Doreen Marshall, PhD, vice president of mission engagement for the American Foundation for Suicide Prevention. “We did, however, see increases for young adults and marginalized communities, including Black, Native American, Hispanic, and LGBTQ people.”

Whether this trend signals a reverse in the upward trend in suicides in recent decades remains to be seen. But mental health advocates are hopeful that new and ongoing efforts to promote strategic public health approaches to suicide prevention will yield increasingly positive results over time.

“Suicide is a complex public health problem, so we must ensure that a comprehensive approach to suicide prevention occurs in community-based settings as well as health systems,” says Dr. Marshall. “This involves ensuring prevention activities and interventions are effective and culturally relevant for the community being served.” As part of this comprehensive approach, the American Foundation for Suicide Prevention is leading Project 2025, a nationwide initiative that seeks to reduce the suicide rate 20% by 2025. Using evidence-based practice, Project 2025 has identified four key areas (firearms, health care systems, emergency departments, and corrections systems) con-
"One of the major initiatives we're supporting as part of this effort is the national rollout of 988," reports Dr. Marshall. "This is a move to a three-digit [phone] number to access the National Suicide Prevention Lifeline, similar to the way 911 can engage emergency support. The implementation of 988 provides an opportunity to reform and improve our nation’s mental health crisis response system. [988] is an essential component of a strong health care system. We’re also advocating for leaders in health care and policy to implement new suicide prevention strategies, offer accessible mental health care, and make these resources available to all communities.”

For suicide prevention advocates, the challenges are persistent and require engagement at medical, government, community, and individual levels. “I believe we all can play a role in suicide prevention,” concludes Dr. Gonzalez. “This is true not only as health care professionals but as members of communities. Everyone needs to be educated about the risk factors for suicide.”

Dr. Gonzalez also offers a critical reminder. "We have to look at attempted suicide for what it is, which is a cry for help," she says. "It often occurs in moments of desperation and can certainly be compounded by things like substance use and being disinhibited. The most important thing to know is that once a person has made an attempt, their risk of making another attempt or completing suicide gets even higher. This [risk] is why we..."
suicide prevention

have to make sure that people have access to treatment and support, crisis lines, and other resources. We also have to look at some of the community and familial factors. What does their support system look like? What sort of stressors do they have? While we may not be able to influence those, it’s important for us to understand that they are at play and to provide an opportunity for the person to talk about these stressors.”

While the topic of suicide is a somber one, it is not one without hope. In fact, people who survive a suicide attempt or struggle with suicidal ideation can go on to live healthy, functioning lives. “We don’t want people to think or believe or feel for one moment that—just because they’ve become suicidal, or they’ve [made] an attempt—their life is over and they can’t make it,” concludes Dr. Reidenberg. “There’s always hope for people no matter how they struggle.”

With improved access to mental health treatment services, public health awareness, education, and support from friends, family, and community, it is possible to nurture the spirit of hope, recovery, and resilience necessary to counter the suicide crisis in society. 

References