2022 Region 1 Epidemiological Profile Worksheet: Suicide

Problem Statement

Suicide is defined as death caused by self-directed violence with an intent to die.[1] Suicide is a growing public health problem and is now the 12th leading cause of death in the United States. Suicide affects individuals across the lifespan; however, it is the second leading cause of death among people 10-14 years old & 25-34 years old.[2] In 2020, suicide deaths were among the top 9 leading causes of death for ages 10-64.[2]

As of June 2022, the National Institute on Mental Health (NIMH) reported that the age adjusted suicide rate was 13.5 per 100,000 in 2020.[2] This is a decline from previous 2018 findings, which reported the rate was 14.2. Among females, the suicide rate was highest for those aged 45-64 (7.9 per 100,000), highest for those aged 75 and older (40.5 per 100,000) for males in 2020.[2]

According to the 2021 National Survey on Drug Use and Health (NSDUH) among adults ages 18+, 12.3 million individuals had serious thoughts of suicide in the past year.[3] From 2020-2021, there was a 7.5% increase in the number of adults reporting serious thoughts of suicide. Among this same group, 3.5 million (1.4%) made suicide plans, & 1.7 (0.7%) million people nationally attempted suicide in the past year. [3]

Magnitude (prevalence)

Compared to national averages, Connecticut (CT) suicide data is lower. Yet, according to the Office of the Chief Medical Examiner (OCME), while the number of suicide deaths per year in Connecticut decreased in 2020 (359 suicide deaths) from 2019 it has risen yet again in 2021 (392 suicide deaths).[4] In 2021, the crude suicide rates per 100,000 population across CT was 10.9. The previous year was 9.9. This rate is highest among ages 65+ with a rate of 16.8 deaths per 100,000.[4] The second highest age group was ages 45-64 with a rate of 13.6 deaths per 100,000 population. This age range (45-64) had the highest crude suicide rate from 2015 through 2019.[4]

Preliminary 2022 data from the Connecticut Department of Public Health (CT DPH) reveals that 97% of suicides across the state of Connecticut occurred in individuals ages 19 or older.[5] Ages 19+ had a crude statewide rate of 13.3 per 100,000. Ages 0-18 had a crude rate of 1.2 per 100,000. [5] 2022 numbers thus far reveal that Southwestern Connecticut (SW CT) had a total of 57 deaths, 9% of which occurred in ages 0-18, 81% of which occurred in ages 19 and older. [5]

From 2020-2022, the number of suicide deaths, that occurred in DMHAS Region One, remained steady. 2020 had 53 deaths by suicide (5.5 crude rate per 100,000), 2021 had 54 deaths by suicide (5.6 crude rate per 100,000). Preliminary data for 2022 reveals 57 deaths by suicide (crude rate of 6.0 per 100,000).[5]

The 2022 CT DPH Self Harm Emergency Department Visit Report found that the age adjusted rate per 10,000 for suicidal ideation was highest among ages 10-17 (5.8%) followed by ages 18-24 (3.5%) & then ages 25-34 (2.6%).[6] Generally, suicidal ideation is higher among young adults. In 2022, SW CT had the lowest rate (0.6%) emergency department visits for suicide ideation across the state.[6]

2016-2018	**4.17**	**4.30**	**4.23**	**4.63**	**3.94**	**4.00**
2018-2020	**4.38**	**4.01**	**4.69**	**4.77**	**4.16**	**4.48**

Prevalence Among Youth:
According to data from the 2021 Connecticut School Health Survey (CT YRBSS), 1 in 7, 14.1% high school students reported seriously considering attempting suicide in the past year.[7] In 2021, 1 in 17 high school students reported attempting suicide one or more times in the past 12 months. In one urban area of the Region, there were reports that 11.4% of adults' experienced suicidal ideation in 2020.[7]

Data from CT OCME from 2020 -2022 found that rural areas of SW CT reported higher crude suicide rates at 9.76% whereas urban towns in SW CT had a crude rate of 5.83%.[4]

Risk Factors and Subpopulations at Risk

- Nationally, from November 1st, 2021-October 31st, 2022 preliminary findings showed that 52.8% of suicidal ideations were male across the lifespan.[3]

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- In SW CT the rate of suicidal ideation was highest among White individuals (2.2%), followed closely by Black individuals (2.0%) & then Asian individuals (1.7%). [5]
- Nationally, suicide rates among non-Hispanic American Native/Alaska Native individuals increased nearly 20% from 2015 (20.0 per 100,000) to 2020 (23.9) compared to a less than 1% increase among the overall US population (13.3 to 13.5). [8]
- Region 1 findings show that those who identified as "Not Hispanic" had higher rates of suicidal ideation (201.2 per 10,000 visits) then those who identified as Hispanic or Latino (153.1 per 10,000 visits).[6]
- There is a high correlation between problem gambling, mental health & suicidality.
- Exposure to a death by suicide leads to an increased risk of suicide attempt or completion for those closely impacted; often referred to as suicide contagion.
- LGBTQIA+ youth experience increased suicidal ideation and behavior compared to their peers.[1]
- Mental illness is a risk for suicide, including depression, anxiety, bipolar disorder, and general depressed mood.[3]
- For those over 45, other risks include physical illness, such as terminal illness and chronic pain, as well as intimate partner problems.[3]

Other risk factors include[1]:

- Family history of suicide;
- Childhood abuse/trauma;
- Previous suicide attempts;
- History of substance misuse;
- Cultural and religious beliefs;
- Local epidemics of suicide;
- Isolation;
- Barriers to treatment;
- Loss (financial, relational, social, work); and
- Easy access to lethal means.

According to CDC, the 2020 CT age-adjusted rate for drug-induced mortality was 39.1 per 100,000 compared to the 2020 national rate 28.3.[9] There is a high prevalence of co-occurring disorders (ie. presence of mental health diagnosis and substance use disorder) & may be a large contributing factor to the rates of overdose deaths in the state as well as within SW CT. [10]

While suicide rate among pre-teens remains lower than the rate among adolescents, it has been rising. Suicide is the second leading cause of death for ages 10-14 nationally. A longitudinal study completed by CRS from 2018 to 2020 found that the rate of suicide completions for ages 0 to 17 increased from 0.95 to 1.4. Ages 0 to 17 was the only category, which saw an increase in the rate of suicides. All others saw a significant decrease in rates.[11]

Data from the 2021 Connecticut School Health Survey shows the percentage of female high school students who seriously considered attempting suicide was higher (19.8%) than males (8.7%).[7] Additionally, the percentage of students identifying as gay, lesbian, or bisexual reporting considering attempting suicide is significantly higher than their heterosexual peers (34.2% vs. 8.4%).[6] A significantly greater percentage of female students reported attempting suicide (8.8%) compared to male students (3.3%). Additionally, Hispanic students reported this at a higher rate (7.6%) than Black non- Hispanic students (7.5%) or White non-Hispanic students (4.0%).[6]

In CT in 2021, ages 4 -64 had the highest frequency of suicide deaths (135 deaths) followed by ages 65+ (106 deaths). These findings are reflective of national 2021 data showing these two age brackets also ranked 1st and 2nd for the highest suicide death rates [5]. As focus group findings that The Hub conducted show, ages 65+, has seen an increase in suicidal ideation, suicide attempts & suicide completions in recent years, especially since the onset of the COVID-19 pandemic.[11] There are multiple theories, which suggest this can be a result of increased isolation & lack of connectedness to others & resources. This could also be due to difficulty in accessibility & utilization of technology.[11]

Burden (consequences)

- Suicide impacts the health of the community and those around the individual. Family & friends experience many emotions including shock, guilt, & depression.[1]
- People who attempt suicide & survive can sometimes experience serious injuries which can have long term health effects.[1]

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- The impacts and implications of a suicide on the community at large are far reaching. Aspects of contagion, lack of connection to resources, stigma & fear surrounding suicide are reported in SW CT. [11]
- Local organization, Kids in Crisis, reported that in the 2021-2022 school year, 291 students received group counseling and 132 risk assessments were provided. Among these assessments, the primary presenting problem was suicidal ideation. [12]
- In fiscal year (FY) 2020, 17,254 children were screened in CT. 16% were flagged for thoughts of suicide. This number reached 22% in FY 2021. [13]
- Regional providers report increased need for immediate intervention services. Reports of delays in psychiatric bed availability & connection to appropriate care is often mentioned.[10] Providers report the lack in standardization of screening as a gap in early identification of mental health & suicidal symptoms, especially among youth.[10]
- Focus group findings show an increased need for mental health & suicide related services offered to undocumented individuals, those on public insurance, non-English speaking residents, homeless, elderly, pregnant women & new parents.[10]
- One hospital in Region 1 is in the process of closing their psychiatric unit, which will present heighted barriers and stress in accessibility.

Capacity and Service System Strengths

Statewide entities such as the Connecticut Suicide Advisory Board (CT SAB) have positioned themselves to focus on legislation, which advocates for funding, longevity & sustainability of suicide specific programming. Funding for Regional Suicide Advisory Boards through DMHAS & DCF have allowed for the infrastructure within the CT SAB to be disseminated across the state in partnership with Regional Behavioral Heath Action Organizations.

One resource to come from the suicide prevention field in recent months has been the rollout of 988; The National Suicide and Crisis Lifeline which became effective on July 16, 2022. This system is aimed at aligning crisis services in the hopes of de-escalating situations and decreasing Emergency Room admissions for psychiatric calls. From April 2022 to October 2022, CT received 15,645 988 calls. The average speed of answer in seconds was 4.86. An additional 25,922 calls were made to 211 for crisis or suicide intervention in 2021.[14] Mobile Crisis will also be transitioning into 24 hour services, which will assist in bridging current gaps in timely connection to services.

Community Readiness Survey: Mean Stage of Readiness for Mental Health Promotion

	CT	Region 1	Region 2	Region 3	Region 4	Region 5
2020	4.88	4.86	5.00	4.71	4.89	4.88
2022	4.98	5.36	5.11	4.54	4.91	4.79

The 2022 Community Readiness Survey showed an increase in overall perception regional readiness for mental health promotion. While data suggests that suicidal ideation & related symptoms persists, SW CT has a strong network of nonprofit partners, clinical & general heightened collaboration of stakeholders.[13]

SW CT groups including peer-led *Alternatives to Suicide Group,* and peer support through, PIPPLE, SOSA & others. Trumbull, Darien, Greenwich & Westport host suicide bereavement groups. SW CT has increased awareness & visibility in relation to suicide prevention through involvement in the American Foundation for Suicide Prevention's regional walk & fundraiser as well as a 3-month digital campaign promoting the new roll out of 988 & other resources.

In the 2022 calendar year, The Hub offered 47 Question, Persuade, Refer (QPR) Suicide Gatekeeper Trainings within the community in which 1,337 individuals were QPR certified. Many other community partners outside of The Hub also continue to offer QPR trainings within the region as well. Embedded social workers and crisis intervention trained officers reflect an overall increase in mental health awareness. School based health centers, which focus on mental health, connected students to appropriate resources.

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Footnotes:

[1] CDC, Suicide Prevention, 2022

[2] NIMH, Suicide, 2022

[3] National Survey on Drug Use and Health (NSDUH), 2021

[4] Connecticut Office of the Chief Medical Examiner (OCME), 2021

[5] CT Department of Public Health (DPH), 2022

[6] CT DPH, Suicidal Ideation and Self Harm Emergency Department Visit Report, 2022

[7] CT Youth Risk Behavior Surveillance System (YRBSS), 2021

[8] CDC, Suicides Among American Indian & Alaska Native Persons, 2022

[9] CDC, Drug Overdose Mortality by State, 2022

[10] The Hub Stakeholder Focus Group, 2022

[11] Community Readiness Survey (CRS), 2021

[12] Kids in Crisis, 2022

[13] CT Mirror, *Children with Psychiatric Needs are Overwhelming Hospital Emergency Departments in CT*, 2021

[14] DCF/DMHAS/United Way 988 Power Point, 2022