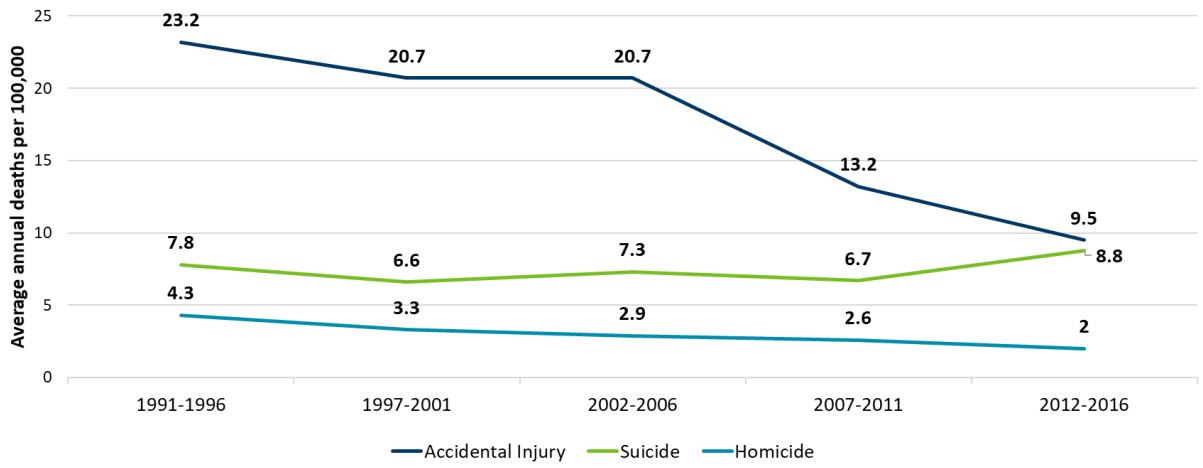
Adolescent Suicide

THE ACT OF TAKING ONE'S OWN LIFE

Why It's Important

Minnesota has a higher suicide rate (14.8 per 100,000) than the national rate (13.1 per 100,000) among adolescents and young adults (ages 15-24).[1] The suicide rate for Minnesota youth has been higher than the United States average for a long time. In Minnesota, suicide is the second leading cause of death for young people ages 10-24. In 2016, 111 Minnesotans between the ages of 10 and 24 died of suicide, representing roughly 15 percent of all suicides in the state in that year.[2] Data from the 2016 Minnesota Student Survey shows that of 8th, 9th, and 11th graders, 17 percent of female students and 8 percent of male students reported either seriously considering attempting or attempting suicide in the last year – **that's over 14,000 students**.

Figure 1. Leading Causes of Death for Adolescents, Ages 10-24



Source: Minnesota Vital Statistics

There is not one single path that leads to suicide. Many factors can increase the risk of suicidal thoughts and behaviors, such as childhood trauma and adversity, serious mental illness, physical illness, alcohol or other abuse, a painful loss, exposure to violence, social isolation, and easy access to lethal means. Factors such as meaningful relationships, coping skills and safe and supportive communities can decrease the risk of suicidal thoughts and behaviors.[3] Adolescent suicide prevention efforts require improving access to comprehensive mental health services and building communities that support youth and families and their mental well-being. Evidence shows most suicides are preventable, mental illness is treatable, and recovery is possible.

Suicide is preventable.

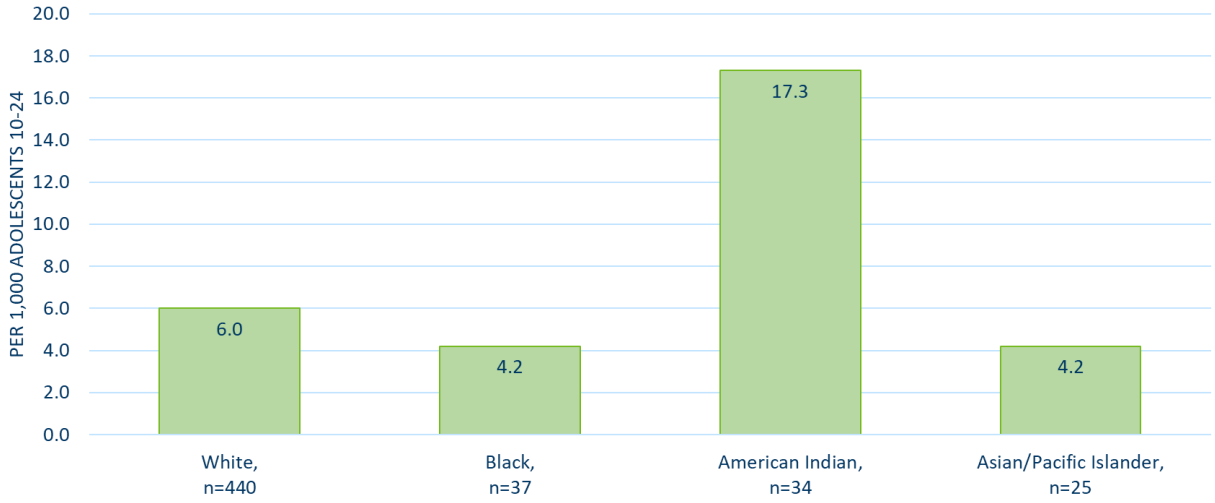
"Do more for mental health in schools. We need a funded, wellness coordinator in every school district. Our counseling ratio of staff/students ranks at the bottom nationally. Suicide is up, especially for girls." – Needs Assessment Discovery Survey Respondent

Focus on Health Equity

Suicide is not experienced equally across age groups, genders or geography in Minnesota. We know that the suicide risk increases with age from 10-24, peaking at 19 and 23-24 being an especially difficult age.

There are large race/ethnicity disparities in suicide, with American Indian adolescents experiencing the highest rate of suicide. In Minnesota, American Indian and Alaska Native youth experience suicide rates that are nearly 3 times that of youth of other races. Minnesota is also starting to see an increase in suicides among Black youth, which is similar to what is being found nationally. American Indian youth in Minnesota have the highest rate of suicide (28 per 100,000) followed by White (8.8 per 100,000), Black (7.6 per 100,000), and Asian (6.7 per 100,000) youth.[3]

Figure 2. Minnesota Suicide Rate by Race, ages 24 and under, 2012-2016



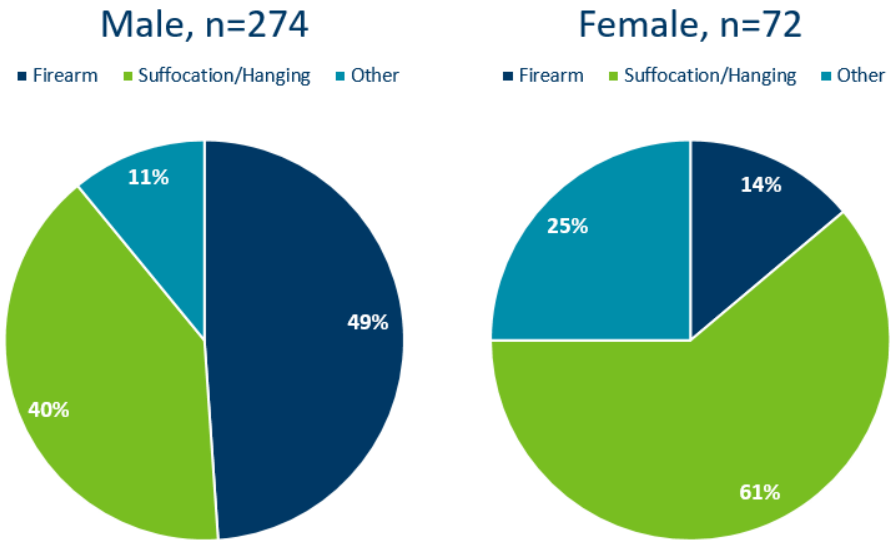
Source: Minnesota Vital Statistics

Historical trauma, living in poverty, childhood adversity, lack of access to culturally relevant mental health services, and experiencing interpersonal violence are all experienced in higher rates among American Indian populations and are all associated with an increased risk of suicidal behavior.[4] The contagion effect, also referred to as suicide clusters, refers to the increase in suicidal behavior among those who have lost a friend or family member to suicide.

Among communities where suicide is prevalent, the risk of suicide among adolescents can increase by as much as 4 times following the loss of a friend or family member to suicide.[4]

In Minnesota, the suicide rate among females decreased 10 percent from 2016 to 2017 but increased 9 percent among men during this same period of time.[2] The suicide rate for adolescent males between 15 and 19 years old (19.6 per 100,000) is almost 4 times the suicide rate for females of the same age (5.2 per 100,000). There is a well-studied gender paradox in method used for suicide attempt with men of all ages selecting more lethal methods and therefore are more likely to complete a suicide attempt. It is likely that a similar pattern is seen among adolescent suicides.[5]

Figure 3. Suicide by Means and Gender, Ages 10-24, 2014-2016



Source: Minnesota Vital Statistics

Gender and sexual identity can impact risk and rate of suicide as well with LGBTQ youth reporting higher rates of suicidal ideation and suicide attempts than cisgender youth.[6] The Minnesota Student Survey shows that 9th and 11th grade LGBTQ youth were over 3 times more likely to have suicidal thoughts and 5 times more likely to attempt suicide in the past year than their straight, cisgender peers. A loss of supportive relationships with family members, discrimination, and bullying are thought to impact this higher rate of suicidal behavior among LGBTQ youth.

Additional Considerations

In Minnesota, over half of all non-fatal self-inflicted injuries (SII) occur among adolescents and young people between the ages of 10 and 24 with the greatest amount of SII occurring among 15 to 19 year olds.[7] Females make up 2 out of 3 cases of hospital treated SII cases. The most common type of SII in Minnesota is poisoning followed by cutting.

Firearms are the most common method among deaths by suicide.[2] Reducing access to firearms and other lethal means can reduce the likelihood that a person exhibiting suicidal behaviors will attempt or complete suicide.

Suicide prevention efforts are complex and are comprised of improving familial support, community connection, and behavioral health treatment. An estimated 13 percent of adolescents living in Minnesota experienced at least 1 major depressive episode in the past year and 46 percent of these adolescents struggling with their mental health did not receive treatment.[8] Adolescents living in Greater Minnesota face additional barriers when compared to urban youth in accessing mental health services including fewer behavioral clinics and psychiatrists, increased distances to travel to clinics, and fewer beds in psychiatric hospitals or access to hospitals with psychiatric units in general.[9] Developing mental health crisis response teams in partnership with law enforcement can help to provide support to individuals experiencing suicidal behavior. Trained law enforcement professionals can respond to crisis, safely de-escalate a situation, and connect the individual with mental health care.[7]

Important Note on Equity and Intersectionality

The Minnesota Department of Health's Title V Needs Assessment team acknowledges that generational structural (social, economic, political and environmental) inequities result in poor health outcomes. They have a greater influence on health outcomes than individual choices or one's ability to access health care, and not all communities are impacted the same way.

All people living in Minnesota benefit when we reduce health disparities through policies, practices and organizational systems.

We also acknowledge "there is no such thing as a single-issue struggle because we do not live single issue lives." The need addressed in this brief does not exist in isolation– which is important to remember when we start thinking about how we might approach solutions. In addition to the needs themselves being intersectional, we also recognize the intersecting processes by which power and inequity are produced, reproduced, and actively resisted.

Citations

1. America's Health Rankings. (2019). Teen Suicide in Minnesota in 2018. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/MN.
2. Heinen, M. & Roesler, J. (2018, December). Suicide in Minnesota, 1999-2017 - Data Brief. Saint Paul, MN: Minnesota Department of Health. Retrieved from https://www.health.state.mn.us/communities/suicide/documents/2017suicidedatabrief.pdf.
3. Centers for Disease Control and Prevention. (2017). Preventing Suicide: A Technical Package of Policy, Programs, and Practices. Retrieved from https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.
4. Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). Suicide Clusters within American Indian and Alaska Native Communities: A review of literature and recommendations. Retrieved from https://store.samhsa.gov/system/files/sma17-5050.pdf.
5. Canetto, S.S. & Sakinofsky, I. (1998). The Gender Paradox in Suicide. *Suicide and Life-Threatening Behavior 28*(1):1-23.
6. Eisenberg, M.E., Gower, A.L., McMorris, B.J., Rider, G.N., Shea, G., & Coleman, E. (2017). Risk and Protective Factors in the Lives of Transgender/Gender Nonconforming Adolescents. *Journal of Adolescent Health 61*(4): 521-526.
7. Coutinho, S., Heinen, M., Carter, T., & Roesler, J. (2018, December). Non-Fatal Self-Inflicted Injury Fact Sheet. Retrieved from https://www.health.state.mn.us/communities/suicide/documents/2017nonfatalselfinflictedinjury.pdf.
8. Substance Abuse and Mental Health Services Administration (SAMHSA). (2017). Behavioral Health Barometer: Minnesota, Volume 4. Retrieved from https://www.samhsa.gov/data/sites/default/files/Minnesota_BHBarometer_Volume_4.pdf.
9. Kaul, G. (2018, December 14). Minnesota's suicide rate continues to rise, and it's higher in Greater Minnesota than the metro. MinnPost. Retrieved from https://www.minnpost.com/health/2018/12/minnesotas-suicide-rate-continues-to-rise-and-its-higher-in-greater-minnesota-than-the-metro/.
10. Roth, A. (2018, December 24). St. Paul police expanding new mental health unit. MPR News. Retrieved from https://www.mprnews.org/story/2018/12/24/st-paul-police-already-want-to-expand-new-mental-health-unit.

Child and Family Health Division
Title V Maternal and Child Health Needs Assessment
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-3589
health.cfhcommunications@state.mn.us
www.health.state.mn.us

8/1/2019

To obtain this information in a different format, call: 651-201-3589. Printed on recycled paper.