How Can We Support Adolescents Amid Pandemic Spikes in Suicide Risk?

Behavioral Health

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During the 2021-22 school year, children and adolescents regained some sense of normalcy as in-person learning and extracurricular activities resumed. However, we should not assume that the return to school has translated to a return to pre-pandemic levels of well-being. As clinical psychologists and researchers focused on adolescent depression and suicide, we have witnessed firsthand the rise in suicidal thoughts and behaviors that a number of teens have experienced in the wake of the pandemic. Below, we will discuss recent data from our research that illuminates this issue.

In our work focused on school-based depression prevention, we have students complete screenings for depression and then conduct a diagnostic interview. We have been struck by the number of adolescents who reported more significant clinical concerns this year. In the 2020-21 academic year when students had virtual or hybrid learning, 3.33% of adolescents reported having serious thoughts of wanting to kill themselves or that they made a suicide attempt in the past year. In the 2021-22 academic year, that rate was 7.7%—meaning the rate of serious suicidal risk more than doubled.

Of note, the 2021-22 interviews coincided with the surge of the COVID-19 omicron variant, a time of increased stress.

While we recognize this is one data point, the observed increase in suicide risk is alarming. School counselors and administrators echoed this increase in the interviews we conducted as part of this same study. One school counselor commented, “I think we have done more suicide risk assessments this year than the past 5 years combined…Every day I was doing at least one, if not more, and I'm one person.”

What factors may be contributing to this increase?

We cannot pinpoint the cause of this increased risk for suicide, but our data suggest there are likely substantial, emerging repercussions of the COVID-19 pandemic. Some potential reasons for these changing trends might be related to transitions that have occurred during the pandemic and the overall length and cumulative impact. For example, there are many benefits to the return to in-person learning, but there is likely a subset of students for whom the transition back to school reintroduced stressors (e.g., academic demands, face-to-face social interactions) that surpassed their coping capacities at the time.

Additionally, the longer the pandemic continues, and the more uncertainty that brings, the more students may struggle. For instance, the omicron surge likely renewed COVID-related stress for many and may have thwarted students’ adjustment just as they were beginning to re-acclimate to academic and social demands.

So, what can we do?

We in mental health fields can partner with school personnel to ensure they have the resources needed to identify and address suicide risk. We can provide trainings, consultation, and access to evidence-based measures and interventions that can augment the suicide prevention efforts already happening in the school setting.

Recently, several leading children's health organizations, including the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association, advocated for school-based mental health services, and President Biden reinforced this message in his State of the Union Address in March. School-based mental health services capitalize on the fact that youth spend much of their time at school and, therefore, it can be an ideal setting to increase access to evidence-based mental health services and maximize equitable mental health outcomes. These services can be provided by school personnel such as school psychologists, school counselors, or school social workers or by embedded licensed providers from community agencies. PolicyLab researchers in our Behavioral Health Portfolio have developed and evaluated school-based interventions, and several recently released a white paper describing innovative strategies implemented by states and municipalities in support of comprehensive behavioral health services in schools. To realize the full potential of school-based mental health services, changes in policy, as well as increases in funding and workforce expansion, will be required.

Additionally, we should consider ways to increase communication between primary care clinicians and school personnel. In pediatric primary care, screening for depression is often part of routine care and many depression screeners include questions about suicide risk. At the same time, many schools conduct their own suicide assessment and prevention efforts. It would be beneficial for primary care clinicians to share screening results with school personnel, and vice versa.

With this information, school personnel, such as school counselors, could aid in monitoring these students and communicating with their caregivers, and health systems can help facilitate truly integrated care. For such collaboration to take place, it's important to take into account Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) laws about what information can be shared between schools and health systems to facilitate cross-system communication.

The personal and public health crisis of youth suicide is not going away overnight. No one clinician, team or school can eradicate this crisis on their own. This means opportunities for collaborative efforts are key to reduce youth suicide risk. We are hopeful that the increased focus on youth mental health and the proposed policy solutions, including more school-based mental health programming, will help to mitigate suicide risk among children and adolescents. Capitalizing on the momentum around these issues will be critical for saving young lives.

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