Youth Suicide

Current Trends and the Path to Prevention

December 6, 2023

The Jed Foundation

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About The Jed Foundation (JED)

The Jed Foundation is a nonprofit that protects emotional health and prevents suicide for our nation's teens and young adults. We're partnering with high schools and colleges to strengthen their mental health, substance misuse, and suicide prevention programs and systems. We're equipping teens and young adults with the skills and knowledge to help themselves and each other. We're encouraging community awareness, understanding, and action for young adult mental health.

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Executive Summary

Suicide is the second leading cause of death for young people ages 12–24. This deeply concerning trend has become a national priority and a focus of U.S. Surgeon General Vivek Murthy. Young people are not only at a critical time in their development but also grappling with very real challenges different from previous generations, including constant digital connection and much less in-person connection, the COVID-19 pandemic, the climate crisis, school shootings, widely broadcast incidents of violence, and legislation aimed at decreasing protections for LGBTQIA+ youth. At the same time, mental health care is difficult to access, and lethal means, such as firearms, are too often easy to access. These stressors can affect all youth, but there are also groups of teens and young adults who are disproportionately impacted, often because of structural inequities or additive risk factors.

In this report, we explore the data on youth mental health and suicide, outlining the extent of the problem, investigating contributing factors, and proposing effective, evidence-based action to reduce suicide risk for *all* of our nation's teens and young adults.

Challenges this generation faces

Loneliness: Young people ages 15–24 are spending less than half as much time in person with friends as they were two decades ago.

The COVID-19 pandemic: Global rates of childhood depression and anxiety symptoms doubled during the pandemic.

Access to firearms: Researchers estimate that 4.6 million children live in households with at least one loaded, unlocked firearm.

Fears about the future: Nearly 60% of youth ages 16–25 say they are either very or extremely worried about the climate.

Constant digital connection: 46% of teens ages 13–17 say they use the internet "almost constantly."

Financial insecurity: 3 in 5 college students face some type of essential needs insecurity, including housing insecurity, food insecurity, or lack of access to affordable health care.

Lack of access to care: Among youth with major depression, 60.3% do not receive any form of treatment.

Groups that face additional challenges

American Indian/Alaska Native (AI/AN) youth (ages 10–24) suicide rates are almost twice as high as the overall national average.

Youth in rural areas (ages 10–24) are nearly twice as likely to die by suicide as those in large metro areas.

Black youth (ages 10–24) are experiencing the fastest increasing suicide rates.

Youth involved with the criminal legal system (ages 10–24) die by suicide two to three times more often than the general youth population.

LGBTQIA+ youth (ages 13–24) are at increased risk of suicide: 41% seriously considered attempting suicide in the past year, and 14% attempted suicide.

Young women (ages 15–24) have suicide rates that have been increasing faster than boys', doubling in the last two decades.

9 Essential Steps to Reducing Youth Suicide

1. Take a comprehensive approach

Adopting a comprehensive approach is essential to reducing suicide risk. JED's Comprehensive Approach to Mental Health Promotion and Suicide Prevention in schools is built around seven strategic domains:

- Developing life skills
- Promoting social connectedness
- Identifying students at risk
- Increasing help-seeking behavior
- Providing mental health and substance misuse services
- Establishing and following crisis management procedures
- Promoting means safety

2. Create community and connection

In the surgeon general's 2023 advisory *Our Epidemic of Loneliness and Isolation,* youth are highlighted as a group that is especially disconnected and isolated. To address this, we must:

- Design communities of care within our schools
- Create opportunities and spaces for young people to meet and gather organically
- Support intergenerational connections

3. Meet basic needs and address trauma

There are strong links between poverty, societal and racial inequity, trauma, and mental health struggles. To address these, we must:

- Strengthen social safety nets that ensure access to housing, food, education, and health care
- Expand availability of trauma-informed care
- Employ community- and family-based, trauma-informed approaches for reducing youth involvement in the criminal legal system

4. Increase coping and emotional support skills

Self-awareness and interpersonal skills help young people better solve problems, manage emotional stressors, and control impulses, improving their ability to move through challenges as they arise. Additionally, community members — including youth — who are trained to identify signs of struggle, listen actively, respond supportively, and know when and how to connect a young person to professional help, if needed, can play a vital role in supporting youth mental health.

5. Meaningfully increase access to care

Too many young people reach out for professional help and run into barriers when trying to connect to it. To improve access to care for youth, we must support implementation and enforcement of the Mental Health Parity and Addiction Equity Act, require insurance coverage of mental health services delivered in schools, ensure that provider networks adequately serve diverse populations, and design crisis services to meet the needs of communities.

6. Make widespread use of proven suicide-prevention treatments and interventions

There are treatment approaches that meaningfully reduce suicidal thoughts and attempts but are underutilized. These approaches — including dialectical behavior therapy (DBT), Collaborative Assessment and Management of Suicidality (CAMS), cognitive behavioral therapy for suicide prevention (CBT-SP), attachment-based family therapy (ABFT), brief safety planning interventions, and pharmacological interventions — must be prioritized in mental health care settings to lower suicide rates.

7. Reduce access to lethal means — especially firearms

Putting time and distance between someone experiencing a crisis and access to lethal means is a critical intervention to lower suicide deaths. This applies especially to firearms, which are 90% fatal when used in a suicide attempt. Homes without firearms have lower suicide rates than homes with firearms, and among gun-owning homes, the risk of suicide, particularly for youth, is lower when guns are stored locked and unloaded. Everyone from families to gun owner groups to legislators should be involved in systemic and individual approaches to reduce the risk of firearm suicides.

8. Advocate for safe online spaces

Young people are increasingly engaged in online activities in a largely unregulated space. It is imperative that policymakers and other stakeholders take a pro-safety approach to apps and platforms where young people spend time, centering youth in any efforts to improve them.

9. Leverage technology to support youth mental health

Although mobile devices such as smartphones, tablets, and virtual reality (VR) headsets can pose risks for young people, they also offer more ways to connect with one another and access mental health care. Technology can be leveraged to improve mental health by expanding access to professional help through telemedicine, connecting to young people where they are in digital spaces, and making use of the virtual worlds of gaming, the metaverse, and extended reality to offer resources and support in real time.

Youth suicide is preventable through comprehensive, integrated, evidence-based approaches that take into account the unique challenges faced by specific groups of young people. We must address the conditions that put young people at risk, including poverty, violence, discrimination, isolation, and lack of access to care, so that we may support this generation of young people in becoming thriving adults. We can achieve lasting change if we come together and do what we know works.

Introduction

Adolescence is a critical time in everyone's development. It is a moment of remarkable opportunity and growth, as teens and young adults[1] learn to make decisions, manage emotions, and create deeper connections with peers and their communities. They also build resilience and develop interests, passions, and meaningful goals that shape their adult lives. Young people's developing brains are well suited to these tasks, but too often the systems that serve them are not.

This generation is growing up in an era of new and daunting challenges, including the COVID-19 pandemic and its emotional and financial fallout, the reality of climate change, frequent and devastating mass shootings, race-based violence and constant exposure to images of it online, continual connection to social media and screens that can lead to or worsen isolation, a student debt crisis and large-scale systemic financial inequities, and a legislative push at the state level to reduce the rights of LGBTQIA+[2] youth and restrict discussion of the historic and current realities of racial discrimination.

In the face of these pressures, youth are doing everything they can to increase their resilience. They are talking about mental health more than any generation before them. They make use of mental health care when they have access to it. They find creative ways to connect despite spending less time with one another in person, and they work hard to create strong relationships and personal boundaries. They are disappointed by the world they see in front of them, and still, they stand up for themselves, their peers, and what they believe is right.

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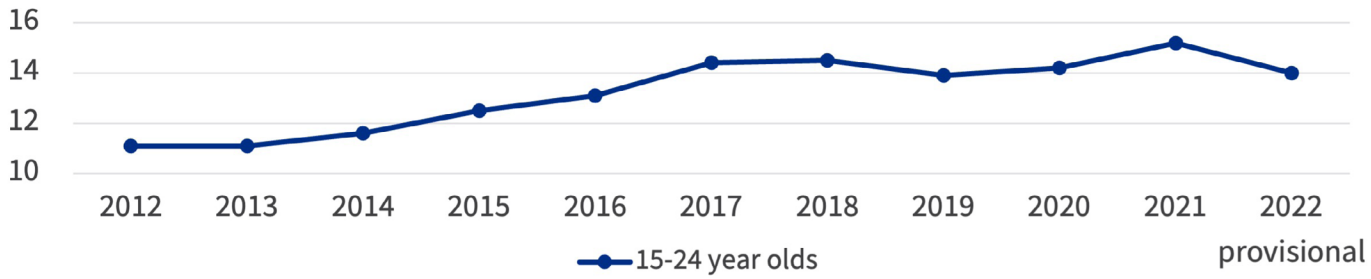
[1] At JED, we generally use the terms "teen" and "adolescent" to designate individuals ages 13–17 and the term "young adult" to refer to people ages 18–25. We use the terms "youth" and "young person" to refer to the broader age group between the ages of 13 and 25. Where specific ages were provided by researchers, we indicate the ages studied.

[2] JED's style guide generally follows the Associated Press Stylebook, though we are a youth-centered organization, so we emphasize the use of terminology that includes the breadth of young people's experiences. In this report, we use the acronym LGBTQIA+ to represent lesbian, gay, bisexual, transgender, queer, intersex, and asexual communities. Where this acronym is replaced with another, the change has been made to accurately reflect the identities of participants identified in a particular data set.

They are committed to change, but they cannot do it alone. The pressures they face are too great, and the support available to them is inadequate. And this likely contributes to young people experiencing mental health difficulties at increasing and record rates — including suicidal ideation and suicide attempts.

Suicide is the second leading cause of death for young people ages 12–24,[3] [4] with 10% of high school students attempting suicide in the last year for which data is available (2021). Furthermore, the percentage of high schoolers who report feeling persistently sad or hopeless increased from 28% to 42% over the decade from 2011 to 2021.

Figure 1: Youth suicide rates 2012–2022 (per 100,000)



CDC WONDER Online Database (2021).

2022 provisional data from the Centers for Disease Control and Prevention (CDC) suggest some potentially positive developments. Although overall suicide rates have continued to increase, the data show an 18% drop for young people ages 10–14 and a 9% drop for young people ages 15–24, from 2021 to 2022. Non-Hispanic American Indian/Alaska Native populations, which have some of the highest suicide rates, also reportedly had a 5% decrease in suicide rates from 2021 to 2022. Importantly, these data are provisional and therefore subject to change with additional information, and not all drops are statistically significant given the small size of some groups.

[3] Centers for Disease Control and Prevention (CDC) suicide death data are publicly available through the online database WONDER, which allows for comparisons among deaths occurring from 1999 to 2020 and from 2018 to 2021, respectively. 2020 was the last year for which race bridging was used. Because of this change, statistics in this report that refer to trends over time most often use 1999–2020 data. Additionally, unless specified, race-based WONDER data in this report refer to all ethnic origins within each racial category. This is important to note because suicide rates can vary substantially within racial groups based on ethnicity. For example, being Hispanic/Latiné decreases suicide risk in general, but the effect is stronger for certain racial groups. For white people, being Hispanic/Latiné decreases risk of suicide by more than half. For Black people, risk is decreased by more than 60%. And for American Indian/Alaska Native people, being Hispanic/Latiné decreases suicide risk by 93%.

[4] The leading cause of death in this age group is unintentional injuries, which includes drug poisoning. Drug poisoning makes up 5.6% of fatal unintentional injuries among young people ages 10–14, but rises to 49.3% for those ages 20–24. Substance use disorders are a significant mental health concern for young people, especially older teens and young adults, and can result in additional mental health–related deaths.

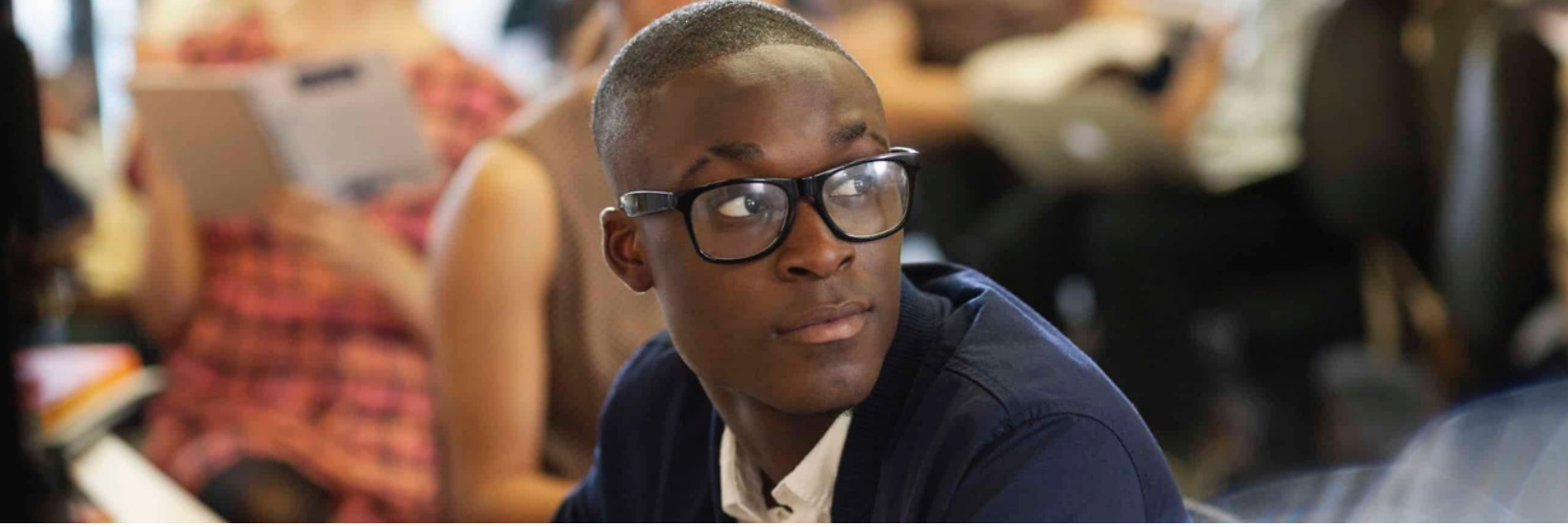
How We Put This Report Together

At JED, we keep a close eye on youth mental health and suicide data to inform our work — from strategic planning with schools to educational campaigns. At the same time, we frequently hear from advocates, elected officials, reporters, and others that this information is tough to find, difficult to wade through, and hard to interpret. We produced this report to provide a resource for those interested in learning more about trends in youth mental health and suicide prevention.

Our initial discussions focused on the most important national studies of youth mental health. These included CDC data sources, such as the Youth Risk Behavior Surveillance System, the Adolescent Behaviors and Experiences Survey, and the National Violent Death Reporting System; the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health; The Trevor Project's 2023 National Survey on the Mental Health of LGBTQ Young People; the Healthy Minds Network's Healthy Minds Study; and the American College Health Association's National College Health Assessment. As we reviewed these studies, trends emerged related to mental health concerns and suicide rates in particular populations over time.

Next, we engaged a group of experts with experience in various aspects of youth mental health, including specialization in youth suicide and suicide prevention, lethal means reduction, LGBTQIA+ youth, Black youth, girls and young women, and American Indian/ Alaska Native youth. These experts helped us to identify factors contributing to the rise in mental health concerns and suicide rates — some related to cultural changes, such as increasing access to firearms, and others related to specific groups facing additional or unique stressors or risk factors. We then worked with these experts to map out the most promising approaches to address overall youth suicide trends, as well as those affecting specific populations.

This report is not intended to be a review of the entire landscape related to suicide risk among youth. Our goal is to illuminate the trends uncovered in the most recent data and share the most effective practices and solutions from research and clinical experience in the field. Mental health is dynamic, as are the challenges and opportunities for youth. Our response to it must be similarly nimble, data-informed, thoughtful, and comprehensive so that we are effectively supporting youth mental health and making and influencing the changes they need to truly thrive.



Contributing Factors Associated With Youth Suicide Risk

Suicide is a complex behavior that has multiple and varied contributing factors. Although there is no one single cause, certain experiences and traits can increase young people's risk for suicide, including:

- Genetic and other biological factors
- Family characteristics and childhood experiences
- Personality and cognitive traits
- Having an existing mental health disorder

Some risk factors are byproducts of social determinants of health, such as:

- Discrimination
- Economic hardship
- Limited affordable housing
- Lack of educational opportunities
- Barriers to accessing physical and mental health care

Two of the most intractable social determinants of health are structural racism and cumulative trauma. Structural racism is defined as "macro-level societal conditions that limit opportunities, resources, and well-being of less privileged groups on the basis of race/ethnicity." Cumulative trauma arises from repeated negative experiences during childhood or over a lifetime, including adverse childhood experiences such as poverty or abuse, parental incarceration, and exposure to hate crimes and race-based violence and discrimination. There is increasing focus — especially by the National Institute on Minority Health and Health Disparities and the U.S. Department of Health and Human Services Office of Minority Health — to acknowledge and incorporate the effects of structural racism and discrimination into health research and interventions.

Finally, environmental forces also shape young people's mental health in powerful ways and affect whole generations at once. A number of recent trends have created an unusual set of challenges for young people today, including the COVID-19 pandemic and rapidly changing technology.

Figure 2: Trends over time in the Youth Risk Behavior Survey of high school students

Percentage of high school students who:	2011	2013	2015	2017	2019	2021	Trend
Experienced persistent feelings of sadness or hopelessness	28	30	30	31	37	42	
Experienced poor mental health[†]	–	–	–	–	–	29	–
Seriously considered attempting suicide	16	17	18	17	19	22	
Made a suicide plan	13	14	15	14	16	18	
Attempted suicide	8	8	9	7	9	10	
Were injured in a suicide attempt that had to be treated by a doctor or a nurse	2	3	3	2	3	3	

 In wrong direction  No change

[†]Variable introduced in 2021.

Centers for Disease Control and Prevention (2022). Youth risk behavior survey: Data summary and trends report 2011-2021, p. 58.

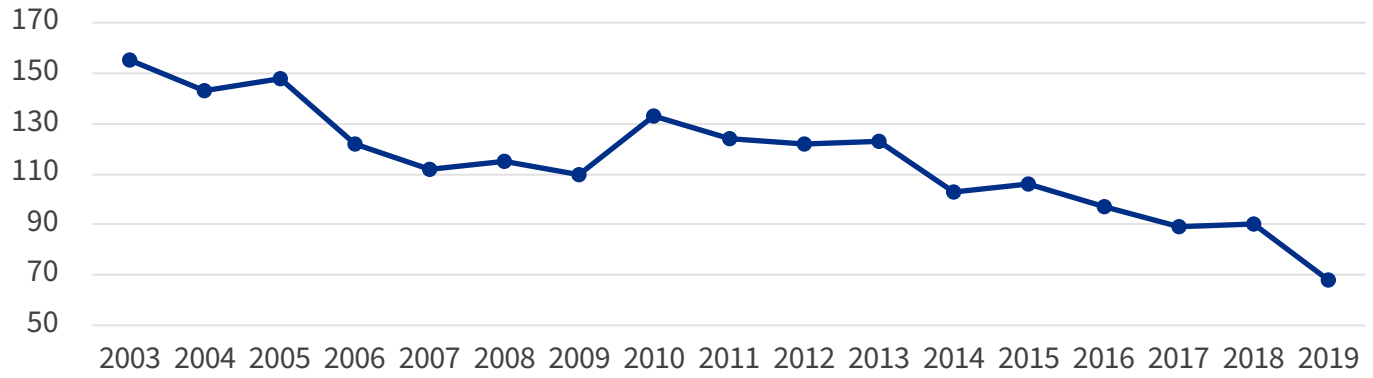
7 Current Factors Affecting Youth Suicide

1. Adolescents and young adults are experiencing increasing isolation and loneliness.

In his 2023 report on the epidemic of loneliness in this country, the surgeon general pointed out that Americans are spending less time with friends and loved ones than in the past. This trend is especially pronounced among adolescents and young adults. Social connectedness is strongly linked to physical well-being throughout life. Loneliness affects both mental and physical health and increases risk of mortality. Consider the following findings:

- While time spent online can be social, it does not directly replace loss of in-person time, and for young people ages 15–24, time spent in person with friends dropped by more than half over the last two decades — from more than 150 minutes per day in 2003 to less than 70 minutes per day in 2019.
- The pandemic deepened loneliness, especially for youth. In a 2020 survey, 61% of young people ages 18–25 reported feeling serious loneliness.
- A recent systematic review suggests that post-pandemic feelings of loneliness have persisted, with some studies finding that more than half of children and adolescents are experiencing at least moderate levels of loneliness.

Figure 3: Teen and young adult (ages 15–24) in-person social engagement with friends, annual daily average in minutes, 2003–2019



SSM – Population Health (March 2023), US trends in social isolation, social engagement, and companionship – nationally and by age, sex, race/ethnicity, family income, and work hours, 2003–2020.

2. The COVID-19 pandemic had a largely negative impact on youth mental health.

- Global rates of childhood depression and anxiety symptoms doubled during the pandemic.
- In the United States, mental health–related emergency room visits increased 22% for teen girls in the second year of the pandemic relative to the pre-pandemic levels of 2019.
- People of color were more likely than white people to be adversely affected by COVID-19 and to screen positive for anxiety and depression during the pandemic.

3. Gun ownership and access to firearms is increasing.

Although there are multiple factors that elevate the risk of suicide, a person's survival may ultimately come down to one thing: what methods are readily available and how lethal they are.

Gun sales have surged since 2020, and along with them the increased risk of suicide. Multiple studies, including a recent analysis of California residents, demonstrate that gun owners and their families are not at higher risk of thinking about or attempting suicide, but are at greater risk of death by suicide.

Nearly 90% of suicide attempts with a firearm are fatal. Suicidal crises often escalate quickly, and the instant a trigger is pulled, there is no longer an opportunity to interrupt the crisis or for a person to change their mind before being seriously injured or killed.

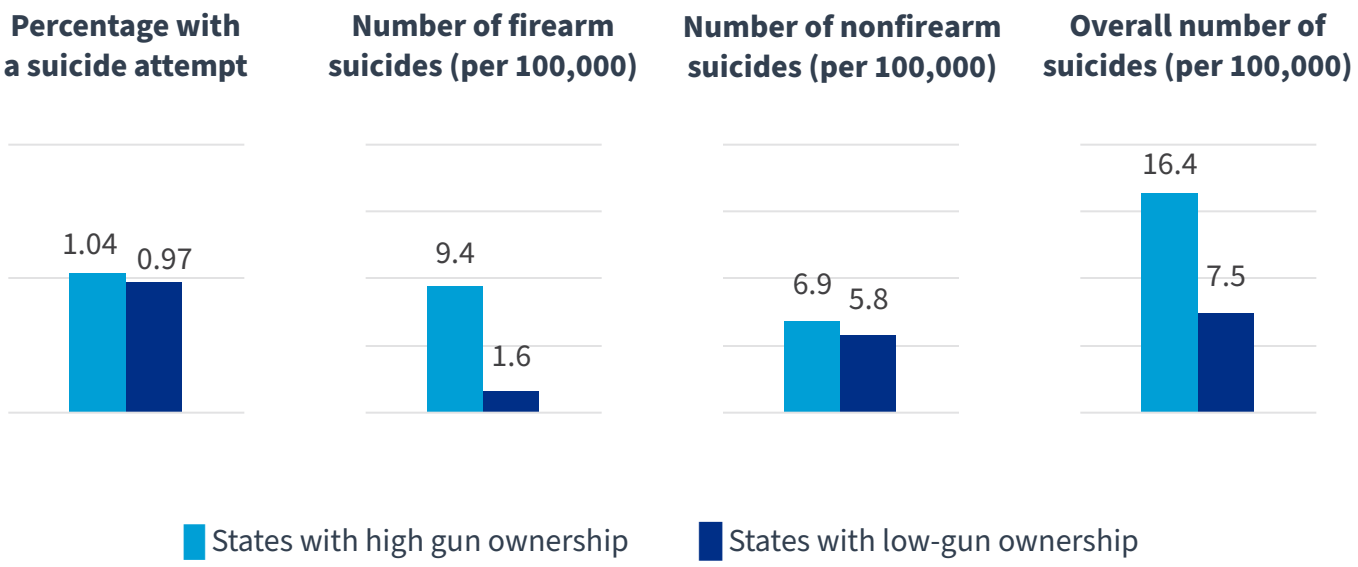
Gender and Firearms

Although more girls and young women attempt suicide, boys and young men have higher rates of death by suicide primarily due to their use of more lethal means. Boys and young men (ages 15-24) who die by suicide are twice as likely to have used firearms than girls and young women who die by suicide, and 9 out of 10 young people (ages 10-24) who die by suicide using firearms are boys and young men.

Additional relevant data on firearms and suicide:

- Firearms were used in more than half (52.4%) of suicides by young people ages 15–24 in 2020.
- Researchers estimate that 4.6 million children live in households with at least one loaded, unlocked firearm.
- Adolescents' risk of death by suicide is more than three times higher if they live in homes with a firearm than if they do not.
- In an analysis of CDC data across five states, nearly 80% of the firearms used in suicides by youth under the age of 18 were owned by parents or other family members.

Figure 4: Deaths by suicide in young adults (ages 18–29) in states with high gun ownership versus states with low gun ownership, over one year (2008–2009)



In states with high gun ownership (AL, AK, AR, ID, IA, KY, LA, MS, MT, NE, ND, OK, SD, TN, WV, WY), 51% of adults live in households with firearms. In states with low gun ownership (CT, HI, MA, NJ, NY, RI), 15% of adults live in households with firearms.

American Journal of Epidemiology (September 2013), Firearms and suicide in the United States: Is risk independent of underlying suicidal behavior? p. 946-955.

4. Teens are deeply worried about the world and their future.

- More than two-thirds of young people report feeling very or somewhat stressed about our nation's future.
- Nearly 60% of youth ages 16–25 say they are either very or extremely worried about the climate.
- Among teens ages 14–17, 36% report little or no purpose or meaning in life, and this absence is strongly correlated with depression and anxiety.

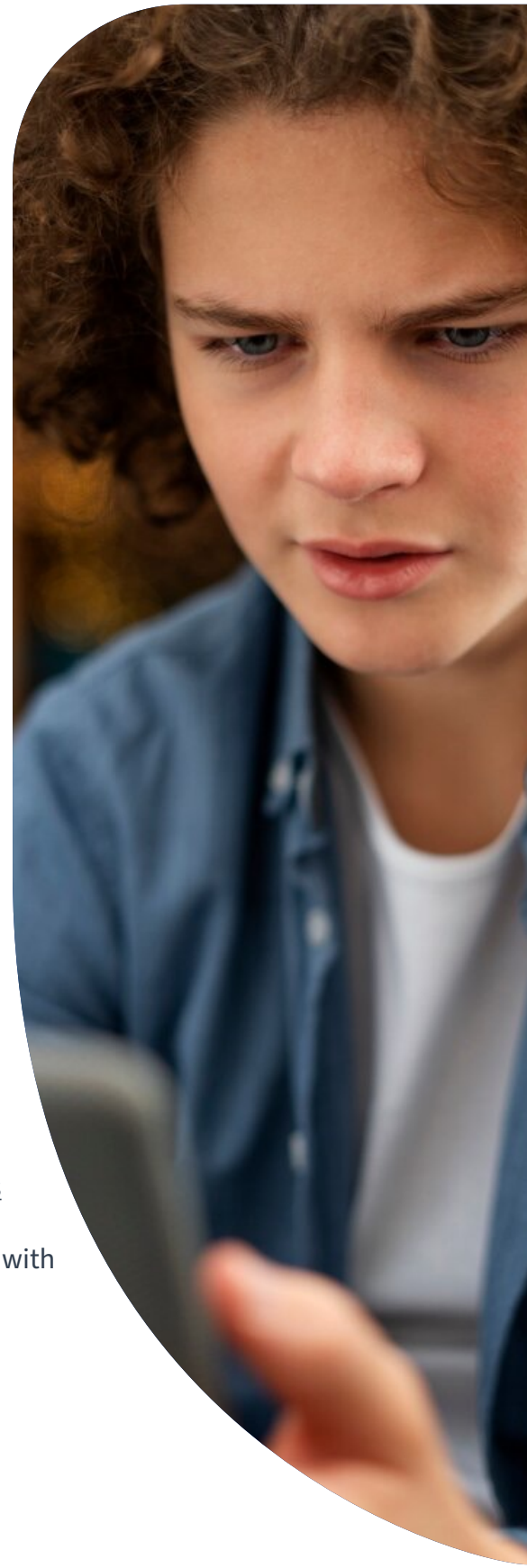
5. Teens and young adults live in a world of constant digital connection.

From phones to virtual reality (VR) headsets, rapidly accelerating technological innovation means most youth have a constant flow of information at their fingertips at all times. Nearly half of teens ages 13–17 say they use the internet "almost constantly."

Although there are important benefits to new and evolving technology — such as opportunity for connection, creation, and collaboration — the high-speed stimulation, 24/7 availability, and features built in to command and keep attention pose significant challenges for young people, who are learning self-regulation. JED explored the complex risks and opportunities related to social media and other new technologies in the report *Can the Metaverse Be Good for Youth Mental Health?*

Risks:

- **Exposure to harmful content.** Researchers have shown that teen social media users can encounter suicide-related content within three minutes of opening an account. Black and Hispanic/Latiné youth ages 11–19 who experience more frequent race or ethnicity-based traumatic events online report more symptoms of depression and post-traumatic stress disorder (PTSD).
- **Cyberbullying.** Young people who are victims of cyberbullying are at greater risk of self-harm and suicide attempts.
- **Chronic engagement online.** This behavior is fueled by algorithms, rewards, and design elements that erode natural stopping cues and take advantage of our human need for social validation.
- **Social comparison**, leading to body image issues and disordered eating. According to the surgeon general's report on the impact of social media on youth mental health, "a synthesis of 20 studies demonstrated a significant relationship between social media use and body image concerns and eating disorders, with social comparison as a potential contributing factor. Social comparison driven by social media is associated with body dissatisfaction, disordered eating, and depressive symptoms."



Opportunities:

- **Safe spaces and support.** Young people who may have trouble finding these in real life, such as LGBTQIA+ youth, would benefit from more safe spaces and support.
- **A source of health information.** Among teens and young adults (ages 14–22), 87% have gone online for health information, 64% have used a mobile health app, and 39% have sought out others with shared health issues.

6. Financial insecurity drives mental health challenges in young people.

- Nearly 3 in 5 college students face some type of essential needs insecurity, including housing insecurity, food insecurity, or lack of access to affordable health care.
- More than half of borrowers link their mental health issues to their student loan debt.
- Having debt is associated with an increased risk of depression, suicide attempts, and death by suicide.

7. Young people are not getting the mental health treatment they need.

Despite the fact that more than half of mood, anxiety, impulse control, and substance use disorders begin by age 14 — and many young people without diagnosable mental health conditions could benefit from counseling — mental health care remains difficult for teens and young adults to access.

- Among youth ages 12–17 with major depression, 60.3% do not receive any form of treatment.
- More than 40% of young adults ages 18–25 with mental illness go without needed mental health care, compared to 26% of all adults.
- College students who report a need for mental health services cite financial issues, including care being too expensive or not covered by insurance, as one of the top three reasons they do not seek it.

These are the challenges presenting themselves right now. Addressing them in a thoughtful, comprehensive, and systematic way will lead to measurable improvements in youth mental health and the well-being of our country.

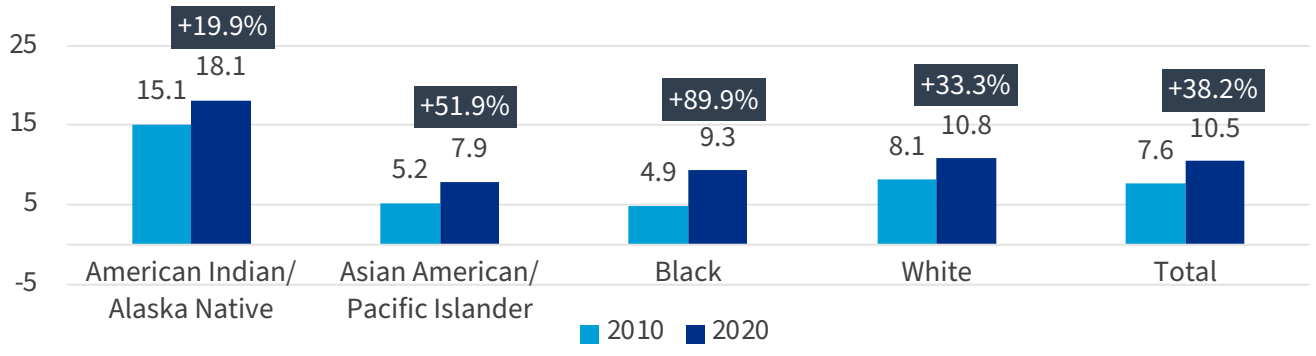
Young People Who Are Disproportionately Impacted

Many of the factors contributing to rising mental health challenges and suicidal ideation among young people affect youth as a whole. But not all groups of young people are impacted in the same way. Some face additional stressors, such as bias-based victimization and social disenfranchisement, that increase their risk for mental health challenges or risk factors, such as easy access to firearms. These all require thoughtful and targeted solutions.

From an intersectional perspective, a person's position or social location in society, based on social demographics such as race, gender, class, sexual orientation, and geography, among others, results in unique experiences. In this respect, particular communities are especially affected by social determinants of health, which can lead to higher rates of suicidal thoughts, suicide attempts, or deaths by suicide.

We have highlighted specific groups of young people in this report, focusing on those with significant disparities in mental health or suicide outcomes, as well as those where trends indicate areas of growing concern. These groups do not represent all populations at increased risk or facing unique challenges. Additionally, groups overlap, and young people may fall into more than one, resulting in intersectional identities that inform their experiences.

Figure 5: Trends in youth (ages 10–24) suicide rates by race, 2010–2020 (per 100,000)



CDC WONDER Online Database (2021).

American Indian and Alaska Native Youth

American Indian and Alaska Native (AI/AN) communities in the United States bring a wealth of cultural strengths and resources to support the health and wellness of youth, which can include a prevalence of extended family and kinship ties, a shared sense of collective community responsibility, and ancestral knowledge and wisdom — as well as the retention and reclamation of traditional languages and cultural practices. Despite these protective factors, AI/AN youth and young adults are at alarming risk:

- AI/AN communities are grappling with the country's highest suicide rates.
- The AI/AN youth (ages 10–24) suicide rate is almost twice as high as the national average.
- The rate of firearm suicides among AI/AN youth ages 10–24 has risen 63% in the last two decades.

One clear contributor to the persistently high rate of suicide among AI/AN youth is the enduring legacy of long-standing cultural trauma. According to Hunkpapa/Oglala Lakota scholar Maria Yellow Horse Brave Heart, PhD, historical trauma is the "cumulative emotional and psychological wounding over one's lifetime and from generation to generation following loss of lives, land, and vital aspects of culture."

It is estimated that AI/AN communities suffered a death toll of 89% as a result of European colonization. In addition to physical genocide, AI/AN communities in the United States endured cultural genocide, an intentional process designed to dismantle rich ancestral knowledge and ways of living and being, as evidenced by the systematic stripping of language and culture that took place in government-funded boarding schools for AI/AN children. Additional contributing factors:

- AI/AN communities have higher poverty rates than any other group.
- The prevalence of PTSD in AI/AN people is almost twice that of the general population.
- The Indian Health Service faces significant funding issues, poor staffing, and difficulties deploying culturally sensitive services.

Supporting American Indian/ Alaska Native (AI/AN) Youth

Advocate for AI/AN histories, peoples, and cultures to be taught in schools, with curricula designed by AI/AN educators.

Champion AI/AN-led storytelling, to expand narratives and counteract the erasure and invisibility of AI/AN people in mainstream media.

Promote national healing through truth and reconciliation practices that address the legacies of genocide and damaging government programs like AI/AN boarding schools.

Invest in community-based AI/AN-led mental health and suicide prevention initiatives such as WeRNative, Healthy Native Youth, Paths Remembered Project, StrongHearts Native Helpline, iknowmine.org, and THRIVE Project.

Center AI/AN knowledge in creating messaging campaigns for AI/AN youth and provider trainings for professionals engaging with AI/AN youth.

Rural Youth

Young people living in rural communities often benefit from a slower pace of life, more contact with nature, and close social ties. Generally speaking, communities with strong social ties can promote positive youth development. These same strengths can be risk factors because rural social networks can be more insular, offering less connection to diverse social or professional experiences. Rural communities often also have lower rates of insurance, provider shortages, and elevated rates of mental health–related stigma.

All of these factors mean that young people in rural areas are likely to face more barriers to getting help. These barriers become potentially lethal when coupled with easy access to firearms, which is common for youth in rural communities. Although studies show similar rates of suicidal thinking among rural and urban teens (grades 8–12), rural youth have higher rates of death by suicide when compared to their urban peers, because of their increased access to loaded and unlocked firearms. Firearm suicide attempts are 90% fatal. Consider the following statistics:

- Youth ages 10–24 in rural areas are nearly twice as likely to die by suicide as those in large metro areas.
- Youth (ages 10–24) firearm suicides are 2.5 times higher in rural areas than in urban areas, and they are 3.8 times higher among American Indian/Alaska Native youth living in rural versus urban areas.
- Only 3% of youth living in rural areas have access to a mental health facility that offers suicide prevention services.
- Among rural counties, 65% do not have a single psychiatrist, 81% have no psychiatric nurse practitioners, and 47% have no psychologists.

Supporting Rural Youth

Take advantage of strong social ties that often exist in rural communities by training adults to recognize youth at risk and intervene to support them.

Increase opportunities for rural youth to connect with people outside their communities and find professional opportunities.

Expand access to mental health care through school mental health partnerships and expansion of telehealth services.

Work to reduce mental health-related stigma in rural communities through targeted campaigns, education, and programming.

Reduce access to lethal means by educating families about responsible firearm storage and forming partnerships between community agencies, gun shops, and gun-owner groups invested in firearm safety.

Black Youth

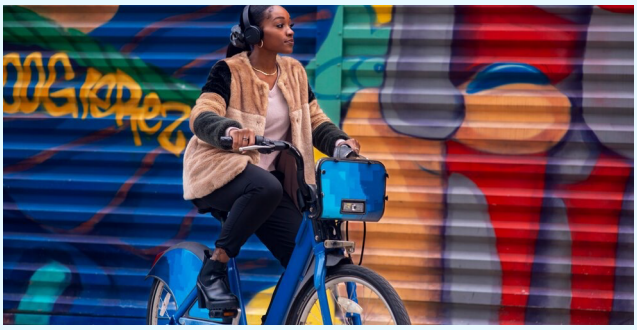
It is impossible to discuss the mental health of Black youth without addressing the history of Black America. Black Americans have contributed to American society in many influential ways, including, but not limited to: inventions, literature, the arts, cultural revolutions, political movements for social justice, and advancements in science.

They have made these advancements in the face of enduring inequalities, including enslavement; institutional discrimination during the Jim Crow era; race-based violence; the closing of diversity, equity, inclusion, and accessibility (DEIA) offices; and ongoing legislative pushes to restrict schools from teaching accurate history. Many Black Americans have leaned on a sense of intercultural strength and pride that has protected them from some of the adverse mental health outcomes that would be expected given the hardships they have had to overcome.

In fact, historically, Black youth have had lower documented suicide rates than their white peers, but that is changing. Suicide rates are rapidly rising, particularly among Black girls and young women, who have seen the greatest increase in suicide death rates of any demographic group over the last decade. Additionally:

- Black high school students have higher rates of suicide attempts compared to their white peers.
- Black youth are experiencing the fastest increase in suicide rates, with the rate almost doubling among young people ages 10–24, from 2010 to 2020.
- Black children younger than 13 are approximately twice as likely to die as a result of suicide than white children the same age.
- For the first time, in 2022, the gun suicide rate among Black teens ages 13–19 was higher than the rate among white teens of the same ages.

Supporting Black Youth



Teach accurate history about the role of Black communities in America.

Create affirming and safe environments for Black students in schools, with strong support systems, spaces to gather, and connections to supportive adults.

Train educators and mental health professionals to recognize signs of racial trauma and move from punishment-based approaches to trauma-informed models of care.

Invest in community initiatives that center Black voices, promote belonging, and foster creativity and leadership.

Fund pipeline programs to increase the representation of Black mental health providers, providing Black youth increased access to clinicians who reflect their backgrounds and experiences.

Structural racism and community trauma have had a cumulative effect on the mental health of Black youth. Specifically:

- Studies consistently find that Black individuals have greater exposure to violence, trauma, and systemic racism.
- More than half of Black U.S. high school students (grades 9–12) report experiencing racism in school, with Black teens on average reporting five racist encounters a day.
- Teens who face racial discrimination are more likely to have mental health challenges and suicidal thoughts and attempts.
- Only about 4% of psychologists and psychiatrists in the United States are Black, which means that if Black youth do have access to care, they may have a harder time finding a mental health professional who looks like them.

Youth in the Criminal Legal System

Youth involved with the criminal legal system have often experienced trauma or live with mental health issues that have resulted in behavioral symptoms that were disciplined rather than treated appropriately. Their subsequent involvement with the system — including being on probation — increases their risk for isolation and despair, leading many to consider or attempt suicide.

Youth of color are at increased risk of involvement in the criminal legal system, with Black youth being more than four times as likely to be detained or committed to juvenile facilities as their white peers. Once in the system, separation from family and community, disciplinary actions, and extended periods of isolation all have powerful negative impacts. Consider the following:

- More incarcerated youth ages 10–24 die by suicide than by any other cause of death.
- Youth ages 10–24 involved with the criminal legal system die by suicide two to three times more often than the general youth population.
- Individuals under age 25 who are being held in adult facilities experience suicide death rates up to five times higher than those not in custody.
- More than 50% of youth entering the criminal legal system meet criteria for a mental health disorder, and studies suggest that 70%–90% have experienced trauma.
- Young people who are suspended are more likely to have contact with the criminal legal system, and one survey of middle schools found that students at schools with high suspension rates had a significantly increased risk of arrest and incarceration as young adults.
- There is a widespread lack of behavioral health screening, mental health programs, and related services for youth in the criminal legal system and on probation. The absence of resources contributes to many preventable deaths.

Supporting Youth in the Criminal Legal System

Reduce initial involvement in the system, as well as recidivism, through crisis intervention teams (community-based units trained to support youth in acute distress by connecting them to care rather than the criminal legal system) and restorative justice approaches that focus on repair and connection rather than punitive discipline.

Care for the mental health of youth in the system by utilizing research-supported therapeutic modalities such as cognitive behavioral therapy, Functional Family Therapy, Family Integrative Transitions, and Multisystemic Therapy.

Bring youth in the criminal legal system out of isolation through structured and supported family involvement and ongoing connection to their schools to improve likelihood that behavior will not be repeated following release.

Offer comprehensive mental health care, including standard behavioral health screening, mental health programs, and related services, for youth who are incarcerated and on probation.

LGBTQIA+ Youth

LGBTQIA+ communities have a long history of community building, resilience, and resistance, creating supportive connections and "chosen families" during even the most difficult times. Today, LGBTQIA+ young people continue to craft community through a variety of means, from conferences to gender and sexuality alliances to online forums. Despite the work they are putting in, we are still seeing disparities in mental health outcomes among LGBTQIA+ youth because of ongoing societal stigma and discrimination.

Young people who identify as LGBTQIA+ are at a higher risk for suicidal thoughts and attempts than straight, cisgender youth. Among LGBTQIA+ young people, those who are transgender or nonbinary are more likely to think about or attempt suicide than their cisgender peers. Additionally, LGBTQIA+ youth who are American Indian/Alaska Native, Black, or Hispanic/Latiné are at a higher risk than white LGBTQIA+ youth.

It is critical to note that the increased rates of mental health issues and suicidality in LGBTQIA+ youth do not stem from their sexual orientations or gender identities. Rather, LGBTQIA+ youth experience poor mental health because of how they are treated. Additional relevant statistics:

- Nearly 70% of LGBQ+ high school students experienced persistent feelings of sadness or hopelessness over the past year compared to 35% of heterosexual youth.
- Among LGBTQIA+ youth ages 13–24, 41% seriously considered attempting suicide in the past year, and 14% attempted suicide.
- Transgender youth have the highest rates of mental health issues among LGBTQIA+ youth. Nearly 1 in 5 transgender or nonbinary youth ages 13–24 have attempted suicide.
- Among LGBTQIA+ young people, 16% of Black youth and 22% of Native/Indigenous youth ages 13–24 attempted suicide in the past year, compared with 11% of white youth.

Supporting LGBTQIA+ Youth

Promote family acceptance of LGBTQIA+ youth to maximize self-esteem and protect against depression, substance abuse, suicidal thoughts, and suicide attempts. LGBTQIA+ youth with high levels of family support attempt suicide at less than half the rate of those with low or moderate support.

Create affirming environments for LGBTQIA+ youth in schools. Schools that have a Gender-Sexuality Alliance (GSA) show better results for all students, not just those who identify as LGBTQIA+, including an overall reduction in bullying, increased feelings of belonging, and lower rates of victimization, mental health issues, and substance misuse.

Encourage community support of young people's identities. Transgender and gender-nonconforming youth who live with people who respect their pronouns have lower rates of suicide attempts, and those who are supported in their identities have similar levels of mental health issues as their cisgender peers.

Advance legislation that protects LGBTQIA+ youth. Major medical organizations, including the American Academy of Pediatrics, recognize the harm that anti-LGBTQIA+ legislation can have on young people, who "deserve equal protection and treatment when accessing health care, and when attending school and participating in extracurricular activities."

- Fewer than 40% of LGBTQIA+ young people ages 13–24 say they live in homes that affirm their gender identity, and one study of LGBTQIA+ young people ages 21–25 showed that those who were rejected by their parents were more than eight times as likely to attempt suicide, almost six times as likely to be diagnosed with depression, and over three times as likely to use illegal drugs as those who were not.
- LGBTQIA+ high schoolers face elevated rates of bullying and victimization compared to their straight, cisgender peers, and LGBTQIA+ youth who are bullied are more likely to have mental health issues.
- Anti-LGBTQIA+ legislation affects young people's mental health. Almost 2 out of 3 LGBTQIA+ young people ages 13–24 said hearing about laws banning discussion of LGBTQIA+ people at school made their mental health much worse.
- Over the past year, 56% of LGBTQIA+ young people ages 13–24 who wanted mental health care were not able to get it.
- It's important to note that the benefits of local and national laws protecting LGBTQIA+ people against discrimination extend beyond the LGBTQIA+ population. Before federal legalization of same-sex marriage, the implementation of state same-sex marriage laws was associated with a 7% relative reduction in the proportion of high school students — of all genders and sexual orientations — attempting suicide.

Girls and Young Women

The link between the health of societies and the well-being of girls and young women is well established. When girls are educated, are equal participants in their social and political economies, are protected from female-targeted violence, and are afforded the health care and support they need to thrive, societies flourish. Healthy girls bring vitality, social awareness, and relational sensibilities that are elemental contributors to the health and well-being of the groups and communities they inhabit.

Unfortunately, in many places in the United States and around the world, girls and young women are not thriving. Earlier this year, the CDC released a report focused on rising mental health challenges among girls and young women. Using data from the Youth Risk Behavior Surveillance System (YRBSS), the CDC reported that teen girls are confronting the highest levels of sexual violence, sadness, and hopelessness they have ever reported to YRBSS. Additional relevant statistics:

- Nearly 60% of high school girls have felt persistently sad or hopeless in the past year, almost double the rate of boys, and the highest level reported by girls over the past decade.
- More than 1 in 4 high school girls have seriously considered suicide, and more than 1 in 10 have attempted suicide.
- Emergency department visits for suspected suicide attempts in girls ages 12–17 increased 51% from 2019 to 2021.
- Female college students report higher levels of anxiety, stress, depression, PTSD, and self-injury than male students.
- Although suicide rates for girls ages 10–19 remain lower than those for boys, the gap is narrowing. Suicide rates of young women (ages 15–24) have been increasing faster than those of young men, doubling in the last two decades.
- Compared with other groups of young people, Black girls have had the largest annual percentage rise in suicides in recent years.

Supporting Girls and Young Women

Lift girls out of poverty by ensuring their essential needs are met, including housing, food, and health care. Poverty increases risk of trauma, and girls and young women are already at higher risk than boys and young men.

Proactively address trauma in girls and young women by surrounding them with community support, taking trauma-informed approaches in schools, and utilizing trauma-specific therapies to address emerging mental health issues.

Expand girls' connections to their bodies through participation in movement-based activities like sports and dance, as well as education about sexual and reproductive health.

Strengthen leadership opportunities for girls through mentorship programs that connect them with strong, supportive role models in their communities.

For Black girls and young women, there are many unique experiences that may be contributing to this increase. Black girls grow up in communities that have experienced historical traumas, which increase their risk for mental health struggles. Historically, Black girls have been stereotyped as needing less nurturing, protection, and support than their white counterparts, and have been viewed as more independent. This has led to lower baseline support than their white peers. Black girls also face harsher disciplinary practices in schools. They are six times more likely than white girls to be suspended, are the fastest-growing population in the criminal legal system, and receive more severe sentences when they enter the system than girls from any other racial group.

Among other contributing factors, all girls and young women are significantly more likely than boys and young men to experience sexual abuse or assault, a well-known contributor to suicide. Abuse and neglect cause mental health impacts that can be lasting, often leading girls and young women to engage in dangerous behaviors, including suicide attempts:

- Of those who experience sexual abuse or assault under age 18, 82% are female.
- Girls and young women ages 16–19 are four times more likely than the general population to experience rape, attempted rape, or sexual assault.
- Child sexual abuse survivors are three times more likely to experience depression as adults, and four times more likely to develop PTSD.

Other Groups of Youth

The groups of youth highlighted in this report have some of the highest or fastest rising suicide rates, but there are other groups who also have high suicide rates or face unique challenges, including:

White boys and young men: Historically, the suicide rate among non-Hispanic white boys and young men has been consistently higher than most other demographic groups except American Indian and Alaska Native boys and young men. In 2021, the suicide rate for 15- to 24-year-old non-Hispanic white males was 76% higher than the U.S. average for that age group. One significant contributing factor to the high rates is that 65% of the suicides among this group were by firearm. Therefore, implementing safe firearm storage is a critical lifesaving intervention to lower suicide rates among non-Hispanic white boys and young men.

Asian American and Pacific Islander (AAPI) youth are a large, diverse group with a variety of different cultures and backgrounds, many of which involve family or personal immigration experiences. Anti-Asian hate crimes spiked during the early COVID-19 pandemic, and in a 2023 national survey, half of Asian Americans reported feeling unsafe, and 80% did not fully feel they belonged and were accepted in the United States. AAPI girls and young women have not historically had high suicide rates, but their rates have doubled in the last decade (2010–2020), increasing almost as fast as those of Black girls and young women. There is also some indication that AAPI college student suicide attempt rates may be higher than those of white students. According to the 2021 National Survey on Drug Use and Health, among those with mental health issues, AAPI Americans are less likely to receive mental health services than white, Black, or Hispanic/Latiné Americans. The National Latino and Asian American Study found that only 8.6% of Asian Americans sought mental health services, compared to 19.2% of the general U.S. population in other studies.

Hispanic/Latiné communities, overall, have lower rates of suicide than those who are not part of these communities. For young people ages 10–24, the Hispanic/Latiné suicide rate is two-thirds that of the non-Hispanic/Latiné rate, but has increased by 58% over the last decade. Those born in the United States are more at risk. It has been suggested that the difference is linked to decreasing religiosity and family/community bonds with immigration, and that suicide prevention efforts should therefore be culturally centered.

9 Essential Steps to Reducing Youth Suicide

Suicide is preventable.

To reverse the trends of the last two decades, we must take a comprehensive, environmental, and holistic approach applied at all levels — from macro legislative solutions down to individual treatment approaches. Through a combination of proven but underutilized methods and innovative new strategies, we can design multiple safeguards and supportive environments that not only create a safety net for youth but also foster connection and purpose in their lives and build stronger, more connected communities where we can all thrive.

1. Take a comprehensive approach

Adopting a comprehensive approach is a vital first step in reducing suicide risk because it ensures that no important areas are overlooked. The Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and JED all offer comprehensive frameworks for guiding system-level approaches to mental health promotion and suicide prevention.

JED's Comprehensive Approach to Mental Health Promotion and Suicide Prevention, originally rooted in the effective, evidence-based Airforce Suicide Prevention Program, provides guidance for higher education institutions, high schools, and preK–12 school districts.

This strategic approach is built around seven domains, each based in research, that are critical in any communitywide effort to support mental health and prevent suicide:

- Developing life skills
- Promoting social connectedness
- Identifying and supporting students at risk
- Increasing help-seeking behavior
- Providing mental health and substance misuse services
- Establishing and following crisis management procedures (including postvention plans that minimize the risk of additional tragedy in the wake of suicide)
- Promoting means safety

To address systemic inequities and challenges specific to different geographic regions and populations, JED applies an equity lens to ensure that our work is customized to support the entire school community.

In addition to frameworks, there are a variety of other suicide prevention tools and resources that can be used to support suicide prevention efforts:

- The Zero Suicide Toolkit helps health care systems to implement suicide prevention models based on core components of safe care established by suicide prevention experts.
- The National Strategy for Suicide Prevention — currently being updated for release next year — includes recommendations for all sectors, including public health, mental health, health care, social services, the military and Department of Veterans Affairs, business, entertainment, media, faith communities, and educational institutions.
- The CDC's Suicide Prevention Resource for Action details the strategies known to help prevent suicide, specific approaches to advance each strategy, and policies, programs, and practices that have evidence of impact. It argues for a comprehensive approach that includes strengthening economic supports, creating protective environments, improving access to and delivery of suicide care, promoting healthy connections, teaching coping and problem-solving skills, identifying and supporting people at risk, and lessening harms and preventing future risk.
- The National Governors Association's *Strengthening Youth Mental Health* is a playbook for helping states implement comprehensive approaches to youth mental health and suicide prevention.
- The *Model School District Policy on Suicide Prevention*, co-created by the American Foundation for Suicide Prevention, The Trevor Project, the American School Counselor Association, and the National Association of School Psychologists, outlines model policies and language for K–12 school districts in their suicide prevention efforts.
- Two helpful resources for postvention planning are the middle and high school guidebook *After a Suicide: A Toolkit for Schools*, produced by the Suicide Prevention Resource Center, Education Development Center, and American Foundation for Suicide Prevention, and *Postvention: A Guide for Response to Suicide on College Campuses*, put out by the Higher Education Mental Health Alliance.

2. Create connection and community

Social connection is an essential element of individual and societal health, resilience, safety, and engagement, and is a source of meaning in people's lives. Unfortunately, as highlighted in the surgeon general's 2023 advisory *Our Epidemic of Loneliness and Isolation*, large and growing numbers of people of all ages report feeling disconnected and isolated. Given the power that connection has to improve well-being, it is essential that our nation invest now in programs and policies that promote social connections to improve mental health for all young people.

Specifically, we need to:

- **Design inclusive school climates** that incorporate social acceptance into their value systems, making all students — particularly those who come from groups that have been marginalized or are underrepresented — feel more connected and protected.
- **Create opportunities for young people to meet and spend time with each other** while exploring their identities and interests. Programs may be run by schools or the government, local nonprofit organizations, or faith-based groups.
- **Encourage youth to give back to their communities** through volunteering or advocating for causes they care about. These activities help young people to find others who share their values and give them a sense of purpose and meaning.

- **Support intergenerational connections.** Research shows that connecting youth and older generations improves key characteristics in youth, including patience, sensitivity, compassion, respect, empathy, peer relationships, conflict resolution, self-confidence, and problem-solving skills. When a person makes more and better connections to people from a different generation, it can also help reduce anxiety, sadness, and stress, and improve mood. It is an underused but powerful approach to improving mental health across the board.

3. Meet basic needs and address trauma

There are strong links between poverty, societal and racial inequity, trauma, and mental health struggles. In times of financial hardship, depression and suicide rates increase, and childhood poverty is an independent risk factor for adult depression. Trauma, such as sexual violence, has a significant impact on young people, leading to increased rates of psychological distress, self-harm, and suicide attempts. Poverty and trauma are also interconnected. Community-level poverty predicts greater exposure to trauma, and trauma can lead to poor psychological functioning, with subsequent difficulty maintaining employment. Understanding these connections can help us to design interventions that address important root causes of suicide.

Specifically, we need to:

- **Ensure access to housing, food, and education**. Research shows that anti-poverty programs can have lasting effects on mental health. For example, guaranteed income has been shown to reduce depression and anxiety, and increasing the minimum wage decreases suicide rates.
- **Expand availability of trauma-informed care** by training clinicians in techniques known to aid those who have experienced trauma, such as EMDR and trauma-focused cognitive behavioral therapy.
- **Employ community- and family-based, trauma-informed approaches** for reducing youth involvement in the criminal legal system.

4. Increase coping and emotional support skills

Self-awareness and interpersonal skills help young people to better solve problems, manage emotional stressors, and control impulses, improving their ability to face challenges as they arise. Programs that support the development of life skills have been shown to decrease emotional distress and reduce anxiety and depressive symptoms. Additionally, peers who are trained to actively listen, respond supportively, and know when and how to connect someone to help can make a significant difference in youth mental health trajectories. Parents/caregivers and other adults who work with youth, as well as youth themselves, should be educated in these areas.

To assure that young people are surrounded by individuals with the knowledge and skills to recognize and respond to psychological distress, we recommend that communities:

- **Provide life skills education to all youth** in order to increase resilience and coping skills.
- **Train caring adults and youth** to identify someone who may be struggling with their mental health, reach out to them, and connect them to resources and health care, as well as ensure that adults and youth are aware of key resources for connecting to help, including the 988 Suicide & Crisis Lifeline.
- **Create spaces for youth-led dialogue** about mental health, such as school-based programs where students actively engage in conversations and role-play related to mental health.

5. Meaningfully increase access to care

Access to high-quality mental and physical health care is an instrumental part of assuring that youth have the support they need. Within the U.S. health care system, access to care is extremely uneven. Provider "deserts" are common and linked to increased suicide risk. Even when there are providers available, particular groups of young people may have trouble finding providers who share their cultural backgrounds or experiences. For example, AI/AN youth face challenges both in accessing care, in general, and in finding culturally responsive and reflective care. Similarly, although the number of Black, Hispanic/Latiné, and male providers has increased over the past few years, there continues to be a significant gap between youth who need help and providers who look like them.

We specifically recommend that communities:

- **Support implementation and enforcement of the** Mental Health Parity and Addiction Equity Act, which ensures that mental health is covered by insurance in a similar manner to physical health.
- **Require insurance coverage of mental health services delivered in schools.** Young people spend much of their time in school, and yet there are systemic barriers to them receiving mental health care there. The newly released *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming* offers schools additional guidance on how best to deliver mental and other health-related services to students.
- **Ensure provider networks adequately serve their populations** by including sufficient numbers of mental health professionals and ensuring that providers match the diversity of the covered populations.
- **Design crisis services to meet the needs of communities** by minimizing police involvement, increasing the presence of clinicians, and offering alternatives to emergency room care, such as crisis respite centers.
- **Leverage schools, colleges, and universities** to expand mental health care services for youth. Schools — where adolescents and teens spend the majority of their time — and higher education institutions offer ideal spaces in which comprehensive mental health support can reach the greatest number of young people and address barriers to care. A unique approach that utilizes resources at both schools and universities is the creation of university-school partnerships, where graduate students can provide direct services to teens, under the supervision of licensed faculty.

6. Make widespread use of proven suicide-prevention treatments and interventions

Multiple treatments have been shown through research to help with suicidal thoughts and attempts. Many, however, are underutilized because of barriers such as funding issues and low levels of provider training in them. Additionally, training often does not include discussion of how to effectively fuse treatment components with culturally competent approaches.

Treatments and interventions that have been shown to decrease suicidal thoughts and attempts include:

- **Dialectical behavior therapy (DBT)**: This group-based skills training program helps young people learn to tolerate distress and regulate their emotions. They can use these skills in a moment of acute distress, including when they have suicidal thoughts. DBT has been shown to decrease suicidal behavior, including in adolescents at high risk for suicide.

- **Collaborative Assessment and Management of Suicidality (CAMS)**: This individual treatment focuses on collaboration between the client and the therapist so that the client can lead in identifying their drivers for suicide, reasons for living, and interventions that may help them. Research shows that CAMS reduces suicidal thoughts.
- **Cognitive behavioral therapy (CBT)**: This behavioral-based therapy focuses on altering thought patterns and behaviors to impact emotions. Research indicates that CBT can decrease suicidal thoughts and attempts. A specific form of CBT designed for suicide prevention, called CBT-SP, has shown initial positive results.
- **Attachment-based family therapy (ABFT)**: This form of therapy helps to build emotionally protective, secure relationships between family members and support caregivers in being a safety net for a young person in crisis. Further research is needed, but initial results indicate that ABFT may decrease suicidal thoughts.
- **Safety planning interventions:** In a brief intervention, a provider works with a client to create a prioritized list of coping strategies and sources of support that can be used to alleviate a suicidal crisis. Safety planning interventions can be administered on their own in emergency rooms or in combination with ongoing treatments.
- **Pharmacological interventions**: Two psychiatric medications shown to reduce the rate of suicide in certain populations are lithium and clozapine, and providers should consider them when clinically appropriate. Recent trials also suggest that ketamine can decrease acute suicidality.

7. Reduce access to lethal means, especially firearms

Putting time and distance between a person in a suicidal crisis and lethal means (methods) of attempting suicide is one of the most powerful tools we have in reducing suicide deaths. Research has shown that limiting a person's access to, for instance, toxic chemicals, lethal jump points, and firearms can significantly reduce the risk of suicide.

There are multiple examples of successful lethal-means safety efforts:

- Sri Lanka had one of the world's highest suicide rates, and toxic pesticides were the leading method of suicide. After a ban on toxic pesticides, the suicide rate dropped by 50%, and the rate drop was driven primarily by a decrease in pesticide suicides. Suicides by other methods did not change significantly.
- More recently, after many years of planning and construction, a suicide deterrent system has been installed about 20 feet below the bridge deck for the entire span of the Golden Gate Bridge, in San Francisco. Although the data are preliminary, there were 22 suicides in 2022, and so far in 2023, since the netting has been significantly expanded, the number is 13, a promising reduction and less than half the average annual rate of 33.5 per year.

In the United States, where firearms are the leading method of completed suicide, the research evidence indicates that homes without firearms have lower suicide rates than homes with firearms, and that among gun-owning homes, the risk of suicide, particularly for youth, is lower when guns are stored locked and unloaded in a gun safe. And for families who have a self-defense firearm or a service weapon (military, law enforcement), it should be stored in a manner that prevents access from unauthorized users, such as in a biometric safe.

Although suicidal episodes can escalate quickly, they can also *subside* quickly. In one long-term study, 87% of people who survived a serious suicide attempt did not go on to die by suicide. That means that the

majority of lives spared in the short term are lives saved. At the core, lethal means reduction works because it protects a person in crisis from being able to act on an impulse to harm themselves.

Ensuring that young people do not have access to firearms during times of crisis is a critical way that adults can help keep youth safer. For many young people, buying time creates an opportunity to find the support or treatment that they need.

Caring leaders, policymakers, and community members can find common ground around the goal of saving young people's lives. This shared goal is the springboard to meaningful discussions and advancing substantial changes in firearm safety. Everyone from families to gun owner groups to legislators can be a part of this solution. Specifically:

- **Families with guns at home should store them locked and unloaded, with ammunition stored and locked separately** and ensure that youth have no access to the keys or combination. Approximately three-quarters of suicides occur at home. It is not recommended that gun owners hide their firearms rather than lock them, because young people often know their hiding places.
- **For families who have a self-defense firearm or a service weapon** (military, law enforcement), it should be stored in a manner that prevents access from unauthorized users, such as in a biometric (e.g., fingerprint) safe.
- **Those who are considering becoming gun owners should be educated about gun suicide.** People who do not own a gun, including young people, may be thinking about buying one for safety and may not know that most firearm deaths are suicides. First-time gun owners should be supported in creating a responsible storage plan (using the specific recommendations above) to better protect those in the home who might experience a sudden suicidal crisis.
- **Schools can share universal safe-storage recommendations with students** as part of health lessons or through support services, and provide this information directly to the families of students. For families of youth who have been identified as being at risk for suicide, additional steps are recommended, including storing firearms (or a critical component of them) away from home.
- **Gun owner groups, gun retailers, and firearms instructors can promote suicide prevention as a basic tenet of firearm safety,** using trainings and resources like those developed by the New Hampshire Firearm Safety Coalition, Means Matter, and the collaboration between the National Shooting Sports Foundation (NSSF) and the American Foundation for Suicide Prevention (AFSP).
- **Clinicians should learn the basic principles of means safety** and undergo training such as Counseling on Access to Lethal Means (CALM) so they can inform and protect their patients and communities.
- **Legislators can work with gun owners and suicide prevention groups to write, sponsor, and pass bills** that help promote suicide prevention measures targeted to reducing youth access to firearms.

State Efforts to Reduce Suicide by Firearms

Several states are taking action to prevent suicide by encouraging firearm safety:

- In Virginia, the Lock & Talk program partners with firearm retailers and shooting ranges, encouraging them to display research-based posters about suicide prevention, offer suicide prevention handouts with purchases, and include a suicide prevention slide in their firearms safety courses.
- In Washington, Safer Homes Suicide Aware offers firearms retailers a one-hour course on firearms safety and suicide and provides free gun lockboxes to all individuals who complete a brief survey and conversation about suicide prevention.
- In Utah, Live On offers suicide prevention resources, including information about safe storage options and how to request being placed on a temporary voluntary "do not sell" list. Utah also passed a new state law to promote suicide prevention in K–12 districts, which includes the dissemination of materials about means safety, designed by JED, to parents of children who have made suicidal statements.

8. Advocate for safe online spaces

Young people spend a significant portion of their lives online — in spaces that are largely unregulated and where effects are not well understood. It is imperative that policymakers and other stakeholders take a pro-safety approach to apps and platforms where young people spend time, centering youth in any efforts to improve digital spaces. Prioritizing safety standards and algorithmic transparency will allow for the most benefits from social media and the least harm.

JED's recommendations:

- **Center youth and their rights** in any efforts to improve digital spaces.
- **Include mental health experts** in the design of platforms and regulatory systems.
- **Provide clear guidance and incentives that prioritize youth mental health** in policy and regulatory frameworks, and implement penalties if rules are violated. Frameworks should include moderation and removal of harmful content, bans on advertising to youth, and algorithmic transparency accompanied by prohibitions on practices that promote constant engagement.
- **Increase support for research and data collection and analysis** to understand the impact of social media on youth mental health.
- **Equip youth, caregivers, educators, influencers, and mental health providers** with the information and resources they need to manage and make the most of digital spaces, including through digital literacy programs.

9. Leverage technology to support youth mental health

Mobile devices such as smartphones, tablets, and virtual reality (VR) headsets offer more ways to connect with each other and with mental health care than ever before. New technology has the potential to overcome barriers to access, provide accurate and effective mental health information, monitor mental well-being, and connect young people to care.

Technology can be used to:

Expand access to professional help through telemedicine.

The COVID-19 pandemic ushered in increased access to telehealth services. Private insurance companies and Medicaid removed certain pre-pandemic restrictions on coverage and reimbursement, and multiple states issued temporary licenses to providers licensed in other states. Telehealth can have significant benefits, but it presents new challenges. There are few guidelines to help schools confidently choose providers. *Critical Considerations Before Contracting With a Teletherapy Vendor* offers helpful parameters for engaging teletherapy platforms. There are also other considerations, especially for young people without reliable internet access and those who do not have private spaces to interact with providers. Ongoing research and investment is needed to ensure that telehealth services meet the needs of young people across the spectrum.

Connect to young people where they are.

By engaging with youth in the spaces they already frequent, we can meet them where they are with effective messaging and information that will help them have conversations with each other and with caring adults.

Specifically:

- **Social media and other interactive platforms** can be used to provide mental health information and space to talk about difficult topics, and can also help young people build social connections and create a sense of belonging and community.
- **Digital campaigns** are effective ways to bring mental health messaging to young people. An example is JED's Seize the Awkward campaign, developed with the American Foundation for Suicide Prevention in collaboration with the Ad Council, which utilizes trusted messengers like celebrities and musicians to highlight the importance of reaching out to friends.
- **Smartphone apps** that focus on mental health can provide coping skills, symptom monitoring, psychoeducation, and resources.

As young people spend more time in immersive spaces, video games, and augmented or virtual reality (AR/VR) environments, it is important that we also work to foster a metaverse ecosystem that emphasizes mental health and well-being for youth.

Opportunities:

- **Social VR platforms and immersive digital spaces** offer promising potential for remote therapeutic interaction. They have been used to enhance diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD) and in exposure therapy simulations for anxiety disorders and PTSD.
- **Peer-to-peer VR support groups** can help young people access peer-based mental health care services with adult facilitators. Virtual support groups for transgender youth and adolescents and young adults with cancer help to create a secure and accepting environment for all individuals to support one another and express themselves comfortably.
- **Nonsocial VR**, including therapeutic video games created with mental health researchers, can help youth reduce stress levels and learn positive behaviors. VR apps now offer immersive mindfulness experiences and biofeedback to help young people learn breathing techniques. Apps also assist therapists in delivering certain forms of therapy, including CBT, to young people.

Conclusion

No young person should die by suicide when there are effective strategies to prevent it. Prevention and early intervention for mental health issues have been shown to help young people navigate life challenges and decrease suicide risk. Suicide stems from a complex mix of factors and affects people of all backgrounds. Therefore, effective approaches to prevention and intervention depend on comprehensive, integrated, evidence-based approaches deployed across all sectors of society.

Positive mental health begins with a holistic approach to promote success in life. Rather than just treating symptoms, we must transform our communities through large-scale policy change that addresses the conditions that put young people at risk, such as poverty, violence, discrimination, isolation, and lack of access to care. Our goal must be to see young people thrive, and we can do this by helping them to create lives with connection, meaning, and purpose. We know what works, and it is time to do it together.

References

988 Suicide & Crisis Lifeline. (n.d.). *The lifeline and 988*. https://988lifeline.org/current-events/the-lifeline-and-988/

Abrams, A. (2022, March 30). Telehealth companies want Congress to make pandemic expansion of their services permanent. *TIME*. https://time.com/6162804/telehealth-lobbying-push-covid-expansion/

Ad Council. (n.d.) https://www.adcouncil.org/

Adams, S. H., Schaub, J. P., Nagata, J. M., Park, M. J., Brindis, C. D., & Irwin, C. E., Jr. (2022). Young adult anxiety or depressive symptoms and mental health service utilization during the COVID-19 pandemic. *The Journal of Adolescent Health, 70(*6), 985–988. https://doi.org/10.1016/j.jadohealth.2022.02.023

Aggarwal, N. K. (2023). Combatting the Intergenerational Trauma of Structural Racism Through Practice, Policy, and Research. *Journal of the American Academy of Child and Adolescent Psychiatry*, 62 (10). https://doi.org/10.1016/j.jaac.2023.05.019

Alvidrez, J., & Tabor, D. C. (2021). Now is the time to incorporate the construct of structural racism and discrimination into health research. *Ethnicity & Disease, 31*(Suppl 1), 283–284. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8143854/

Amani, B., Milburn, N. G., Lopez, S., Young-Brinn, A., Castro, L., Lee, A., & Bath, E. (2018). Families and the juvenile justice system: Considerations for family-based interventions. *Family & Community Health, 41*(1), 55–63. https://doi.org/10.1097/FCH.0000000000000172

American Academy of Pediatrics. (2021, March 5). *Major health, education, and child welfare organizations oppose anti-LGBTQ state-based legislation*. https://www.aap.org/en/news-room/news-releases/aap/2021/major-health-education-and-child-welfare-organizations-oppose-anti-lgbtq-state-based-legislation/

American College Health Association. (2022). American College Health Association-National college assessment III: Undergraduate student reference group executive summary Spring 2022. https://www.acha.org/documents/ncha/NCHA-III_SPRING_2022_UNDERGRAD_REFERENCE_GROUP_EXECUTIVE_SUMMARY.pdf

American Foundation for Suicide Prevention. (n.d.). https://afsp.org/

American Foundation for Suicide Prevention, American School Counselor Association, National Association of School Psychologists & The Trevor Project (2019). *Model School District Policy on Suicide Prevention: Model Language, Commentary, and Resources* (2nd ed.). New York: American Foundation for Suicide Prevention. www.thetrevorproject.org/wp-content/uploads/2021/08/Model_School_Policy_Booklet.pdf

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). *After a suicide: A toolkit for schools* (2nd ed.). Waltham, MA: Education Development Center. https://sprc.org/wp-content/uploads/2022/12/AfteraSuicideToolkitforSchools-3.pdf

American Psychological Association. (2018). *Stress in America: Generation Z.* https://www.apa.org/news/press/releases/stress/2018/stress-gen-z.pdf

American Psychological Association. (2022). *Suicide Among Asian Americans.* https://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/suicide#4Kisch

Angelakis, I., Austin, J. L., & Gooding, P. (2020). Association of childhood maltreatment with suicide behaviors among young people: a systematic review and meta-analysis. *JAMA Network Open,* 3(8). https://doi.org/10.1001/jamanetworkopen.2020.12563

Asmelash, L. (2023, June 14). *DEI programs in universities are being cut across the country. what does this mean for higher education?* CNN. https://www.cnn.com/2023/06/14/us/colleges-diversity-equity-inclusion-higher-education-cec/index.html

Bacher-Hicks, A., Billings, S., & Deming, D. (2021). Proving the school-to-prison pipeline: Stricter middle schools raise the risk of adult arrest. *Education Next, 21*(4), 52-57. https://www.educationnext.org/proving-school-to-prison-pipeline-stricter-middle-schools-raise-risk-of-adult-arrests/

Baiden, P., LaBrenz, C. A., Onyeaka, H. K., Muoghalu, C., Nicholas, J. K., Spoor, S. P., Bock, E., & Taliaferro, L. A. (2022). Perceived racial discrimination and suicidal behaviors among racial and ethnic minority adolescents in the United States: Findings from the 2021 adolescent behaviors and experiences survey. *Psychiatry Research*, *317*. https://doi.org/10.1016/j.psychres.2022.114877

Barber, C., Azrael, D., Miller, M., & Hemenway, D. (2022). Who owned the gun in firearm suicides of men, women, and youth in five US states? *Preventative Medicine, 164*. https://doi.org/10.1016/j.ypmed.2022.107066

Bassett, D., Buchwald, D., & Manson, S. (2014). Posttraumatic stress disorder and symptoms among American Indians and Alaska Natives: a review of the literature. *Social Psychiatry and Psychiatric Epidemiology, 49*(3), 417–433. https://doi.org/10.1007/s00127-013-0759-y

Beacon Press. (2015). *An indigenous peoples' history of the United States*. https://www.beacon.org/An-Indigenous-Peoples-History-of-the-United-States-P1164.aspx

Beautrais A.L. (2000). Risk Factors for Suicide and Attempted Suicide among Young People. *Australian & New Zealand Journal of Psychiatry*, *34*(3):420-436. https://doi.org/10.1080/j.1440-1614.2000.00691.x

Bentivegna, F., & Patalay, P. (2022). The impact of sexual violence in mid-adolescence on mental health: a UK population-based longitudinal study. *The Lancet Psychiatry*, *9*(11), 874-883. https://doi.org/10.1016/S2215-0366(22)00271-1

Bhargava, V. R., & Velasquez, M. (2021). Ethics of the attention economy: The problem of social media addiction. *Business Ethics Quarterly*, *31*(3), 321-359. https://doi.org/10.1017/beq.2020.32

Borschmann, R., Janca, E., Carter, A., Willoughby, M., Hughes, N., Snow, K., Stockings, E., Hill, N. T., Hocking, J., Love, A., Patton, G. C., Sawyer, S. M., Fazel, S., Puljević, C., Robinson, J., & Kinner, S. A. (2020). The health of adolescents in detention: a global scoping review. *The Lancet Public Health*, *5*(2). https://doi.org/10.1016/S2468-2667(19)30217-8

Bouchery, E. E., Barna, M., Babalola, E., Friend, D., Brown, J. D., Blyler, C., & Ireys, H. T. (2018). The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization. *Psychiatric Services*, *69*(10), 1069-1074. https://doi.org/10.1176/appi.ps.201700451

Branch, J. (2023, November 5). *What the Golden Gate is (finally) doing about suicides*. The New York Times. https://www.nytimes.com/2023/11/05/us/golden-gate-bridge-suicide-nets.html

Branson, C. E., Baetz, C. L., Horwitz, S. M., & Hoagwood, K. E. (2017). Trauma-informed juvenile justice systems: A systematic review of definitions and core components. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(6), 635. https://doi.org/10.1037/tra0000255

Bridge, J. A., Horowitz, L. M., Fontanella, C. A., Sheftall, A. H., Greenhouse, J., Kelleher, K. J., & Campo, J. V. (2018). Age-related racial disparity in suicide rates among US youths from 2001 through 2015. *JAMA Pediatrics, 172*(7), 697–699. https://doi.org/10.1001/jamapediatrics.2018.0399

Brown, G. K., Ten Have, T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts. *JAMA, 294*(5), 563. https://doi.org/10.1001/jama.294.5.563

Calkins, H. (2020, September 1). Increasing the visibility of providers of color. *Monitor on Psychology, 51*(6), 68. https://www.apa.org/monitor/2020/09/increasing-providers-color

Canady, V. A. (2021). CDC data finds sharp rise in suicide attempts among teen girls amid COVID-19. *Mental Health Weekly*, *31*(24), 1-3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8441786/

Center for Countering Digital Hate. (2022). (rep.). Deadly By Design: TikTok pushes harmful content promoting eating disorders and self-harm into users' feeds. https://counterhate.com/research/deadly-by-design/

Centers for Disease Control and Prevention. (n.d.). *Adolescent behaviors and experiences survey (ABES).* https://www.cdc.gov/healthyyouth/data/abes.htm

Centers for Disease Control and Prevention. (2023). *Adverse Childhood Experiences (ACEs)*. https://www.cdc.gov/violenceprevention/aces/index.html

Centers for Disease Control and Prevention. (2021). *CDC report shows concerning increases in sadness and exposure to violence among teen girls and LGBQ+ youth.* https://www.cdc.gov/nchhstp/newsroom/fact-sheets/healthy-youth/sadness-and-violence-among-teen-girls-and-LGBQ-youth-factsheet.html#teen-girls

Centers for Disease Control and Prevention. (n.d.). *Comprehensive Suicide Prevention.* https://www.cdc.gov/suicide/programs/csp/index.html

Centers for Disease Control and Prevention. (n.d.). *Disparities in suicide.* https://www.cdc.gov/suicide/facts/disparities-in-suicide.html

Centers for Disease Control and Prevention. (n.d.). *How does social connectedness affect health?* https://www.cdc.gov/emotional-wellbeing/social-connectedness/affect-health.htm

Centers for Disease Control and Prevention. (2023). *Mental Health Treatment Among Adults: United States, 2019.* National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db380.htm

Centers for Disease Control and Prevention (2023, August 10). *Provisional Suicide Deaths in the United States, 2022*. https://www.cdc.gov/media/releases/2023/s0810-US-Suicide-Deaths-2022.html

Centers for Disease Control and Prevention. (2023). *Suicide mortality in the United States, 2001-2021.* National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db464.htm

Centers for Disease Control and Prevention. (2022). *Suicide prevention resource for action: A compilation of the best available evidence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/suicide/pdf/preventionresource.pdf

Centers for Disease Control and Prevention. (2021). *Youth risk behavior surveillance system (YRBSS).* https://www.cdc.gov/healthyyouth/data/yrbs/index.htm

Centers for Disease Control and Prevention. (2022). *Youth Risk Behavior Survey: Data summary and trends report 2011-2021.* https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System. As compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

AAPI girls and young women have not historically had high suicide rates, but their rates have doubled over the past decade (2010-2020), increasing almost as fast as those of Black girls and young women.

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2010. Group By: Race; Gender. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2020. Group By: Race; Gender. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

AI/AN communities are grappling with the country's highest suicide rates.

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Year/Month: 2021. Group By: Single Race 6. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per:100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

American Indian/Alaska Native (AI/AN) youth (10-24) suicide rates are almost twice as high as the overall national average — the highest across all racial groups.

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2021. Group By: Single Race 6. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Black youth are experiencing the fastest increasing suicide rates, with the rate almost doubling (a 90% increase) among 10-24 year olds from 2010-2020.

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2010. Group By: Race. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2020. Group By: Race. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Boys and young men who die by suicide are twice as likely to have used firearms than girls and young women who die by suicide.

Query criteria: Year range: 2020-2020. Suicide All Injury Deaths. Sex: Female. Age range: 15 to 19 - 20 to 24. Race: All races. Ethnicity: All ethnicities. Metro vs. Non-metro: Select all.

Query criteria: Year range: 2020-2020. Suicide All Injury Deaths. Sex: Male. Age range: 15 to 19 - 20 to 24. Race: All races. Ethnicity: All ethnicities. Metro vs. Non-metro: Select all.

Drug poisoning makes up 5.6% of fatal unintentional injuries among young people 10-14, but rises to 49.3% for those ages 20-24.

Query criteria: Year range: 2020-2020. Suicide All Injury Deaths. Sex: Both sexes. Age range: 10 to 14. Race: All races. Ethnicity: All ethnicities. Metro vs. Non-metro: Select all.

Query criteria: Year range: 2020-2020. Suicide All Injury Deaths. Sex: Both sexes. Age range: 20 to 24. Race: All races. Ethnicity: All ethnicities. Metro vs. Non-metro: Select all.

Firearms were used in over half (52.4%) of suicides by young people ages 15-24 in 2020.

Query criteria: Year range: 2020-2020. Suicide All Injury Deaths. Sex: Both sexes. Age range: 15 to 19 - 20 to 24. Race: All races. Ethnicity: All ethnicities. Metro vs. Non-metro: Select all.

For young people ages 10-24, the Hispanic/Latiné suicide rate is two thirds that of the non-Hispanic/Latiné rate, but has increased by 58% over the last decade.

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2021. Group By: Hispanic Origin. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2010. Group By: Hispanic Origin. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per:100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2020. Group By: Hispanic Origin. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per:100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

In 2021, the suicide rate for 15– to 24–year-old non-Hispanic white males was 76% higher than the U.S. average for that age group.

Query criteria: Hispanic Origin: Not Hispanic or Latino. ICD-10 Codes: X60-X84 (Intentional self-harm). Ten-Year Age Groups: 15-24 years. Year/Month: 2021. Group By: Gender; Single Race 6. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Year/Month: 2021. Group By: Ten-Year Age Groups. Show Totals: Disabled. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Leading causes of death for 12-24 year olds, by age, 2021 (per 100,000).

Query Criteria: Single-Year Ages: [Search was undertaken for each age consecutively, starting with age 12 and proceeding through age 24]. Year/Month: 2021. Group By: 15 Leading Causes of Death. Show Totals: Disabled. Show Zero Values: Disabled. Show Suppressed: Disabled. Calculate Rates Per: 100,000.

Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Oct 1, 2023.

Mortality 2018-2021 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2021. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Oct 1, 2023.

Overall, members of Hispanic/Latiné communities have lower rates of suicide than those who are not part of these communities.

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Year/Month: 2021. Group By: Hispanic Origin. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per:100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Provisional Mortality on CDC WONDER Online Database. Data are from provisional data for years 2022-2023. Accessed at http://wonder.cdc.gov/mcd-icd10-provisional.html on Oct 1, 2023.

Suicide is the second leading cause of death for young people ages 12-24.

Query criteria: Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2021. Group By: 15 Leading Causes of Death. Show Totals: Disabled. Show Zero Values: Disabled. Show Suppressed: Disabled. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Suicide rates are rapidly rising, particularly among Black girls and young women, who have seen the greatest increase in suicide death rates of any demographic group over the last decade.

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2010. Group By: Race; Gender. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2020. Group By: Race; Gender. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Trends in Youth (ages 10-24) Suicide Rates by Race, 2010-2020, per 100,000.

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2010. Group By: Race. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 10 years; 11 years; 12 years; 13 years; 14 years; 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2020. Group By: Race. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Within certain racial groups, ethnicity significantly affects suicide rates. Non-Hispanic/Latiné Americans are 2.2 times as likely to die by suicide compared to Hispanic/Latiné Americans if they are white, 2.7 times as likely if they are Black, and 14.1 times as likely if they are American Indian/Alaska Native (AI/AN).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single Race 6: American Indian or Alaska Native. Year/Month: 2021. Group By: Hispanic Origin. Show Totals: Disabled. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per:100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single Race 6: Black or African American. Year/Month: 2021. Group By: Hispanic Origin. Show Totals: Disabled. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per:100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query Criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single Race 6: White. Year/Month: 2021. Group By: Hispanic Origin. Show Totals: Disabled. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per:100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Young women's suicide rates have been increasing faster than boys, doubling in the last two decades.

Query criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Ten-Year Age Groups: 15-24 years. Year/Month: 2001. Group By: Gender. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Ten-Year Age Groups: 15-24 years. Year/Month: 2021. Group By: Gender. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Youth suicide rates 2012-2022 (per 100,000).

Query criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Single-Year Ages: 15 years; 16 years; 17 years; 18 years; 19 years; 20 years; 21 years; 22 years; 23 years; 24 years. Year/Month: 2012; 2013; 2014; 2015; 2016; 2017; 2018; 2019; 2020. Group By: Year. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Ten-Year Age Groups: 15-24 years. Year/Month: 2021. Group By: Year. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Query criteria: ICD-10 Codes: X60-X84 (Intentional self-harm). Ten-Year Age Groups: 15-24 years. Year/Month: 2022 (provisional). Group By: Year. Show Totals: True. Show Zero Values: False. Show Suppressed: False. Calculate Rates Per: 100,000. Rate Options: Default intercensal populations for years 2001-2009 (except Infant Age Groups).

Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2003). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). https://wisqars.cdc.gov/data/explore-data/home

One significant contributing factor to the high rates is that a large number of the suicides (65%) among this group were by firearm.

Data Filters: Injury Outcome: Fatal. Injury Type: All Injury. Data Years: 2021. Geography: United States. Intent: Suicide. Mechanism: All Injury. Age: 15 to 19 through 20 to 24. Sex: Males. Race: White. Ethnicity: Non-Hispanic. Metro/Non-Metro Indicator: None Selected. YPLL Age: 65. Year and Race Options: 2018-2021 by Single Race.

Boys and young men (ages 15-24) who die by suicide are twice as likely to have used firearms than girls and young women who die by suicide.

Data Filters: Injury Outcome: Fatal. Injury Type: All Injury. Data Years: 2021. Geography: United States. Intent: Suicide. Mechanism: All Injury. Age: 15 to 19 through 20 to 24. Sex: Males. Race: All Races. Ethnicity: All Ethnicities. Metro/Non-Metro Indicator: None Selected. YPLL Age: 65. Year and Race Options: 2001-2021 with No Race.

Data Filters: Injury Outcome: Fatal. Injury Type: All Injury. Data Years: 2021. Geography: United States. Intent: Suicide. Mechanism: All Injury. Age: 15 to 19 through 20 to 24. Sex: Females. Race: All Races. Ethnicity: All Ethnicities. Metro/Non-Metro Indicator: None Selected. YPLL Age: 65. Year and Race Options: 2001-2021 with No Race.

Centers for Medicare & Medicaid Services (CMS). (2023). *Delivering Service in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming*. https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf

Centers for Medicare & Medicaid Services (CMS). *The Mental Health Parity and Addiction Equity Act (MHPAEA)*. (n.d.). https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity

Cheeseman Day, J. (2023, February 8). *Rates of uninsured fall in rural counties, remain higher than Urban counties*. United States Census Bureau. https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html

Child's Play. (n.d.). *Online therapeutic video game guide.* https://childsplaycharity.org/guide

Clarke, A., Sorgenfrei, M., Mulcahy, J., Davie, P., Friedrich, C. & McBride, T. (rep.) (2021). *Adolescent mental health: A systematic review on the effectiveness of school-based interventions*. London, England: Early Intervention Foundation. https://www.eif.org.uk/report/adolescent-mental-health-a-systematic-review-on-the-effectiveness-of-school-based-interventions

Collins, P. H. (2019). *Intersectionality as Critical Social Theory*. Duke University Press. https://doi.org/10.2307/j.ctv11hpkdj

Columbia University Department of Psychiatry. (2023, February 1). *Innovative intervention addresses youth suicide risk in the Juvenile Justice System.* https://www.columbiapsychiatry.org/news/innovative-intervention-addresses-youth-suicide-risk-juvenile-justice-system

Connect: Training Professionals & Communities in Suicide Prevention & Response. (n.d.). *Suicide Prevention: A Role for Firearm Dealers and Ranges*. NH Firearm Safety Coalition. https://theconnectprogram.org/resources/nh-firearm-safety-coalition/

Conner, A., Azrael, D., & Miller, M. (2019). Suicide Case-Fatality Rates in the United States, 2007 to 2014. *Annals of Internal Medicine*, *171*(12), 885–895. https://doi.org/10.7326/M19-1324

Coppersmith, D. D., Ryan, O., Fortgang, R. G., Millner, A. J., Kleiman, E. M., & Nock, M. K. (2023). Mapping the timescale of suicidal thinking. *Proceedings of the National Academy of Sciences*, *120*(17). https://doi.org/10.1073/pnas.2215434120

Correa, D., & Wilson, N. (2022, September 22). *Fact Sheet: Gun Violence in Rural America.* Center for American Progress. https://www.americanprogress.org/article/gun-violence-in-rural-america

Counseling on Access to Lethal Means. (n.d.) https://www.calmamerica.org/

Crockett, L. J., Shanahan, M. J., & Jackson-Newsom, J. (2000). Rural youth: Ecological and life course perspectives. *Adolescent Diversity in Ethnic, Economic, and Cultural Contexts*, 43–74. https://doi.org/10.4135/9781452225647.n3

D'Anci, K. E., Uhl, S., Giradi, G., & Martin, C. (2019). Treatments for the prevention and management of suicide: a systematic review. *Annals of Internal Medicine*, *171*(5), 334-342. https://doi.org/10.7326/M19-0869

Davidson, P. M., McGrath, S. J., Meleis, A. I., Stern, P., Digiacomo, M., Dharmendra, T., Correa-de-Araujo, R., Campbell, J. C., Hochleitner, M., Messias, D. K., Brown, H., Teitelman, A., Sindhu, S., Reesman, K., Richter, S., Sommers, M. S., Schaeffer, D., Stringer, M., Sampselle, C., Anderson, D., … Krassen Covan, E. (2011). The health of women and girls determines the health and well-being of our modern world: A white paper from the International Council on Women's Health Issues. *Health Care for Women International, 32(10),* 870–886. https://doi.org/10.1080/07399332.2011.603872

DeCou, C. R., Comtois, K. A., & Landes, S. J. (2019). Dialectical behavior therapy is effective for the treatment of suicidal behavior: A meta-analysis. *Behavior Therapy, 50*(1), 60–72. https://doi.org/10.1016/j.beth.2018.03.009

Department of the Air Force Integrated Resilience. (n.d.). *Suicide Prevention*. https://www.resilience.af.mil/suicide-prevention-program/

Development Services Group, Inc. (2017). *Intersection B*etween Mental He*alth and the Juvenile Justice System*. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf

Diamond, G. S., Kobak, R. R., Krauthamer Ewing, E. S., Levy, S. A., Herres, J. L., Russon, J. M., & Gallop, R. J. (2019). A Randomized Controlled Trial: Attachment-Based Family and Nondirective Supportive Treatments for Youth Who Are Suicidal. *Journal of the American Academy of Child and Adolescent Psychiatry, 58*(7), 721–731. https://doi.org/10.1016/j.jaac.2018.10.006

Durlak, J. A., Mahoney, J. L., & Boyle, A. E. (2022). What we know, and what we need to find out about universal, school-based social and emotional learning programs for children and adolescents: A review of meta-analyses and directions for future research. *Psychological Bulletin, 148*(11-12), 765–782. https://doi.org/10.1037/bul0000383

ELVTR Magazine. (n.d.). *The financial and mental cost of the United States' higher education issues.* https://elvtr.com/blog/a-failing-system-the-financial-and-mental-cost-of-the-united-states-higher-education-issues

English, D., Lambert, S., Tynes, B., Bowleg, L., Zea, M.C., & Howard, L. (2020). Daily multidimensional racial discrimination among black U.S. American adolescents. *Journal of Applied Developmental Psychology, 66*(1). https://doi.org/10.1016/j.appdev.2019.101068

Epstein, R., Blake, J., & Gonzalez, T. (2020). (rep.). *Girlhood interrupted: The erasure of black girls' childhood.* Georgetown Law Center on Poverty and Inequality. https://genderjusticeandopportunity.georgetown.edu/wp-content/uploads/2020/06/girlhood-interrupted.pdf

Everytown for Gun Safety. (2022). (rep.) *The rise of firearm suicide among young Americans*. https://everytownresearch.org/report/the-rise-of-firearm-suicide-among-young-americans/

Eyllon, M., Salhi, C., Griffith, J. L., & Lincoln, A. K. (2022).

Giano, Z., Wheeler, D. L., & Hubach, R. D. (2020). The frequencies and disparities of adverse childhood experiences in the US. *BMC Public Health*, *20*(1), 1-12. https://doi.org/10.1186/s12889-020-09411-z

Goharinejad, S., Goharinejad, S., Hajesmaeel-Gohari, S., & Bahaadinbeigy, K. (2022). The usefulness of virtual, augmented, and mixed reality technologies in the diagnosis and treatment of attention deficit hyperactivity disorder in children: an overview of relevant studies. *BMC Psychiatry, 22*(1), 4. https://doi.org/10.1186/s12888-021-03632-1

Gower, A. L., Rider, G. N., McMorris, B. J., & Eisenberg, M. E. (2018). Bullying victimization among LGBTQ youth: Critical issues and future directions. *Current Sexual Health Reports, 10*(4), 246–254. https://doi.org/10.1007/s11930-018-0169-y

Han, S., Riddell, J. R., & Piquero, A. R. (2022). Anti-Asian American hate crimes spike during the early stages of the COVID-19 pandemic. *Journal of Interpersonal Violence, 38(3–4),* 3513–3533. https://doi.org/10.1177/08862605221107056

Hankerson, S. H., Moise, N., Wilson, D., Waller, B. Y., Arnold, K. T., Duarte, C., Lugo-Candelas, C., Weissman, M. M., Wainberg, M., Yehuda, R., & Shim, R. (2022). The intergenerational impact of structural racism and cumulative trauma on depression. *American Journal of Psychiatry*, *179*(6), 434–440. https://doi.org/10.1176/appi.ajp.21101000

Hart, B., & Roberson, M. (2021, February 26). *The ballroom scene has long offered radical freedoms for black and brown queer people. Today, that matters more than ever.* TIME. https://time.com/5941822/ballroom-voguing-queer-black-culture-renaissance/

Harvard T.H. Chan School of Public Health (n.d.). *Firearms Instructors.* Harvard University. https://www.hsph.harvard.edu/means-matter/firearm-instructors/

Harvard T.H. Chan School of Public Health (n.d.). *Gun shop project.* Harvard University. https://www.hsph.harvard.edu/means-matter/gun-shop-project/

Harvard T.H. Chan School of Public Health. (n.d.). *Where do suicides occur?* Harvard University. https://www.hsph.harvard.edu/means-matter/basic-suicide-facts/where/

Healthy Minds Network (n.d.). https://healthymindsnetwork.org/hms/

Healthy Minds Network. (2021). (rep.). *The Healthy Minds Study: Winter/Spring 2021 Data Report*. https://healthymindsnetwork.org/wp-content/uploads/2021/09/HMS_national_winter_2021.pdf

Healthy Native Youth. (n.d.) https://www.healthynativeyouth.org/

Heard-Garris, N., Boyd, R., Kan, K., Perez-Cardona, L., Heard, N. J., & Johnson, T. J. (2021). Structuring poverty: How racism shapes child poverty and child and adolescent health. *Academic Pediatrics*, *21*(8). https://doi.org/10.1016/j.acap.2021.05.026

Hemez, P., Brent, J. J., & Mowen, T. J. (2020). Exploring the school-to-prison pipeline: How school suspensions influence incarceration during young adulthood. *Youth Violence and Juvenile Justice, 18(*3), 235–255. https://doi.org/10.1177/1541204019880945

Herrenkohl, T. I., Hong, S., & Verbrugge, B. (2019). Trauma-informed programs based in schools: Linking concepts to practices and assessing the evidence. *American Journal of Community Psychology, 64*(3–4), 373–388. https://doi.org/10.1002/ajcp.12362

Hickman, C., Marks, E., Pihkala, P., Clayton, S., Lewandowski, R. E., Mayall, E. E., Wray, B., Mellor, C., & van Susteren, L. (2021). Climate anxiety in children and young people and their beliefs about government responses to climate change: A global survey. *The Lancet Planetary Health*, *5*(12). https://doi.org/10.1016/s2542-5196(21)00278-3

Higher Education Mental Health Alliance. (2014). *Postvention: A Guide for Response to Suicide on College Campuses*. https://hemha.org/wp-content/uploads/2018/06/jed-hemha-postvention-guide.pdf

Hochschild, A., Grunebaum, M. F., & Mann, J. J. (2021). The rapid anti-suicidal ideation effect of ketamine: A systematic review. *Preventive Medicine, 152*(Pt 1). https://doi.org/10.1016/j.ypmed.2021.106524

Holt-Lunstad, J. (2017). The potential public health relevance of social isolation and loneliness: Prevalence, epidemiology, and risk factors. *Public Policy & Aging Report*, *27*(4), 127-130. https://doi.org/10.1093/ppar/prx030

Hoogsteder, L. M., ten Thije, L., Schippers, E. E., & Stams, G. J. J. M. (2022). A Meta-Analysis of the Effectiveness of EMDR and TF-CBT in Reducing Trauma Symptoms and Externalizing Behavior Problems in Adolescents. *International Journal of Offender Therapy and Comparative Criminology*, *66*(6–7), 735–757. https://doi.org/10.1177/0306624X211010290

I Know Mine: Truthful, Accurate Information for You(th). (n.d.). https://www.iknowmine.org/

Illuminative. (n.d.). https://illuminative.org/

Indian Country Echo. (n.d.). https://www.indiancountryecho.org/

Innerworld. (n.d.). https://www.inner.world/home/

John, A., Glendenning, A. C., Marchant, A., Montgomery, P., Stewart, A., Wood, S., Lloyd, K., & Hawton, K. (2018). Self-harm, suicidal behaviours, and cyberbullying in children and Young People: Systematic Review. *Journal of Medical Internet Research, 20*(4). https://doi.org/10.2196/jmir.9044

Johns Hopkins Bloomberg School of Public Health. (2023, July 27). *CDC Provisional Data: Gun Suicides Reach All-time High in 2022, Gun Homicides Down Slightly from 2021*. https://publichealth.jhu.edu/2023/cdc-provisional-data-gun-suicides-reach-all-time-high-in-2022-gun-homicides-down-slightly-from-2021

Johns Hopkins Bloomberg School of Public Health. (2022). *New analysis: guns drove the increases in homicides and suicides from 2019 to 2021.* https://publichealth.jhu.edu/new-analysis-guns-drove-the-increases-in-homicides-and-suicides-from-2019-to-2021

Johns, M., Lowry, R., Haderxhanaj, L., Rasberry, C., Robin, L., Scales, L., Stone, S., & Suarez, N. (2020). Trends in violence victimization and suicide risk by sexual identity among high school students- youth risk behavior survey, United States, 2015-2019. *Supplements, 69*(1), 19-27. http://dx.doi.org/10.15585/mmwr.su6901a3

Jones, S. C., Anderson, R. E., & Metzger, I. W. (2020). "Standing in the gap": The continued importance of culturally competent therapeutic interventions for black youth. *Evidence-Based Practice in Child and Adolescent Mental Health*, *5*(3), 327-339. https://doi.org/10.1080/23794925.2020.1796546

Kannan, V. D., & Veazie, P. J. (2023). US trends in social isolation, social engagement, and companionship – nationally and by age, sex, race/ethnicity, family income, and work hours, 2003–2020. *SSM - Population Health*, *21*. https://doi.org/10.1016/j.ssmph.2022.101331

Kauh, T. J., Read, J. G., & Scheitler, A. J. (2021). The Critical Role of Racial/Ethnic Data Disaggregation for Health Equity. *Population Research and Policy Review, 40(1),* 1–7. https://doi.org/10.1007/s11113-020-09631-6

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 593-602. https://doi.org/10.1001/archpsyc.62.6.593

Knipe, D. W., Gunnell, D., & Eddleston, M. (2017). Preventing deaths from pesticide self-poisoning — learning from Sri Lanka's success. *The Lancet Global Health, 5*(7). https://doi.org/10.1016/s2214-109x(17)30208-5

Kruse, G., Lopez-Carmen, V. A., Jensen, A., Hardie, L., & Sequist, T. D. (2022). The Indian Health Service and American Indian/Alaska Native health outcomes. *Annual Review of Public Health, 43(1)*, 559–576. https://doi.org/10.1146/annurev-publhealth-052620-103633

Ku, B. S., Li, J., Lally, C., Compton, M. T., & Druss, B. G. (2021). Associations between mental health shortage areas and county-level suicide rates among adults aged 25 and older in the USA, 2010 to 2018. *General Hospital Psychiatry*, *70*, 44-50. https://doi.org/10.1016/j.genhosppsych.2021.02.001.

Lee, H., Slack, K. S., Berger, L. M., Mather, R. S., & Murray, R. K. (2021). Childhood poverty, adverse childhood experiences, and adult health outcomes. *Health & Social Work*, *46*(3), 159-170. https://doi.org/10.1093/hsw/hlab018

Leong, F. T., & Lau, A. S. (2001). *Mental Health Services Research, 3(4),* 201–214. https://doi.org/10.1023/a:1013177014788

Lin, L., Stamm, K., & Christidis, P. (2018). How diverse is the psychology workforce? *Monitor on Psychology, 49*(2), 19. https://www.apa.org/monitor/2018/02/datapoint

Live On. (n.d.). Utah Suicide Prevention Coalition. https://liveonutah.org/

Lock & Talk. (n.d.). https://www.lockandtalk.org/

Lubin, G., Werbeloff, N., Halperin, D., Shmushkevitch, M., Weiser, M., & Knobler, H. Y. (2010). Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: a naturalistic epidemiological study. *Suicide & Life-threatening Behavior, 40*(5), 421–424. https://pubmed.ncbi.nlm.nih.gov/21034205/

Maguire-Jack, K., Font, S., Dillard, R., Dvalishvili, D., & Barnhart, S. (2021). Neighborhood poverty and adverse childhood experiences over the first 15 years of life. *International Journal on Child Maltreatment: Research, Policy and Practice*, *4*, 93-114. https://doi.org/10.1007/s42448-021-00072-y

Mahowald, L. (2022, March 24). *LGBTQI+ nondiscrimination laws improve economic, physical, and mental well-being.* The Center for American Progress. https://www.americanprogress.org/article/lgbtqi-nondiscrimination-laws-improve-economic-physical-and-mental-well-being/

Mann, J. J., Michel, C. A., & Auerbach, R. P. (2021). Improving suicide prevention through evidence-based strategies: A systematic review. *American Journal of Psychiatry, 178*(7), 611–624. https://doi.org/10.1176/appi.ajp.2020.20060864

Mass General Brigham McLean. (2023). *Understanding child abuse and its effects on mental health.* McLean Hospital. https://www.mcleanhospital.org/essential/effects-child-abuse#:~:text=Children%20who%20experience%20abuse%20may,early%20pregnancy%20and%20suicide%20attempts

McCauley, E., Berk, M. S., Asarnow, J. R., Adrian, M., Cohen, J., Korslund, K., Avina, C., Hughes, J., Harned, M., Gallop, R., & Linehan, M. M. (2018). Efficacy of dialectical behavior therapy for adolescents at high risk for suicide: A randomized clinical trial. *JAMA Psychiatry, 75*(8), 777–785. https://doi.org/10.1001/jamapsychiatry.2018.1109

Mendel, R. (2023). (rep.). *Effective Alternatives to Youth Incarceration*. Washington, DC: The Sentencing Project. https://www.sentencingproject.org/reports/effective-alternatives-to-youth-incarceration/#what-works

Michael, K.D., & Ramtekkar, U. (2022). Overcoming barriers to effective suicide prevention in rural communities. In Horowitz, L., & Ackerman, J. (Eds.), *Youth Suicide Prevention and Intervention: Current Best Practices and Policy Implications.* New York, NY: Springer. https://link.springer.com/chapter/10.1007/978-3-031-06127-1_17

Michael, K.D., Renkert, L., Wandler, J. & Stamey, T. (2009). Cultivating a New Harvest: Rationale and Preliminary Results from a Growing Interdisciplinary Rural School Mental Health Program, *Advances in School Mental Health Promotion, 2(2*), 40-50. https://doi.org/10.1080/1754730X.2009.9715703

Michael, K.D., Yaros, A., Counts, J., Hersh, J. (2023). Preparing School Mental Health Providers for Practice in Rural Communities. In: Evans, S.W., Owens, J.S., Bradshaw, C.P., Weist, M.D. (eds) Handbook of School Mental Health. *Issues in Clinical Child Psychology.* https://doi.org/10.1007/978-3-031-20006-9_21

Miller, M., & Azrael, D. (2022). Firearm Storage in US Households With Children: Findings From the 2021 National Firearm Survey. *JAMA Network Open*, *5*(2). https://doi.org/10.1001/jamanetworkopen.2021.48823

Miller, M., Barber, C., White, R. A., & Azrael, D. (2013). Firearms and suicide in the United States: Is risk independent of underlying suicidal behavior? *American Journal of Epidemiology, 178*(6), 946–955. https://doi.org/10.1093/aje/kwt197

Miranda-Mendizabal, A., Castellví, P., Parés-Badell, O., Alayo, I., Almenara, J., Alonso, I., Blasco, M. J., Cebrià, A., Gabilondo, A., Gili, M., Lagares, C., Piqueras, J. A., Rodríguez-Jiménez, T., Rodríguez-Marín, J., Roca, M., Soto-Sanz, V., Vilagut, G., & Alonso, J. (2019). Gender differences in suicidal behavior in adolescents and young adults: Systematic review and meta-analysis of longitudinal studies. *International Journal of Public Health*, *64*(2), 265–283. https://doi.org/10.1007/s00038-018-1196-1

Moagi, M. M., van Der Wath, A. E., Jiyane, P. M., & Rikhotso, R. S. (2021). Mental health challenges of lesbian, gay, bisexual and transgender people: An integrated literature review. *Health SA Gesondheid*, *26*(1). https://doi.org/10.4102/hsag.v26i0.1487

Monuteaux, M. C., Azrael, D., & Miller, M. (2019). Association of increased safe household firearm storage with firearm suicide and unintentional death among US youths. *Journal of the American Medical Association Pediatrics, 173*(7), 657–662. https://doi.org/10.1001/jamapediatrics.2019.1078

Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science, 4(5)*, 463–467. https://doi.org/10.1017/cts.2020.42

Morgan, E. R., Rowhani-Rahbar, A., Azrael, D., & Miller, M. (2018). Public perceptions of firearm-and non–firearm-related violent death in the United States: A national study. *Annals of Internal Medicine*, *169*(10), 734-737. https://doi.org/10.7326/M18-1533

Mpofu, J. J., Cooper, A. C., Ashley, C., Geda, S., Harding, R. L., Johns, M. M., Spinks-Franklin, A., Njai, R., Moyse, D., & Underwood, J. M. (2022). Perceived racism and demographic, mental health, and behavioral characteristics among high school students during the COVID-19 pandemic — adolescent behaviors and experiences survey, United States, January–June 2021. *MMWR Supplements, 71*(3), 22–27. https://doi.org/10.15585/mmwr.su7103a4

Murphy S. M. (2014). Determinants of adolescent suicidal ideation: rural versus urban. The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association, 30(2), 175–185. https://doi.org/10.1111/jrh.12042

Nass, D. & Barton, C. (2020, August 3). *How many guns did Americans buy last month?*. The Trace. https://www.thetrace.org/2020/08/gun-sales-estimates/

National Alliance on Mental Health. (n.d.). *Crisis intervention team (CIT) programs.* https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs

National Alliance on Mental Health. (n.d.). *Asian American and Pacific Islander.* https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Asian-American-and-Pacific-Islander

National Endowment for the Humanities. (n.d.). *African American History and culture in the United States*. https://edsitement.neh.gov/teachers-guides/african-american-history-and-culture-united-states

National Governors Association. (2023). *Strengthening youth mental health: A governor's playbook.* https://www.nga.org/youthmentalhealth/

National Institute of Mental Health. (2023, July 19). *Youth emergency department visits for mental health increased during pandemic.* https://www.nimh.nih.gov/news/science-news/2023/youth-emergency-department-visits-for-mental-health-increased-during-pandemic#:~:text=Relative%20to%20baseline%2C%20mental%20health,(aged%2013%20to%2017).

National Institutes of Health. (2020, November 10). *Rural youth often lack access to suicide prevention services.* U.S. Department of Health and Human Services. https://www.nih.gov/news-events/nih-research-matters/rural-youth-often-lack-access-suicide-prevention-services

Native American Rights Fund (2019). (rep.). Trigger Points: Current State of Research on History, Impacts, and Healing Related to the United States' Indian Industrial/Boarding School Policy. Boulder, CO. https://narf.org/nill/documents/trigger-points.pdf

Native Hope. (2018, May 25). Understanding Historical Trauma and Native Americans. https://blog.nativehope.org/understanding-historical-trauma-and-native-americans

Ng, Q. X., Yong, B. Z. J., Ho, C. Y. X., Lim, D. Y., & Yeo, W. S. (2018). Early life sexual abuse is associated with increased suicide attempts: An update meta-analysis. *Journal of Psychiatric Research*, *99*, 129-141. https://doi.org/10.1016/j.jpsychires.2018.02.001

Nguyen, L. H., Anyane-Yeboa, A., Klaser, K., Merino, J., Drew, D. A., Ma, W., Mehta, R. S., Kim, D. Y., Warner, E. T., Joshi, A. D., Graham, M. S., Sudre, C. H., Thompson, E. J., May, A., Hu, C., Jørgensen, S., Selvachandran, S., Berry, S. E., David, S. P., Martinez, M. E., … Chan, A. T. (2022). The mental health burden of racial and ethnic minorities during the COVID-19 pandemic. *PloS one, 17*(8). https://doi.org/10.1371/journal.pone.0271661

Nguyen, A., & Drane, K. (2022, October 7). *Gun violence in American Indian and Alaska native communities*. Giffords Law Center To Prevent Gun Violence. https://giffords.org/memo/gun-violence-in-american-indian-and-alaska-native-communities/

Nishi, K. (2012). *Student's Corner: Mental Health Among Asian-Americans.* American Psychological Association. https://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/article-mental-health

North, S. (2021). These Four Telehealth Changes Should Stay, Even After the Pandemic. *Family Practice Management, 28*(3), 9-11. https://www.aafp.org/fpm/2021/0500/p9.html

Northwest Portland Area Indian Health Board. (n.d.). *Social Marketing Campaigns*. https://www.npaihb.org/social-marketing-campaigns/

Northwest Portland Area Indian Health Board. (n.d.). *THRIVE*. https://linktr.ee/npaihbthrive

Office of the U.S. Surgeon General. (2012, September). National Action Alliance for Suicide Prevention (US). 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington, DC: US Department of Health & Human Services (US). https://www.ncbi.nlm.nih.gov/books/NBK109917

Office of the U.S. Surgeon General. (2023). *Our epidemic of loneliness and isolation.* U.S. Department of Health and Human Services. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

Office of the U. S. Surgeon General. (2023). *Social media and youth mental health.* https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/social-media/index.html

O'Keefe, V. M., Cwik, M. F., Haroz, E. E., & Barlow, A. (2021). Increasing culturally responsive care and mental health equity with indigenous community mental health workers. *Psychological Services*, *18*(1), 84. https://doi.org/10.1037/ser0000358

Okoya, W. (2022, March 30). *Opinion: The fight for black lives needs to happen in schools.* The Hechinger Report. https://hechingerreport.org/opinion-the-fight-for-black-lives-needs-to-happen-in-schools/

Olson, K., Durwood, L., DeMeules, M., & McLaughlin, K. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics, 137*(3). https://doi.org/10.1542/peds.2015-3223

Orca Books. (n.d.). *Speaking Our Truth.* https://www.orcabook.com/Speaking-Our-Truth

Paths (Re)membered Project. (n.d.). https://www.pathsremembered.org/mental-health-services/

Pesky gNATs, (n.d.). *Transforming adolescent mental health interventions through technology.* https://peskygnats.com/

Phillips, J., Davidson, T., & Baffoe-Bonnie, M. (2023). Identifying latent themes in suicide among black and white adolescents and young adults using the national violent death reporting system, 2013–2019. *Social Science & Medicine, 331*(1), 116144. https://doi.org/10.1016/j.socscimed.2023.116144

Pointer, L. (2021, August 5). What is "Restorative Justice" and How Does it Impact Individuals Involved in Crime? *BJANNTAC National Training and Technical Assistance Center*. https://bjatta.bja.ojp.gov/media/blog/what-restorative-justice-and-how-does-it-impact-individuals-involved-crime

Poverty USA (n.d.). *Poverty facts: The population of Poverty USA*. https://www.povertyusa.org/facts

Price-Feeney, M., Green, A. E., & Dorison, S. (2020). Understanding the mental health of transgender and nonbinary youth. *Journal of Adolescent Health, 66*(6), 684–690. https://doi.org/10.1016/j.jadohealth.2019.11.314

Puthenpura, V., & Marks, A. M. (2021). Clinical application of digital technologies in adolescent and Young Adult Oncology Supportive Care. *Journal of Adolescent and Young Adult Oncology, 10*(2), 127–130. https://doi.org/10.1089/jayao.2020.0153

Racine, N., McArthur, B. A., Cooke, J. E., Eirich, R., Zhu, J., & Madigan, S. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: A meta-analysis. *JAMA Pediatrics*, *175*(11), 1142–1150. https://doi.org/10.1001/jamapediatrics.2021.2482

Raifman, J., Moscoe, E., Austin, S. B., & McConnell, M. (2017). Difference-in-differences analysis of the association between state same-sex marriage policies and adolescent suicide attempts. *JAMA Pediatrics, 171*(4), 350–356. https://doi.org/10.1001/jamapediatrics.2016.4529

Rape, Abuse & Incest National Network. (n.d.). *Children and teens: Statistics.* https://www.rainn.org/statistics/children-and-teens

Reinert, M, Fritze, D. & Nguyen, T. (2021). (rep.). *The State of Mental Health in America 2022*. Alexandria, VA: Mental Health America. https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf

Reyes, M. V. (2020). The disproportional impact of COVID-19 on African Americans. *Health and Human Rights*, *22*(2), 299. https://pubmed.ncbi.nlm.nih.gov/33390715/

Richardson, T., Elliott, P., & Roberts, R. (2013). The relationship between personal unsecured debt and mental and physical health: a systematic review and meta-analysis. *Clinical Psychology Review*, *33*(8), 1148–1162. https://doi.org/10.1016/j.cpr.2013.08.009

Rideout, V., Fox, S., & Well Being Trust. (2018). *Digital Health Practices, social media use, and mental well-being among teens and young adults in the U.S.* Providence St. Joseph Health Digital Commons. https://digitalcommons.providence.org/publications/1093

Ridley, M., Rao, G., Schilbach, F., & Patel, V. (2020). Poverty, depression, and anxiety: Causal evidence and mechanisms. *Science*, *370*(6522). https://doi.org/10.1126/science.aay0214

Rothwell, J., Perry, A. M., & Andrews, M. (2020, November 23). *The Black innovators who elevated the United States: Reassessing the golden age of invention.* Brookings Institution. https://www.brookings.edu/articles/the-black-innovators-who-elevated-the-united-states-reassessing-the-golden-age-of-invention/

Roy, N. (2023). (rep.). *Critical Considerations Before Contracting with a Teletherapy Vendor*. Washington, DC: American Council on Education. https://www.acenet.edu/Documents/Critical-Considerations-Teletherapy-Vendor.pdf

Ruch, D. A., Sheftall, A. H., Schlagbaum, P., Fontanella, C. A., Campo, J. V., & Bridge, J. A.(2019). Characteristics and precipitating circumstances of suicide among incarcerated youth. *Journal of the American Academy of Child and Adolescent Psychiatry, 58(5),* 514-524. https://doi.org/10.1016/j.jaac.2018.07.911

Ruch, D. A., Sheftall, A. H., Schlagbaum, P., Rausch, J., Campo, J. V., & Bridge, J. A. (2019). Trends in suicide among youth aged 10 to 19 years in the United States, 1975 to 2016. JAMA Network Open, 2(5). https://doi.org/10.1001/jamanetworkopen.2019.3886

Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S., Mintz, J., Williams, S. R., Arne, K. A., Breitbach, J., Delano, K., Wilkinson, E., & Bruce, T. O. (2015). Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. *American Journal of Psychiatry*, *172*(5), 441-449. https://doi.org/10.1176/appi.ajp.2014.14070843

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123(1),* 346–352. https://doi.org/10.1542/peds.2007-3524

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing : Official Publication of the Association of Child and Adolescent Psychiatric Nurses, Inc*, *23*(4), 205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.x

Safer Homes Suicide Aware. (n.d.). *What is a safer home?.* https://saferhomescoalition.org/what-is-a-safer-home/

Salsberg, E., Quigley, L., Mehfoud, N., Acquaviva, K. D., Wyche, K., & Silwa, S. (2017). (rep.). *Profile of the Social Work Workforce.* Washington, DC: The George Washington University Health Workforce Institute. https://hsrc.himmelfarb.gwu.edu/sphhs_policy_workforce_facpubs/16

Seize The Awkward. (n.d.). *Be the friend who listens.* https://seizetheawkward.org/

Sheftall, A., Vakil, F., Ruch, D., Boyd, R., Lindsey, & M., Bridge, J. (2021). Black youth suicide: Investigation of current trends and precipitating circumstances. *Journal of the American Academy of Child and Adolescent Psychiatry, 61*(5), 662-675. https://doi.org/10.1016/j.jaac.2021.08.021

Silva, C., & Van Orden, K. A. (2018). Suicide among Hispanics in the United States. *Current Opinion in Psychology, 22*, 44–49. https://doi.org/10.1016/j.copsyc.2017.07.013

Silver, L., Van Kessel, P., Huang, C., Clancy, L., & Gubbala, S. (2021). What makes life meaningful? Views from 17 advanced economies. *Pew Research Center*, *221*. https://www.pewresearch.org/global/wp-content/uploads/sites/2/2021/11/PG_11.18.21_meaning-in-life_fullreport.pdf

Smithsonian. (n.d.). *About native knowledge 360°*. National Museum of the American Indian | Smithsonian. https://americanindian.si.edu/nk360/about/native-knowledge-360

Specter, M. (2021, June 7). *How Act Up changed America.* The New Yorker. https://www.newyorker.com/magazine/2021/06/14/how-act-up-changed-america

Stack S. (2021). Contributing factors to suicide: Political, social, cultural and economic. *Preventive Medicine*, *152*(Pt 1). https://doi.org/10.1016/j.ypmed.2021.106498

Stanley, B., & Brown, G. K. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256–264. https://doi.org/10.1016/j.cbpra.2011.01.001

Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., Chaudhury, S. R., Bush, A. L., & Green, K. L. (2018). Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry, 75*(9), 894. https://doi.org/10.1001/jamapsychiatry.2018.1776

Stanley, B., Brown, G., Brent, D. A., Wells, K., Poling, K., Curry, J., Kennard, B. D., Wagner, A., Cwik, M. F., Klomek, A. B., Goldstein, T., Vitiello, B., Barnett, S., Daniel, S., & Hughes, J. (2009). Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *Journal of the American Academy of Child & Adolescent Psychiatry*, *48*(10), 1005-1013. https://doi.org/10.1097/CHI.0b013e3181b5dbfe

Stebbins, S. (2013). 1.1: In 1491 how many people were living in the Americas, how did they get here, how long had they been here, and what had they accomplished? In *Native peoples of North America*. Open SUNY Textbooks.

Stronghearts Native Helpline. (n.d.). https://strongheartshelpline.org/

Studdert, D. M., Zhang, Y., Swanson, S. A., Prince, L., Rodden, J. A., Holsinger, E. E., Spittal, M. J., Wintemute, G. J., & Miller, M. (2020). Handgun Ownership and Suicide in California. *The New England Journal of Medicine*, *382*(23), 2220–2229. https://doi.org/10.1056/NEJMsa1916744

Substance Abuse and Mental Health Services Administration (SAMHSA). (2009). *CultureCard: A guide to build social awareness, American Indian and Alaska Native.* https://store.samhsa.gov/sites/default/files/sma08-4354.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Highlights by race and ethnicity for the 2021 National Survey on Drug Use and Health.* https://www.samhsa.gov/data/sites/default/files/2022-12/2021NSDUHFFRHighlightsRE123022.pdf

Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Treatment for Suicidal Ideation, Self-harm, and Suicide Attempts Among Youth.* SAMHSA Publication No. PEP20-06-01-002 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. https://store.samhsa.gov/sites/default/files/pep20-06-01-002.pdf

Suicide Deterrent Net. Golden Gate Bridge, Highway & Transportation District. (n.d.). https://www.goldengate.org/district/district-projects/suicide-deterrent-net/

Suominen, K., Isometsä, E., Suokas, J., Haukka, J., Achte, K., & Lönnqvist, J. (2004). Completed suicide after a suicide attempt: a 37-year follow-up study. *American Journal of Psychiatry*, *161*(3), 562-563. https://doi.org/10.1176/appi.ajp.161.3.562

Swanson, S., Eyllon, M., Sheu, Y., & Miller, M. (2020). Firearm access and adolescent suicide risk: Toward a clearer understanding of effect size. *Injury Prevention, 27,* 264-270. https://injuryprevention.bmj.com/content/27/3/264

Swift, J. K., Trusty, W. T., & Penix, E. A. (2021). The effectiveness of the collaborative assessment and management of Suicidality (CAMS) compared to alternative treatment conditions: A meta-analysis. *Suicide and Life-Threatening Behavior, 51*(5), 882–896. https://doi.org/10.1111/sltb.12765

Tan, M., & Mao, P. (2023). Type and dose-response effect of adverse childhood experiences in predicting depression: A systematic review and meta-analysis. *Child Abuse & Neglect*, *139*. https://doi.org/10.1016/j.chiabu.2023.106091

The Asian American Foundation (TAAF). (2023, May 2). *STAATUS Index 23 Press Release*. https://www.taaf.org/news/staatus-index-23-press-release

The Associated Press. (2023, February 1). *Revised AP African American studies class drops controversial topics after criticism.* NPR. https://www.npr.org/2023/02/01/1153364556/ap-african-american-studies-black-history-florida-desantis

The Congressional Black Caucus. (n.d.). (rep.). Ringing the alarm: The Crisis of Black Youth Suicide in America. A report to congress from the Congressional Black Caucus Emergency Task Force on Black youth suicide and mental health. https://theactionalliance.org/sites/default/files/ring_the_alarm-_the_crisis_of_black_youth_suicide_in_america_copy.pdf

The Firearm Industry Trade Association and the American Foundation for Suicide Prevention. (n.d.). *NSSF/AFSP partnership*. NSSF. https://www.nssf.org/safety/suicide-prevention/nssf-afsp-partnership/

The Glimpse Group. (n.d.). *Using VR to facilitate support groups for transgender youths.* https://www.theglimpsegroup.com/case-studies/using-vr-to-facilitate-support-groups-for-transgender-youths

The Hope Center for College, Community, and Justice. (n.d.). *The hope center student basic needs survey.* Temple University. https://hope.temple.edu/research/hope-center-basic-needs-survey

The Jed Foundation. (2023, July 19). *Can the metaverse be good for youth mental health?*. https://jedfoundation.org/wp-content/uploads/2023/07/Can-The-Metaverse-Be-Good-For-Youth-Mental-Health-Jed-Foundation.pdf

The Jed Foundation. (2023). *District Comprehensive Approach*. https://jedfoundation.org/district-comprehensive-approach/#:~:text=Based%20on%20JED%27s%20proven%20approach,suicide%20for%20millions%20of%20students

The Jed Foundation. (2022, August 1). *JED urges research into telehealth effectiveness for youth mental health.* https://jedfoundation.org/jed-urges-research-into-telehealth-effectiveness-for-youth-mental-health/

The Jed Foundation. (2019). *JED's Comprehensive Approach to Mental Health Promotion and Suicide Prevention for Colleges and Universities.* https://www.jedfoundation.org/wp-content/uploads/2021/07/JED-Comprehensive-Approach_FINAL_July19.pdf

The Jed Foundation. (2021). *JED's Comprehensive Approach to Mental Health Promotion and Suicide Prevention for High Schools.* https://jedfoundation.org/wp-content/uploads/2021/07/The-Comprehensive-Approach-to-Mental-Health-Promotion-and-Suicide-Prevention-for-High-Schools_JED.pdf

The Jed Foundation. (2023, May 23). *JED's Response to the Surgeon General's Advisory on Social Media and Youth Mental Health.* https://jedfoundation.org/jeds-response-to-the-surgeon-generals-advisory-on-social-media-and-youth-mental-health/

The Jed Foundation, Jordan Porco Foundation, Partnership for Drug-Free Kids, conducted by Harris Poll. (2015) *The first-year college experience: A look into students' challenges and triumphs during their first term at college.* https://www.jedfoundation.org/wp-content/uploads/2021/06/First-Year-College-Experience-Data-Report-for-Media-Release.pdf

The National Native American Boarding School Healing Coalition. (n.d.). https://boardingschoolhealing.org/

The Racial Empowerment Collaborative at Penn GSE. (n.d.). *Preventing Long-term Anger and Aggression in Youth (PLAAY)*. Racial Empowerment Collaborative (REC) - PLAAY. https://www.recastingrace.com/research/plaay

The Sentencing Project (2021). *Black disparities in youth incarceration: Racial disparities persist but fall from all-time high.* https://www.sentencingproject.org/app/uploads/2022/08/Black-Disparities-in-Youth-Incarceration.pdf

The Trevor Project. (2023). *2023 national survey on LGBTQ youth mental health.* https://www.thetrevorproject.org/survey-2023/

The Trevor Project. (2022). *2022 national survey on LGBTQ youth mental health.* https://www.thetrevorproject.org/survey-2022/

TRIPP Research. (n.d.). https://www.tripp.com/research/

Tsong, Y., Young, J. T., Killer, J. D., Takemoto, M. A., Compliment, B. (2018). Suicide prevention program on a diverse college campus: Examining the effectiveness of a peer-to-peer model. *Journal of College Student Psychotherapy, 33(2)*, 131–144. https://doi.org/10.1080/87568225.2018.1434716

Tynes, B., Willis, H., Stewart, A., & Hamilton, M. (2019). Race-related traumatic events online and mental health among adolescents of color. *Journal of Adolescent Health*, *65*(3), 371–377. https://doi.org/10.1016/j.jadohealth.2019.03.006

Underwood, L. A., & Washington, A. (2016). Mental illness and juvenile offenders. *International Journal of Environmental Research and Public Health, 13*(2), 228. https://doi.org/10.3390/ijerph13020228

UNICEF. (n.d.). *Girls' Education*. https://www.unicef.org/education/girls-education

United States Census Bureau. (2022). *The number of people primarily working from home tripled between 2019 and 2021.* https://www.census.gov/newsroom/press-releases/2022/people-working-from-home.html

U.S. Department of Health and Human Services. (2023, May 3). New surgeon general advisory raises alarm about the devastating impact of the epidemic of loneliness and isolation in the United States. https://www.hhs.gov/about/news/2023/05/03/new-surgeon-general-advisory-raises-alarm-about-devastating-impact-epidemic-loneliness-isolation-united-states.html

U.S. Department of the Interior. (n.d.). *Editorial Guide | Indian Affairs.* https://www.bia.gov/guide/editorial-guide#:~:text=Most%20tribal%20nations%20prefer%20to,use%20%22AI%2FAN.%22

USAFacts. (n.d.). *Most firearm deaths are suicides*. https://usafacts.org/data-projects/firearms-suicides

Utah State Legislature. (2023). *H.B. 481 firearm safety and suicide prevention education requirements.* https://le.utah.gov/~2023/bills/static/HB0481.html

Van Berkel, A. S. (2023). Change is the Only Constant: How Dialectical Behavior Therapy (DBT) Can Be Made More Culturally Responsive Across Treatment Settings. *Psychology Doctoral Specialization Projects*. 21. https://encompass.eku.edu/psych_doctorals/21

Vogels, E. A., Gelles-Watnick, R., & Massarat, N. (2022). (rep.). *Teens, Social Media and Technology 2022*. Washington, DC: Pew Research Center. https://www.pewresearch.org/internet/2022/08/10/teens-social-media-and-technology-2022

Walton, J., & Truong, M. (2022). A review of the model minority myth: Understanding the social, educational and health impacts. *Ethnic and Racial Studies, 46*(3), 391–419. https://doi.org/10.1080/01419870.2022.2121170

Wasserman, D., Hoven, C. W., Wasserman, C., Wall, M., Eisenberg, R., Hadlaczky, G., ... & Carli, V. (2015). School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial. *The Lancet*, *385* (9977), 1536-1544. https://www.doi.org/10.1016/S0140-6736(14)61213-7

We R Native. (n.d.) https://www.wernative.org/

Weissbourd, R., Batanova, M., Laski, M., McIntyre, J., Torres, E., Balisciano, N., Irving, S., Eskander, S., & Bhai, K. (2023). (rep.). *Caring for the Caregivers: The Critical Link Between Parent and Teen Mental Health*. Cambridge, MA: Harvard University Graduate School of Education's Making Caring Common Project. https://mcc.gse.harvard.edu/reports/caring-for-the-caregivers

Weissbourd, R., Batanova, M., Lovison, V., & Torres, E. (2021). (rep.). *Loneliness in America: How the Pandemic Has Deepened an Epidemic of Loneliness and What We Can Do About It* . Cambridge, MA: Harvard University Graduate School of Education's Making Caring Common Project. https://mcc.gse.harvard.edu/reports/loneliness-in-america

West, S., Baker, A. C., Sukhi Samra, & Coltrera, E. (2021). (rep.). *Preliminary Analysis: SEED's First Year*. SEED Stockton Economic Empowerment Demonstration. https://static1.squarespace.com/static/6039d612b17d055cac14070f/t/6050294a1212aa40fdaf773a/1615866187890/SEED_Preliminary+Analysis-SEEDs+First+Year_Final+Report_Individual+Pages+.pdf

White J., Sepúlveda M.J., Patterson C.J., editors. (2020). Understanding the well-being of LGBTQI+ populations. *National Academies of Sciences, Engineering, and Medicine*. https://doi.org/10.17226/25877

Williams Crenshaw, K., Ocen, P., & Nanda, J. (2015). (rep.). *Black Girls Matter: Pushed Out, Overpoliced and Underprotected.* New York, NY: Center for Intersectionality and Social Policy Studies. https://scholarship.law.columbia.edu/faculty_scholarship/3227/

Winton, J. (2022, November 17). *Confronting mental health challenges in rural America.* National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/November-2022/Confronting-Mental-Health-Challenges-in-Rural-America

Women's Sports Foundation. (2016, August 30). *Benefits - why sports participation for girls and women.* https://www.womenssportsfoundation.org/advocacy/benefits-sports-participation-girls-women

Wyse, R., Hwang, W.-T., Ahmed, A. A., Richards, E., & Deville, C. (2020). Diversity by race, ethnicity, and sex within the US Psychiatry Physician Workforce. *Academic Psychiatry*, *44(5),* 523–530. https://doi.org/10.1007/s40596-020-01276-z

Yale Medicine. (2023, May 31). *Virtual reality cancer supports groups for teens: What parents should know.* https://www.yalemedicine.org/news/virtual-reality-cancer-support-groups-for-teens

Ybarra, M. L., Mitchell, K. J., Palmer, N. A., & Reisner, S. L. (2015). Online social support as a buffer against online and offline peer and sexual victimization among US LGBT and non-LGBT youth. *Child Abuse & Neglect*, *39*, 123-136. https://doi.org/10.1016/j.chiabu.2014.08.006

Zero Suicide. (n.d.). *Zero suicide toolkit.* https://zerosuicide.edc.org/toolkit/zero-suicide-toolkitsm