Suicide was recognized as a major public health challenge long before COVID-19 refocused attention on the particular challenges in accessing mental health care in the United States. The bipartisan passage of the National Suicide Hotline Designation Act by the US Congress in 2020, which created a national 3-digit number (988) for people in crisis, represented an important step toward acknowledging the scale of this problem, building on the success of the National Suicide Prevention Lifeline launched in 2005. As of July 2022, Federal law mandates the availability of this national suicide hotline accessible by dialing 988 nationwide, an effort to ensure a single point of entry for people in crisis and to begin to bend the curve on suicide.

The willingness to confront suicidality head-on is a welcome departure from the recent past, when depression screening efforts in primary care settings sometimes avoided even asking about suicide, lest they incur medicolegal liability in settings when there were no resources to address a positive response. By comparison, it is hard to imagine screening for heart disease risk without asking about smoking.

In this issue, Newton and colleagues explore one of the next challenges in addressing suicide in the United States: the availability of mobile crisis intervention teams, able to assess and intervene when callers to the 988 hotline are at high risk for suicide and an in-person evaluation is required. The investigators drew on responses to an annual survey from the Substance Abuse and Mental Health Services Administration (SAMHSA) of health care facilities, both public and private, as reflected in a published national directory. Each facility was asked whether they included a crisis intervention team as one of their services. These data are, as the study acknowledges, not entirely complete. Not all facilities are included—most notably those operated by independent clinicians, the Department of Defense, and police forces—and not all respondents elect to be included in the directory. Still, they provide a snapshot of a key step in establishing a safety net for identifying and managing suicidal thoughts.

As of 2020, the investigators found that approximately 88% of the US population lives in counties with at least one crisis intervention team. On the other hand, half of US counties had no such facility. And, the number of counties was essentially unchanged between 2015 and 2020, even though there was a substantial shift in counties offering such services.

Newton and colleagues go on to examine the features of counties without crisis intervention teams. They find that such counties tend to be those with larger uninsured populations, and that they are more likely to be in rural areas. These counties were also more likely to be represented among those in the highest quartile of suicide mortality. In other words, some of the counties where need may be greatest are least likely to have a facility with a crisis intervention team.

So what happens when someone accesses the hotline and no crisis team is available? The safety net may be local police officers, whose level of training to respond to such crises can vary widely. While far better than nothing, this represents a missed opportunity for specialized clinical assessment and intervention.

Faced with a public health challenge like suicide, there is a temptation to engage in magical thinking about new interventions, biomarkers, or machine learning prediction strategies that will solve our health system’s structural problems. Such efforts are necessary and important, but represent an investment in the future—and even under the most optimistic scenarios, breakthroughs are unlikely to obviate the pressing need to improve access to care. For now, a key part of the solution is low-tech: resources. SAMHSA was directed by the US Congress to set aside block grants beginning...
in 2021 to states to support evidence-based crisis care—including, most notably, mobile crisis units. If these investments catalyze further ones, there is reason to be hopeful that availability of crisis teams and downstream resources will increase.

The work by Newton and colleagues more broadly provides a reminder that identifying someone at high risk is only the first step in a complex chain of processes that need to go smoothly to address that risk. Crisis evaluation teams are one of the possible next steps, able to evaluate who needs urgent care, or to facilitate a referral for further evaluation and treatment. Ideally, many people would be able to access care long before they reach the point of calling a crisis hotline—but here too, despite parity laws that ostensibly mandate equal coverage of psychiatric care by insurers, adequate mental health care remains out of reach for many people. Truly bending the suicide curve will require sustained attention and investment, attending not just to the front door to care, but to everything that comes after.

ARTICLE INFORMATION

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