'It's everybody's problem': Goal to end youth suicide unites experts, organizations
by Alyson Sulaski Wyckoff, Associate Editor

More than 130 Americans will take their lives today. High school students will make over 3,700 attempts to kill themselves.

Suicide is the second leading cause of death for individuals ages 10-34 years - representing 425 deaths a year. Yet most health care settings are not screening for this risk. Improved training is needed on early identification of suicide risk, assessment, follow-up and counseling.
Those were among recommendations at the recent Virtual Summit on Youth Suicide Prevention co-hosted by the AAP, American Foundation for Suicide Prevention (AFSP) and National Institute of Mental Health (NIMH). Participants included experts in psychiatry, education, pediatrics, family medicine, research and epidemiology. They discussed ways to identify and address suicide risk, the evidence base for suicide prevention, access to lethal means, impact of media and the value of partnerships.

A suicide prevention blueprint will be released later this year.

AAP President Lee Savio Beers, M.D., FAAP, said an AAP survey pre-pandemic found 44% of pediatricians had a patient attempt or die by suicide in the previous year. Eighty percent indicated they had lost a patient to suicide at some point in their career.

"The increasing rate of suicide among children and adolescents is an incredibly serious and growing health concern," Dr. Beers said.

Conference take-aways

The speakers highlighted the following:

- Prevention efforts fail to reach some at-risk populations, including those who are Black, Indigenous and people of color. Strategies should involve individuals who reflect those communities.
- Even children under 10 may need screening.
- There is no one-size-fits-all protocol.
- Consider diverse, nontraditional partnerships.
- Reduce youth access to lethal means like firearms.
- Increased funding is needed for research and inpatient care.
- Experts must work with the media to help portray resilient behavior and correct misinformation.
- Suicide research should report racial demographics.

'Lived experiences'

Two speakers shared personal connections.

Christopher T. Veal, a fourth-year medical student at University of Vermont (UVM), coped with various issues during his first two years. The only Black man in his class, Veal felt isolated as he dealt with a friend's suicide plus his own family’s rejection when Veal announced he is gay. Following academic setbacks, a dean inquired if he really wanted to become a doctor.

"I went into a stairwell, dropped to my knees and cried," he said. "I had never been that depressed in my entire life."

Considering suicide, he called his late friend's parents, both physicians. They agreed to let him stay with them while taking a leave. During that time, he studied and received therapy. Veal now is thriving and advocates for the mental health of medical students through the UVM Larner Stories Project.

Anne Moss Rogers conveyed the anguish of her 20-year-old son's suicide after a drug relapse. She knew Charles had depression and anxiety, but he was getting treatment. Still, Charles had poor experiences with the health system and never was screened for suicidal ideation.
A digital marketer, Rogers now writes books and blogs and uses her marketing know-how to reach young people in crisis - and to honor her son's legacy.

"I merged my passion to prevent suicide with my marketing expertise," she said.

**Who is at risk and why?**

American Indian/Alaska Natives and those who are LGBTQ have the highest youth suicide rates. In addition, Blacks under age 12 years are at risk for under-identification and misdiagnosis.

Contributing factors include victimization and discrimination. Neighborhood violence and historical trauma are associated with depression and post-traumatic stress.

For youth who are marginalized, "... the experience of seeing someone who looks like yourself repeatedly shown on television being victimized is a significant psychological stresstor," said Tami Benton, M.D., psychiatrist-in-chief and chair of the child and adolescent psychiatry department at Children's Hospital of Philadelphia.

Data are lacking on the effectiveness of current screening assessments and interventions for Black youths, she said. Collaborations with Black, Indigenous and people of color and gender-nonconforming communities are needed, including a diverse research and clinical workforce.

Other youth stressors linked to suicide are fights with parents, relationship break-ups and celebrity suicides. However, suicide is complex and there are many drivers.

**Power of primary care**

"We have to mount preventive efforts because we'll never be accurate enough to be able to identify all the kids who were at risk," said David Brent, M.D., professor of psychiatry, pediatrics, epidemiology and the endowed chair in suicide studies at University of Pittsburgh School of Medicine. "An alliance with pediatricians is important because they are trusted figures who really know their patients and often have long-term relationships with them."

Most youths who die by suicide visited a health care provider months, sometimes weeks, before they died, said Lisa Horowitz, Ph.D., M.P.H., staff scientist and clinical psychologist at NIMH. This creates an "amazing opportunity to identify them and get help," she said, "except they don't come in and say, 'I want to die.'"

It's important to start with a strengths-based, culturally sensitive approach. Several speakers noted that not all teens need to be sent directly to the emergency department (ED), which can be an intense experience as they give up their phone and sit in a hospital gown while waiting for care.

**Overcoming obstacles**

Even when distress is high, suicide prevention strategies can be effective - but it is a matter of implementing them and scaling them up, said Christine Moutier, M.D., AFSP chief medical officer.

Many people avoid talking about suicide due to stigma, but "it's everybody's problem," said Teri Brister, Ph.D., director of research and quality assurance at the National Alliance for Mental Illness.

The task is "how to encourage people to engage and speak about the suicidal impulse while at the same time communicating that suicide is not a logical or appropriate or rational response," said John Campo, M.D.,

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professor and director of child and adolescent psychiatry at Johns Hopkins School of Medicine.

Talking about suicide does not cause suicide, experts pointed out.

Schools can play a protective role, unless they emphasize punitive measures. Other barriers are parental notification laws, fragmented recordkeeping, poor follow-up and denial.

Widespread screening is important for children and teens admitted to EDs for any reason, experts said.

Tools that are suicide-specific include the Ask Suicide-Screening Questions, Columbia-Suicide Severity Rating Scale and the Computerized Adaptive Screen for Suicidal Youth.

If you or someone you know is considering suicide, contact the National Suicide Prevention Lifeline at 1-800-273-8255 (Español: 1-888-628-9454; deaf and hard of hearing: 1-800-799-4889) or the Crisis Text Line by texting HOME to 741741.

**Resources**

- AAP suicide prevention resources
- American Foundation for Suicide Prevention
- National Institute of Mental Health publications on suicide prevention