Children's Hospital of Philadelphia
PolicyLab

Expert Q&A: Expanding Research and Building Evidence to Address Youth Suicide

Behavioral Health

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World Mental Health Day is recognized each year in October and this year, the focus is on suicide prevention. To take a closer look at this topic, we sat down for a conversation with Dr. Rhonda Boyd, a researcher at PolicyLab and the associate director of Children's Hospital of Philadelphia's (CHOP) Child and Adolescent Mood Program in the outpatient clinic of the Department of Child and Adolescent Psychiatry and Behavioral Sciences, where she practices as a licensed psychologist specializing in evaluating and treating youth with depression. We talked about the latest trends in youth suicide, research being conducted to help children and teens at risk and where there is still more work to be done.

What got you interested in research in the youth suicide space?

Dr. Boyd: Several years ago, I co-developed the Child and Adolescent Mood Program with the chair of CHOP's Department of Child and Adolescent Psychiatry and Behavioral Sciences, Dr. Tami Benton. As part of this program, we focus on helping youth with mood disorders such as depression, as well as common conditions that may occur simultaneously, such as anxiety.

While doing that work and through my general clinical practice doing therapy with youth with depression, I noticed I had been encountering a lot more suicidal risk, suicidal ideation and behaviors—I could not ignore this epidemic that was happening. As a result, my colleagues and I decided that we would expand our research in the Child and Adolescent Mood Program beyond depression to include youth suicide. Our research focuses on risk factors for and protective factors against suicide, and we're hoping to expand it further to look into prevention and models of treatment.

The focus of this year's World Mental Health Day is suicide prevention. What do we need to know about recent trends in youth suicide?

Dr. Boyd: One of the more striking trends is that suicide rates over the last decade have been increasing across most demographics—different ages, gender, race and ethnicity. Suicide is the second leading cause of death among youth age 10-24 in the United States. It's a problem here in the U.S. and in other countries as well.

Do we know anything about why there is an increasing trend in youth suicide?

Dr. Boyd: There are multiple potential factors, but the short answer is that we're not sure. We know that rates of depression have been increasing over time. Although there isn't a clear 1:1 relationship between depression and suicide, depression is a significant risk factor for suicidal thoughts and attempts. Our society is now more open to talk about suicide, so are people just reporting it more? Is social media causing this? We don't know. Kids and teens are under a lot of stress from multiple sources—school, the need to be successful, media and technology, busy schedules and many others—and that can be overwhelming. At the same time, when we think about what teenagers are experiencing developmentally, they may not think about tomorrow or beyond the short-term impact of their decisions.

What is unique about suicide prevention among youth and adolescents?

Dr. Boyd: Often we're relying on parents to help identify that there's a problem and to be engaged and involved with treatment. What can make this challenging is that parents often aren't aware that their child is thinking about suicide. In a recent study my colleagues and I published, we found that about 50% of parents weren't aware their children were having thoughts of suicide. This makes it particularly challenging to identify youth who are at risk.

Another area that stands out is that we still need to develop suicide interventions specifically for youth. We can't assume what works for adults will also work for teens and adolescents because their emotional, physical and social development varies across their lifespan. It can't be a one-size-fits-all model. The evidence is still being built and we want to know how we can take what we learn clinically to determine best practices to address youth suicide risk. For example, my colleagues as part of CHOP's Zero Suicide initiative recently developed a clinical pathway for assessing for and intervening with suicidal risk for youth that can be transported into other mental health settings.

What data point or research has been most surprising to you around youth suicide?

Dr. Boyd: What struck me and probably fueled some of my interest was recent national research that found black youth between the ages of 5-12 were increasing their rates of suicide completion. In fact, the rates were almost two times higher than for white youth in the same age group. We still don't know why and it's alarming because these children are so young. Most past research has focused on suicide, suicide identification and treatment among adolescents. More analysis needs to be done to determine the causes of this trend among this younger age group and to understand the treatments that work for black youth.

You recently were invited to join the Congressional Black Caucus (CBC) emergency taskforce workgroup on Black Youth Suicide and Mental Health. What are the main goals of this group and what are you hoping to learn?

Dr. Boyd: This is an interdisciplinary workgroup of experts convened by the CBC emergency taskforce. The members of the CBC task force wanted to increase awareness of the issues that are impacting black youth given recent evidence about suicide rates among this population and related to mental health more broadly.

One thing we do know is that although suicide rates are increasing, black youth often don't go to treatment and there is a huge health disparity in access to mental health treatment. In addition, there is a lack of research to help us understand mental health among black youth. From our perspective, this is an area that has been neglected and we want to identify the gaps and needs to address these issues.

We're in the process of developing a report including recommendations that could be disseminated to congressional members, but also to foundations and other organizations that are interested in this topic. We hope to offer solutions to make policy changes at the national level that will hopefully trickle down to the states.

What additional research is needed on the topic of youth suicide in order to make a real difference for youth?

Dr. Boyd: There are so many gaps that exist. In particular, we don't understand what it means to assess and measure suicide risk among younger children, nor do we know what suicide means to them and how they understand it.

We need to look more closely at high-risk youth—particularly racial, ethnic, and cultural groups, as well as the LGBTQ community to understanding who is at risk. We must also explore risk across different age groups because children and teens change developmentally as they grow.

Ultimately, we need to develop interventions that could be appropriate across age groups, racial, cultural, and ethnic groups, and other groups that are at high risk.

Practice wise, we need to increase awareness of providers seeing these youth and ensure we know how to screen and treat and triage these kids. Although providers are screening for adolescent depression, that doesn't necessarily mean they are screening for suicidal ideation. Based on 2014 data from the U.S. Preventive Services Task Force, there wasn't enough evidence to support this type of screening. More research needs to be done in that area in order to understand what it would mean to screen for suicidal thoughts and to make recommendations for screening based on that information.

Identification of risk and development of evidence-based treatments that are gender, age and culturally responsive will allow us to make strides in fostering mental health among youth.

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