Effective Screening and Treatment to Reduce Suicide Risk Among Sexual and Gender Minority Youth

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In this issue of *Pediatrics*, Luk et al[1] describe the risk of suicidal behavior within a 7-year nationally representative longitudinal sample of US adolescents. They found that sexual minority adolescents had an earlier onset of suicidality and faster progression from suicide ideation to a suicide plan, compared with that of heterosexual adolescents. The increased risk for suicidal ideation and behavior among this vulnerable population of youth is well described.[2] The findings in this report regarding the early emergence and rapid progression of suicide risk among sexual minority adolescents suggest that early identification of risk and implementation of risk reduction interventions are critical.

Rates of suicide[3] and suicide-related emergency department visits[4] are increasing among adolescents in the United States. Screening for depression is currently recommended at annual visits from the age of 12 years,[5] and the American Academy of Pediatrics (AAP) has developed resources, tool kits, and trainings to facilitate this activity.[6,7] In recent research, it is suggested that screening for depression alone may not capture many suicidal youth[8,9] because 32% of patients at risk for suicide in an inpatient medical sample were not identified by depression screening. In other reviews,[10,11] authors cite accumulating evidence that suicide risk is better captured by direct questions about suicidal ideation. Validated instruments to identify suicide risk are available, and accurate identification of risk allows referral for emergency consultation or treatment that has the potential to prevent suicidal behavior.

In addition to screening all youth for depressive symptoms and suicidal ideation, routine screening for sexual minority status has the potential to enhance prediction of suicide risk among youth, given the early and elevated risk among sexual minority youth. Higher risk for suicidal behavior among gender minority adolescents, including transgender and gender diverse adolescents, has been increasingly documented,[12] indicating that screening for both sexual and gender minority (SGM) status has the potential to improve care for SGM youth. Screening for SGM status during adolescence would also allow providers to make more effective referrals for SGM youth to mental health service providers who are competent in SGM issues and can provide validating care, directly addressing psychosocial stressors experienced by SGM youth that have known associations with risk for suicidal behavior. Beginning screening for SGM identities at the age of 12 years, to coincide with initiation of screening for depressive symptoms, would capture SGM status data when youth typically begin to experience same-sex attractions.[13,14] Because sexual attractions emerge

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before self-identified sexual orientation, the assessment of sexual attractions during adolescence captures the widest swath of sexual minority youth,[15] and providers can assess attractions in-person by using the following prompt: "Many children your age experience sexual attraction to other people. Do you feel attraction to boys, girls, both, or neither?" In addition, using self-report survey items to assess attraction, identity, and sexual behavior will yield the most reliable information about sexual minority status during adolescence.[15] Finally, assessing gender identity is also critical during this developmental period, and it has been recommended that providers use validated measures to assess whether youth have questions about their gender identity.[16]

Because many parents of SGM adolescents are not aware of their child's SGM identity, providers must take caution when assessing this information because inadvertent disclosure of SGM status to parents can exacerbate risk for conflict with or mistreatment by family members and lead to a rupture of provider–patient rapport if not handled sensitively. Providers should assess SGM status privately without parents present, including level of parental knowledge of their patient's SGM identities.[17] Beginning at the 11-year-old patient visit, the AAP recommends discussion of confidentiality and time alone for the adolescent.[18] The same attention to confidentiality applied to the typical adolescent social history that includes questions about sexual behaviors, depression and/or suicide risk, and substance use, among other topics, should be applied to information related to SGM status. However, additional challenges include parents' ability to access their child's medical records during adolescence. Increased access to more medical record components is often beneficial and has become more direct under the 21st Century Cures Act that implements "no cost" access to most clinical notes "without bureaucratic delays." This poses additional challenges for providers when ensuring the confidentiality and safety of SGM adolescent patients.[19] Confidentiality protection of content in the medical record varies by state, electronic medical record (EMR), and health system, and it currently falls on the providers of care to adolescents to maintain the confidentiality of specific content or entire notes in their EMR, by following specific procedures to protect content and document the reason for confidentiality.[20–22] Both in verbal and written communication, providers should ensure they do not inadvertently disclose their patients' SGM status to parents, with the ultimate goal of assisting the family to facilitate both communication about topics related to SGM identities and appropriate mental health referrals for SGM youth when necessary.

If we screen youth for suicide risk and SGM status, the tenets of screening assume we can offer services that will have an impact on outcomes.[23] In the United States, we are facing a pediatric mental health and behavioral health care crisis of growing proportions. Importantly, the coronavirus disease 2019 pandemic has escalated experiences of distress among adolescents.[24] Behavioral health providers and institutions are stretched and unable to handle the demand for inpatient care, intensive outpatient services, and outpatient care. Waiting times and wait lists are longer.

This crisis is exacerbated among SGM adolescents because many mental health providers are unprepared to effectively provide validating and accepting clinical care to SGM adolescents and their families. Rarely, there are services that are SGM-focused, and they are usually located in urban neighborhoods and mostly absent from suburban and rural areas. Thus, these specialized services cannot meet the needs of SGM youth alone. It is critical that primary care and mental health service providers receive training to provide culturally competent care for SGM youth and their families. This training is currently not offered within the vast majority of medical and mental health training curricula,[25] and systemic change is required to emphasize and prioritize training in cultural competence with SGM populations. In addition, continuing education programs can reduce provider biases toward SGM patients and increase comfort providing care for SGM individuals.[26] Training for all medical and mental health providers to build competence with SGM populations is pivotal to ensure SGM youth and their families receive high quality services, providing a path toward parity in mental health services for this vulnerable population.[27,28]

For mental health services in general and SGM services in particular, we need an aggressive development plan, exploring models of workforce development and training, service delivery of remote and face-to-face mental health care, and quality, evaluation, and outcome measures to grow and modify practice and care. If pediatricians and other primary care providers are to screen adolescents for risk for suicide and SGM identities with the goal of treating depression and preventing suicide, pediatricians need to be prepared to refer or offer care and services to the individuals and families identified through screening efficiently, effectively, and within accessible payment and care delivery systems. Unless parity is addressed, we will not reduce disparities.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
EMR: electronic medical record
SGM: sexual and gender minority

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