

## Suicide prevention: time for 'zero tolerance'

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Despite predictable outbreaks of concern in the popular media and the professional literature, youth suicide is often viewed as a troubling, yet irrefutable aspect of our world rather than a public health disaster. Suicide is the third leading cause of death in adolescents and young adults, behind only accidents and homicide, yet our societal investment in addressing youth suicide as a major public health problem appears to be lukewarm at best. Suicidal behavior is also responsible for an enormous burden of suffering, lost productivity, and cost beyond completed youth suicide, its most catastrophic outcome. In 2006, suicide was the cause of death for 4189 Americans between the ages of 15 and 24 years, more than deaths in that age group due to cancer (1644), cardiovascular disease (1376), stroke (210), HIV (206), influenza and pneumonia (184), diabetes (165), septicemia (139), asthma (135), and meningitis (47) combined [1]. In the same year, the National Institutes of Health devoted \$32 million to suicide research across the lifespan, a relative pittance compared with \$276 million for pediatric HIV research (\$2.9 billion across the lifespan), \$157 million for the health effects of climate change, and \$108 million for autism [2].

Why such an apparent skew in our societal approach to the problem of suicide, given that suicide is responsible for such a large proportion of pediatric deaths and such an overwhelming burden of suffering? The answer is likely elusive, but several potential explanations come to mind. Clearly, suicide is a daunting and multifaceted problem that defies narrow public health conceptualizations by virtue of moral, philosophical, and spiritual dimensions. The apparently willful, self-directed nature of the act may contribute to suicide being viewed as more closely related to sin and moral failing than to the public health. Perceived moral failings are easily extended beyond the suicidal youth to parents and families, generating thoughts about complicity and culpability that can compete with feelings of compassion and making the phrase 'suicide victim' sound like an oxymoron. How can society

and healthcare professionals take on the challenge of suicide prevention with the same enthusiasm devoted to preventing pediatric cancer given the sense of negation communicated by the suicidal act?

Suicide also appears to engender a sense of collective helplessness and hopelessness in its wake. Convincing data regarding the effectiveness of current and past efforts to prevent youth suicide have been difficult to come by and sometimes generate doubt as to whether meaningful reductions in completed suicide can be achieved. Such perceptions and beliefs can encourage the sort of nihilistic mindset toward suicide prevention that often accompanies the suicidal act itself. How much does our behavior as professionals, concerned citizens, and family members really matter? How much do we really believe that suicide represents preventable death? If we affirm that suicide is a human problem that truly can and should be prevented via directed efforts at all levels of our society, we must then confront how our words and behaviors are not, and have not been, aligned to date.

Ideally, strategies for suicide prevention should target risk factors that appear to be both causal and modifiable [3], and any broad view of suicide prevention will include universal interventions designed for use in the general population (primary prevention), selective efforts that target difficult to identify or nonclinical high-risk youth (secondary prevention), and indicated interventions focused on clinically, institutionally, or self-identified high-risk youth (tertiary prevention). A seminal review of existing strategies to prevent suicide identified several promising approaches, including population-based strategies, such as suicide awareness programs and actively influencing media reports of suicide and suicidal behavior, screening to identify high-risk individuals, reducing access to lethal means, and effective treatment of associated psychiatric disorders [4]. This section of *Current Opinion in Pediatrics* will highlight the epidemiology of pediatric suicide, with special attention to known risk factors, and then focus on selective and indicated interventions for high-risk youth, which are likely of greatest relevance to clinicians.

Our hope is that this collection of articles addressing pediatric suicide will catalyze the discussion and commitment that this important problem deserves.

Can pediatricians, organized healthcare, and society at large really afford to treat pediatric suicide as anything but preventable? Although the degree to which youth suicide is completely preventable is an empirical question, there is no doubt it is a major public health problem deserving the attention not just of health and mental health professionals, but of all with a commitment to fostering meaningful and productive lives for children and adolescents. The time to adopt a 'zero-tolerance' mindset is now.

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## References

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