Supplemental content

Methods | This study followed the relevant portions of the STROBE reporting guideline. Per Common Rule, institutional review board approval was not sought because the study did not involve human participant research. Data for the analysis were drawn from the 2019 to 2020 Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS). The study sample included all individuals aged 3 to 17 years from all 50 states, Washington, DC, Puerto Rico, and the US Virgin Islands who were enrolled in Medicaid or CHIP for at least 6 consecutive months in the year. Suicidal ideation (ICD-10-CM code R45.851) and suicide attempt or intentional self-harm (ICD-10-CM codes T14.91X, T36.0X2-T65.9, and X60-X84) measures were expressed in number of encounters per 1000 enrollees per month and were examined for the overall sample and within each of the following groups from the demographic and eligibility file of T-MSIS: non-Hispanic American Indian or Alaska Native, non-Hispanic Asian, non-Hispanic Black, Hispanic, non-Hispanic White, and non-Hispanic other (including Native Hawaiian and Other Pacific Island and multiracial).

Results | The Figure shows that before and during the pandemic, encounters related to suicidal ideation and suicide...
Suicide attempt or intentional self-harm were twice as high among American Indian or Alaska Native youth compared to youth from all other racial and ethnic groups. March through May 2020 saw a decline in suicide-related encounters for all groups, but as the pandemic continued, the rate of these encounters increased. Compared to prepandemic levels, the rate of encounters for suicidal ideation was lower (1.23 vs 1.07 encounters per 1000), but the rate for suicide attempt or intentional self-harm was higher (0.31 vs 0.33 encounters per 1000). American Indian or Alaska Native youth were the only group that experienced a decline (6%) in the rate of encounters related to suicide attempt or intentional self-harm, although this rate remained almost twice as high as for other groups.

Discussion: Our study documented a disproportionately higher rate of suicidal ideation and intentional self-harm encounters among American Indian or Alaska Native youth compared to youth from other racial and ethnic backgrounds during the pandemic. Since the findings are based on claims data, it is important to note that these data were captured when children interacted with the health care system, meaning that these encounters can be used as opportunities to engage youth in follow-up services and potentially prevent future suicide-related events. This is particularly important for American Indian or Alaska Native young people, as the rate of suicide-related mortality is highest among American Indian or Alaska Native persons.

Suicide attempt and intentional self-harm encounters increased during the pandemic for children and adolescents in all racial and ethnic groups except American Indian or Alaska Native. A potential implication could be that the policy initiatives aimed toward preventing suicide among American Indian or Alaska Native communities is having their intended intent, but more research is warranted to determine why the pandemic did not seem to impact this group as much as others in this particular way. However, given the persistent high rate of suicidal behavior among American Indian or Alaska Native youth, continued policy efforts targeted toward this group might be warranted. The Zero Suicide model has been adapted for use within tribal communities and is an established initiative under the Indian Health Service, incorporating cultural knowledge and practices to meet the needs of American Indian or Alaska Native communities.

As with all analyses with administrative data, our findings should be interpreted with caution given the difficulty in identifying and possibility of underreporting of suicidal behavior in medical claims records. Future analysis could benefit from combining claims data with information from medical charts or electronic health records to identify suicidal behavior.

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Author Contributions: Drs Ali and Lieff had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

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Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Ali, West, Dubenitz.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Ali, End of Horn, Paschane, Lieff.

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Supervision: Ali, Dubenitz.

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Data Sharing Statement: See Supplement.


ADOLESCENT MENTAL HEALTH
Availability of LGBTQ Mental Health Services for US Youth, 2014 to 2020
Approximately 1 in 10 children and youth in the US identifies as being in a sexual or gender minority group (lesbian, gay, bisexual, transgender, queer [LGBTQ]). Compared with heterosexual or cisgender youth, LGBTQ youth have 3 times higher prevalence of depression and anxiety, and 42% have considered suicide.² ³

Fifty-four percent of LGBTQ youth reported wanting mental health care but not receiving any, partly due to adverse experiences with clinicians and perceptions that clinicians do not understand sexual or gender identity-related mental health needs.³

Supplemental content

Letters

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