I sent my suicidal teen patient to the ED: Whew?

You read “thoughts of being better off dead” on your next patient’s PHQ-9 screen results and break into a sweat. After eliciting the teen’s realistic suicide plan and intent you send him to the ED with his parent for crisis mental health evaluation. When you call the family that evening to follow up you hear that he was discharged with a “mental health counseling” appointment next week.

Have you done enough to prevent this child from dying at his own hand?
I imagine that this haunts you as it does me. It is terrifying to know that, **of youth with suicidal ideation, over one-third attempt suicide, most within 1-2 years, and 20%-40% do so without having had a plan.**

We now know that certain kinds of psychotherapy have evidence for preventing subsequent suicide in teens at high risk due to suicidal ideation and past attempts.

- Cognitive-behavioral therapy (CBT) has the best evidence including its subtypes for youth with relevant histories: for both suicide and substance use (integrated, or I-CBT), trauma-focused (TF-CBT), traumatic grief (CTG-CBT), and CBT-I, for the potent risk factor of insomnia.
- The other treatment shown to reduce risk is dialectical behavioral therapy–adolescent (DBT-A) focused on strengthening skills in interpersonal effectiveness, mindfulness, distress tolerance, and emotion regulation adapted to youth by adding family therapy and multi-family skills training. Interpersonal psychotherapy (IPT) adapted for suicidal and self-harming adolescents (IPT-SA) also has evidence.
- Some school programs have shown moderate efficacy, for example (IPT-A-IN) addresses the social and interpersonal context, and Youth Aware of Mental Health, a school curriculum to increase knowledge, help-seeking, and ways of coping with depression and suicidal behavior, that cut suicide attempts by half.

You may be able to recommend, refer to, or check to see if a youth can be provided one of the above therapies with best evidence but getting any counseling at all can be hard and some, especially minority families may decline formal interventions. Any therapy – CBT, DBT, or IPT – acceptable to the youth and family can be helpful. You can often determine if the key components are being provided by asking the teen what they are working on in therapy.

It is clear that **checking in regularly with teens who have been through a suicide crisis is crucial** to ensure that they continue in therapy long and consistently enough, that the family is involved in treatment, and that they are taught emotion regulation, distress tolerance, and safety planning.

Warm, consistent parenting, good parent-child communication, and monitoring are protective factors but also skills that can be boosted to reduce future risk of suicide.

When there is family dysfunction, conflict, or weak relationships, getting help for family relationships such as through attachment-based family therapy (ABFT) or family cognitive behavioral therapy is a priority. When bereavement or parental depression is contributing to youth suicidal thoughts, addressing these specifically can reduce suicide risk.

Sometimes family members, even with counseling, are not the best supporters for a teen in pain. When youths nominated their own support team to be informed about risk factors, diagnosis, and treatment plans and to stay in contact weekly there was a 6.6-fold lower risk of death than for non supported youth.

But how much of this evidence-based intervention can you ensure from your position in primary care?

- Refer if you can but regular supportive contacts alone reduce risk so you, trusted staff, school counselors, or even the now more available teletherapists may help.

- You can work with your patient to fill out a written commitment-to-safety plan (e.g. U. Colorado, CHADIS) of strategies they can use when having suicidal thoughts such as self-distractions, problem-solving, listing things they are looking forward to, things to do to get their mind off suicidal thoughts, and selecting support people to understand their situation with whom to be in regular contact.

- Any plan needs to take into account how understanding, supportive, and available the family is, factors you are most likely to be able to judge from your ongoing relationship, but that immediate risk may change.

- Contact within 48 hours, check-in within 1-2 weeks, and provision of crisis hotline information are essential actions.

- Recommending home safety is part of routine anticipatory guidance but reduction of lethal means is essential in these cases. Guns are the most lethal method of suicide but discussing safe gun storage has been shown to be more effective than arguing in vain for gun removal. Medication overdose, a common means, can be reduced by not prescribing tricyclics (ineffective and more lethal), and advising parents to lock up all household medications.

- You can ask about and coach teens on how to avoid the hazards of participating in online discussion groups, bullying, and cyberbullying (with risk for both perpetrator and victim), all risk factors for suicide.

- Managing insomnia can improve depression and is within your skills.

- While pediatricians can't treat the suicide risk factors of family poverty, unemployment, or loss of culture/identity, we can refer affected families to community resources.

- Repeated suicide screens can help but are imperfect, so listen to the child or parent for risk signs such as the youth having self-reported worthlessness, low self-esteem, speaking negatively about self, anhedonia, or poor emotion regulation.

- Children with impulsive aggression, often familial, are at special risk of suicide. This trait, while more common in ADHD, is not confined to that condition. You can help by optimizing medical management of impulsivity, when appropriate.

- Most youth who attempt suicide have one or more mental health diagnoses, particularly major depressive disorder (MDD), eating disorder, ADHD, conduct, or intermittent explosive disorder. When MDD is comorbid with anxiety, suicides increase 9.5-fold.
    - Children on the autism spectrum are more likely to have been bullied and eight times more likely to commit suicide.
    - LGBTQ youth are five times more often bullied and are at high risk for suicide.
    - The more common issues of school failure or substance use also confer risk.

While we do our best caring for children with these conditions we may not be thinking about, screening, or monitoring for their suicide risk. **It may be important for us to explain that, despite black-box warnings, rates of SSRI prescribing for depression are inversely related to suicides.**

Child maltreatment is the highest risk factor for suicide (population attributed risk, or PAR, 9.6%-14.5%), particularly sexual misuse.

Altogether, adverse childhood experiences have a PAR for suicide of 80%. Continuity allows you to monitor for developmental times when distress from past experiences often re-emerges, e.g., puberty, dating onset, or divorce.

Getting consent and sharing these highly sensitive but potentially triggering factors as well as prior diagnoses with a newly assigned therapist can be helpful to prioritize treatments to prevent a suicide attempt, because they may be difficult to elicit and timeliness is essential.

You are a trusted professional and your input counts in preventing teen suicide.