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Reflection: Reducing long-term mortality in suicidal adolescents

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Reducing long-term mortality in suicidal adolescents

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I recall the dread I felt when a suicidal teen returned to the emergency department after a medication overdose that nearly killed her, only two days after presenting for suicidal ideation and being discharged into her family's care. In that crisis situation, the team's goal was to risk assess and determine if she needed inpatient hospitalization. We sent her home, where she was surrounded by loving and dedicated family, who weren't able to recognize the signs that she was decompensating. Perhaps if our team had focused more on ensuring the patient's family had the necessary tools to care for her, the outcome could have been different. They should have been taught best practices for supporting the patient, much the same way that parents of diabetic children are educated in how to administer insulin.

Suicide is the third leading cause of death among youth ages between 10 and 24 years.[1] Further, among children and adolescents who attempt suicide, 25-66% make a repeat suicide attempt. The risk of suicide completion is greatest within the first year of the first attempt and remains elevated for ten years.[2] To date, there is no intervention that has reduced mortality for suicidal adolescents. Given this context, suicidal ideation and action among adolescents requires nuance in diagnosis, treatment, and prognosis.

This is complicated by the heterogeneity in suicidal adolescents and in the treatment provided. No two patients are the same, and suicide attempts can result from several psychiatric conditions, including depression, anxiety, dysphoria, mood disorders, psychotic disorders, eating disorders, substance use disorders and personality disorders. Treatment plans vary greatly based on patient and provider preferences. One study found that suicide attempters were more likely to experience poor mental and physical health during adulthood, as well as increase in violent behavior.[3] Cognitive behavior therapy is often recommended but it relies on building patient-provider rapport, which is not easily achieved. There are multiple pharmacologic options for targeting suicidal ideation, all with different indications and side-effect profiles.[4]

As part of my learning to care for this type of patient, I read a relevant article. In 2009, researchers at the University of Michigan conducted a randomized control trial that allowed suicidal adolescents to choose four adults in their lives to be part of their support team, and subsequently offered twelve hours of training in suicide prevention to those adults. This study initially showed no significant impact from youth-nominated support teams (YNST) for adolescents who had suicidal ideation at 12-month follow-up.[5] However, at 11 and 14-year follow-up, it was found that the patients with YNST lived longer in comparison to controls.[6] This study highlights the value of including a patient's support network in the treatment team. In medicine, we often focus on patient education, but it is equally necessary to educate the patient's loved ones. Offering suicidal adolescents the opportunity to identify adults who they feel will be supportive, especially when subsequently offering education to empower those adults, is beneficial to the long-term survival of this vulnerable patient population.

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