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Suicidal ideation and behavior in children and adolescents: Prevention and treatment

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Literature review current through: **Sep 2025**.

This topic last updated: **Oct 15, 2025**.

INTRODUCTION

Suicide is the fourth leading cause of death worldwide among adolescents aged 15 to 19 years [1]. Across 45 countries, the United States has the seventh highest rate of suicide among youth aged 10 to 19 years. In the United States in 2020, suicide was the second leading cause of death among those aged 10 to 14 years (n = 581 deaths), and the third leading cause of death among those aged 15 to 19 years (n = 2216).

This topic reviews the prevention and treatment of suicidal ideation and behavior in children and adolescents. The epidemiology, risk factors, evaluation, and disposition of children and adolescents with suicidal ideation and behavior are discussed separately. (See "[Suicidal behavior in children and adolescents: Epidemiology and risk factors](#)" and "[Suicidal ideation and behavior in children and adolescents: Evaluation and disposition](#)".)

PREVENTION

Although it is feasible to identify youth at high risk for a suicide attempt, predicting suicide in an individual is fraught with challenges [2,3]. Nevertheless, prevention programs that are administered in schools and the community can reduce suicide attempts in students by identifying at-risk individuals and pursuing early treatment before suicidal behavior emerges. In addition, community-based interventions may temporarily reduce suicide attempts and mortality in youth.

School-based prevention — Randomized trials in schools indicate that administering different types of prevention programs, such as psychoeducation about depression and suicidality, can reduce suicidal ideation and suicide attempts in students. The programs involve screening for depression and risk of suicide, educating students to recognize suicidal ideation and behavior and depression in themselves and others, and enhancing social support:

- **Screening and psychoeducation**

- One school-based trial randomly assigned high school students ($n > 4000$) to a control condition or to a program that combined psychoeducation about depression and suicide with screening for depression [4]. Assessments at the three-month follow-up found that suicide attempts occurred in fewer students who received the active intervention than controls (3 versus 5 percent).
- A subsequent open-label, school-based randomized trial in adolescents ($n > 8000$ analyzed) compared a program focused upon youth awareness with two other interventions, gatekeeper training and screening, as well as a control condition [5,6]. The youth awareness program trained students to recognize depression and suicidality in themselves and other students, and encouraged adaptive coping and help-seeking; the program included three hours of role play sessions, two hours of interactive lectures, and a 32-page booklet that students could take home. Gatekeeper training taught teachers to recognize suicidality in students; screening of students was conducted by health professionals, who referred students at risk for suicide to clinical services. During follow-up lasting 12 months, fewer suicide attempts occurred in the youth awareness program than the control condition (0.7 versus 1.5 percent of adolescents). By contrast, the number of suicide attempts was comparable in the gatekeeper/screening and control groups.

- **Enhancing social support** – Another trial compared usual care with a two-hour assessment plus a two-hour counseling session in potential high school dropouts who screened positive for risk of suicide on the basis of factors such as suicidal thoughts and behavior, depression, and substance use ($n = 305$) [7]. Usual care consisted of a relatively brief assessment as well as notifying the parents and school personnel of the results. The counseling session included motivational interviewing and focused upon enhancing social support by contacting the parents and connecting the student to a school-based case manager or a favorite teacher. Assessments nine months after the interventions found that suicidal ideation was less frequent in students who received the active intervention than controls. In addition, the counseling session led to greater decreases in depression and hopelessness.

Community-based prevention — Limited evidence suggests that short term community-based interventions may temporarily reduce suicide attempts and mortality in youth. One community

program that is widely used in the United States to prevent youth suicide is the Garrett Lee Smith Memorial Suicide Prevention Program. This short-term program includes various approaches, such as gatekeeper training, which involves teaching individuals such as teachers and primary care physicians to identify youth at risk for suicide and to refer them for help. The program also includes education, screening, and crisis hotlines. A retrospective study examined suicide attempts in youth (16 to 23 years of age; n = approximately 57,000) living in communities that implemented the program, and youth (n = approximately 84,000) living in communities that did not implement the program (control group) [8]. The active intervention was associated with fewer suicide attempts in the first year after implementation of the program (five fewer attempts per 1000 youth, for an estimated total of more than 79,000 fewer attempts nationwide). However, the rate of suicide attempts in the two groups beyond one year was comparable. Similarly, suicide mortality in the active intervention group was reduced in the first year after implementing the program (1 less death per 100,000 youth, for an estimated total of 427 fewer deaths nationwide); however, this benefit was not sustained beyond one year [9]. The findings suggest that some suicide prevention programs require continuous efforts over time.

MEDICAL STABILIZATION

The first priority for patients who have attempted suicide is medical stabilization. The appropriate surgical service should be contacted for management of trauma. Patients whose attempt involved drug ingestion should undergo decontamination and receive antidotes as indicated. (See ["Classification of trauma in children"](#) and ["Gastrointestinal decontamination of the poisoned patient"](#) and ["Approach to the child with occult toxic exposure"](#) and ["Society guideline links: General measures for acute poisoning treatment"](#).)

CHOOSING TREATMENT

General approach — Treatment for suicidal ideation and behavior in pediatric patients depends upon their clinical presentation; patients may present with:

- Suicidal ideation and no prior suicide attempts
- Suicidal ideation and one prior attempt
- Suicidal ideation and multiple prior attempts

For any patient who presents with suicidal ideation, we recommend a safety plan ([figure 1](#)) (see ['Safety plan'](#) below) and treating the underlying psychiatric disorders; this approach is based upon clinical experience ([algorithm 1](#)). In many cases, such as patients with unipolar major depression or bipolar disorder, treatment of the underlying psychiatric disorder consists of

psychotherapy plus pharmacotherapy. (See ["Overview of prevention and treatment for pediatric depression"](#), section on 'Initial treatment' and ["Pediatric bipolar disorder: Treatment"](#).)

All medications that are prescribed for the suicidal child or adolescent must be monitored and any changes in behavior or side effects must be reported immediately. Although there is some concern that antidepressants may increase the risk of suicidality in pediatric patients, this remains an area of controversy, and the consensus among most mental health specialists is that the benefits of antidepressant therapy outweigh the risks. (See ["Effect of antidepressants on suicide risk in children and adolescents"](#).)

For patients who attempt suicide, we recommend using a safety plan, treating any underlying psychiatric disorders, and using a psychotherapy specific for preventing future attempts. Based upon a review of randomized trials, we suggest the following general principles for using psychotherapy to treat suicidal behavior in children and adolescents [10]:

- Explicit focus upon suicidal risk
- Provide rapid access to clinical services and 24-hour backup
- Match intensity of treatment with clinical need and suicide risk
- Treat underlying psychiatric disorders (eg, depressive disorders and/or substance use disorders)
- Implement suicide-specific interventions
- Address contextual factors (eg, family discord or peer victimization)
- Coordinate care across changes in clinicians and care setting intensity
- Make the environment safer by restricting access to the means for attempting suicide, such as firearms, medications, and household poisons

Safety plan — As part of supporting the patient's ability to manage suicidal ideation and avoid suicidal behavior, clinicians should discuss a safety plan ([figure 1](#)) that specifies how patients can cope with recurrent suicidal urges in the future [1]. The safety plan is a widely used therapeutic tool. In addition, the extent to which patients can commit to use the safety plan provides additional information about their risk for suicidal behavior, and can thus aid the patient evaluation. (See ["Suicidal ideation and behavior in children and adolescents: Evaluation and disposition"](#), section on 'Risk assessment of suicidal ideation'.)

Safety plans are tailored for each patient according to their resources and specify feasible actions for coping with recurrent suicidal urges in the future. These plans include the following elements [11-14]:

- Involvement of the family to regularly monitor the patient until safety has further stabilized
- Restricting access to all lethal means of suicide, particularly firearms and medications
- Identifying warning signs and avoiding triggers for relapse of suicidal ideation
- Educating patients and caregivers about the disinhibiting effects of alcohol and other drugs
- Specifying reasons for living, coping strategies, and healthy activities to manage or distract oneself from suicidal thoughts
- Identifying people who are available to provide support
- Securing mental health follow-up within 48 hours to address the acute factors that precipitated suicidal ideation
- Instructing family members to return to the emergency department if patients decompensate, and to summon the police if patients refuse

Patients who agree to adhere to a safety plan may still be at high risk. A safety plan does not always protect patients or clinicians, and is not a substitute for thorough evaluation, sound clinical judgment, and a therapeutic alliance based upon open dialogue between patients and clinicians [15,16], as well as ongoing assessments of suicide risk over time, particularly with impulsive youth.

Indirect evidence in adults suggests safety plans can be beneficial. A randomized trial compared safety plans with no-harm contracts (contracting for safety) in young adult, active duty soldiers ($n = 97$) who presented to an emergency appointment with suicidal ideation [17]. During the six-month follow-up, fewer patients attempted suicide in the group that developed a safety plan than contracted for safety (5 versus 19 percent; hazard ratio 0.24, 95% CI 0.06-0.96).

Although randomized trials appear to suggest that safety plans are not effective for preventing suicidal behavior in adolescents, the studies were very limited in their methods. As an example, a meta-analysis of three trials ($n = 233$) found that suicide attempts were comparable in adolescents who received a standalone safety plan and in controls [18]. Using a safety plan as a standalone intervention is highly problematic. We suggest that safety plans be used in conjunction with standard interventions (eg, psychotherapy) for suicidality, as well as

treatment for underlying psychopathology (eg, psychotherapy plus antidepressants for depressive syndromes).

Suicidal ideation and no prior suicide attempts — For patients with suicidal ideation and no prior suicide attempts, we suggest a safety plan ([figure 1](#)). In addition, we treat the underlying psychiatric disorders, and in so doing, address the suicidal ideation. In some disorders, such as unipolar major depression or bipolar disorder, treatment includes pharmacotherapy plus psychotherapy.

Information about safety plans is discussed elsewhere in this topic. (See '[Safety plan](#)' above.)

Suicidal ideation and prior suicide attempt — For patients with suicidal ideation and one or more prior suicide attempts, we suggest a safety plan ([figure 1](#)), and we treat the underlying psychiatric disorder.

We also suggest psychotherapy that is specific to preventing future attempts. In choosing a psychotherapy, effective options include cognitive-behavioral therapy (CBT), dialectical behavior therapy, family therapy, interpersonal psychotherapy, and mentalization-based therapy. Although each psychotherapy is suitable for any patient who has attempted suicide, we attempt to use specific therapies for different subgroups who have shown a good response to a particular therapy. Patient subgroups include those with:

- One prior suicide attempt that occurs in the context of prominent family discord – In this setting, we suggest family therapy. General information about administering family therapy is discussed separately in the context of depressed adults. (See "[Unipolar depression in adults: Family and couples therapy](#)".)
- Multiple prior suicide attempts or one prior suicide attempt that occurs in the context of borderline personality disorder or traits – For these patients, we suggest dialectical behavioral therapy or mentalization-based therapy. General information about these two psychotherapies is discussed separately. (See "[Borderline personality disorder: Psychotherapy](#)", section on '[Specific psychotherapies](#)'.)
- One prior suicide attempt aside from the two preceding subgroups – CBT or interpersonal psychotherapy. General information about these psychotherapies is discussed separately. (See "[Overview of psychotherapies](#)", section on '[Cognitive and behavioral therapies](#)' and "[Interpersonal Psychotherapy \(IPT\) for depressed adults: Indications, theoretical foundation, general concepts, and efficacy](#)".)

Evidence supporting the use of these psychotherapies is discussed elsewhere in this topic.

Although the large majority of patients in the trials of dialectical behavior therapy were girls, we

nevertheless recommend the therapy for boys as well. (See '[Efficacy of psychotherapy](#)' below.)

Additional information about safety plans is discussed elsewhere in this topic. (See '[Safety plan](#)' above.)

Monitoring — As part of treating the underlying psychiatric disorder in youth with suicidal ideation and behavior, we suggest that clinicians (eg, pediatricians, psychiatrists, or psychologists) regularly monitor outcomes. The frequency of monitoring depends upon the patient's clinical status and presumed level of adherence. As an example, noticeable worsening in symptoms or missed appointments should prompt an assessment. Patients whose adherence is problematic or who are not responding to treatment are monitored weekly. Relatively new patients who regularly adhere to treatment are monitored monthly. Well-known patients who are thought to be fully compliant are generally assessed every two to three months.

Efficacy of psychotherapy — Multiple trials indicate that psychotherapy can reduce intentional self-harm in adolescents [1,19]. However, no head-to-head trials have compared different types of psychotherapy for preventing suicidal behavior. In addition, trials have often administered a form of psychotherapy that used techniques from multiple types of psychotherapy. Also, assessed outcomes varied among trials.

Many trials have compared psychotherapy with usual care, which typically does not control for nonspecific factors such as the amount of attention received by patients in active treatment. Nevertheless, in some trials usual care included robust treatments, such as pharmacotherapy for depressive disorders.

Evidence supporting the use of psychotherapy to treat youth with suicidal ideation and behavior includes a review of 19 randomized trials that compared psychotherapy with usual care in children and adolescents (n>2000) with at least one episode of self-harm (nonsuicidal self-injury and/or suicide attempts) [20]. The active treatments included several types of psychotherapy (often combined with usual care) and follow-up ranged from 2 to 24 months. The primary findings were as follows:

- A pooled analysis found that subsequent self-harm occurred in somewhat fewer patients who received psychotherapy than usual care alone (28 versus 33 percent). However, heterogeneity across studies was high.
- Specific therapies with the largest clinical effect included CBT, dialectical behavioral therapy, and mentalization based therapy (a type of psychodynamic psychotherapy).
- Reduction of self-harm was observed in trials with treatment that lasted more than one session, and in those with a large family component, but not in trials with a small family

component.

Cognitive-behavioral therapy — For adolescents who present with suicidal ideation or behavior, multiple randomized trials indicate that CBT can reduce the risk of subsequent suicide attempts. CBT is often combined with elements of other psychotherapies, such as family therapy:

- A one-year open-label trial compared usual care (diagnostic evaluation and pharmacotherapy for unipolar major depression) plus CBT with usual care alone in adolescents with suicidal ideation or behavior and substance use disorders (n = 36) [21]. CBT was augmented with family therapy and motivational interviewing; up to 35 sessions were administered during acute and maintenance treatment. At the assessment 18 months postenrollment, fewer suicide attempts had occurred in patients who received usual care plus psychotherapy than usual care alone (5 versus 35 percent of patients). In addition, adjunctive CBT was superior to usual care alone regarding hospitalization (16 versus 53 percent of patients) and arrest by legal authorities (5 versus 41 percent).
- A three-month trial compared CBT plus family therapy with usual care alone in 42 adolescent outpatients with suicidal behavior or nonsuicidal self-injury in the previous three months [22]. CBT plus family therapy included elements of dialectical behavior therapy and focused upon learning safety skills and strengthening support among family members; up to 15 sessions were administered. Usual care included a single session devoted to parent education and at least three telephone calls that focused upon patients obtaining follow-up treatment. Fewer suicide attempts occurred in youth who received CBT plus family therapy than usual care (0 versus 6).
- A randomized trial compared a brief CBT intervention plus usual care with usual care alone in depressed adolescents (n = 66) hospitalized for suicide attempts or suicidal ideation with a plan or intent [23,24]. The active treatment focused upon emotion regulation and safety planning, lasted approximately three hours, and was supported after discharge by two telephone calls and a smartphone application that involved daily text messages for rating one's distress and provided access to distress tolerance strategies and one's specific safety plan. Inpatient usual care focused upon diagnosis, safety assessment, stabilization, pharmacotherapy, psychoeducation, and disposition. Assessments for up to 24 weeks posthospitalization found that suicide attempts occurred in half as many patients who received adjunctive CBT than usual care alone (16 and 31 percent).

Additional information about safety plans is discussed elsewhere in this topic. (See '[Safety plan](#)' above.)

The use of family therapy for managing adolescent suicidal ideation and behavior is discussed elsewhere in this topic, and additional information about CBT for children and adolescents is discussed separately in the context of pediatric unipolar depression. (See ['Family therapy'](#) below and ["Pediatric unipolar depression: Psychotherapy"](#), section on ['Cognitive-behavioral therapy'](#).)

Dialectical behavior therapy — Based upon two randomized trials, dialectical behavior therapy can reduce adolescent self-harm. However, in both trials, the inclusion criteria included symptoms of borderline personality disorder, and the large majority of study patients were girls; thus, it is not clear if the therapy is efficacious for patients without personality disorder traits, or for boys [25]. In addition, the therapy requires extensive training:

- A 19-week, open-label trial compared dialectical behavior therapy with usual care in adolescent outpatients (n = 77, 88 percent female) with at least one diagnostic criterion for borderline personality disorder, and a lifetime history of repetitive self-harm episodes (nonsuicidal self-injury or suicide attempts), including one episode within the past four months [26,27]. Dialectical behavior therapy included weekly sessions of individual therapy, weekly multifamily group sessions addressing skill deficits, and individual family therapy sessions as indicated. Usual care included at least one weekly individual therapy session (eg, psychodynamically oriented therapy or CBT). Pharmacotherapy was allowed in both groups. The mean number of self-harm episodes was less in patients treated with dialectical behavior therapy than usual care (9 versus 23 episodes; a reduction of 56 percent [95% CI -80 to -3]). Posttreatment, prospective one-year and three-year follow-up assessments each found that the benefit of dialectical behavior therapy persisted, such that the average number of self-harm episodes was less in the group that received dialectical behavior therapy than usual care [27,28]. However, the number of treatment sessions was greater with dialectical behavior therapy, and the therapists administering dialectical behavior therapy required extensive training and supervision.
- A six-month trial compared dialectical behavior therapy with supportive therapy in adolescents (n = 173; 95 percent female) with at least three diagnostic criteria for borderline personality disorder, increased suicidal ideation within the past month, at least one lifetime suicide attempt, and a lifetime history of repetitive self-harm [29]. Both treatment conditions provided weekly individual and group therapy as well as parent participation, and pharmacotherapy was allowed in both groups. Dialectical behavior therapy was administered by highly trained therapists who focused upon treatment engagement, reducing self-harm, emotion regulation, and tolerating distress. Supportive therapy emphasized acceptance, validation, and feelings of connectedness and belonging. Suicide attempts occurred in fewer youth who received dialectical behavior therapy than supportive

therapy (10 versus 22 percent). However, follow-up assessments conducted 12 months postbaseline indicated that the advantage of dialectical behavior therapy had dissipated.

Family therapy — Open-label randomized trials indicate that family therapy (often combined with other treatment) can reduce adolescent suicidal ideation and behavior. As an example:

- A four-week trial compared outpatient usual care (eg, supportive psychotherapy and/or pharmacotherapy) plus family therapy with usual care alone in 48 adolescents with unipolar major depression who had at least one episode of self-injurious behavior (eg, cutting or overdosing), or had verbalized thoughts or threats of suicide [30]. Family therapy (four sessions, each lasting two hours) was provided in a single family format to only the parents, and focused upon education about self-injurious behavior and adolescent development, and strategies to manage stress and family conflicts and promote adolescent self-esteem and family harmony. Reduction of suicidal ideation and behavior and other psychiatric symptoms was greater in patients whose parents received family therapy, and the benefits persisted at the six-month follow-up.
- A 12-week trial compared family therapy (average of 10 sessions) to usual clinical management (average of three sessions) in mostly poor and minority adolescents with suicidal ideation (n = 66) [31]. Family therapy included elements of CBT and psychoeducation, and focused upon improving family processes and strengthening the emotional connection between adolescents and their parents. Remission of suicidal ideation occurred in more patients treated with family therapy than usual care (87 versus 52 percent; odds ratio 6.3, 95% CI 1.8-22.6), and the benefits persisted at follow-up assessments 12 weeks posttreatment.

Interpersonal psychotherapy — Interpersonal psychotherapy may decrease suicidal ideation in adolescents. A six-week randomized trial compared interpersonal psychotherapy with usual care in adolescents with moderate to severe depression and suicidal ideation (n = 73) [32]. Both interventions were administered in school and permitted the use of pharmacotherapy. Interpersonal psychotherapy was administered twice weekly along with a weekly telephone call, and focused upon interpersonal conflicts with teachers and peers. Usual care was administered once or twice weekly, and focused upon support and psychoeducation. Suicidal ideation decreased more with interpersonal psychotherapy, as did depression, anxiety, and hopelessness.

Mentalization-based therapy — Mentalization-based therapy appears to reduce adolescent self-harm. A one-year randomized trial compared mentalization-based therapy with usual care (mental health services) in adolescents (n = 80) who presented with self-harm; allocation was concealed from patients and outcome assessors [33]. Mentalization-based therapy is a form of

psychodynamic psychotherapy that focuses upon impulsivity and affect regulation; treatment was administered in weekly individual sessions and monthly family therapy. Nearly all of the adolescents suffered from depressive syndromes and most also suffered from borderline personality disorder. Subsequent self-harm occurred in fewer adolescents who received mentalization-based therapy than controls (43 versus 68 percent). In addition, reduction of depressive and borderline symptoms was greater with active treatment. Mentalization-based therapy appeared to improve self-harm outcomes by improving the quality of attachment between adolescents and their parents, and by improving the ability to conceptualize actions in terms of thoughts and feelings (mentalize).

TREATMENTS WITH LITTLE TO NO BENEFIT

Multiple randomized trials indicate that group psychotherapy is not efficacious for reducing self-harm in adolescents. As an example, a meta-analysis of three randomized trials compared group psychotherapy (six weekly sessions and subsequent booster sessions) with usual care in 490 adolescents with multiple episodes of self-harm [34]. Group psychotherapy in all three trials was administered according to the same treatment manual and included elements of cognitive-behavioral therapy and dialectical behavior therapy. At the 12-month assessment, repetition of self-harm in the two groups was comparable.

In addition, the emergent administration of antidepressants has no role in the acute management of the suicidal child or adolescent. However, many pediatric patients with suicidal ideation or behavior are treated with pharmacotherapy for an underlying psychiatric disorder. (See '[General approach](#)' above.)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "[Society guideline links: Depressive disorders](#)" and "[Society guideline links: General measures for acute poisoning treatment](#)".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short,

easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or email these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on "patient info" and the keyword(s) of interest.)

- Basics topic (see "[Patient education: Suicide prevention \(The Basics\)](#)")

OTHER RESOURCES FOR PATIENTS AND FAMILIES

Other resources for patients and families are listed in the two tables ([table 1A-B](#)).

SUMMARY AND RECOMMENDATIONS

- **Prevention** – Prevention programs that are administered in schools can reduce suicidal ideation and suicide attempts in students, and community-based interventions may temporarily reduce suicide attempts and mortality in youth. (See '[School-based prevention](#)' above and '[Community-based prevention](#)' above.)
- **Medical stabilization** – The first priority for patients who have attempted suicide is medical stabilization. (See '[Medical stabilization](#)' above.)
- **Choosing treatment**
 - **Suicidal ideation and no prior suicide attempts** – For patients with suicidal ideation and no prior suicide attempts, we suggest a safety plan ([figure 1](#)), rather than contracting for safety (**Grade 2C**). In addition, we treat the primary underlying psychiatric disorder, and in so doing, address the suicidal ideation ([algorithm 1](#)). (See '[General approach](#)' above and '[Suicidal ideation and no prior suicide attempts](#)' above.)
 - **Prior suicide attempt** – For patients who attempt suicide, we recommend a psychotherapy specific for preventing future attempts, rather than other forms of psychotherapy (**Grade 1C**). Although the evidence supporting this approach is limited, individuals who attempt suicide are at high risk for future attempts and death. As part of psychotherapy, we help patients develop a safety plan. In addition, we treat the primary underlying psychiatric disorder.

General principles for managing suicidal youth with psychotherapy include the following:

- Explicit focus upon suicidal risk
- Provide rapid access to clinical services and 24-hour backup
- Match intensity of treatment with clinical need and suicide risk
- Treat underlying psychiatric disorders (eg, depressive disorders and/or substance use disorders)
- Implement suicide-specific interventions
- Address contextual factors (eg, family discord or peer victimization)
- Coordinate care across changes in clinicians and care setting/intensity

Effective psychotherapy options include cognitive-behavioral therapy (CBT), dialectical behavior therapy, family therapy, interpersonal psychotherapy, and mentalization-based therapy. Although each psychotherapy is suitable for any patient who has attempted suicide, we attempt to use specific therapies for different patient subgroups:

- Patients with one prior suicide attempt that occurs in the context of prominent family discord – Family therapy.
- Patients with one prior suicide attempt that occurs in the context of borderline personality disorder or traits, or patients with multiple prior suicide attempts – Dialectical behavioral therapy or mentalization-based therapy.
- Patients with one prior suicide attempt – CBT or interpersonal psychotherapy.

(See '[Choosing treatment](#)' above.)

- **Antidepressants** – The emergent administration of antidepressants has no role in the acute management of the suicidal child or adolescent. However, many pediatric patients with suicidal ideation or behavior are treated with pharmacotherapy for an underlying psychiatric disorder. (See '[Treatments with little to no benefit](#)' above.)

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Topic 1230 Version 45.0

GRAPHICS

Figure 1: Pediatric suicide safety plan

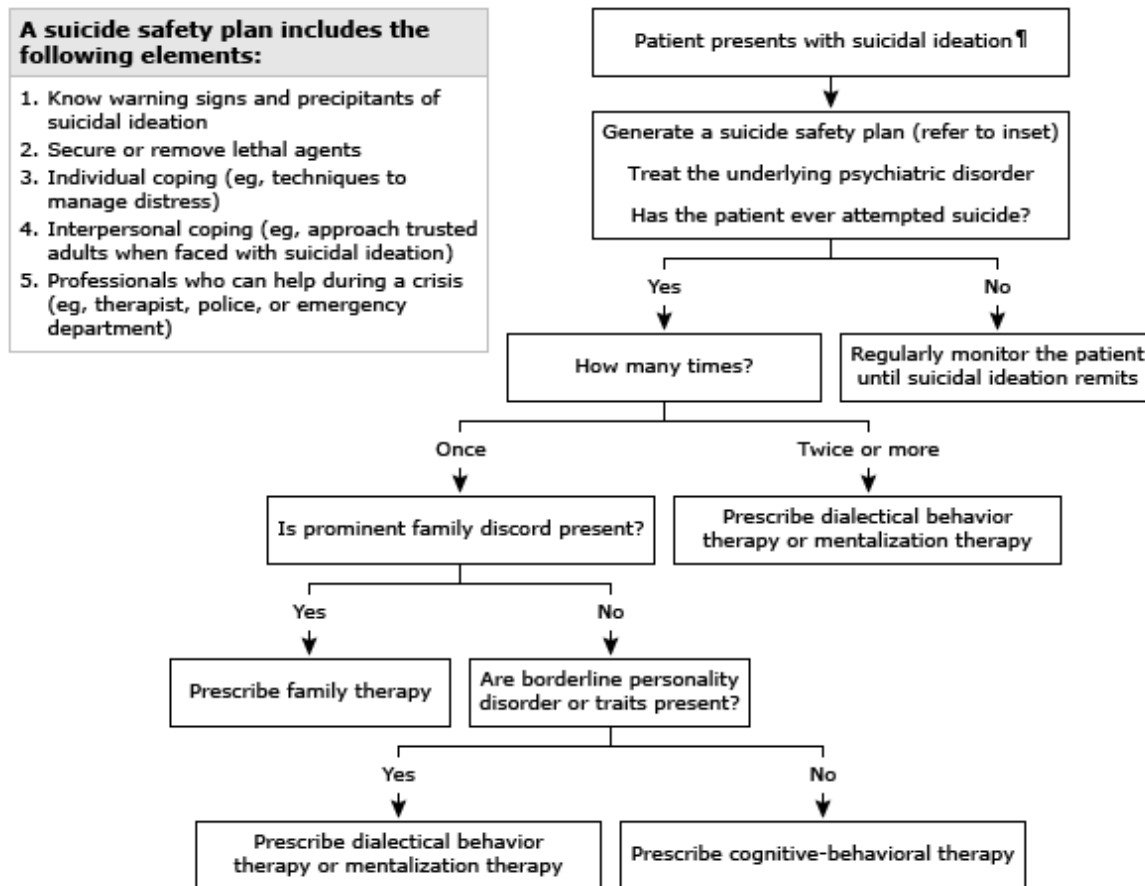
Type of strategy	Intervention
Know warning signs and precipitants	▪ Avoid situations that might precipitate suicidal ideation and behavior. As an example, establish a truce with parents about issues that lead to substantial discord. ▪ Anticipate the need to cope with stressors and problematic situations (eg, being teased or feeling down).
Secure or remove lethal agents	▪ Complete an inventory of firearms, household poisons, medications, and sharps; assess access to lethal agents. ▪ Talk through and agree to specific plan to restrict access either by removal or securing of lethal means.
Individual coping	▪ Review reasons for living. ▪ Distraction activities (eg, singing with loud music or walking briskly outside with a friend). ▪ Use techniques for distress tolerance (eg, calming self talk or visualizing a safe or beautiful place). ▪ Relaxation (eg, progressive muscle relaxation). ▪ Exercise.
Interpersonal coping	▪ Identify friends who can be contacted to help distract or lift mood (NOTE: Same age peer should be sought for distraction and social interaction only, not to discuss suicidal or self-harm thoughts or urges). ▪ Identify trusted adults to approach when trying to cope with suicidal thoughts (eg, parent or relative).
Professionals who can help	Call my therapist: Phone # _____ Call crisis line: Phone # _____ If acutely suicidal, call police or mental health emergency line to go to emergency department: Phone # _____

Adapted from:

1. Stanley-Brown safety plan. Stanley-Brown Safety Planning Intervention. <https://suicidesafetyplan.com/forms/> (Accessed on March 15, 2023).
2. Samra J, Bilsker D. Coping with suicidal thoughts. Consortium for Organizational Mental Health 2007. Available at: <https://psychhealthandsafety.org/cwstarfp/> (Accessed on July 20, 2022).
3. Stanley B, Brown G, Brent DA, et al. Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *J Am Acad Child Adolesc Psychiatry* 2009; 48:1005.

Graphic 110846 Version 5.0

Algorithm 1: Initial treatment of suicidal ideation and behavior in children and adolescents



* Full details of treating suicidal ideation and behavior in youth are discussed in the UpToDate treatment topic.

¶ The patient is medically stable, has been evaluated, and received a disposition.

Graphic 144333 Version 1.0

Table 1A: Suicide resources

In an emergency, call 1-800-SUICIDE (1-800-273-8255), the national suicide hotline	
National Institute of Mental Health (NIMH) www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml	Provides information on preventing suicide.
American Academy of Pediatrics www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Help-Stop-Teen-Suicide.aspx 630-626-6000	Provides information on preventing suicide.
American Academy of Child and Adolescent Psychiatry www.aacap.org 202-966-7300	Provides information about developmental, behavioral, and mental disorders
American Association of Suicidology www.suicidology.org 202-237-2280	Provides information on current research, prevention, ways to help a suicidal person, and surviving suicide. A list of crisis centers is also included.
American Foundation for Suicide Prevention www.afsp.org 888-333-AFSP (2377)	Provides research, education, and current statistics regarding suicide; links to other suicide and mental health sites are offered.
American Psychiatric Association www.psych.org 800-852-8330	Information and referrals to psychiatrists.
Boys Town www.boystown.org 800-448-3000 (crisis hotline) or 800-545-5771	Cares for troubled children - both boys and girls - and for families in crisis. Their hotline staff is trained to handle calls and questions about violence and suicide.
Centers for Disease Control Center for Injury Prevention and Control, Division of Violence Prevention www.cdc.gov/ncipc/ 770-488-4362	Provides links to suicide statistics, the SafeUSA Web site, and safety information.

National Alliance for the Mentally Ill (NAMI) www.nami.org 800-950-NAMI (6264)	Provides information about family support and self-help groups, links to information about teen suicide, child suicide, brain biology and suicide, as well as general suicide information links.
Depression and Bipolar Support Alliance www.dbsalliance.org 800-826-3632	Provides information about mood disorders including support groups and local chapters.

Data from: www.cdc.gov/ncipc/dvp/youth/suicide.htm and www.cdc.gov/safeusa/suicide.htm#Safety%20Resources.

Graphic 69075 Version 3.0

Table 1B: Suicide resources (continued)

In an emergency, call 1-800-SUICIDE (1-800-273-8255), the national suicide hotline.	
National Mental Health Association (NMHA) www.nmha.org 800-228-1114 800-969-NMHA (6642) 800-433-5959 (TTY)	Provides information on depression and its treatment and referrals to local screening sites.
The National Mental Illness Screening Project Suicide Division www.nmisp.org 800-573-4433	Provides information regarding free, confidential screening near you.
Suicide Awareness-Voices of Education (SAVE) www.save.org 612-946-7998	Provides suicide education, facts, and statistics on suicide and depression. It links to information on warning signs of suicide and the role a friend or family member can play in helping a suicidal person.
Suicide Information & Education Centre (SIEC) www.siec.ca 403-245-3900	Library and resource center providing information on suicide and suicidal behavior.
Suicide Prevention Advocacy Network (SPAN) spanusa.org 888-649-1366 Substance Abuse and Mental Health Administration (SAMHSA) www.samhsa.gov	SPAN is a nonprofit organization dedicated to creating an effective national suicide prevention strategy. SPAN links the energy of those bereaved by suicide with the expertise of leaders in science, business, government, and public service to achieve the goal of significantly reducing the national suicide rate by the year 2010.

Data from: www.cdc.gov/ncipc/dvp/youth/suicide.htm and www.cdc.gov/safeusa/suicide.htm#Safety%20Resources.

Contributor Disclosures

Stephanie Kennebeck, MD No relevant financial relationship(s) with ineligible companies to disclose. **Liza Bonin, PhD** No relevant financial relationship(s) with ineligible companies to disclose. **David Alan Brent, MD** Grant/Research/Clinical Trial Support: AFSP [Suicide prevention]; NIMH [Child and adolescent psychiatry]. Consultant/Advisory Boards: Klingenstein Third Generation Foundation [Child and adolescent mental health]. Other Financial Interest: eRT Inc [Royalties – Clinical assessment, electronic self-rated version of the C-SSRS]; University of Pittsburgh [Algorithm development, screening tool, healthcare intervention – Suicidality]; University of Pittsburgh, Ksana Health [App development – Suicidality]. All of the relevant financial relationships listed have been mitigated. **David Solomon, MD** No relevant financial relationship(s) with ineligible companies to disclose.

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