Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Commentary

COVID-19 Takes Adolescent Suicide Prevention to Less Charted Territory

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The last decade saw an increase in national attention to suicide as the second leading cause of death among adolescents [1] and for increased youth suicide prevention efforts. Adolescents at highest risk are typically referred to emergency departments for assessment and immediate safety management, and those who cannot be maintained safely at home are often hospitalized on inpatient psychiatric units until risk decreases. At the outpatient level, mental health interventions include individual and group psychotherapy, family and collateral sessions, and medication management. However, the implementation of social distancing for minimizing the spread of coronavirus disease 2019 (COVID-19) has limited the availability of traditional "in-person" interventions to treat adolescents at risk for suicide. How do we best address the mental health needs of suicidal adolescents during the largest public health crisis of our lifetimes? This question presents an unprecedented challenge for mental health providers, researchers, and families.

The COVID-19 outbreak has hit the U.S. health care system at its weakest points—health care access, affordability, and sufficient workforce and supplies. To maintain the availability of vital resources for youth suicide prevention, mental health providers have rapidly transitioned to offer outpatient services online via "telehealth"—the virtual delivery, coordination, and evaluation of health care [2]—while facing a surge in demand of care and a decreasing number of available professionals and acute services. Although telehealth is a newer modality of service delivery for mental health, technology has been used to enhance the access, delivery, and quality of mental health care for decades. Telephone-based crisis lines, for instance, have played a prominent role in suicide prevention efforts in the U.S. since the mid-20th century [3]. However, there is a dearth in evidence-based studies on the effectiveness of telehealth as a first-line approach for the assessment and treatment of adolescents with suicidal behavior. For example, we know that having a strong relationship with a therapist is a protective factor against suicidal behavior; however, whether "virtual" interactions with a therapist adequately substitute for in-person interactions has not been tested. It is also unclear to what extent suicide risk assessment conducted via telehealth is equivalent in accuracy to in-person assessment.

Furthermore, the lack of coverage of telehealth by some insurance plans has pressured mental health providers to advocate for coverage for their young clients, to scale fees, and to be creative in how they reach their clients. Not all families have access to the necessary technology and reliable internet coverage to receive telehealth services, nor have the digital literacy to use these services [4]. Even when families are prepared to access telehealth services, the system may not be ready to serve clients who cannot speak English. Therefore, disparities in telehealth service use may mirror or surpass the racial and socioeconomic disparities observed for in-person mental health service use. These families with fewer resources, who will be hit the hardest by this outbreak, may already be the most in need of mental health services.

Whether the COVID-19 outbreak will result in increases in youth suicidal thoughts and behavior is currently unknown. Adapting to sheltering-in-place and remote schooling, unemployment, unstable housing, and the potential of family sickness and loss may fuel stress and conflict among household members. Such conflict may increase vulnerability to depression, anxiety, and trauma-related disorders and therefore suicide risk among vulnerable adolescents [5,6]. Yet, the COVID-19 outbreak may provide unforeseen benefits for some adolescents. A break from school attendance and problematic peer interactions may offer a temporary reprieve from suicidal thoughts [7]. Being at home may also increase parents' ability to limit access to lethal means and to closely monitor their children.

Telehealth services may also offer unique advantages and solutions to provide patient-centered care. Some adolescents

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may prefer "online" versus in-person therapy sessions, as electronic methods of communication are commonly selected by this age group. Telehealth can also address and potentially eliminate some of the barriers to accessing mental health services for both adolescents and their caregivers and improve session attendance [2], such as finding time for an in-person session within a busy schedule and commuting to a provider. Telehealth sessions may also allow the parent to have greater participation in the teen's treatment without having to miss work, spend time in a waiting room, or find childcare for other children in the home. Access to telehealth services may also facilitate nonhospital opportunities for adolescents and their parents to manage a suicidal crisis in the real-world contexts in which they occur.

Based on the authors' interactions with colleagues and professional organizations during the COVID-19 pandemic, mental health providers working with suicidal youth have reported providing the full range of in-person treatment modalities via video-conferencing platforms. The second author is one of the leaders of an intensive outpatient program for suicidal and self-harming adolescents that has been conducted entirely via Zoom for the past 2 months. The program uses dialectical behavior therapy [8] and includes individual therapy sessions, adolescent group sessions, and multifamily skills groups. The ability to provide the intensive outpatient program via telehealth has allowed for the continued availability of intensive outpatient care, which typically services as a bridge between inpatient/residential and standard outpatient treatment. At the same time, because treatments such as dialectical behavior therapy are time intensive and resource intensive, this may be an opportunity to use telehealth and other forms of technology to increase access to such treatments among adolescents and families served by clinics with fewer existing resources.

Clinicians offering services via telehealth can benefit from using mobile phone applications specifically designed for suicide prevention and safety planning, which allow them to standardize and personalize safety and coping plans for adolescents [9–11]. Finally, collecting patient-reported outcome measures between telehealth visits have the potential to facilitate close monitoring, relationship development, and continuity of care for adolescents at high risk for suicide, especially in the absence of the in-person contact. Those measures can also be collected through online platforms or applications designed to administer standardized self-report measures and collect information to assess suicide risk in real time and in the natural environment.

Providing telehealth services is not without its challenges, including issues related to privacy and data security. Institutions should be aware of the risks of conducting telehealth visits through third-party digital platforms and make sure that protected health information is not stored in those systems or that the platforms can guarantee a minimum risk of data breach. Therapists can also have "ground rules" for individual and group sessions. To maintain both privacy and safety, youth may be required to verify their address at the beginning of the session and to have a parent in the home and accessible during the session. In addition, youth should participate in a private setting and be encouraged to use headphones to prevent conversations from being overheard. Zoom also provides functions for the therapist to mute or end participation for youth who are violating group rules and/or are engaging in behaviors that may be problematic for other group members.

Despite best efforts to keep adolescents safe at home, we recognize that some families may still need professional guidance. We recommend that parents and caregivers use the following evidence-based strategies to decrease suicide risk and the need for emergency services among vulnerable adolescents during the COVID-19 outbreak:

- Restrict access to dangerous or potentially life-threatening items in the home, such as firearms, knives, medications, and other harmful substances.
- Closely supervise adolescents with a history of suicide attempts and nonsuicidal self-injurious behavior and limit time spent alone to prevent opportunities to engage in self-harm.
- Collaboratively monitor the adolescents' phone calls, texts, and social media use. Make sure they are not watching videos about self-harm or suicide. Adolescents are particularly vulnerable to "contagion" of self-harm behavior via both peer interactions and media exposure [12]. Another reason to monitor their social media is that adolescent bullying often occurs online. During shelter-in-place, set limits around internet usage and encourage other activities to prevent excessive exposure to or use of harmful social media.
- Attempt to keep conflict in the home low, so that adolescents feel comfortable turning to their parents or caregivers for help. This is particularly relevant during shelter-in-place, during which families are spending an increased amount of time together under stressful circumstances.
- Frequently check how the adolescent is feeling and create spaces for dialog, even when the adolescent does not engage in the conversion.
- Treat any talk of self-harm or suicide seriously and go to the nearest emergency room or call 911 if the adolescent cannot be kept safe in the home.

This is a critical time for studying the short- and long-term impact of COVID-19 on adolescent suicide rates, the effectiveness of telehealth interventions, and disparities in telehealth access. Adolescents are experts in connecting with friends and family over technology. Therefore, they should be regarded as invaluable consultants in research studies seeking to assess telehealth interventions for suicide prevention. Similarly, parents and caregivers are at the frontline for youth suicide prevention and can provide input as to which strategies are working to reduce youth suicide risk in the home. Finally, we need to include input from mental health providers who are outside of academia in pilot studies testing the feasibility and acceptability of translating evidence-based practices to telehealth platforms.

Although the COVID-19 outbreak has highlighted cracks in our health care system and fears about the "unknown," it is crucial that mental health care providers, families, and adolescents focus on what they do know in preventing suicide. Mental health care providers, no matter their current comfort with virtual care, have years of experience supporting people through crises. We have the tools to weather this storm. In doing so, we must seek to improve our telehealth services for suicide prevention, positioning us to be better prepared for future crises where social distancing and quarantine may be necessary, as well as for providing alternatives to in-person treatment to reduce barriers to care.

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References

[1] CDC. Web-Based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: US Department of Health and Human Services, CDC; 2016. http://www.cdc.gov/injury/wisqars/index.html. Accessed May 12 2020.
[2] Fairchild RM, Ferng-Kuo SF, Rahmouni H, Hardesty D. Telehealth increases access to care for children dealing with suicidality, depression, and anxiety in rural emergency departments. Telemed E-health 2020. https://doi.org/10.1089/tmj.2019.0253.
[3] Crosby Budinger M, Cwik MF, Riddle MA. Awareness, attitudes, and use of crisis hotlines among youth at-risk for suicide. Suicide Life Threat Behav 2015;45:192–8.
[4] Velasquez D, Mehrotra A. Ensuring the growth of telehealth during COVID-19 does not exacerbate disparities in care. *Health Aff Blog*. Published May 8, 2020. Accessed May 12, 2020, https://doi.org/10.1377/hblog20200505.591306.
[5] Carballo JJ, Llorente C, Kehrmann L, et al. Psychosocial risk factors for suicidality in children and adolescents. Eur Child Adolesc Psychiatry 2019;25:1–8.
[6] e Mattos Souza LD, Molina ML, da Silva RA, Jansen K. History of childhood trauma as risk factors to suicide risk in major depression. Psychiatry Res 2016;246:612–6.
[7] Lueck C, Kearl L, Lam CN, Claudius I. Do emergency pediatric psychiatric visits for danger to self or others correspond to times of school attendance? Am J Emerg Med 2015;33:682–4.
[8] Linehan MM. Dialectical behavior therapy for treatment of borderline personality disorder: Implications for the treatment of substance abuse. NIDA Res Monogr 1993;137:20.
[9] Bush NE, Smolenski DJ, Denneson LM, et al. A virtual hope box: Randomized controlled trial of a smartphone app for emotional regulation and coping with distress. Psychiatr Serv 2017;68:330–6.
[10] Luxton DD, June JD, Chalker SA. Mobile health technologies for suicide prevention: Feature review and recommendations for use in clinical care. Curr Treat Options Psychiatry 2015;2:349–62.
[11] Stanley B, Brown GK. Safety planning intervention: A brief intervention to mitigate suicide risk. Cogn Behav Pract 2012;19:256–64.
[12] Gould MS. Suicide clusters and media exposure. In: Blumenthal SJ, Kupfer DJ, eds. Suicide over the life cycle: Risk factors, assessment, and treatment of suicidal patients. Washington, DC: American Psychiatric Association; 1990:517–32.