Factors Associated With Revisiting the Emergency Department due to Suicidal Behavior in Children and Adolescents

Ana María de Granda-Beltrán, MD; Inmaculada Peñuelas-Calvo, MD, PhD; María Taracena-Cuerda, MD; Jimena María Merayo-Cano, MD; Lidia Carrillo-Notario, BA; Paula Andrea Hidalgo Muñoz, BA; Hugo J. Bello, PhD; Roberto Rodríguez-Jiménez, MD, PhD; Enrique Baca-García, MD, PhD; and Alejandro Porras-Segovia, MD, PhD

Abstract

Objective: Suicide is a major public health concern with a significant global impact. Among children and adolescents, an increasing incidence of suicidal behavior is being observed. Several studies have noted an increase in the number of emergency department (ED) consultations involving children and adolescents presenting with self-injurious thoughts and behaviors (SITB). However, few studies have yet described risk factors associated with these repeated visits.

Methods: Our sample included all patients under 18 years of age who visited the Child and Adolescent Mental Health ED at Hospital Universitario 12 de Octubre between January 2, 2022, and November 30, 2023. A baseline interview was conducted by an attending psychiatrist during the patient's first emergency visit, followed by a review of their digital medical records 6 months later by the hospital's clinical staff.

Results: A total of 713 patients were treated in the ED during the study period, of whom 429 (60.16%) presented with suicidal behavior. Within 6 months of the initial ED visit, 25.4% of patients returned due to SITB. Specifically, 21.7% of those who initially attended for SITB returned for the same reason. Among patients who initially presented with suicidal ideation or suicide attempts, 25.8% and 25.3%, respectively, returned within 6 months. The variables independently associated with returning to the ED for SITB after the initial visit were nonheterosexual sexual orientation (odds ratio [OR] = 2.10; 95% CI, 1.14–3.87) and prior SITB (OR = 2.14; 95% CI, 1.27–3.60).

Conclusions: In our study, we found that a significant number of children and adolescents who come to the ED for SITB return for the same reason within 6 months. There is also a certain amount of switching between different types of SITB consultations, particularly from ideation to attempt. This should alert us to the significant recurrence of these consultations and the fact that mental health resources continue to be insufficient to address these behaviors.

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Author affiliations are listed at the end of this article.

Suicide is a complex, major public health concern with a significant global impact.[1] Among adolescents, suicidal behavior is an increasingly pressing issue that requires particular attention. According to the World Health Organization,[2] suicide was the third leading cause of death globally in 2021 among individuals aged 15–29 years.[2] In Spain, it is the leading cause of unnatural death in this age group, according to the National Institute of Statistics.[3] Several studies have found that self-injurious thoughts and behaviors (SITB) have increased significantly, especially after age 12, with a higher prevalence among girls.[4] Additionally, an increase in consultations related to suicidal behavior among adolescents has been observed in the past few years.[5,6] Recent studies have also highlighted an increase in emergency department (ED) consultations related to self-injurious and suicidal behavior.[7,8] Another key observation is that often patients will visit the ED on more than 1 occasion for the same reason within a short period of time.[9] Exploring the factors associated with returning to the ED could be valuable for improving care and implementing preventive measures.

Prior research from our group focused on understanding patterns and risk factors associated with repeated ED consultations for suicidal behavior in children and adolescents. Merayo-Cano et al[10] examined predictors of multiple ED visits for suicidal behavior in a smaller, retrospective sample, while Ezquerra et al[6]

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Clinical Points

- Recurrent emergency department (ED) visits for self-injurious thoughts and behaviors (SITB) in adolescents remain poorly understood, despite their increasing prevalence. Understanding these patterns is essential to improve continuity of care and suicide prevention strategies.
- Previous SITB and nonheterosexual orientation were identified as key predictors of ED revisits, underscoring the need for individualized follow-up and early intervention in these high-risk groups.
- Systematic assessment and continuity of care following an initial ED visit are essential to reduce recurrence and improve suicide prevention efforts among adolescents presenting with SITB.

analyzed factors associated with multiple ED visits and hospital admissions in a broader population. These studies provide context for the present prospective study, which aims to further characterize repeated ED consultations and their associated factors over 6 months.

Several studies have recently explored the increasing prevalence, risk factors, and patterns of SITB among adolescents. For instance, a retrospective observational study conducted in the United States found that depression is the most common diagnosis associated with returning to the ED due to SITB, followed by anxiety and alcohol-related disorders.[11] Another study conducted in London found that 15% of the adolescents who self-injured returned to the ED within a year.[4] Some of the factors associated with returning to the ED include a history of mental health disorders.[12]

However, there is still some gap in our knowledge about the nature of repeated ED consultations and their associated factors. Given the growing demand, expanding the evidence in this area could represent a significant advancement and aid in the prevention and management of suicidal behavior in this population.

The aim of this study is to characterize repeated consultations to the ED due to SITB and their associated factors in children and adolescents over 6 months.

Our hypothesis was that factors such as traumatic childhood situations, sexual orientation, gender identity, previous suicidal behavior, and previous mental health history would be associated with return to the ED for SITB.

METHODS

Context and Design

This prospective observational study complied with the principles outlined in the Declaration of Helsinki and was approved by the Ethics Committee of the University Hospital 12 de Octubre in Madrid. This hospital has a catchment area of 445,000 people. As a tertiary-level hospital with 1,196 beds, it is one of the largest referral hospitals in Spain. Although the sample may not be fully representative of all regions of Spain, the hospital does cover a significant proportion of the population, enabling meaningful insights to be gained into adolescents presenting with self-injurious and suicidal behaviors.

Sample

All patients under the age of 18 years who attended the psychiatric ED of the University Hospital 12 de Octubre (Madrid, Spain) between January 2, 2022, and November 30, 2023, were included. There were no restrictions on the inclusion of participants other than age. Data were extracted through interviews with patients during their visits to the ED, as well as through the subsequent review of their electronic health records.

Measures and Outcomes

For the purposes of this study, SITB included suicide attempts, suicidal ideation, and nonsuicidal self-injury (NSSI; deliberate self-harm without suicidal intent), as all cases were evaluated for suicide risk in the ED.

The independent variables collected were gender, age, sexual orientation, gender identity, death of a parent, divorce of parents, migrant patient/parents, socioeconomic level, being adopted, diagnosis (following *DSM-5* criteria), family history of mental illness, and presence of eating problems or drug use (but not meeting *DSM-5* criteria for eating disorder or drug use disorder), previous mental health follow-up, reason for first visit to the ED, history of abuse (emotional, physical, or sexual), being a victim of bullying, and having family conflicts (defined as any kind of problems between close family members).

The primary outcome was returning to the ED for suicidal behavior within the following 6 months.

Procedure

A baseline semistructured clinical interview was conducted by an attending psychiatrist in the ED during each patient's initial visit for suicidal behavior within the specified period, following the hospital's standardized protocol for suicide risk assessment.

This interview was used to obtain clinical diagnoses and details of the incident leading to the ED presentation, and these were subsequently verified using data from the hospital's electronic medical record system (Health Care Information System [HCIS]). This system includes both coded sociodemographic and clinical variables, as well as narrative entries from the health care professionals involved in each patient's care.

All variables included in the analyses were systematically extracted from the standardized ED assessment protocol and the HCIS records. The source of

each variable was predefined in a structured data collection form to ensure consistency and reliability across cases. A detailed correspondence between each variable and its source is available upon request.

To minimize methodological differences between the initial face-to-face assessment and follow-up data collection from digital records, a standardized data collection form was used.

Statistical Analysis

All analyses were performed using SPSS statistical software, version 25.0. Descriptive statistics were provided for the sample and the characteristics of their ED visits. To explore the factors associated with patients returning to the ED, a survival analysis was conducted to examine the time to event (time until a new ED presentation for SITB). The event was defined as the first return visit to the ED for any SITB, including both suicidal and nonsuicidal self-injurious behavior, within the 6-month follow-up period. Kaplan–Meier curves and a Cox proportional hazards regression model were used to assess these factors. All tests were 2-tailed, with 95% confidence intervals, and statistical significance was set at $P < .05$.

RESULTS

Baseline Characteristics of the Sample

Of the 713 patients treated in the ED during the study period, 429 (60.16%) presented with suicidal behavior. Of these patients, 38.7% had attempted suicide, 26.8% had self-harmed without intending to die (NSSI), and 33.6% had experienced suicidal thoughts only. Although NSSI does not imply suicidal intent, it was included within the broader category of SITB, as all such cases were evaluated for suicide risk in the ED. Of those who attempted suicide, drug overdose was the most common method (27.3%), followed by cutting (20.5%).

Among the 429 patients treated for suicidal behavior, 83.2% were female, with ages ranging from 7 to 17 years and a mean age of 14.6 years. Parental divorce was reported in 49.4% of participants, and family problems were present in 52.2% of cases.

The majority of the children had a prior history of suicidal behavior (73.2%), and more than half had a family history of mental illness (52.4%). Nearly half of the sample (49.0%) was receiving follow-up care in Mental Health Services. In terms of diagnoses, the most common finding was the absence of a specific diagnosis (28.9%), likely reflecting that many adolescents were undergoing initial assessment. Among those with a mental health diagnosis, mood disorders were the most prevalent (20.7%), followed by anxiety disorders (7.9%). The sample's characteristics are presented in Table 1.

Within 6 months of the initial ED visit, 25.4% of patients returned for SITB. Specifically, 21.7% of patients who had previously attended the ED for NSSI returned for the same reason. This percentage is 25.8% for suicidal ideation and 25.3% for suicide attempts. Figure 1 shows the flowchart of visits. However, some patients may have returned to the ED for a different type of SITB than the one they presented with initially. For example, of the patients who initially attended for self-harm, some of them returned for suicidal ideation or attempted suicide. The same is true of those patients who came for suicidal ideation, but in this case, there is a higher proportion of patients who returned for suicidal ideation than for the other types of SITB. Among those who came for attempted suicide on the first visit, they returned more often for attempted suicide than for the rest of the SITB. Figure 2 shows the alluvial diagram of the different SITB visits.

Survival Curve of ED Revisit for SITB (Time Until the Next Visit)

Figure 3 presents the Kaplan–Meier survival curve, where the event corresponds to a new ED presentation for SITB. The figure also shows survival curves stratified by psychiatric diagnosis. The mean survival time was 148.06 days (SE = 2.877; 95% CI: 142.426–153.70). A detailed survival analysis shows 29 events with a 93.2% survival rate at 15 days. After 1 month, there were 43 events with a 90% survival rate, and by 2 months, 69 events, with an overall rate of 83.9%. At the end of the follow-up period, 109 accumulated events were observed, with a survival rate of 74.6%.

Cox Regression: Factors Associated With Revisiting the ED for SITB

A Cox regression analysis was performed to study the variables associated with revisiting the ED for new suicidal behavior, as shown in Table 2. Statistically significant differences were found in the following variables: family conflicts (hazard ratio [HR] = 1.486, 95% CI [1.012–2.182], $P = .043$), LGBTIQ+ status (HR = 1.447, 95% CI [1.035–2.022], $P = .031$), sexual orientation (HR = 2.099, 95% CI [1.137–3.875], $P = .018$), previous mental health follow-up (HR = 1.355, 95% CI [0.159–1.584], $P < .001$), previous mental health hospitalizations (HR = 1.363, 95% CI [1.107–1.679], $P = .004$), prior history of suicidal behavior (HR = 2.019, 95% CI [1.218–3.348], $P = .006$), presence of comorbidities (HR = 1.894, 95% CI [1.258–2.850], $P = .002$), eating problems (HR = 1.560, 95% CI [1.070–2.272], $P = .021$), and treatment adjustments during the previous emergency visit (HR = 2.212, 95% CI [1.177–4.159], $P = .014$). Subsequently, a Cox model was run with variables that had a P value < .010. Although this threshold is

Table 1.
Characteristics of the Sample and Their Visits to the ED (Total n = 429)

Variable	n (%)
Female gender	357 (83.2%)
Age at first ED visit, y	Mean = 14.61 (range, 7–17)
Adopted child	6 (1.4%)
LGBTQ	24 (5.6%)
Gay/lesbian/bisexual	23 (5.4%)
Transgender or nonbinary	1 (0.2%)
Divorce of the parents	212 (49.4%)
Family problems	224 (52.2%)
Migrant	101 (23.5%)
Migrant parents	236 (55%)
Low socioeconomic level	169 (39.4%)
Death of parent	15 (3.5%)
History of abuse	99 (23.1%)
Victim of bullying	114 (26.6%)
Eating problems	161 (37.5%)
Drug use	63 (14.7%)
History of suicidal behavior	314 (73.2%)
Family history of mental illness	225 (52.4%)
Previous follow-up in mental health services	210 (49%)
Previous psychiatric hospitalization	95 (21.1%)
Main psychiatric diagnosis	
None	124 (28.9%)
Mood disorders	89 (20.7%)
Anxiety disorders	34 (7.9%)
Psychotic disorders	2 (0.5%)
Emotional dysregulation	122 (28.4%)
Behavioral disorder	9 (2.1%)
Drug abuse	0 (0%)
Eating disorders	22 (5.1%)
ADHD	15 (3.5%)
ASD	6 (1.4%)
Other	6 (1.4%)
Psychiatric comorbidity (2 or more diagnoses)	88 (20.5%)
Suicidal self-injurious thoughts and behavior	
Self-harm	115 (26.8%)
Ideation	144 (33.6%)
Attempt	166 (38.7%)
Drug overdose	117 (27.3%)
Cutting	34 (20.5%)
Asphyxiation	1 (0.6%)
Jumping	3 (1.8%)
Hanging	2 (1.2%)
More than 1 ED visit for suicidal self-injurious thoughts and behavior during the study period	109 (25.4%)
Self-harm	25 (21.7%)
Ideation	41 (28.5%)
Attempt	42 (25.3%)
Hospitalized	0 (0%)
Mental health center	184 (42.9%)
Treatment setting	98 (22.8%)

(continued)

Abbreviations: ADHD = attention-deficit/hyperactivity disorder, ASD = autism spectrum disorder, ED = emergency department, LGBTQ = lesbian, gay, bisexual, transgender, and queer.

stringent, it was chosen to minimize the risk of overfitting. Some variables with weaker bivariate associations may still have a significant impact in the adjusted model. In a supplementary analysis within the subsample of patients presenting with SITB at baseline, we found similar patterns of predictors, confirming the robustness of the associations observed in the full sample. The variables independently associated with returning to the ED for suicidal behavior were nonheterosexual sexual orientation (odds ratio [OR] = 2.10, 95% CI [1.14–3.87]) and prior suicidal behavior (OR = 2.14, 95% CI [1.27–3.60]).

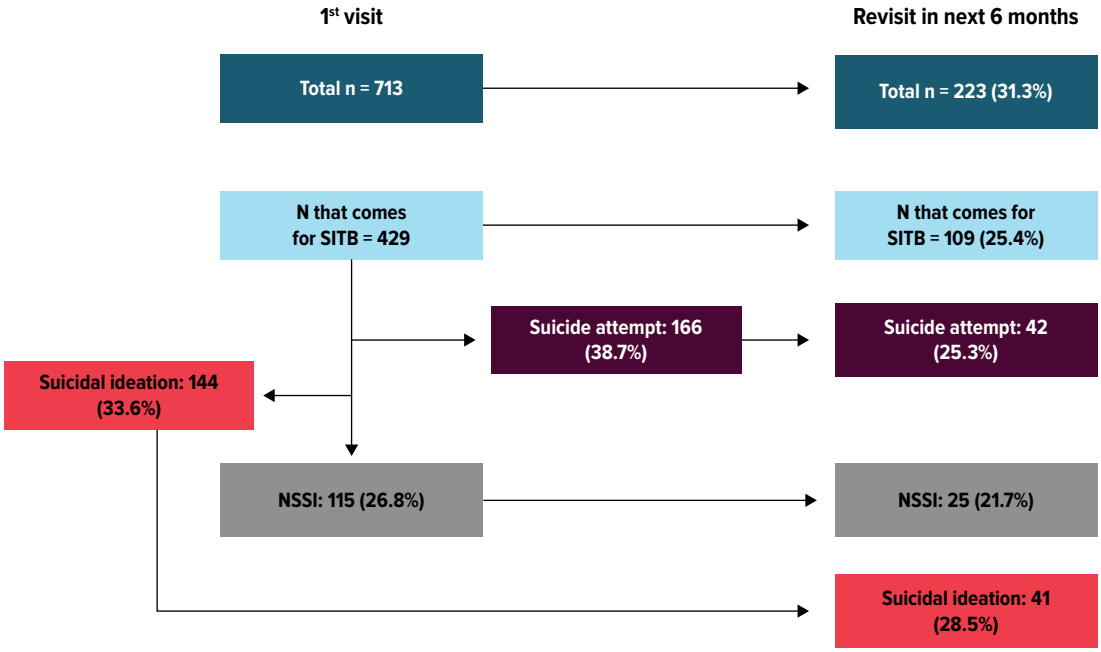
DISCUSSION

In this study, we found that a significant number of children and adolescents who come to the ED for suicidal ideation, suicide attempts, or NSSI tend to return for one of these presenting problems within 6 months. We found that the initial hypothesis was largely confirmed. Children with a history of mental health and previous suicidal behavior revisit more EDs, possibly indicating a profile of greater severity. Those who have suffered difficult situations also return more frequently. Homosexual/bisexual orientation also emerges as an associated factor. However, gender identity does not suggest being a factor associated with ED revisits.

There is also a certain amount of switching between different types of SITB consultations, particularly from ideation to attempt. This should alert us to the significant recurrence of these consultations and the fact that mental health resources continue to be insufficient to address these behaviors.

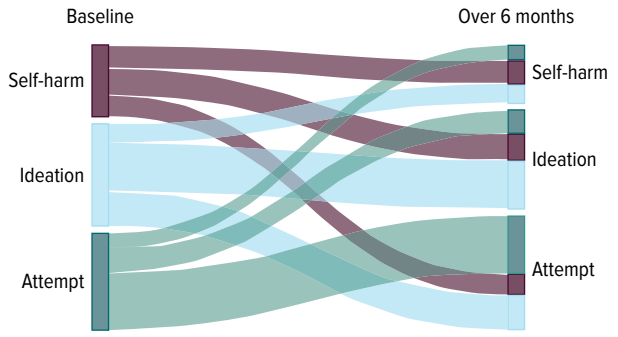
Our findings revealed a higher proportion of females in the sample, consistent with existing literature, which

Figure 1.
Emergency Department Revisits for SITB



Abbreviations: NSSI = nonsuicidal self-injury, SITB = self-injurious thoughts and behaviors.

Figure 2.
Evolution of Suicidal and Self-Injurious Behaviors Over the Follow-Up Period



indicates that suicide attempts are more frequent among females.[13] Similarly, an increasing trend of suicidal behavior among preadolescent and adolescent females has been observed.[14]

Notably, a high percentage of our patients had a prior history of suicidal behavior, underscoring the importance of proper identification and follow-up to prevent future suicide attempts.

The most common diagnosis among the children and adolescents treated was mood disorders. It is well established that individuals diagnosed with depression visit the ED more frequently for suicidal behaviors compared to those with other diagnoses.[11]

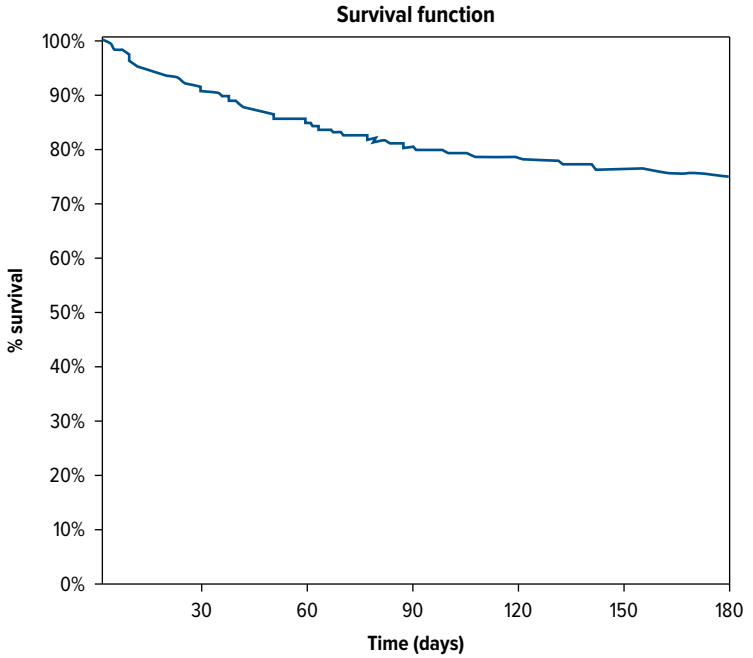
Prior follow-up in outpatient mental health services was identified as a significant factor associated with returning to the ED due to a new suicidal event. Similarly, previous hospitalizations were also linked to revisits, which may suggest a more severe clinical profile.

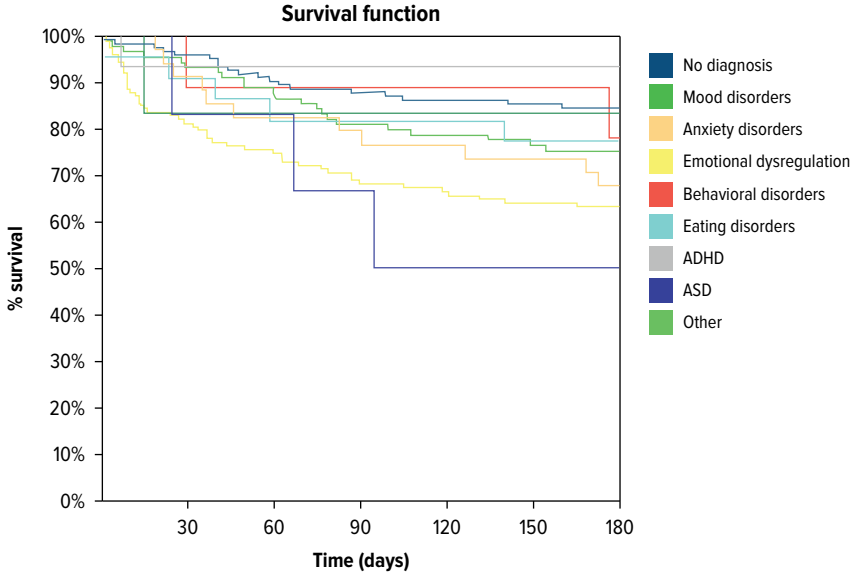
However, it is also possible that the association between receiving follow-up mental health care or previous hospitalization and more frequent ED visits reflects the influence of treatment engagement and safety planning, rather than greater clinical severity alone. Safety plans often instruct patients and their families to return to emergency services if they experience suicidal thoughts or feel unsafe. This proactive approach to seeking help could lead to a higher observed rate of revisits among patients who are more connected to care pathways.

Therefore, revisits may not necessarily indicate treatment failure, but rather the effectiveness of crisis planning and early intervention strategies. This is consistent with prior studies emphasizing the protective role of structured safety plans and follow-up interventions.[15,16] Conversely, individuals who disengage from care or who face barriers such as stigma or limited access to services may have fewer ED visits but may be at higher risk of adverse outcomes, including suicide. This interpretation is supported by emerging literature that

Figure 3.

Survival Curve of Emergency Department Revisit for Suicidal Behavior (Time Until the Next Visit) and Survival Curve Based on Diagnoses





	χ^2 test	df	*P* value
Log rank	22.826	9	< .007

Abbreviations: ADHD = attention-deficit/hyperactivity disorder, ASD = autism spectrum disorder.

Table 2.

Cox Regression: Factors Associated With the Repetition of Suicidal Behavior

Variables	HR	95% CI	*P*
Comorbidity with previous diagnoses	1.894	1.258–2.850	.002
Age	1.071	0.962–1.193	.212
Sex	1.569	0.879–2.801	.127
Adopted	0.570	0.079–4.106	.577
Previous follow-up	1.355	0.159–1.584	<.001
Low socioeconomic status	1.080	0.738–1.581	.692
Migrant	1.120	0.729–1.722	.604
Family conflict	1.486	1.012–2.182	.043
Number of previous hospitalizations	1.363	1.107–1.679	.004
History of SITB	2.019	1.218–3.348	.006
Family psychiatric history	1.113	0.762–1.625	.581
LGBTQ	1.447	1.035–2.022	.031
Gender identity (cis/trans)	1.753	0.814–3.774	.152
Sexual orientation	2.099	1.137–3.875	.018
Eating disorder	1.560	1.070–2.272	.021
Abuse	1.134	0.738–1.742	.567
Bullying	1.188	0.787–1.795	.412
Death of parent	0.236	0.033–1.687	.150
Divorce	1.114	0.765–1.622	.573
Drug abuse	1.087	0.648–1.823	.753
Hospitalized			
Mental health center	20.655	0.001–350766.820	.542
Treatment setting	2.212	1.177–4.159	.014

Abbreviations: HR = hazard ratio, LGBTQ = lesbian, gay, bisexual, transgender, and queer, SITB = self-injurious thoughts and behaviors.

advocates continuous, easily accessible postdischarge support for young people exhibiting suicidal behavior. Such support has been shown to significantly reduce suicide risk through timely outpatient follow-up and adaptive engagement strategies.[17,18]

Another important factor was the presence of comorbidities, meaning 2 or more psychiatric diagnoses. Individuals with multiple diagnoses have a more severe clinical profile, a higher suicide risk, and, consequently, a greater likelihood of returning to the ED.[19,20] In particular, we found that eating problems are associated with an increased risk of revisiting the ED. Eating disorders have been extensively linked to suicidal behavior in the literature, and suicide is one of the leading causes of death in this population.[21]

Family is crucial for emotional development and should provide a sense of security. Family conflicts are associated with poorer mental health in children and adolescents.[22] In our study, we found that family conflicts were associated with a greater likelihood of returning to the ED. This highlights the importance of thoroughly assessing the child's environment.

In our study, the variables independently associated with returning to the ED were previous suicidal behavior and nonheterosexual sexual orientation. Several studies highlight that a history of previous suicide attempts is the most significant factor for predicting suicide risk.[23,24] This finding can be framed within the integrative motivational-volitional model that explains how previous SITB act as volitional moderators, influencing the transition from ideation to suicide attempt. This model explains the presence of factors that can influence as protectors or precipitants in the transition from suicidal ideation to action. There are 3 phases: premotivational phase (biological, genetic, or cognitive vulnerability factors and triggering events that increase the risk of suicide); motivational phase (psychological processes that lead to the onset of suicidal ideation and how motivational moderators will increase or decrease this risk); volitional phase (from suicidal ideation to suicide attempt), and it is at this point where previous suicidal behavior is present, as a volitional moderator, being closer to action, having previously overcome that barrier.[25] This pattern aligns with the findings of the ED-STARS study, which identified prior suicidal behavior as a strong short-term predictor of new suicide attempts among adolescents admitted to the ED.[26]

On the other hand, a systematic review conducted by Miranda-Mendizábal et al[27] found a significant association between sexual orientation and suicidal behaviors. Thus, homosexual and bisexual adolescents were twice as likely to present with SITB compared to heterosexuals. Some studies indicate that this association is mediated by social support and stigmatization: When perceived social support improves, the strength of the association decreases.[28–30]

Therefore, extrinsic factors such as stigmatization, bullying, and hostile environments contribute to the increased risk observed in this population. However, it is noteworthy that in our sample, gender identity was not identified as a risk factor, which contrasts with findings from other studies. For instance, Connolly et al[31] indicate that transgender youth are more likely to experience suicidal behavior and other mental health issues. A possible explanation for this discrepancy could be the small number of transgender people in our sample.

Strengths and Limitations

This study considers a wide range of diagnoses, avoiding focusing on a specific diagnosis, and follows up a relatively large sample of children and adolescents over 6 months. Among the limitations, data collection for the sample was partially conducted through a review of medical records. Another consideration relates to the assessment of suicidal intent. In some cases, adolescents presented with both suicidal ideation and self-injury, and the precise degree of suicidal intent may not always be clear from case records. NSSI was previously categorized based on patients' denial of wanting to die. However, the results remain consistent with literature highlighting NSSI as a strong predictor of future suicidal behavior, despite

no separate category being used for nonlethal self-injury with some suicidal intent. Additionally, only clinical diagnoses were collected, without the use of standardized scales. Finally, it is possible that some patients may have attended other facilities during the follow-up period, which could have led to an underestimation of subsequent ED visits for suicidal behavior. During the 6-month follow-up period, there were no deaths by suicide or other unnatural causes in the sample, which limited the ability to evaluate mortality outcomes.

CONCLUSIONS

A significant number of people who come to the ED for SITB return for the same reason within a short period of time. Our study identified several risk factors associated with repeated ED visits, particularly previous suicidal behavior and nonheterosexual sexual orientation.

Exploring the risk factors that contribute to the onset of SITB allows for targeted intervention. It is crucial to continue advancing this effort, not only within mental health services but also among all professionals involved in the care of children and adolescents. Expanding data collection and research to the educational sector presents another significant opportunity for prevention. Moreover, efforts should be made to promote interventions starting in EDs, ensuring proper coordination that involves not only psychiatric units but also pediatric professionals.

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Author Affiliations: Department of Psychiatry, Hospital Universitario Fundación Jiménez Díaz, Madrid, Spain (de Granda-Beltrán, Merayo-Cano, Baca-García); Mental Health Research Group, Health Research Institute Jiménez Díaz Foundation, Madrid, Spain (de Granda-Beltrán, Merayo-Cano, Baca-García, Porras-Segovia); Department of Child and Adolescent Psychiatry, Hospital Universitario 12 de Octubre, Madrid, Spain (Peñuelas-Calvo, Taracena-Cuerda, Carrillo-Notario, Hidalgo Muñoz); Health Research Institute Hospital 12 de Octubre (i+12 Institute), Madrid, Spain (Peñuelas-Calvo, Rodríguez-Jiménez); Department of Psychiatry, Universidad Complutense de Madrid, Madrid, Spain (Peñuelas-Calvo, Rodríguez-Jiménez); CIBERSAM-ISCIII (Biomedical Research Networking Centre for Mental Health), Spain (Peñuelas-Calvo, Rodríguez-Jiménez); Department of Applied Mathematics, Universidad de Valladolid, Valladolid, Spain (Bello); Department of Psychiatry, Hospital Universitario 12 de Octubre, Madrid, Spain (Rodríguez-Jiménez); Department of Psychiatry, Hospital Universitario Rey Juan Carlos, Móstoles, Madrid, Spain (Baca-García, Porras-Segovia); Department of Psychiatry, Hospital Universitario Infanta Elena, Valdemoro, Madrid, Spain (Baca-García); Department of Psychiatry, Hospital General de Villalba, Villalba, Madrid, Spain (Baca-García); CIBERSAM, Research Group CB/07/09/0025, Madrid, Spain (Baca-García); Department of Psychiatry, Universidad Autónoma de Madrid, Madrid, Spain (Baca-García).

Corresponding Author: Enrique Baca-García, MD, PhD, Department of Psychiatry, Hospital Universitario Fundación Jiménez Díaz. Avda. de los Reyes Católicos, 2. 28040 – Madrid, Spain (research.fjd@gmail.com).

Drs de Granda-Beltrán and Peñuelas-Calvo are co-first authors and contributed equally to this work.

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ORCID: Inmaculada Peñuelas-Calvo: https://orcid.org/0000-0003-4093-1312; Hugo J. Bello: https://orcid.org/0000-0002-3687-1938; Roberto Rodríguez-Jiménez: https://orcid.org/0000-0003-2251-7249; Enrique Baca-García: https://orcid.org/0000-0002-6963-6555; Alejandro Porras-Segovia: https://orcid.org/0000-0003-2019-9099

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