

## Strategies for managing suicidal ideation and reducing risk

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## AMA Moving Medicine

### Strategies for managing suicidal ideation and reducing risk

Nov 12, 2021

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### Featured topic and speakers

Suicide experts share current data on suicidal ideation, the importance of screening early and often, and the connection between child mental health and mental health as an adult. Hear how a pediatrician implemented suicide screening, prevention efforts, risk assessment into their care setting and more.

View the full presentation from the Overcoming Obstacles webinar series.

### Speakers

- Christine Yu Moutier, MD, chief medical officer, American Foundation for Suicide Prevention
- Cori Green, MD, MS, FAAP, director, Behavioral Health Education and Integration, Weill Cornell Medicine

### Host

- Todd Unger, chief experience officer, American Medical Association

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### Transcript

**Dr. Moutier:** While the pandemic brought challenges, it also brought a bursting, open up of the seams in terms of the dialogue around what people are actually experiencing on the

inside as it relates to our mental health.

**Unger:** That's Dr. Christine Yu Moutier, American Foundation for Suicide Prevention's Chief Medical Officer.

**Dr. Moutier:** For young people, we know that suicide is the second leading cause of death. Overall in our nation, it is the 10th leading cause of death.

**Unger:** Dr. Moutier shares her insights on pediatric and adult suicidal ideation, the importance of screening early and often, and the connection between child mental health and mental health as an adult. She is joined by Dr. Cori Green, the director of Behavioral Health Education and Integration at Weill Cornell Medicine.

**Dr. Green:** Only half of the pediatricians surveyed felt prepared on suicide prevention. As part of our grant and part of training residents, we did a baseline survey and this is really promising.

**Unger:** Dr. Green shares her case study on how they've implemented risk reduction efforts in her own practice. All on this episode of Moving Medicine.

**Dr. Moutier:** This is a very timely moment for obvious reasons, still dealing with the pandemic and the way that those disruptions have led to changes in so many of our populations and our lives. It is a time where in the national dialogue around mental health and suicide prevention, even before the pandemic but especially during the pandemic, there have been changes in terms of opening up, realizing that mental health is a part of health, that we can shed stigma.

But it's also a time when we need to take steps within the health system arena to really address suicide as the public health crisis that it is. I have a visual here, just outlining the various layers of a public health approach to suicide prevention which, of course, clinicians are a part of but are not the whole picture. This does involve the need to universally educate individuals, families, in the schools, faith organizations, workplaces.

But at the end of the day where everyone always is referred, if they are deemed to be having suicidal thoughts or be carrying any increase in suicide risk is to their health practitioner and oftentimes that starts with primary care or the emergency department. Many people don't actually end up making it to a mental health professional, although, of course, we want more too. But there is absolutely a role for every one of us and particularly in the health system to play when it comes to reducing suicide risk.

What has been happening even pre-pandemic, is that starting in about the year 2000, the national rate of suicide has been rising steadily year over year for about 20 years. And then a little glimmer of hope

here, in 2019, we saw the first downturn in that national rate of suicide. And while the numbers are still preliminary for the year 2020, we do know that there was a reduction in overall deaths to suicide. However, while there was an increase in overdose deaths.

It's obviously not, not all good news from a mortality and morbidity standpoint in the behavioral health arena but we are hoping that this will be the start of a trend, especially in light of the fact that while the pandemic brought challenges, it also brought a bursting, open up of the seams in terms of the dialogue around what people are actually experiencing on the inside as it relates to our mental health.

For young people, we know that suicide is the second leading cause of death. Overall in our nation, it is the 10th leading cause of death. Now, the science around, not only neuroscience and mental health, but around suicide risk and prevention has been changing a lot. Stigma's going down and people are speaking out more.

And that advocacy on the part of people with their own lived experience having survived an attempt and certainly for people who have lost loved ones to suicide, that combination of grassroots, advocacy and science has led us to understand that some of the old lexicon around suicide has needed to change. We want to make sure that you as health professionals know that the phrase "commit suicide," is no longer recommended. I know it's a bit of a challenge to root it out from our lexicon but it is possible to do that.

We recommend using plain language. The preferred phrase is "died by suicide," and that's really to take out that unintended perpetuation of the myth that suicide is somehow a morally reprehensible act. We know from the science that it is the culmination of intense suffering and the combination of risk factors in the brain, in one's mental health and in one's surrounding environment that leads to that outcome.

And people who succumb are really to be viewed more as victims of that culmination of psychosocial and health risk factors just like other leading causes of death are. Now, one other thing that we know that is very important is that because so much has been changing in the science and in the advocacy arena, that suicide wasn't always viewed as an actual focus for clinical training and as a clinical target. And that has really been changing very appropriately of recent.

We know that there are opportunities within all aspects of the health system to recognize an individual patient's risk and to take key steps to reduce that risk. And that's what we're really going to be focusing today. When Dr. Green gives her portion of the talk, you'll be hearing an example of how in a pediatric setting what those steps of screening, assessment and care can look like. But I do want to say that, that can be done for across the entire age span of our patient population.

Now, we're talking a little bit about this moment and with the pandemic but remember that when it comes to suicide risk, it is not a one cause effect phenomenon. The experiences people are having

during the pandemic are relevant and critically important but we know that suicide risk oftentimes has its roots related to genetics, early childhood events, trauma and other things.

It's not to say that the current environment isn't important but it's to understand the complexity here so that we know that there are multiple points of entry for prevention to occur. Some of the top findings and this will do ... I won't be able to do justice to the top scientific findings but just to understand, as I was mentioning, that while genetics play a role, they don't determine destiny.

While epigenetics are real in terms of trauma and the expression of genes into proteins, so is psychotherapy and some of the steps that Dr. Green is going to go over. That can actually change a person's risk into building up the resilience and protection. And while suicide contagion is a real phenomenon, I think what has happened oftentimes is that has gotten conflated with the opportunity to ask if somebody is having suicidal thoughts, which is not at all the same issue as contagion. It is important to ask very directly if you are worried about someone.

The last thing I'll highlight is that sense of connection and interpersonal support and connectedness, as well as mental health treatment are some of the most protective effects, as well as these steps that we're going to be hearing about in the primary care setting. Fortunately, science is providing interventions that not only identify risk but are being shown through randomized controlled trials to reduce subsequent suicide attempts and reduce suicide risk. This is something that we really didn't have.

Even not that long ago, like 10 to 15 years ago, many of the findings that we're going to go over today are just now culminating with enough science to really put them forward in a consensus sort of expert way as the recommended steps. Some of those steps that Dr. Green will be going over in more detail and I'm going to cover the health system standpoint. I think she will cover a bit more of the individual practitioner and maybe both levels. If you are a health system leader, know that ... and by the way, The Joint Commission supports all of these efforts in terms of their national patient safety goal on suicide risk. That providing education to all of your staff, even your nonclinical staff related to suicide prevention, providing training on lethal means counseling, routinely asking for consent on the part of patients to involve family members or other key people in their life in some aspects of their care is something really, really helpful for suicide prevention.

Because we don't necessarily need to be doing that at the moment of acute risk but to be doing that ongoing during the process of care and certainly starting it from the beginning. Incorporating in some routine screening, some routine ways to briefly assess for suicide risk. Again, from a system standpoint, one of the most powerful things that you can do besides developing a whole collaborative care and integrated care model would be something like putting caring communications into place for particular vulnerable patients.

When the risk is detected, that they get a series of phone calls, emails, text messages ongoing over a period of months. And that science is very strong, showing reduction in subsequent suicide attempts for that group of patients who just simply got those caring communications over time. And of course, incorporating the electronic health record into all of this so that these steps can be made clear for practitioners.

Everyone is trained on what to do, rather than having the individual practitioner feeling that the burden is entirely on them and not supported by the system and ways to get the patient the help that they need and have time for the clinician to take care of the patient. But asking and listening is very recommended. As I've mentioned, health systems, clinicians and loved ones all have a role to play.

Limiting access to lethal means, we didn't really talk much about that but counseling patients and their family members when appropriate on lethal means in the environment is a key suicide risk reducing step. I do want to thank you. I know that you all are on the frontlines and it has not been an easy time. This is for us as health professionals. If we find ourselves or our colleagues struggling, know that there is help available in many different avenues that are safe and confidential for you. I'll turn it over to Dr. Green.

**Dr. Green:** Thank you so much. It's an honor to be presenting with a true expert who gave us a lot of great material. And that's my disclosure. I am not an expert in suicide. I am not a lead researcher and I don't have it all figured out but I am a pediatrician who spent the past decade really thinking about how we can integrate mental health into pediatric care. And along that road, I have realized that suicide, now being the second leading cause of death starting at age 10, is something that we really need to pay attention to.

This is kind of a continuum of care of mental health that you can integrate into practice. We've created policy statements. I've worked with the American Academy of Pediatrics who mental health integration is a top priority as is suicide prevention. But when it comes to suicide, people panic. Let me just step back again. I said I'm not an expert but about two years ago, I did write a small grant with my psychiatry counterpart to become part of a Zero Suicide learning collaborative.

Now that gave me knowledge, skills and a little bit of resources to really start implementing suicide screening, suicide prevention and actually training pediatric residents to do a better job of identification and responding to suicide risk. When we talk about suicide prevention, is it preventable? We have to look at it through that lens. As a primary care clinician, prevention is our cornerstone. As a pediatrician, prevention, promotion, identify early, I mean, that is what we do, right?

We have vaccines and I can count on two hands how many cases of meningitis I've seen compared to my mentors. We give anticipatory guidance as part of the promotion of anticipatory guidance to wear helmets so that if you fall, you're not going to hurt your head. There's really no reason that suicide risk should be any different. Mental health in general, we should be promoting positive parenting

strategies, ways to build resilience and social connectedness in children.

A little bit of background on pediatricians' experiences and attitudes. A national survey done by the American Academy of Pediatrics, two practicing pediatricians who saw patients over the age of nine found that eight out of 10 had a patient attempt suicide in their career. Suicide is scary for a lot of us and we want to refer but we're seeing it, right? And only half of the pediatricians surveyed felt prepared on suicide prevention. As part of our grant and part of training residents, we did a baseline survey, and this is really promising.

100% of our sample, which about 50 residents, agreed that it is the pediatrician's responsible to identify suicide risk. And almost 100%, 96 think it's the pediatrician's responsibility to perform a safety plan when risk identified. This is great. The younger generation has it. A lot of us panic when we see suicide. But we have to learn what the tools are and learn the science and learn how to get help so that we don't panic because we really have to look at this through a prevention lens.

This is from the AAP's toolkit on suicide prevention, really looking at a fact sheet for primary care clinicians and what we should be doing—screening, managing a positive screen, counseling about lethal means restriction, ongoing care and up, and we'll dive into each of those a little bit now. Identification and screening. I will get a little bit into which screening tool we chose after this but these are the ways to identify. Pediatric clinicians love our HEADSS assessment, right?

And it's grown with four S's, social media, but the S's are sexual activity, safety, suicide, social media. There is the validated history. But we do know that a lot of patients disclose more when they're writing it down, when it's by themselves. Screening tools are great and help and they also help with how you word questions. Sometimes when we're busy and there are patients waiting, you get really mixed up and maybe you're not really asking about killing but hurt and you get confused. We really endorse using screening tools.

This is what we use, the PHQ-9 modified for teens, which is the PHQ-9 plus a couple of questions about suicide. Although the PHQ-9 modified for teens has not been validated in research, it has been shown to increase identification over just the normal PHQ-9. There is a question number nine that is on all of the PHQs, thoughts that you would be better off dead or hurting yourself in some way. And then there are two additional questions at the bottom. Has there been a time in the past month when you've had thoughts? Have you ever in your life attempted?

Now, these are questions that can then help you identify the risk and then want to do a further assessment. And right now, this is what we use. We are currently in the process of making this an electronic screen. Sending it out electronically before the visit is tricky, because if there is a safety concern, who's going to see it and when? But we are creating safety in baskets so that our social work team gets notified.



What we do, which there really isn't evidence to support this, is if any of those three questions were positive in the PHQ modified for teen, we then use the Columbia-Suicide Severity Rating Scale. Now, some would say, "You're going to miss people just with the PHQ modified for teens and you should be doing this," or I will show you an additional screen in a second. Those as well because it will catch more. I'm at the stage where I need to get our rate from 60% screening to 99% screening, so I can't ask people to do us a secondary screen.

The PHQ-9A really helps with identification. The C-SSRS really is what is triggered in our electronic health record if the PHQ modified teen is positive. And here are the questions. It doesn't look like this in the EHR, although I wish it did because the color coding really helps you with your risk assessment, which we'll get to. And here is the ASQ, Ask Suicide-Screening Questions. This is another tool that was created and studied and has been validated outpatient pediatric practice, primary care practice, in many different places.

It comes with a whole toolkit. What do you do if a screen is positive? Well, first, our inclination is to panic but it's to back up and kind of ignore that there are patients waiting and go back to our superpowers. Common factors are communication skills that are universal to all types of psychotherapy, regardless of the disorder. It is the interpersonal skills that primary care clinicians have so naturally. But when you're busy or you're worried because of a patient's safety, we sometimes forget them.

The American Academy of Pediatrics really endorses using common factors as an intervention, and we have the health mnemonic that that helps us with what those common factors are, hope for improvement, empathy for E, language, loyalty, permission. This is a big one that I wasn't doing until I started working around common factors. When you see something positive, instead of just going straight into more personal questions, step back. Is it okay if I ask you more about this? I started doing that and it really helps build the rapport.

Partnership plan. What are you doing after you engage the patient, after you use those superpower interpersonal skills? You want to assess the level of risk and intervene accordingly. How safe is this child? And kids are a little bit different here. Bullying is a risk factor that we don't always think about. Abuse. Impulsivity. Our kiddos with ADHD who may be very impulsive, we don't always think about suicide but that's a risk factor. My LGBTQ youth are the ones who are presenting more and more right now with suicidality. On the left, those are your risk factors. That might be a little bit more unique to children. And on the right are the protector factors that I think are a little bit more unique to children.

School and activities, not work, right? Future oriented. I've had patients tell me they don't want to live but yet they really want to be a mom or a pediatrician when they grow up, which makes my heart rate drop a little because that's a good protective factor. There are also tools. Part of the ASQ toolkit has this brief suicide safety assessment to help you go through what are the protective and risk factors and how safe is this child. Number one is praise the patient. It goes along with that H of hope.

It's identify strengths. Thank you so much for disclosing this to me. That was very brave. Number two is to assess the patient. And what does that mean? This tool and the follow-up C-SSRS tool for assessment, ask questions about frequency. How many times a day do you think of suicidality? How many times a week? If you have a plan? One thing I've learned is you really have to separate out that plan from a method, right? You might have a plan to jump off a building. But if you don't have access to one, you don't really have a method.

Little things you have to think through. Mental health symptoms. The reason this tool is really wonderful is because it helps you with the language. It helps you go through every little detail and language. For instance, it asks about plan. Do you have a plan to kill yourself? If yes, what is it? If no, if you were going to kill yourself, how would you do it? A lot of us might not think of that follow-up question but it's important to ask. These are really direct words that we know we should use.

But when you're flustered and patients are waiting and time is an issue, it's nice to have toolkits to kind of go and help guide what you're saying. What do you do after you asked the patient all of these questions? You have to bring in the parent. Now, we all know that confidentiality does not apply when safety is an issue. I have disclosed to parents very often about their child's safety and what they've been thinking, and then the goal is to ask them if they've noticed the same. Sometimes parents know when kids don't think they do.

And again, this is more for youth. This is a brief suicide safety assessment tool for youth, so it really stresses the parent and guardian. And then you want to make a safety plan, which I'll go more into in a second, and determine disposition. That is, ER, home, follow-up with you. No matter what, you want to provide resources. Every patient of mine who endorses some sort of suicidality has to in that moment put in their cell phone the 1-800 suicide prevention hotline number.

Counseling about lethal means restriction has to be part of what you're doing as you're going through that safety assessment, as you're doing a safety plan. This alone saves lives. If you have time to do nothing, you do this. There is science that you do this. It can be very morbid asking these questions but you have to. Are there weapons? What kind of sharp objects are there, like razors, pens for youth who self-harm as well? You have to really get detail about sharp objects that you have to put away. Asking about rope, suffocation, medications.

This is a resource that can help guide your conversation. And then there is also science to show that doing a safety plan can help save lives as well. It is not a safety contract. We know those don't work but this is what we use. After we determine the risk assessment, if you're not red, we do a safety plan, which looks like this.

It asks about warning signs, coping strategies, listening to music, talking to a friend, writing down the phone numbers of people you can call to distract you, writing down the phone number of an adult you can ask for help, putting in those professional hotlines. And then step six, making the environment

safe, like the lethal means restriction. An ongoing care and follow-up kind of determines how things go after. A lot of kids get better when their parents know is what I'm noticing. It takes the relief.

You want to get them into mental health services. Right now, it's two to three months to get into services. I'm seeing some of these patients every two weeks via video visit until they can get into care, as long as I know that they're at a risk level that I'm comfortable with.

**Unger:** You just heard Dr. Christine Yu Moutier and Dr. Cori Green in collaboration with the Behavioral Health Integration Collaborative's Overcoming Obstacles Series.

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