Self-Injurious Behavior vs. Suicidal Ideation

Jennifer Downs, MD
SELF-INJURIOUS BEHAVIOR

Non-Suicidal Self Injury
NON-SUICIDAL SELF INJURY (NSSI)

Cutting

Burning (Fire & Friction)

Head banging

Scratching/Skin picking

Strangulation
DIAGNOSES CARRYING HIGHER RATES OF SELF HARM / VIOLENCE

- ADHD
- Oppositional Defiant Disorder, Conduct Disorder
- Developmental Disabilities
- Intellectual Disability
- Autism Spectrum Disorder
- Psychosis/ Mania
- PTSD
- Intoxication
- Medical illness – delirium, tumor, encephalopathy
WHAT WAS THE INTENT OF THE “GESTURE”?

DEVELOPMENTALLY, IS THE CONSEQUENCE OF THIS BEHAVIOR UNDERSTOOD?

WHAT IS THE RISK:RESCUE RATIO?
SUICIDAL IDEATION

(and attempts)
**Suicide: Indiana 2017 Facts & Figures**

**Suicide Death Rates**

<table>
<thead>
<tr>
<th></th>
<th>Number of Deaths by Suicide</th>
<th>Rate per 100,000 Population</th>
<th>State Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>960</td>
<td>14.4</td>
<td>28</td>
</tr>
<tr>
<td>Nationally</td>
<td>44,193</td>
<td>13.26</td>
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</tbody>
</table>

Suicide is the 11th leading cause of death overall in Indiana.

On average, one person dies by suicide every nine hours in the state.

Suicide cost Indiana a total of $1,023,791,000 of combined lifetime medical and work loss cost in 2010, or an average of $1,184,944 per suicide death.

*In Indiana, suicide is the...*

2nd leading cause of death for ages 15-34

3rd leading cause of death for ages 10-14

4th leading cause of death for ages 35-54

10th leading cause of death for ages 55-64

17th leading cause of death for ages 65 & older

More than twice as many people die by suicide in Indiana annually than by homicide; the total deaths to suicide reflect a total of 20,353 years of potential life lost (YPLL) before age 65.

Based on most recent 2015 data from CDC. Learn more at afsp.org/statistics.

30 Years Strong

American Foundation for Suicide Prevention
afsp.org
Suicide Facts & Figures: Indiana 2018*

On average, one person dies by suicide every eight hours in the state.

More than twice as many people die by suicide in Indiana annually than by homicide.
The total deaths to suicide reflect a total of 21,413 years of potential life lost (YPLL) before age 65.

Suicide cost Indiana a total of $1,023,791,000 of combined lifetime medical and work loss cost in 2010, or an average of $1,184,944 per suicide death.

10th leading cause of death in Indiana

2nd leading cause of death for ages 15-34
4th leading cause of death for ages 35-54
9th leading cause of death for ages 55-64
16th leading cause of death for ages 65 & older

Suicide Death Rates

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<th>Number of Deaths by Suicide</th>
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<tr>
<td>Indiana</td>
<td>1,034</td>
<td>15.36</td>
<td>25</td>
</tr>
<tr>
<td>Nationally</td>
<td>44,695</td>
<td>13.42</td>
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</tbody>
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*Based on most recent 2016 data from CDC. Learn more at afsp.org/statistics.
SUICIDE RISK ASSESSMENT

- Consider risk factors
- Consider protective factors
- Conduct psychiatric evaluation
- Obtain collateral data
- Develop appropriate safety plan
SUICIDE RISK FACTORS

• Prior Attempt(s)
• Current Intensity of SI
• Unstable Home or School Environment
• Social Distress
• Internal Psychological Factors/ Lack of Resilience
• Physical Health Limitations
• Family History/ Genetics
SUICIDE PROTECTIVE FACTORS

• Engagement in appropriate outpatient services
• Perceived family and community support/Connectedness
• Internal Resilience/Temperament
• Skills in problem solving, conflict resolution, nonviolent ways of handling disputes, & other coping
• Cultural and religious beliefs that discourage suicide/support instincts for self-preservation
HOW CAN I SCREEN FOR SUICIDE?

ASQ (Ask Suicide Questions)
• Designed for children / adolescents 10-21 yrs.
• 4 yes/no questions; takes only 20 seconds
• “yes” to one or more of the four questions identified 97% of youth at risk for suicide

C-SSRS (Columbia Suicide Severity Rating Scale)
• Wider range of ages with specialized testing for pre-school children and those with intellectual disability
• Longer and more cumbersome to score

20-33% of adolescent suicide attempts occur without apparent SI
ASK SUICIDE-SCREENING QUESTIONS (ASQ)

1. In the past few weeks, have you wished you were dead? Yes No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
3. In the past week, have you been having thoughts about killing yourself? Yes No
4. Have you ever tried to kill yourself? Yes No
   If yes, how?________________________________________
   When?_____________________________________________

If the patient answers yes to any of the above, ask the following question:

5. Are you having thoughts of killing yourself right now? Yes No
   If yes, please describe:__________________________________
If patient answers “No” to all questions 1 through 4, screening is complete. No need to ask question 5. No intervention is necessary.

If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:

- “Yes” to question #5 = acute positive screen (imminent risk identified)
- “No” to question #5 = non-acute positive screen (potential risk identified)
<table>
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<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS</th>
<th>Since Last Contact</th>
</tr>
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<tbody>
<tr>
<td><strong>Ask questions that are bold and underlined</strong></td>
<td>YES</td>
</tr>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
</tr>
<tr>
<td>1) <em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
</tr>
<tr>
<td>2) <em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
</tr>
<tr>
<td><strong>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6</strong></td>
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| 3) *Have you been thinking about how you might do this?*  
   E.g. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it… and I would never go through with it.” | | |
| 4) *Have you had these thoughts and had some intention of acting on them?*  
   As opposed to “I have the thoughts but I definitely will not do anything about them.” | | |
| 5) *Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?* | | |
| 6) *Have you done anything, started to do anything, or prepared to do anything to end your life?*  
   Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. | | |
COLUMBIA SUICIDE SEVERITY RATING SCALE

SCORING

**Low Risk**
- No to question #2 and no to question #6
- Yes to question #2, but yes to question #6 ≥ 1 year ago

Likely needs non-urgent psychiatric evaluation

**Moderate Risk**
- Yes to questions #2 and #3, but no to questions #4 & #5
- No to question #2, but yes to question #6 ≥ 1 month and < 12 months ago

Likely needs urgent psychiatric evaluation & increased supervision

**High Risk**
- Yes to questions #2 and #3 and yes to questions #4 or #5
- No to question #2, but yes to question #6 in the last 4 weeks

Likely needs emergent psychiatric evaluation & should not be left alone
NEXT STEP: BRIEF SUICIDE SAFETY ASSESSMENT

- Speak with child individually, caregiver individually, and dyad/family together
- Use developmentally appropriate language and interactions with the child
- When possible, obtain collateral from any referring party (i.e. school/police) and any current mental health practitioners caring for the child
- Know when to maintain confidentiality and when to breach this for safety (i.e. reporting abuse to Department of Children’s Services, engaging in duty to warn for threats of homicide, or sharing with parents/caregiver if child is engaging in significant risky behavior unknown to them)
SAFETY ASSESSMENT COMPONENTS

- Praise patient for sharing about this difficult topic
- Clarify responses to the suicide screener and ask more questions
- Perform a psychiatric symptom check-list
- Ask about supports and safety
- Debrief and create plan of care
Suicidal ideation is common and does not indicate a high risk for suicide alone.

Suicide attempts are rare and serious events that require a psychiatric evaluation.

Method of attempt is less important psychiatrically than the patient's concept of what would happen after the attempt.
SPECTRUM OF SUICIDE RISK

No Suicidal Ideation
• Occasional thoughts about mortality, normal focus on end of life for the ill/aged
• No preoccupation with or wish for death

Passive Ideation
• Morbid preoccupation with death, thoughts that life isn’t worth living, feeling they/others would be better off if they were dead
• Has not considered a method to harm self

Active Ideation
• Considering method(s) to harm self, but does not have detailed plan or intent to act
• Recalls reasons for living
• Good impulse control

Suicidal Intent
• Has specific detailed plan to harm self, may be making preparations towards plan
• No reasons for living
• Impulsive/ out of control
FINAL STEPS
Some will need additional safety planning or higher level psychiatric evaluation at a local emergency department or community mental health center.

Everyone can benefit from resources!

National Suicide Prevention Lifeline:
• 1-800-273-TALK (8255) / 1-888-628-9454 (Spanish)

Crisis Text Line:
• Text HOME to 741-741
SAFETY PLANNING AND DISCHARGE COUNSELING

Follow-up via phone call in 24-48 hrs to ensure patients have connected to resources and are successfully navigating their crisis.

1. All sharps (knives, razors, scissors, other blades), ligatures (power cables, ropes, etc.), chemicals (cleaning supplies, gardening chemicals), and medications (prescription and over the counter) will be secured. Firearms will be removed from the home or locked and stored separately from ammunition (also to be locked). Patient will be unable to access these items.

2. Support in the home and school is to be increased until permission is given otherwise by appropriate follow-up providers.

3. Patient will follow up with current therapist and/or psychiatrist to inform him/her of the ED visit and discuss increasing services. If patient does not have a therapist and/or psychiatrist, they will attempt to establish these services with support of their PCP.

4. Patient will immediately go to the ED or call 911 for a recurrence of acute safety concerns. Patient may also call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or access the Crisis Text Line by texting “CONNECT” to 741741.

5. Any additional individual considerations: always a good idea to review triggers, coping mechanisms, social supports and their contact information.
QUESTIONS

Email me: downsjl@iupui.edu