Maryland Behavioral Health Integration in Pediatric Primary Care (MD BHIPP) Crisis Training

May 19th, 2022

Suicide Prevention Part 1: Active Suicidality and Nonsuicidal Self-Injury

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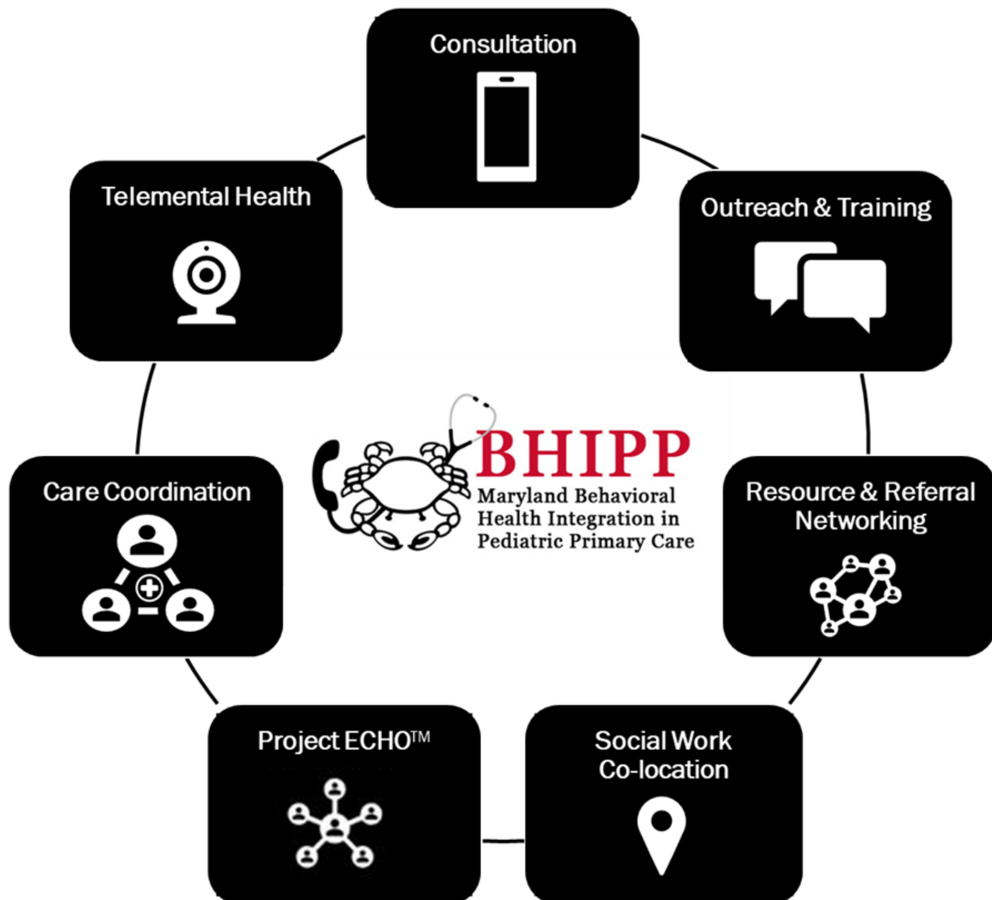
www.mdbhipp.org

Who We Are – Maryland BHIPP



Offering support to emergency medicine and pediatric primary care professionals through free:

- Telephone consultation (855-MD-BHIPP)
- Resource & referral support
- Training & education
- Regionally specific social work co-location (Salisbury University and Morgan State University)
- Project ECHO®
- Direct Telespsychiatry & Telecounseling Services
- Care coordination

Partners & Funding

- BHIPP is supported by funding from the **Maryland Department of Health, Behavioral Health Administration** and operates as a collaboration between the **University of Maryland School of Medicine**, the **Johns Hopkins University School of Medicine**, **Salisbury University** and **Morgan State University**.

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Conflict of interest disclosure

- No potential conflicts of interest
- Faculty at the University of Maryland School of Medicine
- Salary funding from the State of Maryland (BHIPP)
- Member of the American Academy of Child & Adolescent Psychiatry (AACAP)

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Learning Objectives

1) Know how to differentiate suicidal behavior and nonsuicidal self-injury in children and adolescents
2) Identify risk and protective factors for suicide in children and adolescents
3) Learn how to conduct a suicide assessment

Acknowledgement

- A special thanks to Dr. Hal Kronsberg of the BHIPP team who created the majority of the slide content presented today!

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Defining Nonsuicidal Self-Injury (NSSI)

- Nonsuicidal self-injury (NSSI) is the direct and deliberate self-inflicted damage of body tissue without suicidal intention or socially sanctioned purpose.

Brown and Plener 2017

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NSSI in the DSM-5 TR

- “This category may be used for individuals who have engaged in intentional self-inflicted damage to their body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing) in the absence of suicidal intent.”
- **(R45.88) Current Nonsuicidal Self-Injury:** If nonsuicidal self-injurious behavior is part of the clinical presentation
- **(Z91.52) History of Nonsuicidal Self-Injury:** If nonsuicidal self-injurious behavior has occurred during the individual’s lifetime

DSM-5 TR (2022)

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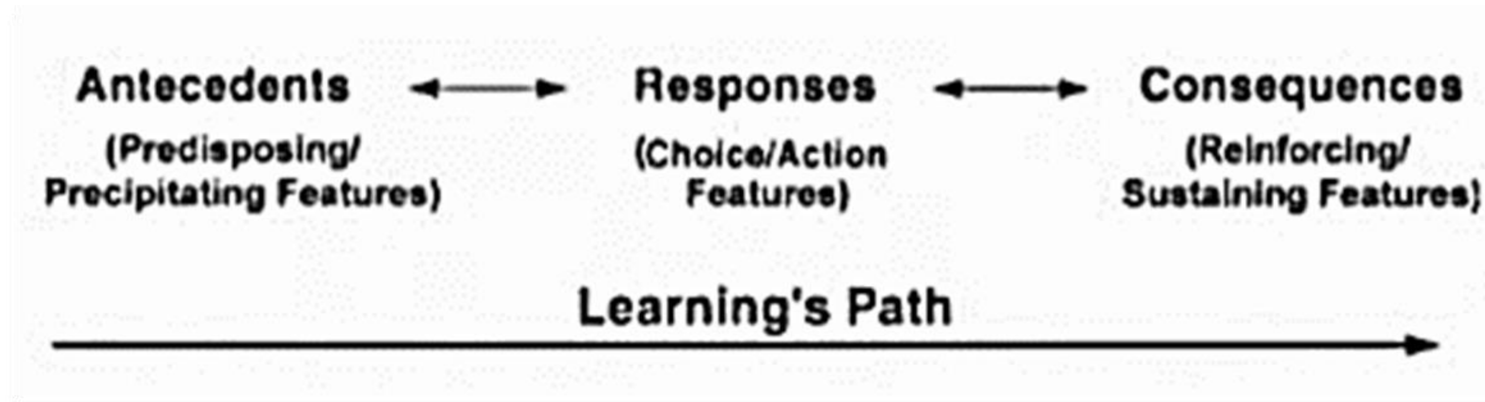
Self-harm as a behavior

- Why see it that way?
  - Self-harm is not necessarily a treatable disorder itself but can signal the presence of other disorders
  - Something reinforces self-harm to enable the behavior to persist
  - To stop self-harm, you must address the antecedents and consequences

Triad of Goal-Directed Behaviors



McHugh & Slavney, *The Perspectives of Psychiatry*, 1998

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Why Do Kids Self-Harm?

Understanding the problem more fully

Self Harm's Four Outcomes

How does self-harm "work"?

- Increase in desired feelings: self-punishment , self-stimulation, "endorphin release"
- Decrease undesired feelings: feel less overwhelmed or sad or angry, reduce the feeling of emptiness
- Increase a desired social response: gain attention or support ("manipulation")
- Decrease undesired social response: stop bullying or fighting

Nock, M. K. (2010). Self-injury. *Annual review of clinical psychology*, *6*, 339-363.

What Kids Report

- 25% to increase a desired feeling
- 65% to decrease an unpleasant feeling
  - 35% to escape anxiety (feeling “overwhelmed”)
  - 24% to escape sadness
  - 20% to escape anger
  - 29% to escape a “bad thought” or “bad memory”
- 4% to create a desired interpersonal outcome
- 15% to decrease a negative interpersonal outcome

Nock, M. K., Prinstein, M. J., & Sterba, S. K. (2009). Revealing the form and function of self-injurious thoughts and behaviors: A real-time ecological assessment study among adolescents and young adults. *Journal of abnormal psychology*, *118*(4), 816.

NSSI or Suicide Attempt?

- The key distinction between a suicide attempt and NSSI is the intent underlying the act.
- In NSSI, the person’s intent is to feel better in some way.
- In a suicide attempt, the person has at least some intent to die, even if considerable ambivalence is present.

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Assessment of NSSI

- Physical Examination
  - Signs of infection?
  - Tetanus Vaccine Status
  - Necessity of Somatic Treatment
- Taking the History

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The "What" of Cutting

- When did it start?
- How do you self-harm?
  - **Cutting? Burning? Scratching? Purging? Using drugs? How many different ways?**
  - **How often?**
  - Where do you self-harm?
  - With what?
  - **Ask to see scars**
- **Who knows?**
  - **How do those people feel about it?**
  - **What do your parents know about your self-harm?**

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The "Why" of Cutting

- In general, how are you feeling before you cut?
- **What does it do for you?**
    - **Does it help you feel more or less of a particular emotion?**
- How do other people react to your cutting?
    - How do you feel about that reaction?
- How "well" does it work?

The "What Next" of Cutting

- **Assess suicidality (self-harm may not be a suicide attempt, but the person self-harming may still be suicidal)**
  - *How much did you want to die when you hurt yourself?*
  - *What did you want to happen when you hurt yourself?*

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NSSI and Suicide

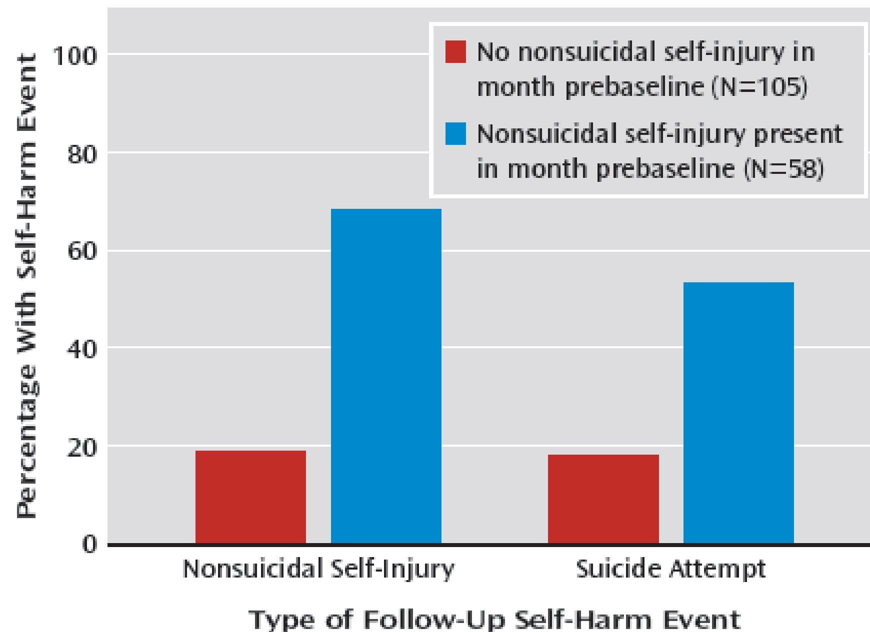
Just how worried should we be?

Self-harm and suicide

- Predictors of self-harm and suicide attempts:
  - Multiple methods of self-injury
  - Hopelessness
  - Parental conflict
  - **Depressive symptoms**

Asarnow, J. R., Porta, G., Spirito, A., Emslie, G., Clarke, G., Wagner, K. D., … & Mayes, T. (2011). Suicide attempts and nonsuicidal self-injury in the treatment of resistant depression in adolescents: findings from the TORDIA study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(8), 772-781.

Self-harm and suicide



Study of depressed adolescents on SSRI treatment

- Six months after assessment:
  - No history of self-harm
    - 1 in 5 self-harm
    - 1 in 5 attempt suicide
  - History of self-harm
    - 3x risk of self-harming again
    - 2x risk of suicide attempt

Wilkinson, P., Kelvin, R., Roberts, C., Dubicka, B., & Goodyer, I. (2011). Clinical and psychosocial predictors of suicide attempts and nonsuicidal self-injury in the Adolescent Depression Antidepressants and Psychotherapy Trial (ADAPT). *American Journal of Psychiatry*.

Key Take-Home Points

Whats

- Cutting alone doesn't tell us everything about diagnosis
- Kids who cut rarely engage in more than 10 discrete episodes in their lives
- Kids who self-harm struggle more with strong emotions
- Kids who self-harm can have poor social judgment
- Non-suicidal self injury is strongly associated with future suicide attempts

Whys

- Most kids typically self-harm to make a feeling go away
- Self-harm is rarely “for attention”

What nows

- Assess suicidality
- Determine the function of the self-harm
- Identify comorbidities

What next

- Treatments work!

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Youth Suicide: A Public Health Crisis

- In the United States, youth suicide is a growing public health problem that contributes to health care costs, lost productivity, morbidity, and premature death.
- Suicide is preventable, and we all have a role in its prevention.

Suicidal Behavior-Definitions

- Suicidal Behavior Includes:
  - Suicidal Ideation: thinking about ending one’s life
  - Suicide Attempt: non-fatal suicidal behavior
  - Suicide: ending one’s life

Suicidal Behavior in the DSM-5TR

- This category may be used for individuals who have engaged in potentially self-injurious behavior with at least some intent to die as a result of the act. Evidence of intent to end one's life can be explicit or inferred from the behavior or circumstances. A suicide attempt may or may not result in actual self-injury. If the individual is dissuaded by another person or changes his or her mind before initiating the behavior, this category does not apply.
- **Current Suicidal Behavior**
- **(T14.91A)** Initial encounter: If suicidal behavior is part of the initial encounter with the clinical presentation
- **(T14.91D)** Subsequent encounter: If suicidal behavior is part of subsequent encounters with the clinical presentation
- **(Z91.51) History of Suicidal Behavior:** If suicidal behavior has occurred during the individual's lifetime

DSM-5 TR (2022)

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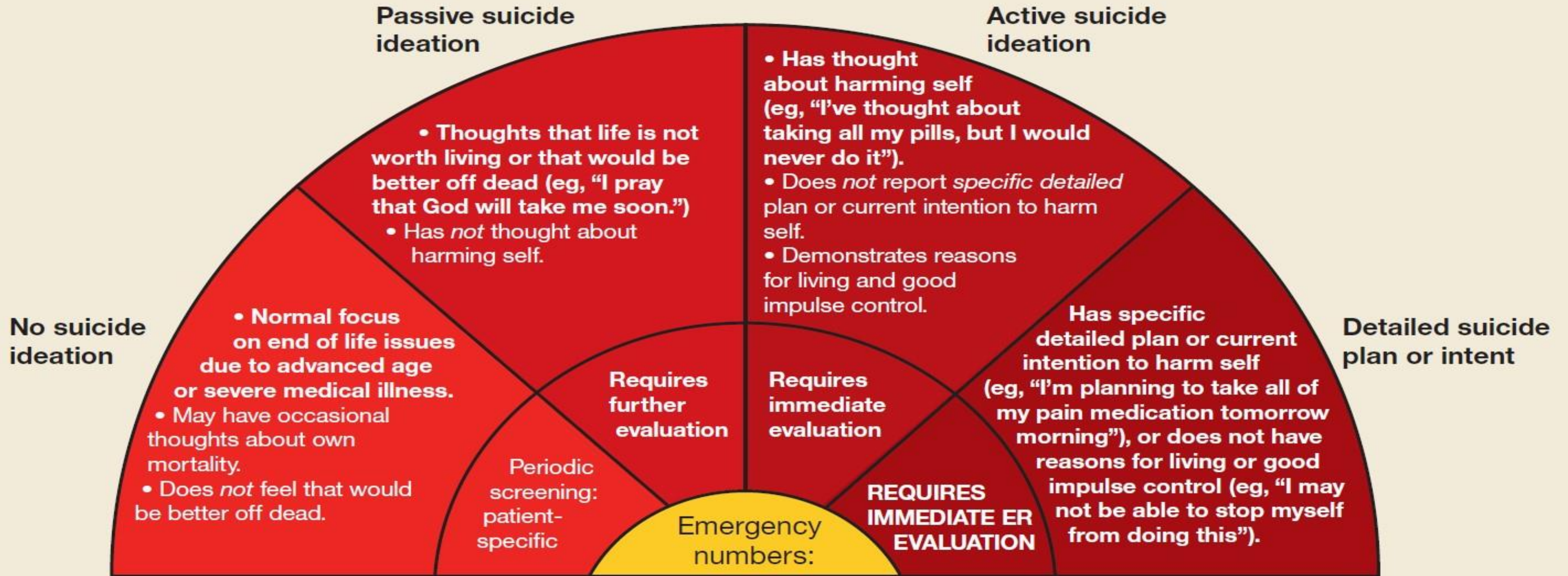

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Raue et al 2006

Take Home from the Data

- Per: Curtin SC, Hedegaard H. Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017. NCHS Health E-Stat. 2019.
  - Suicide rates are much lower among kids 10-14 compared with kids 15-21
  - Suicide rates among kids 10-14 saw a much larger increase relative to older kids from 1999 to 2017
  - Males are at higher risk for ending their lives by suicide than females
  - Suicide rates do vary significantly by race
    - American Indian and Alaska Natives are at highest risk for suicide by a factor of 2

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Risk Factors

Table 5. Estimated Odds of the Association Among Health Care Visits, Clinical Characteristics, and Suicide

Variable	OR (95% CI)	*P* Value
Count of mental health visits, 5-U increase per 30 d	0.78 (0.65-0.92)	.005
Type of mental disorder		
ADHD	1.13 (0.88-1.44)	.35
Conduct[a]	1.18 (0.88-1.59)	.28
Depression	3.19 (2.49-4.09)	<.001
Bipolar and other mood disorders	2.09 (1.58-2.76)	<.001
Anxiety	1.20 (0.87-1.66)	.26
Schizophrenia or psychosis	3.18 (2.00-5.06)	<.001
Adjustment	1.43 (1.01-2.03)	.05
Other mental health conditions[b]	1.41 (0.996-1.99)	.05
Any substance use disorder	2.65 (1.67-4.20)	<.001
Dual diagnosis (substance use and mental health)	1.02 (0.57-1.83)	.95
Type of medical condition		
Asthma	1.28 (0.91-1.78)	.16
Cancer	0.80 (0.41-1.57)	.52
Congenital anomaly	0.59 (0.26-1.34)	.21
Seizure disorder	4.89 (2.81-8.48)	<.001
Diabetes	0.94 (0.43-2.06)	.88
Cerebral palsy	0.23 (0.07-0.81)	.02

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; OR, odds ratio.

[a] Includes oppositional defiant disorder.

[b] Includes all mental health disorders coded as *International Classification of Diseases, Ninth Revision, Clinical Modification*, diagnosis codes 290 to 319 not otherwise categorized above.

Case-control study of Medicaid data of youth 10-18

- More mental health visits w/in 30 days of a crisis decreased odds of suicide
- Suicide most highly associated with MDD, psychotic illness, substance use disorder, bipolar disorder, and seizure disorder

Fontanella CA, Warner LA, Steelesmith D, Bridge JA, Sweeney HA, Campo JV. Clinical Profiles and Health Services Patterns of Medicaid-Enrolled Youths Who Died by Suicide. *JAMA Pediatr.* 2020;174(5):470–477. doi:10.1001/jamapediatrics.2020.0002

Risk Factors

Static Risk Factors

- LGBTQ+ youth have more than 2x rate of suicidal ideation
- Family history of suicide attempts
- History of physical or sexual abuse
- Previous suicide attempt
- History of non-suicidal self-injury

Modifiable Risk Factors

- Firearms in the home (regardless of how they are stored)
- Pathologic internet use (such as visiting prosuicide websites)
- Family conflict
- Academic stressors

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Suicide Screening Tools

Pros and Cons

PHQ-9A

- The PHQ-9A (recommended by the GLAD-PC guidelines) also has suicide screening questions (below)
  - In a large study in pediatric primary care use, 8.6% of kids were positive on the suicide screen and **half** of those kids did not meet the threshold to screen positive for depression (Farley et al 2020)

Has there been a time in the **past month** when you have had serious thoughts about ending your life? ☐Yes ☐No
Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

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ASQ (Ask Suicide Screening Questions)

Ask Suicide-Screening Questions

NIMH TOOLKIT

Suicide Risk Screening Tool

Ask the patient:

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 acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: ____

- Very brief suicide screening tool developed by NIMH
- Meant specifically for use in pediatric primary care
- Validated in ED and outpatient settings in large-scale studies

SUICIDE RISK SCREENING PATHWAY

OUTPATIENT PRIMARY CARE & SPECIALITY CLINICS

Presentation to Outpatient Primary Care & Speciality Clinics

Screen all patients ages 10 above who meet any of the screening criteria.*

*SCREENING CRITERIA

1. New patient
2. Existing patient who has not been screened within the past 30 days
3. Patient had a positive suicide risk screen the last time they were screened
4. Clinical judgement dictates screening

Medically able to answer questions?

NO → Screen at next visit

YES → Administer ASQ (ideally separate from parents)

YES on any question 1-4 or refuses to answer?

NO → NEGATIVE SCREEN Exit Pathway

YES → YES to Q5?

If patient answered "yes" to Q4, and the patient has been screened before, ask: "Since last visit, have you tried to kill yourself?" If they answer "no" and they also answered "no" to Q1-3, no further action needed.

If the only "yes" answer is to Q4 (past suicidal behavior), factors to consider:

- ☐ Was the attempt more than a year ago?
- ☐ Has the patient received or is currently in mental health care?
- ☐ Is parent aware of past suicidal behavior?
- ☐ Is the suicidal behavior not a current, active concern?

If yes to all these, then consider "Low Risk" choice for action.

NO → Non-acute Positive Screen; Conduct Brief Suicide Safety Assessment (BSSA)

Detailed instructions about the BSSA can be found at www.nimh.nih.gov/ASQ

YES → IMMINENT RISK

BSSA outcome (three possibilities)

LOW RISK
No further evaluation needed at this time

Would benefit from a non-urgent mental health follow-up?

NO → No referral needed at this time

YES → REFERRAL to further mental health care as appropriate; Continue medical care; Initiate safety plan for potential future suicidal thoughts

FURTHER EVALUATION NEEDED
Mental health referral needed as soon as possible

Make a safety plan with the patient and parent/guardian to activate as needed.

If mental health evaluation is not available within practice, refer to outpatient mental health clinician.

Schedule a follow up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a mental health appointment

IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation

INITIATE SAFETY PRECAUTIONS[1]
Until able to obtain full mental health evaluation

[1]SAFETY PRECAUTIONS
Per institution protocol; keep patient under direct observation, remove dangerous items, provide safety education, etc.

Send to emergency department for full mental health/safety evaluation

SAFETY PLANNING

- Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
- Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g. ropes, pills, firearms, belts, knives)
- Provide Resources: 24/7 National Suicide Prevention Lifeline
- 1- 800-273-TALK (8255), En Español:1-888-628-9454, 24/7 Crisis Text Line: Text "START" to 741-741

If suicide risk becomes more acute, instruct patient/parent/guardian to contact outpatient healthcare provider to evaluate need for ED visit.

Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made. Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.

asQ -V- 4/2/2021

ASQ (Ask Suicide Screening Questions)

- ASQ is screening portion of a broader suicide assessment
- Positive screens are meant to have a more comprehensive evaluation, including the Brief Suicide Safety Assessment
- Meant to help divide patients into three risk groups requiring differing intensity of interventions

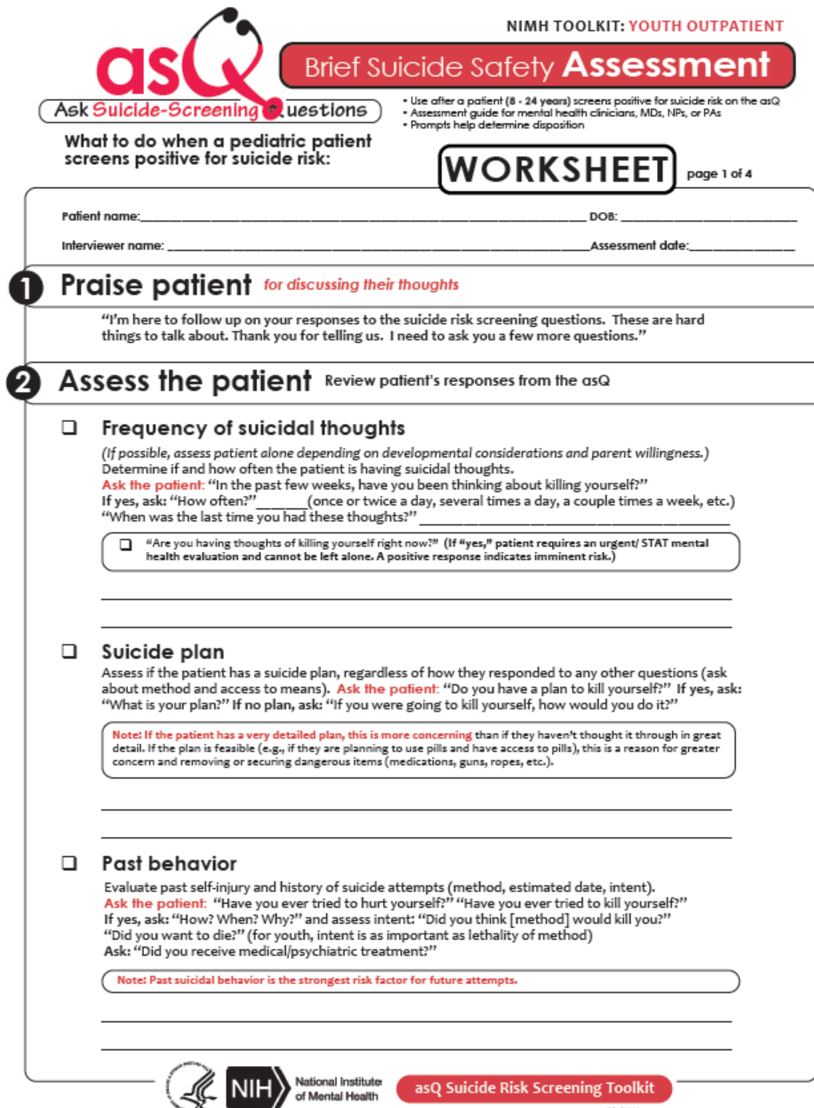
ASQ (Ask Suicide Screening Questions)

Pros

- Takes very little time to administer
- Part of a larger "toolkit" that includes a clinical pathway flowchart and more comprehensive suicide assessment (see right)
- High sensitivity (100%) and high specificity (90%)

Cons

- Fairly low positive predictive value (30% of positive screens were actually "true positives")
- Asking if kids have "ever" tried to kill themselves can be overly broad
- Language used on the screener can be a little jarring to patients.



NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety **Assessment**

- Use after a patient (8 - 24 years) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

What to do when a pediatric patient screens positive for suicide risk:

WORKSHEET page 1 of 4

Patient name:______________________ DOB: ______________

Interviewer name: ______________________ Assessment date:______________

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient Review patient's responses from the asQ

❑ **Frequency of suicidal thoughts**

(If possible, assess patient alone depending on developmental considerations and parent willingness.)
Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"_______(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" ______________________

❑ "Are you having thoughts of killing yourself right now?" (If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)

❑ **Suicide plan**

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). Ask the patient: "Do you have a plan to kill yourself?" If yes, ask: "What is your plan?" If no plan, ask: "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

❑ **Past behavior**

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"
"Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

NIH National Institute of Mental Health

asQ Suicide Risk Screening Toolkit

7/1/2020

Assessing Suicide Directly

- Start broad and open-ended: “Over the last month, how have you been feeling about being alive?”
- Follow-up questions gently move up to a higher level of acuity: “Have you had moments when you wished you were dead?” and “Did you ever reach a point where you thought about trying to end your life?”
- Ask about frequency, intensity, and “how do you manage those thoughts when they come?”
- If there is a specific thought to commit suicide, follow-up again with questions about the plan’s details, including lethality, feasibility, and desire to act on it
- Ask what’s kept them from acting on their plan thus far
- Don’t forget to ask about home: to what extent can parents/caregivers supervise if needed?

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Assessing Suicide Directly

- At the end of your suicide assessment, you should know:
  - Has your patient had thoughts of wanting to be dead?
  - Has your patient had thoughts of committing suicide?
    - How frequent and how intense?
  - Does your patient have a plan for suicide?
    - Specifically, what would your patient do?
    - Does your patient have available the tools/objects to act on that plan?
    - What has kept your patient from acting on that plan?
  - Do parents/caregivers have the ability to provide additional supervision if needed?

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Techniques for Eliciting Sensitive Information

1. Normalization
2. Shame Attenuation
3. Gentle Assumption
4. Symptom Amplification
5. Denial of the Specific
6. Behavioral Incident

Freedenthal, 2018

Normalization

- Normalization involves asking about suicidal ideation only after making clear that it is normal to think of suicide at one time or another, especially in painful or difficult circumstances.
- *"Many people with depression like yours can feel so bad that they think of suicide. Have you had suicidal thoughts?"*

Freedenthal, 2018

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Shame Attenuation

- Many people feel ashamed of their suicidal thoughts or behaviors and blame themselves.
- The technique of shame attenuation blames the person's pain, illness, or situation instead.
- *"With all the pain and hopelessness you feel, do you think of killing yourself?*

Freedenthal, 2018

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Gentle Assumption

- If someone feels any shame, embarrassment, or fear about disclosing suicidal ideation, then “yes-no” questions can deter the person from answering honestly.
- To avoid that problem, the technique of gentle assumption calls for you to act as if the person has already answered “yes.”
- *“What are some ways you have thought of killing yourself?”*
- *“How many times in your life have you attempted suicide, if at all?”*

Freedenthal, 2018

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Symptom Amplification

- You need to know not only if the person is thinking of suicide, but also how often and how intensely.
- Symptom amplification calls for you to exaggerate the possibilities, which gives room for the person to answer honestly without necessarily feeling that they are thinking of suicide excessively.
- *"How many times a day do you think of suicide? 20? 30? (to which the person responds, "Oh gosh no, not that much. Only 5-10 times, I'd say.")*

Freedenthal, 2018

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Denial of the Specific

- Instead of asking a single overarching question that covers many possibilities, the denial of the specific technique requires you to ask separately about each possibility.
- Ask separately about each specific possibility rather than stringing together multiple options in one question.
- With each of these possibilities, the professional waits for the person's response before moving on to the next possibility.
- *"Have you ever thought of jumping off a high place, like a bridge or a building…Have you thought of taking an overdose?....Hanging yourself?...Shooting yourself?...Cutting yourself?*

Freedenthal, 2018

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Behavioral Incident

- Ask questions about each step in the person's thoughts and behaviors in response to stress, pain, hopelessness, or other difficult emotions or situations that might trigger suicidal thoughts.
- By breaking the person's experience down into very concrete details, you help strip away any vagueness or distortions that might obscure the person's true experience.
- *"When you took out the bottle of pills, what happened next?...What did you do next?...Then what did you do?...What were you feeling when you did that?"*

Freedenthal, 2018

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Resource for Patients

988

A new crisis hotline number

Patients experiencing mental health crises can call or text 988 and will be directed to the National Suicide Prevention Lifeline.

Coming July 16th nationwide!

Learn more at https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/

To Be Continued....

- Please join us for Suicide Prevention Part 2: Safety and Crisis Planning on Thursday June 16th

Thank you!

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www.mdbhipp.org
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For resources related to the COVID-19 pandemic, please visit us at BHIPP Covid-19 Resources.