# UNC SON ECHO ABC for MAT

## Addiction and Behavioral Clinic for Medication Assisted Treatment

# SUICIDE PREVENTION AND SUBSTANCE USE DISORDER

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# Suicidal behavior

"**Suicidal behavior** is a continuum that includes suicidal ideation, planning, attempts and even suicide completion."

Rodriguez-Cintas et al. (2018)

# Risk factors for suicidal behaviors

History of previous suicide attempts

Substance use

Mental disorders

Impulsivity and aggressiveness

**Synergistic effects of all the above**

# POTENTIAL MECHANISMS EXPLAINING SUBSTANCE USE ASSOCIATION WITH ELEVATED RISK FOR SUICIDE

Neurobiological Suicide Risk Factors Associated with Acute Intoxication and SUD

Sociocultural Suicide Risk Factors Associated with SUD

Health-Related Suicide Risk Factors Associated with SUD

Genetic Risk Factors Associated with SUD

# Neurobiological risk factors

Alcohol and sedative hypnotic--disinhibit executive functioning

Stimulant intoxication--associated with increased impulsivity and aggression

Opioid intoxication—risk related to respiratory depression as well as social disconnection

Hallucinogens can alter cognitive reasoning that can increase self-harm risk

# Sociocultural risk factors

Adverse childhood events—strong, positive association with substance use initiation as well as lifetime risk for SUD and attempted suicide

Poverty, low educational attainment, unemployment, rural housing associated with increased mortality due to suicide and substance poisoning

Lack of readily available health care

# Other risk factors

Health-related risk factors

- Chronic pain
- Infectious diseases and disability

Genetic risk factors

- multiple genetic determinants contribute to the risk for and maintenance of SUD
- Genetic risk factors for suicide include dysregulation of stress responses

# Suicide Prevention in SUD

Screening:

- Primary care providers can start the screening and engage in conversation around mental health, suicidal ideation, and substance use.

Brief intervention

- Opportunity to mitigate risks and prevent suicide

Medication for OUD

- Reduce substance use and relapse with potential for improving lifestyle and health related risk factors
- Buprenorphine and methadone both may have direct pharmacological suicide prevention effects.

# Gap in screening

Up to 84% of individuals who die by suicide have visited a healthcare provider in the year prior to death

45% who die by suicide have visited their primary care provider within the previous month prior to death

Many providers have not received adequate training and/or do not feel confident in their ability to provider treatment for patients with suicidal thoughts or behaviors

Primary care providers can start the screening and engage in conversation around mental health, suicidal ideation, and substance use.

# Depression screening and suicide screening

PHQ-2—doesn't capture suicidal ideation or behaviors

PHQ-9 is a good place to start

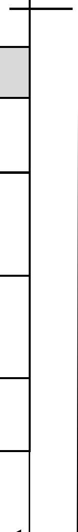
C-SSRS Screener/recent—self-report—short form

If positive response to suicidal thought or ideation, can choose from several tools to further assess

- P4 Screener (past history, plan, probability, preventive factors)—very short
- ASQ (Ask Suicide-screening questions) by NIMH—short
- C-SSRS (Columbia-suicide severity rating scale)—3 pages, more detailed

**COLUMBIA-SUICIDE SEVERITY RATING SCALE**
***Screener/Recent – Self-Report***

| | In The Past Month | |
|---|---|---|
| Answer Questions 1 and 2 | **YES** | **NO** |
| **1)** ***Have you wished you were dead or wished you could go to sleep and not wake up?*** | | |
| **2)** ***Have you actually had any thoughts about killing yourself?*** | | |
| If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6 | | |
| **3)** ***Have you thought about how you might do this?*** | | |
| **4)** ***Have you had any intention of acting on these thoughts of killing yourself? (As opposed to you have the thoughts but you definitely would not act on them.)*** | | |
| **5)** ***Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you intend to carry out your plan?*** | | |



| | In Your Lifetime | |
|---|---|---|
| **6)** ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>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. | | |
| ***Did you do any of these things in the past 3 months?***<br>***If YES, what did you do?*** ____________________ | | |

# P4 Suicidality Screener

If a patient has a positive answer to suicide question on PHQ-9, then P4 screening tool can better assess suicidality

P4 is a mnemonic for the 4 screening questions:

- past history, plan, probability, preventive factors

Have you had thoughts of actually hurting yourself? If yes:

- Have you ever attempted to harm yourself in the past?
- Have you thought about how you might actually hurt yourself? (if yes, how?)
- There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?" (rate not at all likely, **somewhat likely, very likely**)
- Is there anything that would prevent or keep you from harming yourself? (what?)

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# Clarifying questions for P4

**Optional Clarifying Questions (if it is unclear if patient has a plan)** ***shaded response = risk***

1. Do you live alone? (No ___ Yes ___)
2. Have you thought about taking an overdose of medication, driving your car off the road, using a gun, or doing something else serious like this? (No ___ Yes ___ → What is it? ______)
3. Do you own a gun? (No ___ Yes ___)
4. Have you been stockpiling (saving up) medication? (No ___ Yes ___)
5. Do you feel hopeless about the future? (No ___ A little ___ Somewhat ___ Very ___)
6. Do you feel you can resist your impulses to harm yourself? (No ___ Yes ___)
7. Right now, how strong is your wish to die? (No wish _____ Weak _____ Strong _____)

NIMH TOOLKIT

# asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

## 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: ______________________________________________

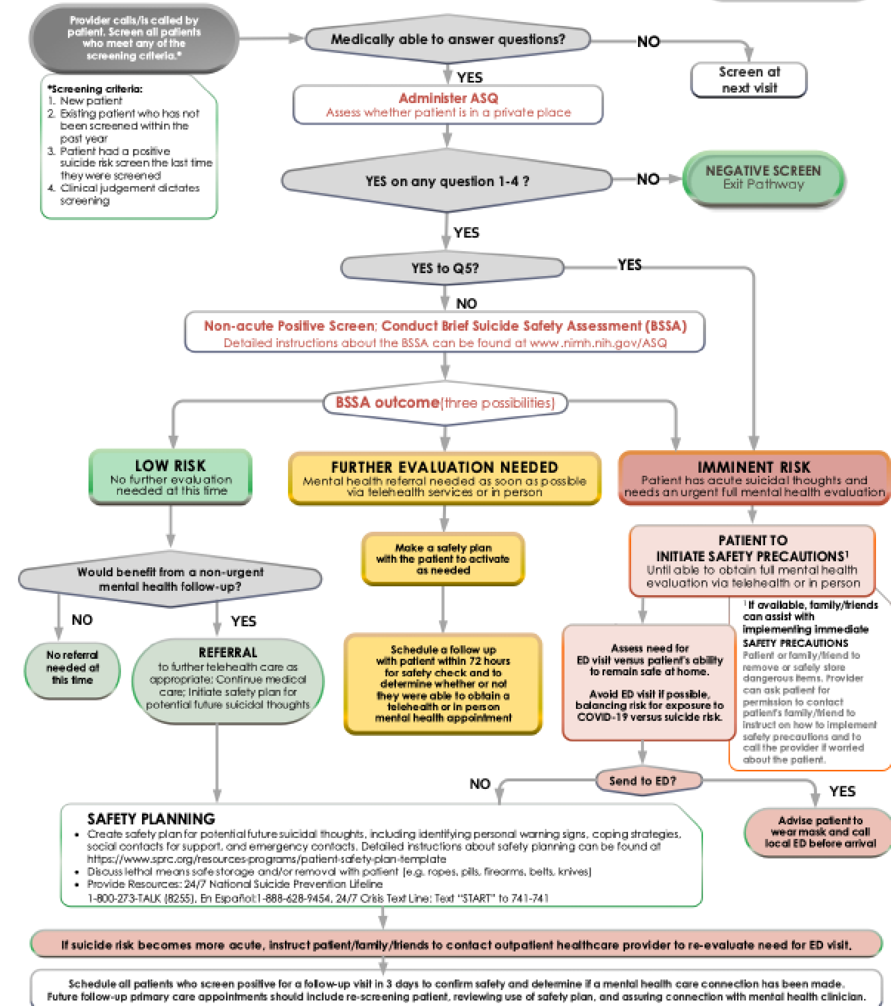
## Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen).*
- **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)
    - **Patient requires a STAT safety/full mental health evaluation.** Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed.** Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

## Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741





# Brief suicide safety assessment guide
## (if patient screens positive for suicide risk)

Praise patient for discussing thoughts

Assess the patient

- Frequency of suicidal thoughts
- Suicide plan
- Past behavior (depression, anxiety, impulsivity/recklessness, hopelessness, anhedonia, isolation, substance use, alcohol use, sleep, appetite, other concerns)
- Social support and stressors (support network, family situation, employment, domestic violence, suicide contagion, reasons for living)

# Safety plan

Make a safety plan. “Our first priority is keeping you safe. Let’s work together to develop a safety plan for when you are having thoughts of suicide.”

Securing or removing lethal means

Ask safety questions: Do you think you need help to keep yourself safe?

# Determine disposition

If patient at imminent risk: Emergency psychiatric evaluation

Intermediate risk: Further evaluation of risk is necessary: review safety plan and send home with mental health referral (hopefully within 72 hours)

Nurse or provider to call patient within 48 hours

Low-risk: Non-urgent mental health follow-up/referral

# Provide resources for all patients

988 Hotline

24/7 National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

En Espanol: 1-888-628-9454

24/7 Crisis Text Line: Text “HOME” to 741-741

Hope4NC

# References

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