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SUBSTANCE USE DISORDERS AND SUICIDE: ADDRESSING A CO-OCCURING EPIDEMIC

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>>> The broadcast is now starting. All attendees are in listen-only mode.

>> Hello. Welcome to Substance Use Disorders and Suicide, a Current Epidemic, presented by Geoff Wilson. My name is Jessie O'Brien.

I am the training and professional development content manager here at NAADAC, the Association for Addiction Professionals.

I'm going to be the organizer. The permanent home page for NAADAC webinars is www.NAADAC.org/webinars. Make sure to bookmark this page to stay up to date on the latest in addiction education.

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As you may know, every NAADAC webinar has its own web page that has everything you need to know about that particular webinar. Immediately following today's live event, you will find the online CE quiz link on the exact same website that you use to register for this event. So that means everything you need to know will be permanently hosted at www.NAADAC.org/SUD-suicide-epidemic-webinar.

Today, we are using go-to webinar for this event. You will notice the go-to webinar control panel that looks just like the one on my slide. You can use that orange arrow any time to minimize or maximize the control panel.

If you have any questions for the presenter, just type them into the questions box. We are going to gather those questions and ask them to our presenter during the live Q and A towards the end of today's presentation.

Any questions that we do not get to, we will collect directly from the presenter and post the questions and answers on our website.

Under the questions tab, you will see another tab that says handouts, you can download the PowerPoint slides from that handout tab and a user friendly instructional guide on how to access our online CE quiz and immediately earn your CE certificate. Please make sure to use the instructions in our hand-out tab when you're ready to take the quiz.

Let me introduce you to our presenter, Geoff Wilson, a licensed clinical social worker and licensed clinical alcohol and drug counselor. He has been practicing in the mental health and substance use disorder treatment fields in Kentucky for over 25 years.

Geoff is currently in full-time private practice with Lexington Counseling and Psychiatry in Lexington, Kentucky. In 2004, he received the Robert Straus Award for Outstanding Service in the field of substance abuse in Kentucky. In 2008, he was on the Board of Alcohol and Drug Counselors serving for over ten years. In 2013, he was selected by NSW Kentucky as the social worker of the year. He is the president of the Kentucky Association of Addiction Professionals. Geoff, if you are ready, I'm going to hand this over to you.

>>> Thank you very much, Jessie. It is a real pleasure to be here with you guys today and talk to you about a topic that I have pretty much dedicated my whole professional career to.

I enjoy doing training. Man, this is just such an interesting year for doing training. I'm really glad to be here with you all today to talk to you about a topic that's really near and dear to me. My contact information is on here for you guys to take a look at. If you have any questions after this presentation, you can also feel free to reach out to me as well about that.

We're going to start off with a quick polling question. I always like to get a sense of who is in the audience. Jessie, I'll let you get that ready.

>> Great. I am getting ready to launch this now. It should pop up on your screen. There we go.

>> If everybody could just real quick let me know who is in the audience, that would be great. Just please select one of those.

>> Don't forget, if you have questions, please put them in the question box so we can have them at the end of the presentation. I'm going to give everybody about five more seconds. All right. I'm going to go ahead and close the poll and share the results. They should pop up shortly on the screen. There we go.

>> We have got a really good mix of folks in the audience. That's great. I'm really glad to see that. That's helpful for me to get a sense of who all is in the audience as well. I want to start off and give you guys a little bit of a perspective of where I'm coming from with this.

As far as my experience, I've been working in the field for about 25 years. Fourteen years of that, I spent working in an in-patient psychiatric and chemical dependency hospital, 110 bed facility for children, adolescence and adults, had a variety of positions during that time and three years as director of clinical operations. I managed the clinical product of all the services for those populations a partial hospitalization and inpatient programs and mental health and substance abuse for adolescents and adults.

Our organization contracted with the group that created AMSR, Assessing and Managing Suicide Risk to develop an inpatient curriculum for AMSR for in-patient

hospitals.

My responsibility was to go through the training of trainers for that and then to train all of our nurses, clinical staff and everybody on all of our in-patient units and outpatient programs. The biggest reason behind that, in one sense, it is excellent curriculum. It is extremely helpful for the population that we are going to be talking about.

During that period of time, depending upon whether you looked at the joint commission or the American hospital association about anywhere from 4-11% of all suicides in the United States occurred in an in-patient psychiatric facility. Obviously, you know, individuals that are coming into care that need to be supported and need that assistance, the last thing we want to see is somebody in that environment take their life.

That was an effort that was really helpful in addressing the population to make sure we keep people safe. We also do a really good job of assessing who is at most risk and what steps can we take to make sure we do everything we can to keep people safe and address their needs.

Part of what I'm going to be sharing with you are pieces from that that I know have been really helpful for me, especially I see clients every day. I have an outpatient practice along with training and consulting. I used some of what I am sharing with you all yesterday with the clients. I want to give you a perspective that I am coming from.

I want to start off introducing you to a very rare individual. I am going to show a couple of slides and give you a description of why we are talking about Mady today. Y'all just take a second and read that for me.

So many of our clients that we work with that struggle with a substance use disorder feel like Mady. They have experienced things like Mady as far as their mood and their sense of despair.

We may not ever know that that's what's going on with them. We may address a great deal about their substance use disorder, their addiction to heroin, methamphetamine, cocaine, everything else.

They might not ever share with us the despair that they may feel and the questions that are really important for us to ask to assess this is key in addressing their

needs and, hopefully, helping somebody achieve recovery for their substance use disorder as well as their mental health issues. We will come full circle with Mady.

She is a very brave individual that is doing some great work in helping folks recognize the topic we are talking about today.

We are going to spend some time with the prevalence of suicide in high risk populations and getting into screening and assessment, the synthesization of that information, along with assessing and managing risk.

I want to introduce to you a couple of concepts around risk status and risk state. I'll be the first to

Say, especially working in an in-patient facility, oftentimes we may say, I think this patient is high risk. I think this patient is high risk. Based on what? What makes me think this person is high risk? Let's have a good understanding of that to address the need of the clients we work with. We'll talk some about that, along with risk factors and warning signs for suicidality.

When we get into how we best help our clients, especially with, you know, suicide prevention, oftentimes, we are going to look at their protective factors and what are some things we can do to really assist clients in creating and steering them toward more protective factors. They are a part of a crisis safety plan.

Many of you are familiar with the concept of recovery capital. Oftentimes, that is a big piece for our clients what those protective factors me be.

There are some issues that we need to pay attention to when we are assessing and managing suicide risk. If we all step back into when we first got into the field, you know, our ability to maintain that first point, calm, compassion that's needed and sometimes can be difficult when we are working with somebody that is at risk for taking their life.

For that individual client, our ability to stay calm, cool, collected, stay present, use empathic language and listening skills is part of assessing their risk.

It is good to know, point 2, the rates and risk factors in the population we are working with. I want to share with everything we are seeing in the pandemic and the impact it is having on our clients with mental health and substance use disorders. A lot of the individuals that we are working with, they won't tell us they are at risk.

That's the piece I think is really important with making sure we ask very specific questions to ascertain that and not shy away from that.

Point four, we have to make judgment calls about unpredictable outcomes, often with not the best information or contradictory information. Some of our clients are really good historians and some really struggle with it. We might not have the ability to have consultation with family members, spouses, parents.

Sometimes the best information we have and the only information we have is perhaps from an emergency room, a residential facility or the client, themselves, which means we may not have a lot of information.

Lastly, there is a big gulf between the offer and use of safety or treatment options. Our ability to ascertain this person is at risk, here is what we need to do to help them and how are we actually going to utilize these skills and interventions can be really difficult to pull together.

I'm going to reference pieces of assessing and managing suicide risk. This is not AMSR-approved training or making you certified. This is through the suicide prevention center. It is important I mention that and give you a sense of the information I'm going to be sharing with you all today too.

Understanding it, defining the terms, that should be know the statistics and understanding risk and protective factors.

Our ability to make sure we have a solid understanding of suicide and what it means for that individual client is of utmost importance. For our own definition, some terms that I think we can look at that are helpful are these.

What is suicide? Death caused by self-directed injurious behavior with any intent to die as a result of that behavior.

The intent to actually take my life, that attempt typically a nonfatal, self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury. We'll talk a little bit about that.

Oftentimes, about have that person comes on our radar as a counselor or a peer support specialist, social worker, in a hospital, in an outpatient setting, this may not be their first attempt.

In fact, oftentimes, they have had other attempts before we even find out. So, again, really important to keep in mind not only may we not know about it but it did not result in any type of injury. It is not uncommon that this person, perhaps under the influence, took some pills, decided they didn't want to wake up and they wake up the next day. They get ready and go to work and nobody knows and they may do that multiple times before they receive care.

Suicidal ideation, thinking about considering, or planning for suicide. Nonsuicidal self-directed violence, self-injurious behavior. A good definition, self-directed and deliberately results in injury or potential for injury. There is no evidence, implicit or explicit, of suicidal intent.

Many of the people that I work with that have struggled with self-injurious behavior have never had a desire to take their life. It is more of a coping strategy for some pretty significant emotions that they have experienced, trauma, things of that nature.

However, it is important to realize that if you are working with an individual that has participated in self-injurious behavior throughout their life, they are seven times more likely to have a suicide attempt.

When I sit down with an individual and they share a history of cutting themselves, burning themselves, something of that nature, I have to realize this person is seven times more likely to have an attempt in their life.

I don't know if that is going to be next week, next month or seven years from now. That's always something we want to keep in mind.

So, know, what's the perspective of what we are seeing in this epidemic. This is 2018 information. We had over 48,000 suicide in the United States that year, which was an increase significant compared to 2014.

On average, adjusted to age, the annual suicide rate in the United States increased 24%, between 1999 and 2014. We went from 10.5 to 13 suicide per 1,000 people, which is the highest rate we have seen in 28 years.

We are seeing an increase. Several states already have eclipsed last year's suicide rate. Even perhaps going back to August in some states. We are really having to pay attention to everything behind the impact of the pandemic, isolation, lack of ability to

access services, economic impact.

Here we are getting ready to go into what is usually a pretty difficult time for our clients. My fear is it is going to get much worse.

There are more than 2.5 times as many suicides as there were homicides. Think about that for a second, the magnitude of individuals to take their life is unbelievable.

Suicide is the second leading cause of death for ages 10-34. Second leading cause of death for college age in younger individuals, 12-18.

I spent six years as president of the stop you suicide campaign in Kentucky, which is a really great organization that we started with the University of Kentucky adolescent department and Dr. Hadamobar. That rate of adolescence that experienced suicidal ideations and suicidal attempts and complete suicide, we are seeing an increase in that population, especially related to the pandemic.

More teenagers, young adults, die from suicide than cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined.

Yet out of all of those that I listed, which receives the least amount of funding? Suicide. It is one of the most preventable forms of death that is present.

Our ability right now to make sure to lobby with our legislators to get funding and support for mental health care and substance use care is so important that we need to pay attention to.

The 2016 national survey on drug use and health, one question they asked, in the past 12 months, how many of you have seriously considered suicide? Ten million adults said they had had serious thoughts of suicide in that questionnaire. You think about 1.3 million mentioned they had made a suicide attempt in the last year. That's about 1 out of every 200 adults in our country.

Much more significant than people realize. As far as how many adults in our country experience suicidal ideations, that last bullet there, you see given that there are about 10 million adults that seriously considered it, yet only 1.3 million that engaged in suicidal behavior, there's a lot of opportunity to work with that population to prevent them from moving to a suicide attempt.

That bridge between, I'm experiencing this, I've considered it but, you know, I haven't

gotten to a point where I have actually thought about a plan, put the plan into action, attempted. There is a gap there where we have a lot of opportunity to provide care, especially if we are recognizing warning signs and risk factors.

We'll spend some time talking about that more.

It's important to keep in mind, suicide knows no boundaries, across all ages, economic, social, ethnic boundaries. If you look at right now, some of you probably saw in the last couple weeks, Japan, their rate of suicide is the highest it has ever been. They are really struggling with this in their country right now. Other countries similarly have seen a dramatic increase as well. Again, I think that comes back to the impact we are having from Covid.

Females do attempt suicide more than three times as often as males. Males do die by suicide four times more often than females. Males use a more lethal means, typically, that involves a handgun or some type of firearm.

Kentucky, we are a gun state. That's always a big concern. The facility that I mentioned to you before where I worked, we did say client discharge planning, which meant every patient that left our facility, whether out-patient or in-patient, we always sat down with the client and their parent/guardian to talk about how can we make the home safe? How can we remove things that have lethality attached to them. Oftentimes, people were receptive and story after story, I can tell you of families that were not exactly ready to do that or felt it was necessary.

Reducing risk, one of the best things we can do is to decrease access to a lethal means. That's another reason why males tend to have more medically significant suicide attempts as well.

If you look at the age of 10-24 group, about 81% of deaths are male versus female. Statistics, older white adults have triple the suicide risk than younger, non-white adults. Again, thinking about races, age, ethnicity, culture, there are certain parameters that we want to pay attention to that might present more risk factors. Those with a substance use disorder are six times more likely to complete suicide than those without.

For all of you working in this field, when you sit down with an individual that has a history of alcohol use disorder or opioid disorder or some type of a substance use

disorder, immediately you know they are six times more likely to take their life than the general population that does not, which is really important to make sure that that's all that's on our radar outside of asking the general things that we do about, hey, since I saw you last, talk to me about your sobriety, recovery, craving management, what you are doing to keep yourself in a good place, how you are taking care of yourself.

What about your mood, sleep, appetite, thoughts that you might have had? Have you felt hopeless in any way? Those are important aspect that is we need to make sure we are paying attention to.

The rate of completed suicide among men with alcohol and drug abuse problems is two to three times higher than among those without it.

Again, that kind of echos that point about the risk that comes with a substance use disorder.

Women who abuse substances are 6-9 times higher risk of suicide compared to women who do not have one.

Again, working with a female with a substance use disorder, it has to be on my radar that they are much higher risk to potentially take their life, especially if they are struggling with their mood.

Suicide is the leading cause of death among people with substance use disorders. Suicide is the leading cause of death among people with substance use disorders. Colleagues I have in the field and panels I have been a part of, and working with different committees, especially where a coroner is involved and having conversations with them.

What we have seen with the opioid epidemic and overdose, was this an attempt to take their life or they ingested too much of a substance or an overdose? It is really hard to determine what might have occurred.

One of the last clients I worked with in an in-patient facility before I transitioned to my current job, I was doing an assessment with them.

They had had a heroin overdose, heroin and Fentanyl, and were referred by the emergency room. I asked him the question, talk to me about how you were feeling with the overdose, what you remember before waking up and there you are in the back of an

ambulance?

Do you think this was an attempt to take your life or do too much or whatever?

He said, you know, Geoff, I was at a point of, if I wake up, okay, if I don't wake up, okay. Is that an individual that's suicidal? I would say yes. They got to the point where that level of despair was, it didn't matter to me. This is an individual that had a history of a depressive disorder. That comorbidity we know also increases the risk even further compared to the general population.

People treated for alcohol abuse are about at a ten times greater risk for suicide. We'll talk more about that. Statistically speaking, we know from autopsy reports that alcohol is 30%-40% of the times present in somebody's system related to a suicide.

That impact of how it decreases inhibitions, people get to a point where their level of despair increases and they become much more impulsive. The risk is much greater, especially if somebody returns to substance use.

2018, data here, we had about 21 million adults that had a Substance Use Disorder, diagnosable with a substance use disorder. About 44 million had a Mental Health Disorder. About 8.4 million had comorbidity, where they experience both a substance use and a mental health disorder.

It gives you kind of an idea of the population that we are talking about that is at a pretty great risk with this.

Specific to opioid use, many of you are seeing, here in Kentucky, what we are seeing with heroin and Fentanyl and methamphetamine and Fentanyl and the rate of overdoses, it is important to look at statistically, how does that present? We had about close to 12 million people that abused prescription opiates in the United States and about 1 million uses heroin and 650,000 that used heroin and abused prescription opioids.

This specific risk factor with opiate use disorder is important. We know individuals that use opiates are at a much greater risk to have an overdose.

There are some links to this that I think are important that we are aware of. We know, number one, high doses of opiates offer increased access to a lethal means. We started off talking about Mady and what she was experiencing.

The fact that readily available is the ability to take somebody's life, you know, under the influence, in despair, really struggling, that's when somebody is at very high risk. On top of all that, dose to dose, what I may have taken at 8:00 a.m., what I am about to take at 2:00 p.m. is completely different. It is a higher dose of Fentanyl.

My tolerance might not be able to handle it. It is going to result in a death. That's on top of all of this already.

Number two, opioids have this disinhibiting effects. We know it increases the likelihood of perhaps acting on an impulse for somebody to take their life. This inhibition that occurs where there is a reduction of that oftentimes can mean that somebody could be much more impulsive at that point.

Depending upon the psychosocial stressors in their life, what they are experiencing in relationships, work, child care, everything else, there are some really big stressors that could play a role in that.

Lastly, number three, people who take higher opioid doses share other characteristics that explain the link to suicide. What we mean by that is I might be prescribed opiates for chronic pain. If you work with individuals with chronic pain or experienced it yourself, you know that it has a debilitating effect not only on my quality of life but also my mood.

Many people with chronic pain suffer from depression. So that can be there. Oftentimes, you know, individuals and specifically older adults may be prescribed opiates for arthritis, other types of medical issues that, again, depending upon a diagnosis, my quality of life, my ability to get around, that can have a significant impact on our mood too.

The take-home, if there are a few things you take from this, one of them is, individuals that have an opioid use disorder are 13 times more likely to die by suicide than the general population.

If you are working in a medication-assisted program, a residential program, a detox unit, if you are doing out-patient counseling, anything of that nature, when you are sitting down with an individual that has an opiate use disorder, you need to keep in mind that they are about 13 times more likely to potentially take their life.

Being aware of that kind of starts off with risk, status risk state, eventually, if you are not really paying attention to this individual client and what their mental health needs are as well.

We know alcohol use very much amplifies suicide risk. We talked about opiates. We are going to shift to alcohol. Alcohol is the most common substance used that we still see. If I look at who shows up in my particular practice, I have many more people that present with alcohol use disorder than opiate use disorder.

Then, again, if I go down to the closest long-term residential substance use facility here in Kentucky, it is going to be the direct opposite. Many more individuals with opiate use disorder will be there.

We know about 40-60% who do die by suicide are intoxicated, close to half typically have some alcohol in their blood at the time of death. We know that middle or older aged alcoholics are at a greater risk than younger alcoholics. What are the different stressors in somebody's life? What are the losses, maybe, they have experienced, divorce, separation, work stressors, things like that?

Also, physically, what may be going on? Younger alcoholics may not have experienced some of those consequences yet. Middle or older age alcoholics are at a much greater risk. I had a new client I started to see yesterday. Trying to do the assessment and got to a point for the last five years of consuming 24 beers a day and eventually went off to a 30-day inpatient program, had a lapse and wept into a 14-day program and then they referred him to me for the outpatient counseling.

He had not had a job issue, no legal charges, had his own place, decent amount of enabling going on with the family. Ultimately, we finally got to, tell me the consequences. He has early stage cirrhosis at the ripe old age of 39. That middle age, getting close to it, he falls in that category, where depending upon maintaining recovery, sobriety and recovery, and treating himself physically better, that's going to be a big variable in his overall progress, real similar to what we are speaking about here.

Why is there this link? Intoxication by drugs or alcohol decreases inhibition. That's a big piece. It presents in a way that that individual that's struggling with their mood, that's struggling with some despair and specifically psychological distress.

That level of distress, when inhibitions are decreased, there is a greater likelihood somebody with be impulsive, that increased aggressiveness. I won't think through, perhaps, the repercussions of what may happen. My judgment is impaired. That's when somebody can be very risky.

Hence, alcohol intoxication we know plays a proximal risk factor for suicide. That individual, I share with you about, that I just started to see, that is very much something I am paying attention to and we have already started to talk about a safety plan to prevent relapse but also to make sure he is doing well.

He has been diagnosed with anxiety in the past. How much of that is substance related versus actually having that. We need to kind of get a good period of sobriety to assess that. That's definitely something I am paying attention to.

Alcohol use increases the lethality of medications. Oftentimes, somebody has already ingested alcohol and also taking whether it is over-the-counter medication or prescription pills, that lethality increases with that combination.

You know, potentially, there can be some really significant medical complications if somebody doesn't take their life that, again, also has a real impact for the future for that client and their stability.

We've kind of talked about this. We know, with alcohol use and suicide, this level of impairment because of the comorbidity at play is a major issue.

Alcohol is a depressant. You know, I just shared with you about a client that's consuming 12-24 beers a day. That's a mass amount of a depressant that somebody is putting on their brain that may already have anxiety, depression, trauma. The rate of trauma that our clients have experienced, that level of impairment is so significant that, you know, upon sobriety, a lot of us can think. I talk to families and spouses a lot about this. They are sober. Everything is going to be great. You all know as well as I, the best part about sobriety is to get your feelings back and the worst part about sobriety is you get your feelings back.

Here is this wave of raw emotion and despair and looking at their substance abuse and everything else, that's when somebody can be at their riskiest, when they have 10 days, 20 days, 30 days sobriety. Being able to pay attention to their mood and how they

are feeling and the impact the substance use has had and looking at assessing ongoing psychiatric care is really a big piece of this.

Alcohol dependence is a type of chronic suicide. I have seen that over my career of individuals that continue down this road for a long period of time, where even though there is this payoff that comes from the ingestion of the alcohol and the illness of it. At the same time, the significant impact it is having on the person ultimately will take their life.

That happens much more often than people realize. When is the suicide risk greater? Other risk factors like we have been talking about, depression, what's the relationship status for the person? That's really important. If somebody has a partner, if they are in a relationship of some kind, that can be a protective factor. If it is toxic, it can be a risk factor.

Depending upon the person's impulsivity, that also comes into play. We do know specifically individuals with a personality disorder, especially borderline personality disorder, who are isolated. They are probably the highest risk population that we have.

Alcohol or substance use disorder with borderline personality disorder tends to fall into the riskiest population that we see. Working in the inpatient psychiatric facility, oftentimes we have clients that present with really substance abuse, borderline personality disorder and a trauma history and an overdose history, a very complicated client that need long-term consistent care.

Listen, I've seen a lot of clients like that get into recovery and do really well and treat their personality piece along with the substance use disorder and their mood. Oftentimes, that takes a lot of significant and intense care in the beginning and a willingness with the client as well for that

I want to talk to you a little bit about some specific risk factors for suicide. Oftentimes, when somebody gets to a point where they are verbalizing either I'm experiencing these thoughts, I have an intent to take my life, I've contemplated this, perhaps I've sent a message, social media. I've said something to a family member. I've contacted a crisis line, community hotline, but, you know, when an individual gets to that point, their risk goes up significantly.

In one sense, I'm really glad to hear them share what they are experiencing, how they are feeling. That gives us a chance to actually intervene. It also lets us know, too, that their risk has gone up.

They are at a much greater risk to potentially take their lives. Comments that are made, I'd be better off dead. I won't be bothering you much longer. I'm going to take my life. I feel like taking my life. That is really important that we are aware of that.

I spent a period in my career doing business development for a facility, working a lot with referral sources and programs, making sure that we get all the information to referral sources after they completed care.

Part of my job was to look at every phone call that came in the facility, what was the situation, what was the client, did they receive an assessment, if not, why, if they were assessed, what happened, what was their disposition.

Every day of doing that, would I see three, four, five, six calls related to an Instagram message, text message, Facebook messenger post, a letter. It wasn't verbal. It was something written. It is very common to find out that way as well.

Teenagers oftentimes, it is word of mouth. They have told a friend and the friend goes to the school counselor or somebody else. It is on Instagram, Snapchat, it is really important to make sure we are monitoring those things, especially when we have an individual that may be struggling with a substance use or mood disorder.

Some specific risk factors for older adults, our older adult population is a higher risk population for a lot of different reasons. It is important to recognize when I'm sitting down with, perhaps, a 70-year-old alcoholic that's coming into outpatient care, things that I want to assess for.

Do they have guns in the home? Access to weapons, things like that. What's their physical health status? Are they struggling with a certain diagnosis or medical comorbidity that's important to be aware of? Do they have depression or anxiety? Are they recently divorced or widowed, which can put somebody at a much higher risk? Is there some type of family discord that's going on, conflict with children, aunts, uncles, cousins, people like that, major changes in social roles.

Oftentimes, we get to here is an individual that presents. They have just retired.

Many of us any about, wow, it is going to be so great to retire. For a lot of individuals, they really struggle with this.

Right now, in the past four or five months, I have had two or three clients come into care that that's what presented, their sense of self, identity, I'm important, people need me. This is where I get all my social interaction, is work. I'm sought after. People want my knowledge.

Then, on a Friday, I get a cake. We celebrate. Thirty years is over. I go home p I don't have anything. I don't golf. I don't have as many friends. Everything was related to work. Somebody can really decompensate and struggle. That is also a time where somebody can be at a higher risk.

If they have had a prior suicide attempt, we know that's probably one of the biggest risk factors for an individual, loss of a loved one or especially a spouse or a child, social isolation.

This is one of the big things that related to Covid I think we are really seeing. You have heard, the opposite of addiction is connection. Our ability to connect with other human beings, we are pack animals and need that social connection that can help us in a difficult time.

For so many of my clients shall the gravitation from getting in a car, driving to an Alcoholics Anonymous meeting, seeing people that are glad to see me, interacting with them, having that interaction, going home is very different than doing it how we are doing this training.

Finding ways to still have that social interaction with a peer group, friends, things of that nature is really helpful, a big risk factor for somebody that doesn't have it.

Socially dependant, substance use disorder is a big risk factor for older adults. Right now in the United States, I believe, the last time I saw this, about 6,500 people are going to turn 65 every day. This is the fastest growing population, older adults, many of which have a prior history of a substance use disorder that may be coming no care more often now, outpatient and inpatient.

Lastly, you see uncontrollable pain or fear perhaps of a prolonged illness that can I also be a risk factor for an older adult. About 20% of older adults experience

undiagnosed depression. At any given time, 1 out of 5 older adults are walking around with a major depressive disorder, some type of depression. Only about 12-25% with it will get some type of treatment.

So there is a big gap there of actually who receives care. Many adults will gravitate toward alcohol use to cope with that or they may be prescribed a medication for something and perhaps might start taking more of that.

The thing that I always talk to families about and older adults is, depressive disorders, that's not a normal part of aging, you know. It is not how we are supposed to feel. If that's going on, that needs to be assessed by a professional and can oftentimes be treated, versus, well, this is just a part of life and how I am supposed to feel, which is not the case.

One of the last articles I saw about that, older adults, a high percentage of them, within 30 days of having a suicide attempt, will see their primary care physician.

PCPs have gotten better at asking questions and assessing for mood issues, suicidality. We still have a good way to go with how we do that.

Oftentimes, for an individual experiencing depression, suicidal thoughts are a symptom of it. That can be an indication that somebody's depression is getting worse when there is that presence of thoughts of, would life be better if I wasn't here? Would people be better if they didn't have to deal with me? Would things be easier? Starting to experience some psychological distress that's really a result of a mood disorder.

Younger individuals, you know, children, adolescents, college age, youth, lots of time will not volunteer they are having these thoughts. It's really important we ask. It's very appropriate for us to do that. We need to ask and ask often.

So many things can change from session to session, day to day, week to week. Listen, part of the -- I'm going to share this with you guys in a few minutes.

The AMSR approach to in-patient care was the recognition that the first group of the day, I may ask, in group, have you experienced any suicidal thoughts currently, plan, anything like that? No.

Well, if they are not asked that again throughout the rest of the day, they may have a phone call at 10:00 that's going to change that. I would see patients sometimes get

served divorce papers while they are in psychiatric care at noon. Things could change. By 2:00, things could change, by 8:00. If we are not asking often, we may miss something.

You all know I'm talking about a higher acute population. For my alcohol use disorder client that's coming into weekly out-patient care, it makes sense that I should probably ask that every time I see them, just to assess that.

Things to understand. For the individual that is having suicidal ideation, for them, it makes sense when viewed in their context of what they are experiencing. What I mean by that is, their vulnerabilities, their mental anguish, the trauma history that they have, the current distress that they are in, the thought of life would be better if I wasn't here, that makes sense to them.

It is important for us as providers that we understand this is a solution for that person. That state of mental pain and anguish oftentimes render them really unable to see that there can be other options.

A lot of people I work with, they will get some pretty significant tunnel vision. This is the only way I may experience relief. Now, that being said, we also know too that even though somebody may be experiencing that, there is a piece of them that also may have hope, that also wants to live, that also sees a life worth living.

Right then and there, it can be really difficult for them to see that, understand it and actually see that things can get better.

Understanding that is really important. We also want to view each client in their own unique miniculture. Again, their actual culture and ethnicity, their family culture, what's going on with their relationship, their neighborhood, their state, where they live, their work.

I can have five clients that all present with suicidal ideation, all five of them are very different as far as their miniculture.

Taking the time to empathize, gain understanding and insight for that particular client is really imperative, not only with trying to build a therapeutic alliance but really understanding that client and what they are going through.

Knowing that there is hope for each person, to have a meaningful life is really

important. You know, my willingness and ability to be committed to helping them, it is good for them to hear that. It is good for them to hear that I want to work with you to help you feel better.

My experience is that by doing this, people do feel better. I know it is really hard for you to see that right now. My ability to express that to the person, that things can change. Hopefully, what we are trying to do is tap into that part that is there that really says, I want to be well, I want feel better and I have a life that's worth living.

For a lot of our clients that struggle with this, it can be really hard to see that with everything going on. That suicidal perspective, can't stop the pain, can't think clearly, can't make decisions, can't sleep, eat, or work, can't get out of the depression, can't seem to get control, understanding that that is their perspective when we interact with them is key.

Let's take them where they are. I may want to think that, well, maybe things aren't that bad or things can get better and everything else. That's where that particular client is.

I have to be cognizant and aware of that. Right then and there, for a lot of our clients, the level of distress is, this is a solution. What happens is, you have one person that sees, this is a solution for my distress. Here we come. No, I want to help you stay here and be present.

You have two people in very different positions with what their goals are. Understanding that, I think, is helpful to really feel where the client is.

So that being said, what are some warning signs? What are some things you want to be aware of? A previous suicide attempt is probably one of the most significant warning signs for a client that we work with. We know statistically speaking, if somebody has had a suicide attempt in the past, they are probably anywhere from 7-13 times more likely to have another one. We don't know when that's going to be. The fact that somebody has moved from, I've contemplated if life would be better? I've thought about maybe how I would take my life with my substance use and everything else.

I've even thought about the ingestion of pills. To move from that to I've actually attempted. Things have changed. That person's risk goes up dramatically. Their

lethality goes up. If I have seen they have a prior attempt, I need to pay attention to that, session to session, to ascertain questions to see how their mood is and any type of psychological distress.

Current talk of or making a plan is a significant warning sign, a strong wish to die or preoccupation with death, increased alcohol or drug use. So, you know, if I have a client that, you know, they have maintained they have got 30 days of sobriety recovery, 45, 60, and they have returned to using, and they have had a relapse, that's really important.

That means their risk has gone up, especially for the client you have that has co-occurring mood disorder. Just from the standpoint of their vulnerability, and depending upon the substance and how much and how often ad the severity of their substance use disorder.

We know that's a very significant risk or warning sign for suicidality. Recent suicide attempt by a friend or family member, if in this person's world somebody recently had an attempt or actually did take their life, their risk goes up.

Now, somebody in my orbit has actually taken that step, a step that right now that person is also contemplating. So that's really important for us to be aware of. We would want to kind of pull up the crisis safety plan and talk about that.

At the end of the training, we'll spend some time about what needs to be in a crisis safety plan for clients.

Interpersonal conflict or loss is one of the common precipitants of completed suicide, relationships, break-up, separation, divorce.

Put me in a group with oppositional defiant disorder, substance using teens and I'm happy as all get-out. Many of you are diagnosing me. That's a population. They deal with a lot of interpersonal conflict.

Statistically speaking, anywhere from a third to a quarter of kids will commit a rash, impulsive, not thought-out act, no warning signs.

These are the kids where everybody in the school is, we had no idea. They do something impulsive. They get a gun. They take medication. They actually take their life. Oftentimes, when we peel it back and look at what led to that, it was either a

conflict, a relationship, some type of loss or, the next one, some type of legal or disciplinary problem that was related to it.

We had a suicide this year in Lexington where a 13-year-old got into a huge thing in school, got in trouble, went home, big blow-up there at the house. Father had a handgun, went down stairs and got the gun and shot himself and took his life, never seen a provider, never been on anybody's radar, a rash, impulsive act related to this.

However, larger percentage will be on our radar, in our car, seen a doctor, on an antidepressant, seeing the school counselor or me. We have a better chance to recognize some warning signs.

Family loss and instability is considered a nonspecific predictor of suicide, loss of a loved one, a move of some kind. Obviously, when there might be a divorce or separation, that instability can come into play as well.

Some of y'all, I know, are familiar with Gabor mate. This kind of brings this home, as far as recognizing that draining family relationships have been identified as risk factors in virtually every category of major illness.

What is your client's family relationships like? What is it? Is there toxicity? Do they come from an invalidating environment? We mentioned borderline personality disorder, emotion regulation issues along with somebody who comes from an invalidating environment.

These family relationships can be a huge determinant from somebody struggling with their mood and substance use disorder.

When we look at that research that predicts who is luckily to become sick, we find people with greater risk of those that experience pretty severe boundary invasions before they were able to construct an autonomous sense of self, emotional/physical abuse, things of that nature and really significant damaging family relationships.

In doing our assessment, it is important to be aware of that role in the client's substance and mental health issues.

We have talked a little bit about alcohol and depression. As far as a warning sign, you all know some of this information I have kind of shared with you. This is kind of looking at it again.

Substance-induced depression, where we see prolonged use of a substance, that plays a role in a mood disorder. We want to pay attention to that.

It's which came first? Part of our assessment, being able to work with the client to determine when did their substance use start, when did they first notice changes with their mood? Obviously, making sure we really make sure we pay attention to somebody's trauma history.

Working in inpatient psychiatric and chemical dependency hospital, those that came into our adult rehab unit, the teenagers that came into our 45-day adolescents substance use disorder program, many of them had a history of trauma.

If you go back and look at where was their age of onset of use, it wasn't uncommon it was around that period of time.

We know that there is a link that's there with that.

>> Talking a little bit about assessment, this gets into the when and the what of getting the right information. Part of that assessment is starting off with can this client be stabilized in the community.

Are they starting off at the right level of care? Are they too high risk for a certain treatment environment? If I'm sitting down with a client in an outpatient environment, have you had thoughts of taking your life? Yes. When is the last time you had that thought? Today. Have you thought about how you might take your life? Yes.

I am thinking of a compliant that I had last year close to this time. She, her roommate's boyfriend's gun was in the closet. She knew where it was. She had thought about it. I could not maintain her stability in this level of care.

We referred to the hospital and she went to the hospital. Part of that assessment, can they be stabilized in the community?

That also means re-assessing often. You heard me mention before, next session, perhaps that's daily, multiple times a day, depending upon what level of care, it might be each shift, depending on residential, any new thoughts or plans.

Then, also, perhaps maybe you are getting a referral from a client that just completed partial hospitalization or residential treatment and they are coming down to outpatient.

Again, somebody can be really risky when they have gone from 24 hours a day, 7 days a week of care to one hour a week along with maybe an hour meeting a day.

That might be as much as they can get. Their risk could go up. That really echos the point of ongoing care that is consistent.

I kind of look at this as, especially for individuals that have co-occurring mental health and substance use disorder, it is kind of the dental model of care.

All of us are going to go to the dentist this year, the next year, the year after. A lot of our clients, they will be in care long-term at varying degrees of intensity, sometimes weekly, sometimes daily.

I have clients that I see four times a year. It is because they are doing well. They are stabilized. Then, again, some that I don't see anymore at all. Some will always be in some type of care even if it is, you know, 20 years recovery, going to AA every day, sponsoring people.

We also want to think about what's called Observation Driven Assessment, the person in front of me, what am I seeing? In kind of stressor involving loss of dignity or respect? That can get into loss of a job.

Right now, so many people we are working with because of the pandemic, they have been let go, furloughed, really struggling in that aspect. There is a loss of dignity that comes with that. A Breakup of some kind, some family disorder can be involved as well. There can be some legal issues that can result in this.

Those are some significant stressors that can come into play.

Stressors that may have precipitated a previous suicide attempt. I'm going to share with you guys a case that has a piece of that that's important to recognize, again, what is that client's history in understanding their history that's really important.

Change in clinical presentation. I saw him last session, bright affect, felt calm, joined with me in the session as far as enter participation. Here they are next session, they are a little more agitated, knees bouncing up and down, a little sweaty. You know, you can notice a pretty significant change in their presentation.

Decreased hope for recovery. What's going on as far as their ability to look at the positivity that's coming with their recovery? Perhaps they have had a lapse of some

kind, a return to use.

Do they have hope they can get back into recovery? Withdrawal, isolation, that's a big one. Lots of times, clients, I get more concerned. I'm seeing this more often where this is a person that attended NAA meetings live and now they start doing Zoom. Now, they are only doing one or two a week. It's not the same.

They went from five, six, seven dedicated hours of care to one or two to none and maybe just me as a provider. We really have to move toward, let's get back to where we were when it was helpful.

Sometimes unexplained improvement in affect can also be a warning sign. That's something that, you know, I think is important to pay attention to, where all of the sudden, somebody that's been working on their depression and anxiety, you have seen a little bit of progress. They come in one session, everything is great, wonderful, like they have just won the lottery.

I really want to pay attention to that. That might be the fact that this person has come to terms with taking their life and they are at peace with it and about to be very risky. We always pay attention in inpatient treatment. That could be a really significant warning sign for that person.

Change in their care experience. If all of the sudden maybe somebody was seeing a doctor and come into your session and they are like, I'm not seeing them anymore. I don't like them. I stopped taking my medication. What's going on there? Change in the treatment setting, you know, that's when somebody can be a little bit riskier, perhaps going from residential level of care to outpatient or inpatient to IOP. IOP to just doing meetings.

Change in the treatment approach is important as well. If I'm an outpatient provider, periodically, maybe they saw a provider a year ago and started to struggle and wanted to come back into care. It is helpful to know what was the prior treatment approach like so I can tailor more to that client?

Also, what's the quality of the relationship with us? The research shows that, you know, that therapeutic alliance is much more helpful and predictive of outcome more so than what's the theoretical approach that I use.

If you look at what's called therapist Allegiance, does the client think you think you can help them. If the client thinks I think I can help them, they are much more likely to stay engaged with me, much more likely to do the interventions, much more likely to work through some of the things that might be difficult and are going to be good for them. If that client thinks you have the short straw to see me today, this is how you get a check, you might get compliance or something, it is going to be hard for them to progress.

That's a big important driver of care. Ongoing screening, it is important periodically, just like we talked about assessment. I want to screen for, how is my client doing? Clients that are involved in substance use disorder treatment, they should be screened for suicidal thoughts and behaviors routinely. Not only an assessment but also at different points throughout their care.

Whether I'm a client in residential treatment, intensive outpatient treatment, outpatient treatment, we want to make sure that that screening occurs regularly. Screening for high risk factors, we want to make sure, especially, that might be related to perhaps having a relapse, making sure that we are really paying attention to that.

This is kind of a breakdown of what's the what of getting the right information. As far as suicide risk assessment, what are some things that myself as clinician, I always pay attention to and I'm assessing.

Long-term risk factors. This gets into the length of their substance use disorder, the length of their mental health disorder. That can be trauma. That can be some of the family dynamics we talked about.

Impulsivity or self-control, do they have a substance use disorder that could make them more impulsive. Do they have a mood disorder such as bipolar disorder that could make them more impulsive? And then past suicidal behavior. If this is a person that has had an attempt, all of those, that's part of the background factors that increase vulnerability.

Past suicidal behavior and recent/present suicidal ideation, again, that's a huge piece of suicide risk assessment, what's not only the past of the client but currently are they experiencing any type of suicidal ideation.

Dynamic factors that can change or intensify rapidly, identifiable stressors. We've talked about some of those, making a rent payment, what's going on with childcare. I have an open child protective case I'm trying to work. You know, I've got traumatic reminders I'm trying to deal with.

We are in a very stressful time for all of us. For our clients, especially, holidays, how different they are going to be, the pandemic. Again, a lot of identifiable stressors we want to pay attention to.

Their clinical presentation we just went through, any changes that I see, group to group, session to session, shift to shift.

Lastly, what about the engagement reliability of the client? That gets into what's my relationship like, the therapeutic alliance or with the treatment team if they are perhaps, in a residential or inpatient program and what's the client's history as a historian? Are they reliable? Is this a client that oftentimes might be pretty cagey about their responses are not the best historian.

These are all important pieces. If we are paying attention, that's an important part of suicide risk assessment. We are going to do a more accurate job with that.

This is specific and developed and related to in-patient programs. That's routine repeat screening. New thoughts since you were last asked. Have you actually had any new thoughts about taking your life or killing yourself. It no, any type of new behavior. If yes, have you been thinking about how you might? Have you had some intention of acting? Have you started to work out how you would do this?

You notice there at the very top, since you were last asked, that's really important. Depending upon your level of care, they might be asked five times a day, once a week. That's an important change, since you were last asked as a part of repeat screening with clients.

Here is a list of a few screening tools that can be really helpful. It is not uncommon for me with a client that perhaps every session I am going to give them a Beck Depression Inventory to fill out or a PHQ-9. The SAFE-T or The Columbia-suicide Severity Rating Scale can be very effective. It is a valuable part of assessing right then and there how that client is doing or I can use it as a comparison session to session

over a period of time.

I had a client recently we just kind of decided to move down to monthly sessions and I went back and looked at the original Beck Depression Inventory, scored a 37. Here six months later, he was a 13.

Huge progress, a lot of change. Longer-term recovery now. He has a sponsor, working the program. Family relationships are going great. Work is going great. It was helpful for me to point that out to him the differences. Some of those he didn't even realized had improved the way they had.

So going back for a second here to, let me find it, this piece. I'm going to read a case to you all.

Just listening to the long-term risk factors, impulsivity, past suicidal behavior, all these aspects, I want you to kind of listen for some pieces you would pick up related to that.

Doug is a 45-year-old male client referred to a 28-day inpatient treatment program by you. He has a history of first being depressed going back to middle school. He began drinking at age 18 followed by sporadic use of Cannabis at age 19. He started experiencing with opioids at 22. At 28, he had an overdose and was admitted to inpatient treatment. After becoming suicidal during a Breakup with a girlfriend. At 30, had another overdose, not suicide attempt but as result of an opioid overdose. He is employed in five years with a company that is supportive, has a girlfriend with you became more depressed after they had a recent fight and discussed breaking up. He has taken an antidepressant, stopped taking it a couple of months ago, a father that has a history of alcoholic and mother treated for depression. They are both supportive. He had a car accident at 40 and upon stabilization achieved two years sobriety and eventually relapsed and started abusing narcotics and led to inhaling heroin. He now has intermittent periods of sobriety, most recently 60 days, utilizing AA before this last relapse.

He has seen you off and on for four years in an outpatient level care. He reached out after he became distraught with the argument with his girlfriend. He is tearful, verbalized he contemplated taking his life and said he would take a large amount of

narcotic to do something. He does not have a plan to do it today and does not desire to take it today. He is craving significantly and not sleeping well and appetite sporadic. He is willing to seek a high-level of care after meeting with you and recognizes he needs it.

How do we formulate risk with Doug? What are Doug's long-term risk factors? What are the impulsivity and self-control issues at play? Does Doug have a history of recent or present suicidal behavior, identifiable stressors or precipitants and what is Doug's engagement and reliability and clinical presentation?

How do we determine his risk? This gets into risk status and risk state. Risk status is, we are going to compare Doug to other clients in a standard population. Comparing Doug to the other clients on the in-patient unit, the other clients in a partial hospitalization program, the other clients in your outpatient practice.

In light of these factors, especially two prior attempts or an overdose, Doug's risk status is somewhat higher than the other patients on the inpatient unit.

That might be how I look at Doug's risk status. Then, again, depending upon the clients that are there, on his admission, it could be different. Really, it kind of comes down to that individual client versus -- compared to a partial hospitalization environment where everybody is going home every day.

Doug is much higher. His risk status is much higher than the other patients in a partial hospitalization program.

That's risk status.

Risk state is I am going to compare Doug to a baseline at another time period in his life. So, for example, I'm seeing Doug two times a month over a six-month period and he is in recovery. What's his risk state now compared to then?

Again, what about when he had an overdose as a suicide attempt and was hospitalized? So, for example, with this one, his risk state is lower than in a previous suicide attempt and a previous inpatient treatment but remains higher than his outpatient baseline.

These are really important factors that I use to consider this individual client I'm working with, what is really their true risk.

So I find it very helpful to look at what is this client's risk status compared to other

people in my practice. What is this client's risk state compared to how long I have been working with them or other levels of care they have been in? Right now, I can quickly pull up in my head two or three clients in my practice that their risk status, you know, is higher than the other clients generally in my practice.

At the same time, their risk state is lower than when they were actually in the hospital. Hence, they are in an outpatient level of care. This is kind of another way to look at this. I think it really gets more into understanding how we view a client's risk. I think it will be very helpful in helping us determine what's the next move for us in trying to help that individual.

Here is a take-home. At the end of the day, none of us in this training can predict who is going to take their life? It is impossible to predict who will take their life? However, using everything that I'm sharing with you all, you know, looking at the right assessment information, their risk status, their risk state, along with the formulation of coping resources, crises safety plan, we can do a good job of doing everything we can to decrease risk, and, hopefully, keep somebody safe and help them maintain recovery.

So documenting and synthesizing the information. Doug's therapeutic alliance with you and his willingness to try interventions, he has a history of taking prescribed medications, supportive family and a good place of employment. That will help us with the crisis safety plan.

We know if he attempts sobriety and recovery and returns to using, has a relapse that could lead to an overdose, decides not to reduce his use, were to perhaps lose his job or there was that Breakup or maybe have a physical setback. His risk state would increase quickly.

For that individual client, these are the things that I want to consider in kind of pulling off that information together.

So let's start thinking about coping resources for Doug. He has good connection to treatment. He has a history of utilizing treatment, supportive family, willingness to try interventions.

He sought us out during that crisis, which is a good coping source. He has a history of going being involved in alcoholics anonymous. That would lead us to look at

relationship with sponsors and other helping professionals. That's really important.

If he was prescribed medication, he has had a psychiatrist he has a good relationship with. There are a lot of good coping resources, pieces there could be there that we are not sure about, spirituality, other things of that nature.

Potential triggers, what are my client's potential triggers, whether that is related to their mood, their substance use disorder. Also, those stressors that all of us can experience from time to time and can have an affect on our mood and return to substance abuse.

Now, we also want to look at important Protective Factors. Things we want to keep in mind for our clients, when I am sitting there and I'm meeting with them, especially the first time, I'm really paying attention to what are this individual client's protective factors currently? What are some things I might want to bring up or reduce to them that might be helpful in reducing their risk?

One of the biggest ones is their reason for living. I'll ask clients sometimes directly about that. Today, talk to me about your reason for living and what your mind-set is about that and whether that is goals they have they want to achieve, their children, spouses, work friend, friends, colleagues, their spirituality, their sense of achievement. It can be a variety of different reasons.

Risk factors are when a client is really struggling with that reason and what that can be.

Being in recovery is a protective factor. Being in recovery for my mental health issue along with my substance use disorder, I'm prescribed Prozac for my depression or I'm prescribed Lexapro for my anxiety and I have a sponsor. I'm working a program. I'm in recovery.

Hence, attendance to some type of 12-step support group, perhaps I have involvement with a Peer Support Specialist. I have a client I've been working with for a while. He had a relapse. Right now, he has about last session, last week, about 45 days recovery.

I referred him to an organization here in Lexington. Now, he has a recovery coach. Man, I feel really good about it. I'm anxious to hear next week what that first experience

was like for him.

That's such a big step to add a protective factor, not only the coach but this whole organization that has free groups and yoga and medication.

Another protective factor, religious attendance and internalized spiritual teaching against suicide. Individuals that have grown up with that perspective or perhaps that's a perspective they have that's part of a religion. That is a protective factor for a client.

Presence of a child in the home or child rearing responsibilities, that's a protective factor. Employment is a protective factor. Pets can be a protective factor. I'll talk to clients sometimes about the benefit of taking care of something, the benefit of that relationship is significant for individuals.

I'm a dog lover. I've got two at home. Unconditional love, that feels good. It is good to have.

Trusting relationship with a counselor, physician, peer support, provider or other type of service provider, social worker, that relationship is very much a protective factor for clients.

Employment, we know waking up, I've got a responsibility, I have to get ready. People are counting on me. I get the sense of satisfaction of doing a good job, even if maybe it has been a stressful day. You know, I have relationships with work. There are so many things that come from employment that make a protective factor.

Again, when I can make referrals to help clients with that, that's really significant. If I can refer them to a program that has an employment part to it, man, that can be such a big piece of their recovery.

Trait optimism. Is this a client you are working with that sees the glass half full or half empty. That makes a difference as far as resiliency.

What's this client's level of resiliency. I had a lady I started working with a few months ago, really significant trauma history. She has been in in-patient treatment before. She has achieved stabilization now, got about three months recovery, working a good program with a sponsor.

I looked at her and said, you know, I don't know if anybody has ever told you this, you are one of the most resilient people I have been around. She said, you are the first

person to say that to me. Man, you have fallen off the horse and gotten back up and kept going. Here you are achieving some really awesome things, you know.

Always working toward increasing their recovery capital and any step I can take to help them increase that is going to be helpful as part of their Protective Factors but, also, when we sit down and look at a crisis safety plan.

We are kind of circling back to Mady here. Michael Botticelli, currently with the Boston medical center, he says, the vast majority of people I know in recovery often talk about this profound sense of reestablishing and sometimes for the first time a connection to a much larger community. This is the rare person I have seen that does this on their own. Usually, there are other people that are involved.

Mady, that quote, meetings, 12 steps, sponsorship, and networking, being involved with people and doing what I'm doing, that list of priorities that she has as a part of her recovery and now a part of her outreach in what she does every day to help other people that have experienced what she has experienced.

It really gets us back to the importance of those protective factors.

Shifting into the Developing a Crisis Response Plan, an individual client, what are their top one or two triggers?

What are the things in their life that if this occurs could lead putting some type of substance in my body or lead to an exacerbation of my mood.

What are these things that are in that particular mini-culture of the client you have that are very specific to them?

We want to know that early on in care so we can start to come up with strategy to be helpful.

It is not only those top two. It is also the warning sign that those triggers and warning signs, we want to make sure we have got some good coping strategies for that. Some of those are internal.

This kind of gets into what can the client do on their own? Whether that is, what's their internal monologue, thought-stopping techniques, medication, internal coping strategies that can be really helpful when a trigger arises or some type of warning signs.

We want to lift those out, okay? Part of therapy or counseling, and peer support, can be how do we move them into some of those, introduce them, help them practice those.

Basically, gain confidence and self-efficacy in that. Who are the people to ask for help? If it is break glass, pull handle who are those people, sponsor, family member, uncle John that has 20 years recovery, me, the psychiatrist, the hospital support line, a pastor, somebody in the church, celebrate recovery, voices of hope, a lot of different people.

Social situations, who are the people there to distract me? Who are the people I can call up and other supportive individuals that can be there to help me work through a trigger along with professional or agencies I can contact in a crisis. Here at the end, I'll share a couple of resources for you.

We have 911 for emergencies. Here in 2021, we are going to have a line for that, for mental health issues, 988, I believe it is. It is not going to start for another year or so. Who are those resources that are available to contact in a crisis?

Lastly, as part of a crisis response plan, how can we make the environment safe, especially when there is a period of time when a client is more vulnerable, when they have had a return to use or exacerbation of their symptoms?

I may pick up the phone and contact the emergency contact person or their spouse or somebody else.

I think right now it is good for us to make sure there aren't any guns in the home. I think right now it is good to make sure we don't have any medication that they don't take anymore that's there that could be hoarded.

Again, we might not be able to reduce all of those things. If we can reduce what's immediately available, that makes a huge difference.

I had a client one time. I was going through that. I said, talk to me about what's in the home that's lethal. There air couple of guns. I can make sure we can remove those. What about anything else like knives? They both kind of laughed.

We would want to make sure we do something with that. He said, I have 400 knives. I have been collecting knives when I was a child. What do you do with a 400-knife collection? That's a difficult one.

Any time we can reduce that, that makes a big difference. Lots of time, there are readily available family members, friends, other people that can be a part of helping us with that.

So here is kind of a picture of what that looks like. We know the potential triggers. Trigger one, trigger two, all right.

We know a client's warning signs, isolation, decrease in meetings. They are having issues with sleep, appetite, a variety of different warning signs.

We know their coping strategies. We have listed them. We know the people to ask for help. Here are their phone numbers. We know social situations and things to distract me, whether that is exercising or other things. You have me as the agency and this program and that program and we have made the environment safe.

If we have a good plan like this, much more likely that we are going to reduce a client's risk and they are going to maintain recovery and stabilization.

Not having a plan, not having something organized, structured, I'm really big about handing clients things. We do better when we can see something. Verbally, some of that may stay with us for a minute. Some of it may stay with us a little bit longer. It's really difficult.

This is something that I have written out that I have a copy of and the client has a copy of too. I want to make sure I can reference as well.

Then, documenting the response, all right, in the medical record, in your note, what do you want to make sure is in there? What are the actions and decisions that we made? Let's make sure we have referenced safety and crisis support planning, options that are considered or perhaps rejected.

I might recommend a level of care and perhaps the compliant is not at imminent risk and it doesn't, in their mind warrant that. They choose a different level of care. I want to make sure I have documented what I wanted. I can't necessarily make somebody do something if they are not a danger to themselves or others.

Actions and referrals for unmet needs, what other referrals have I made. What's another attempt I wanted to link up a client to a resource.

Listen, this is probably one of the most important ones. Don't shy away from

consultation.

At the end of the day, one of the best things we can do is reach out to a colleague, a former supervisor, and consult. I can document that. Oftentimes, I may ask a client, would it be okay to consult?

Recently, I consulted with a client last week, a physician that's given them the Vivitrol shot to relapse and come back in, and I track them before they can get their shot.

Documenting consultation is good for us. It reduces our liability and risk. At the end of the day, it's just good client care to utilize consultation.

Connecting the plans to risk in the record, that's kind of what we are talking about. Obviously, knowing what our state and local laws are. This kind of gets into, in Kentucky, we have 202-A criteria. Different states have different criteria, for example, involuntary hospitalization.

Here in Kentucky, we have Casey's Law. If somebody is deemed to be a danger to themselves or others related to their substance use, Casey's Law petition can be completed and assessments to where the client could be court ordered for inpatient treatment.

All of this I am sharing is ultimately to reduce our liability and risk as well.

We're going to end up with some points to keep us on track before we have a little bit of time at the end also for questions.

This is just kind of a succinct way to look at some of the things I've shared with you guys. Almost all of our clients who are suicidal are ambivalent about living or not living.

We know that oftentimes there is this dialectical, I want to be alive and I want to be a better life but I also feel like with my level of distress, this is a solution.

It is not uncommon for clients to be experiencing both things at the same time. Given some of those examples that are listed there where somebody is at that point of an attempt, even with an attempt but also wants to be alive.

That is my ability to tap into that ambivalence and that piece that is there about a life worth living and how life can be better and people can recover.

The message that I give them about my willingness to be there and be a part of that and to align them with other people that can help them is really important.

Suicidal crises can be overcome. Acute suicidality is typically a transient state. There can be individuals that will be at a certain risk status or risk state. Oftentimes, they are going to spend more time not being suicidal. They are going to spend more time being content or at least at a point where they are not feeling that way.

So, you know, we know that they may ebb and flow through that. That being said, it is important for us to recognize that the assessment, the screening really helps us look at avoiding a crises or providing good care and assistance during a crises.

Although suicide cannot be predicted with certainty, suicide risk assessment is a valuable, clinical tool. For us as substance abuse providers that work with high-risk clients, it is hard to determine the accuracy of who may take their life.

At the end of the day, using this information I have shared with you all, that can be very helpful in reducing risk and assessing who or what type of care we need to provide and how we can address somebody who might currently be in a crisis.

Number four, suicide prevention actions should extend beyond the immediate crisis. Clients in substance abuse treatment who have long-term risk factors require treatment of these issues whether or not they show any indication of current risk for suicide. For that individual client, you know, ongoing care that helps them with their mood disorder, their past trauma history, current relationship issues, psychosocial stressors, relapse prevention, we want that to be ongoing. There was a crisis, perhaps they went to the hospital and they were stabilized and went back out.

We know we need to continue to address those issues and provide care to help them increase their coping mechanisms and strategies to reduce the potential of another crises.

Point five, suicide contracts are not recommended and are never sufficient. When I first came in the field in '93, '94, '95, suicide contracts would be utilized. A clinician would draw up a contract that was predominantly about what a client would not do. They won't do this, they won't do that, they won't do that.

A Crisis Safety Plan is what the client will do and what I'm going to do. It is much more effective. It gets into everything that's very specific about that client. Also, really lays out coping strategies, triggers, how do we address those, supportive people, all

these calls I will make, places I will go, things I will do that's found to be much more effective.

Suicide contract we know doesn't hold up in court either. Some clients will be at risk of suicide even after getting in recovery. You heard me share this earlier.

That risk, just because somebody goes into treatment, even though abstinence and sobriety, we want that to be a goal. At the same time, some individuals will definitely remain at risk even during that period of time.

In fact, oftentimes when they come out, I'm looking back at all the things that have occurred, losses, job loss, some legal things, other things, I'm going to be at higher risk. As a provider, we need to be aware when this client maybe gets referred to us and here they are, they have got a period of sobriety, they can be at really high risk. I want to make sure I'm addressing their needs.

Point seven, suicide attempts always must be taken seriously. Whether I may think this person is saying this as a way to get attention. Regardless of that situation, none of us can predict this current day when this client is saying this that that's the day that something may occur.

I take it as serious as the third time, the fifth time, the ninth time. Again, none of us can predict who may actually take their life. Knowing that, think, it's really important to make sure we always take that seriously.

I was working with a lady today and her husband has a history of suicide attempts. Under the influence, whether that is, okay, that's just because they are under the influence and they don't really mean that. They absolutely mean that.

Perhaps this is a part of a way to keep me in the relationship regardless. We always have to take that seriously.

We know that suicidal individuals generally do show warning signs. The majority of individuals will express something. They will verbalize something. They will have some type of communication, oftentimes it may be repeated. We'll see their mood, tearfulness, hopelessness. Perhaps that warning sign is a return to use. There will be something that will lead us to pay attention to them, okay? That's helpful, because that gives us a mechanism to make sure we move toward providing some type of

intervention, right up to whether that is we are going to see the PCP, go to the emergency room, make a referral to emergency care and respond in kind to that warning sign.

It's best to ask clients about suicide and ask directly. It is a complete myth that if I ask a client, you flow, since I saw you last, have you had thoughts of taking your life? That for some reason, that's going to make them start to think about it? Trust me, if the client has considered that, they have considered it before me saying that.

By me asking and asking often, I have experienced this so many times over my career. Some clients may not be prepared for us to ask that. Just by the pause that they give, they have answered the question for you. You know they have considered it or they will just blurt out yes, because it is the first time somebody has asked them and they respond in kind.

I don't want to shy away from asking the question and asking it regularly. Now, can a client decide not to be honest with us? Absolutely. We can't predict that nor can we make a client be honest with us.

At the end of the day, not only is it the right thing to do clinically but I can document that I asked it and this was their response.

The last point here, this is kind of examples of questions and how we can ask that. I kind of shared with you throughout the training.

Point ten, though, the outcome does not always tell the whole story. What this means by this is there are clients that present a certain way. Man, they come into care. We provide good care. They have a good outcome.

Again, whether that means that was the best treatment or not, you know, ultimately, the treatment they received was helpful in their stability.

On the other hand, we can do great screening, great assessing, evidence-based practices and despite all those efforts, somebody may take their life.

Again, even though there is an end to that, that was tragic, that we don't want to occur, everybody did everything they could do. We did the right things.

I've experienced that, losing clients over my career. At the same time, though, ultimately, I want to get to where I know I'm providing the best care I possibly can,

utilizing the information I have shared with you all. The chances are much greater that we will have a positive outcome.

I also have to be realistic. You all know this illness, especially left untreated, chronic, debilitating, and oftentimes the result can be very lethal.

I know you all are aware of that.

Some take-home points. We want to screen for substance use. We want to screen for any type of mood disorder, suicidal ideation of any kind, family history. It really is helpful to know. When you look at another kind of a risk factor, obviously, if there is a family history of not only substance use but suicidal ideation or an attempt or somebody that has taken their life, it is really important to know that information. Kenneth Minkoff, the godfather of integrative care.

When I have a client that has a substance abuse disorder and a mental health disorder, I'm going to treat both concurrently at the same time with the same level of attention. That's integrated care.

Obviously, if there is medication involved, if that person can be right there too, that's really the most effective that we can do.

Then, of course, limiting any kind of access to means is a really important piece of this as well.

A good support line that's available that's a text line for clients that are in crisis. They can text home to 741714, which will immediately get them connect today a crisis counselor 24 hours a day, seven days a week, 365 days a year. Some clients are more comfortable with this response.

They are more used to it. They feel like it is safer than actually calling somebody. Oftentimes, in handouts that I give to people, the crisis safety plan, that's there as a mechanism for them.

Also, here are some additional resources that I found to be very helpful that have some great information. The National Suicide Prevention Lifeline that you see there, I want to make sure every client I'm working with, this is on our radar as part of their care.

They also have that lifeline. I want to make sure that their emergency contact or spouse, parent, somebody else also has this as well that can be utilized for them too.

You also have a list of references as well that are there for you.

Again, my e-mail address is on here, obviously. If you all have any questions or anything, there is also some contact information as well.

We have 15 minutes for questions. I want to make sure we have time for that too.
>>> I'm relieved this is going to be recorded and on demand. There is so much information and such a great resource. We also have a plot of questions. I am going to get right into this.

Question one is from Lindsey from New York. She asks when talking about self-injurious behavior and clients being seven times more likely to engage in suicide if they engage in self-injurious behavior, does that mean chronic or just one instance?
>> No. In fact, the information I have seen, one time of where a client has gotten to that point I am taking something and to cope with this unbearable feeling, I have done this. That is kind of similar to and in some respects of the person that's in a level of despair that's gotten to the point of an attempt.

For me, myself, and some of the literature I have looked at, whether it is one or two times or 24 times, I have worked with clients hundreds of times. I'm going to look at that the same way. It is a really good question.
>> Larry from Ohio asks, I understand these definitions include the intent to die. This was sent earlier in your presentation.

Is there any consistent and universal agreement as to whether this includes one who may inject large quantities of drugs thinking that one may die and is ambivalent about desire or intent to die? Do some counties count this as suicide or attempt and others may not? Are statistics consistent?
>> That's a really good question. What I have seen most in the literature as far as when does somebody determine, okay, what was the person's intent? How do we figure that out?

For most coroners, most people that show up, unless there was verbalization recently of a desire to take their life, unless there was a note, unless they left a note saying they were going to take their life, unless there was some type of communication that acknowledges intent, rarely is that labeled as somebody that took their life, as a

suicide. It is almost always labeled as overdose due to ingesting a substance. What is the rate of suicide, of somebody taking their life?

Let me flip this for a second. There can also be, for the family, perhaps, where they know there is substance use and they had this history of previous suicide attempts, mental health, somebody that overdosed might look differently than somebody that took their life? Perhaps they would rather see it as an overdose, which is interesting to consider. That is also and can also be a play as well. At the end of the day, unless there is some type of acknowledgment of intent to take their life, most of the time, it is not going to be labeled that way.

>> Interesting. So the numbers, in fact, could be much higher and likely are.

Question three, Ann Marie from Olympia, Washington, asks, I'm curious about what you are saying regarding older white adults having higher rates of suicide than younger people of color? Is this based on numbers or percentages of population? When you break it down by population, white and everyone else, does this hold true for native youth, for example? Thanks in advance for your thoughts.

>> That's a really good question. A lot of this is based on state reported data and state to state across the country.

What do we typically see as far as the rates of race, gender, age? Now, listen. That being said, if you ask me right now what are the populations that I am most concerned about, statistically, we are seeing this, where African-American youth, their rate of suicide has gone up, especially in the last four or five years.

With the pandemic, the effect that's going to have, I'm very concerned about that as well. “USA Today,” probably two years ago or three years ago, I referenced that in another training that I do, they did an expose that looked at the concerns around the increase of suicidality with African-American youth.

Then, we take a pull back and kind of get back to the question. That's based on, hey, what are we seeing state to state, the data reported yearly? That's where that comes from.

>> The next question is Sarah from Mississippi asking what are the stats with other racial backgrounds and suicide?

>> Again, Native Americans youth, a much higher risk. We can get into race but then, listen, let's get into other high risk groups also. One of the high risk groups is the LGBTQ population, the suicidal ideation that they experience on a daily basis, their number of attempts and successful suicide is much higher than other cohorts of our society.

That's a higher risk population, Native American population, especially with substance use disorder is a higher risk population.

There are other groups for sure that are very concerning as well.

>> Man, you throw in the pandemic and the level of isolation that people are experiencing, and difficulties with access to care, you all heard me.

I do a lot of work with teens. One of the things I'm really concerned about is what's going on with kids and the fact that they went from on a given day having access to 30 or 40 mandatory reporters in their life to none. They are at home by themselves with family.

The level of abuse that we might be seeing in our country is something we have never experienced before. Domestic violence, I'm really concerned about that as well.

>> Angela from Wisconsin asks, is there an increase in suicide risk for individuals that have binge eating, compulsive eating disorders? I have seen that looked at similar to substance use disorders.

>> It is similar in some respects. I would have to look at that specifically. In another training, I have got that. I can't pull it up. They are a high-risk population for sure.

The other thing that makes that population in some ways unique too is the vulnerability physically of what they are experiencing with their eating disorders.

An individual can go from stable to medically fragile and in serious trouble.

Then, throw in perhaps they might have an alcohol use disorder too. Man, it is hard to determine how much of this was their illness, the natural progression, or was this a suicide attempt?

It is definitely a high-risk population.

>> Lindsey from New York also asks, what kind of recommendations would you make to folks who interact with high-risk clients on suicide hot lines, particularly those clients that

are repeated callers and struggle with available help being involved to them, linkages to additional community resources?
>> It is a real challenge. On one sense, the real positive of that is that individual has dropped an anchor with that hotline. They view that hotline as a resource, a human being, somebody that cares, unconditional. That is a huge, in a sense, a real protective factor for the person.

For the person on the other end of the line, it can be frustrating, because, man, you are giving some of these great interventions, great techniques, all kinds of stuff over the phone. That person may not take that and they call again and again.

The thing I like to say to folks, though, is, you know, what we don't know, is it the 30-second call that they actually make the counseling appointment? Is it the 45th call that they contact the peer support specialist? Is it the 58th call they go to their PCP and talk to them. We don't know.

The thing I always encourage folks to consider is, even though you can almost get kind of burnt out. I am trying everything I can and the person won't do it. Thank goodness, the person keeps calling. They have seen that as an anchor of support necessary a protective factor. That's another way to look at it.
>> It's helpful. I'm sure for the person on the phone, it is also scary.
>> You want to do everything you can. You know, they may not be following through that day. That doesn't mean that they won't do it the next time.
>> I am going to keep asking you all these questions. I have to beware of time. I'm going to ask one more.
>> Okay.
>> Diane from Illinois asks, do you recommend QPR suicide prevention training for friends and family of attempted survivors? If not, what would you recommend?
>> No, QPR is very effective as well. Mental health first aid training can be really helpful. A lot of communities now are providing that and assessing a magic suicide risk. That tends to be more clinical where QPR, you know, it is much more geared toward, I think, loved ones, supportive folks.

There are a lot of good resources too, whether you want to look at, you know, some

of the resources I had in the presentation that are available. The Jason foundation, the national suicide prevention network has some good resources as well that are out there. Certainly, QPR is found to be really helpful.

Mental health first aid is another one too. Our community here, in fact, where I am, our school system got a huge grant so that every bus driver, custodian, teacher, school counselor, whoever might have contact with a child kind of knows what to recognize and how to link them up to some type of support.

That can be very helpful.

>> Okay. All right. Well, I was going to try and fit another one in. I can't. I have to pay attention to time and be respectful to people. Thank you so much, Geoff. This was really great. I know people were supper thrilled about the amount of information. We will send you any other questions. Guys, you will still get information.

Everything you need to know about this webinar is available on this website you see on your screen, including the CE quiz, and make sure you follow the instructions for you to get your certificates.

The schedule for upcoming webinars, a really cool one coming up this Friday, December 11th, an expert panel discussion on opioid use disorder in the black community with Sherra Watkins. Please join us for that. We have a reminder, a great cultural humility webinar series. Lots of great stuff. We have our eight-part cultural humility webinar series. And one was substance disorder in the African-American community and virtual Town Hall events. If you haven't seen that, check that out.

We also have our Covid 19 page and six free webinars obviously relevant. The website is there on the slide. Currently, NAADAC offers two specialty online training series. We are coming out with more this year. Stay tuned.

The first is clinical supervision and the addiction profession, authored by Dr. Thomas Stern, who is protege of the late David Powell and it accompanies his work book, Clinical Supervision.

We have one on addiction treatment in military and veteran culture, which you can find here at this link.

Lastly, a reminder of all the wonderful benefits of being a NAADAC member. The

first and foremost thing I think is great is all the access to CEs and great information like we saw today with Geoff.

It is all free if you are a member. Look about becoming one. If you are not, they also receive free access to our quarterly advances in addiction and recovery magazine, which is also available for CEs. You instantly become a part of our national initiative for advocacy for the professional and those that we serve.

Lastly, a short survey is going to pop up at the end. We love your feedback and use it to inform future webinars. I know Geoff would love to hear what your thoughts are. Please take a few minutes to complete that if you can.

Thank you, guys, for being here today and thank you, Geoff. This was invaluable, great having you here.

I hope everyone has a wonderful weekend, week, I guess. It's Wednesday. Stay connected with us on social media and be well, everybody. Stay safe.

[The webinar concluded at about 5:00 p.m.]