Clinical and Ethical Issues in Managing Suicide Risk in Substance Users

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Objectives

1. Identify risk and protective factors for suicide that are either specific to or more prevalent for substance users.

2. Demonstrate an understanding of the importance of ethical assessment and treatment of substance users.

3. Demonstrate how evidence-based strategies can be used to more effectively assess risk and manage suicidal behavior in a clinical setting.
Advancing treatment.
Transforming lives.
INTRODUCTION
Need for Interventions

• More consideration needs to be given to interventions targeted to populations with, or at risk for, mental health and substance use disorders as an effective strategy for suicide prevention.
Escalating Loss

- Researchers are reporting that suicides and death from drug overdoses now surpass death from diabetes. Many drug overdoses are classified as accidental when it is thought that they are actually suicides.
  – Bloomberg 2018
Suicidal Thoughts and Behaviors Among US Adults (2015)

Figure 9. Past Year Suicidal Thoughts and Behaviors Among U.S. Adults (2015)

- 9.8 million adults had serious thoughts of committing suicide
- 2.7 million adults made suicide plans
- 1.4 million adults attempted suicide
- 1.1 million adults made plans and attempted suicide
- 0.3 million adults made no plans and attempted suicide

Data courtesy of SAMHSA
Suicide is the leading cause of fatal trauma.

#2 leading cause of death in 15-24 and 25-34 year olds (first is accidental).

In 2015, death by suicide is greater than death in motor vehicle accidents (33,736) and homicide (15,872).
Terms

**Risk Factors** - Stressful events or situations that may increase the likelihood of a suicide attempt or death. (Not predictive!)

**Protective Factors** - Personal and social resources that promote resiliency and reduce the potential of suicide and other high-risk behaviors.

**Warning Signs** - the early *observable signs* that indicate increased risk of suicide for someone in the near-term. (Within hours or days.)
Majority of Suicides

- Mental health and substance use disorders accounted for **two-thirds** of all suicides.
  
Post–Acute Withdrawal Symptoms

Post–Acute Withdrawal Symptoms (PAWS) is the recurrent persistence of subtle yet significant emotional and psychological problems that can last for three to six months or (rarely) even longer into recovery and can trigger relapse. PAWS is similar to protracted withdrawal, but the symptoms occur episodically; they can go days or weeks without occurring. When PAWS recurs, it usually lasts for only a few hours to a day. These are the major PAWS symptoms:

- unclear thinking and cognitive impairment
- memory problems
- emotional overreaction and mood swings
- sleep disturbances
- motor coordination and dizziness problems
- difficulty managing stress

Drug craving is also part of the PAWS syndrome, sometimes inducing symptoms that are severe enough to cause relapse. 79,80

(Inaba 89)

SUBSTANCE USE AND SUICIDE
Opioids and Suicide

• The number of opioid prescriptions currently active in pharmacies equals our adult population. The correlation between opioid use and suicide has doubled in strength over the past decade. This is highlighted by a massive increase in overdose deaths, particularly those involving prescription opioids.
  – American Journal of Psychiatry
Alcohol and Risk

- In both men and women, alcohol intoxication was associated with violent methods of suicide and declined markedly with age, suggesting that addressing risks associated with alcohol use may be the greatest aid in the prevention of violent suicides among young and middle age adults.

Increased Likelihood of Attempt

• Alcohol and drug abuse second only to depression and other mood disorders
• 62% of decedents had Blood Alcohol Content of greater than 0.08 g/dL at the time of death.
Suicide Ideation and Attempts Among High School Students by Drinking Status, 2013

- Non-Drinker
- Drinker, Not Binge
- Binge Drinker

Percentage

- Thinking About Suicide
- Attempted Suicide
Long-term Substance Use

• Depletes dopamine, serotonin, and other neurotransmitters linked to feeling good and coping with emotional pain.
• When a person stops using, they may no longer have the ability to cope with mental illness.
  – Possible increase in acute suicide risk.
Duration of Use and Risk

• This study demonstrated that associative abusing certain substances for long duration, in addition to comorbid psychiatric disorders especially with disturbed mood element may trigger suicidal thoughts in polysubstance abusers. Depression and higher suicide probability are common consequences of substance abuse.

Substance use risks

• Makes it easier to go through with suicide attempt.
• Increases risk of attempting through more lethal means.
• Increases risk of overdose.
• Impulsiveness.
• Impaired judgement.
UNIQUE FACTORS
After Primary Care Visit

- Participants reported a high incidence of SI (25.9%) and SA (7.1%) over the year following primary care visits.

Interpersonal Patterns

• The specific interpersonal patterns associated with family history of suicide may interfere with the ability to create stable, long-lasting relationships. In regards to treatment, these personal qualities could cause difficulties in the alliance with health care personnel and make it harder for suicide attempters to accept or benefit from treatment. Attention to suicide attempters’ interpersonal problems is of importance to lower their distress.

Bipolar and Substance Use

• Comorbid AUD/SUB in individuals with bipolar illness are significantly associated with suicide attempts.

• Individuals with this comorbidity should be targeted for intensive suicide prevention efforts.
  
Anxiety and Suicide Risk

• The results of this study corroborate the relevance of anxiety sensitivity cognitive concerns and the depression-distress amplification model to suicide risk in an at-risk clinical sample of SUD patients.

• Findings suggest the importance of assessing anxiety sensitivity cognitive concerns and targeting this vulnerability through brief interventions to reduce suicide risk.

Sleep Problems

• Being awake at night heightened the risks of suicidal thoughts and attempts, which in part was seen as a consequence of the lack of help or resources available at night.

• Secondly, the research found that a prolonged failure to achieve a good night’s sleep made life harder for respondents, adding to depression, as well as increasing negative thinking, attention difficulties, and inactivity.

  – BMJ Open, 2016
ETHICAL CARE
NATIONAL ASSOCIATION OF SOCIAL WORKERS
Know Risks

- Recognize suicidal risks before a problem arises. The best time to think through risk management regarding suicide is before the crisis arises.
Know Laws and Resources

• Understand statutes in your state regarding confidentiality. In some situations breaching confidentiality is legally and ethically valid, especially when the patient is a danger to self or others.

• Be knowledgeable about community resources, referral sources, and hospitalization procedures available to suicidal patients.
Evidence

• Know what the literature and experts say about the epidemiology, risk factors and management of the suicidal patient. Stay current with developments in the field. Participate in continuing education programs to keep skills sharpened.
Supervision

- Retain for supervision or consultation a professional colleague who has expertise in working with suicidal patients. Doing so provides evidence that the clinical social worker responded appropriately even when the result was unfortunate.
Record Keeping

- Practice good record keeping including well-organized treatment plans and thorough assessments that identify risk factors and competence.
- Document all activities performed on behalf of the patient such as consultations, referrals, telephone calls, office visits, clinical judgments, rationales, and observations.
Crisis Coverage

• Provide daily 24-hour office coverage. Arrange for coverage when you will be away from the office. A patient should know how to obtain help in your absence.
ASSESSMENT
JOINER’S THEORY OF SUICIDE

Desire for Suicide

Thwarted Belongingness
“I am alone.”

Perceived Burdensomeness
“I am a burden.”

Capability for Suicide
“I am not afraid to die.”

Suicide or Near-Lethal Suicide Attempt
Risk Assessment-Harvard Medical School

- **Suicide (risk) Assessment** refers to the establishment of a clinical judgment of risk in the very near future, based on the weighing of a very large mass of available clinical detail. Risk assessment carried out in a systematic, disciplined way is more than a guess or intuition – it is a reasoned, inductive process, and a necessary exercise in estimating probability over short periods.
Moving from Risk Factors to Warning Signs

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Warning Signs</th>
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<tbody>
<tr>
<td>Sex</td>
<td>Agitation</td>
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<tr>
<td>Age</td>
<td>Anxiety/panic attacks</td>
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<tr>
<td>Race</td>
<td>Current substance abuse</td>
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<tr>
<td>Marital status</td>
<td>Social withdrawal</td>
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<td>Diagnosis</td>
<td>Insomnia</td>
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<td>Prior suicide attempts</td>
<td>Nightmares</td>
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<tr>
<td>Family history</td>
<td>Purposelessness</td>
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<tr>
<td>Unemployment</td>
<td>Recent (esp. shaming) losses</td>
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<td>Firearms</td>
<td>Plans/preparations</td>
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<tr>
<td>Etc.</td>
<td>“Desperation”</td>
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</table>
Warning Signs - American Association of Suicidology

- Expanded Warning Signs: Increased **substance** (alcohol or drug) **use**
- No reason for living; no sense of **purpose** in life
- **Anxiety**, agitation, unable to sleep or sleeping all of the time
- Feeling **trapped** - like there's no way out
- **Hopelessness**
- **Withdrawal** from friends, family and society
- Rage, uncontrolled **anger**, seeking revenge
- Acting **reckless** or engaging in risky activities, seemingly without thinking
- Dramatic **mood changes**
IsPathWarm

Created by American Association of Suicidology
INTERVENTIONS
“I pity the fool who can’t stop quoting old TV shows!”
Engagement

- The most fundamental and important function of working with any client.
- With a client with suicidal thinking, they need to trust you.
- How do you build rapport with patients?

**KEY Point:** MI is collaborative.
Crisis Intervention

• The goal is to help the client get through an overwhelming period. The focus is on reduction of suicidal thinking, lessening overwhelming feelings, and helping the client access hope.
Questions About Hope

• Questions about hope.
• Do you have hope for your future?
• Do you ever feel hopeless about your future?
Direct Conversations

• Direct conversation: talk openly and directly. Express concerns. Do not fear talking about suicide.
Individual Warning Signs

• Critical to establish warning signs for each individual.
• Having a conversation about what leads them to consider suicide and what protects them from suicidal thinking is an important first step.
Consistent Screening

• Suicide Behaviors Questionnaire-Revised (SBQ-R).
  – Public domain
Persistent Discussion

• Screens cannot replace clinical interviews, rapport building, and persistent communication.
Validating Responses: Some Characteristics

• Communicating that the patient’s feelings *make sense within his or her history and life circumstances*
• Actively accepting the patient and communicating this to the patient
• The patient’s thoughts and feelings are taken seriously and not discounted or trivialized
• Validation is *not* the same as endorsing or agreeing with what the patient is saying.
• *Validation facilitates a good therapeutic alliance, which is essential for valid risk assessment!*

Key Interventions

- Mindful prescribing of medications.
- Work closely with families.
- Appropriate substance use assessment.
- Build social supports in recovery.
- Communicate with all providers.
- Motivational Enhancement.
Aspects of Intervention with Suicidal Patients

Crisis stabilization: Surviving the suicidal episode
  “Containment”
  Means restriction
  Stabilization of mood and sleep
  Emotional support
  Family Involvement
  Etc.

Treatment: Addressing vulnerabilities to suicide
  Depression
  Hopelessness/meaninglessness
  Coping skill deficits
  Self-hatred
  Relationship issues
  Family Involvement
  Etc.
Aspects of Intervention with Suicidal Patients (cont’d)

- Utilizing the Safety Plan (both while in treatment and after)
- Creating an Aftercare Plan to address risk
- Providing Local Crisis Numbers
Safety Plan

Components of a Safety Plan:
- Warning signs
- Coping skills
- People and social relationships
- People who can help
- Professionals who can help
- Environmental safety
Protective Factors

• Strong connections to family and community support
• Fear of pain/dying
• Cultural and religious beliefs that discourage suicide and support self-preservation
• Support through ongoing medical and mental health care relationships
• Skills in problem solving, conflict resolution and nonviolent handling of disputes
• Easy access to effective clinical care and support for help-seeking
• Limited access to highly lethal means of suicide
• Future perspective, values, meaning, goals

Adapted from Suicide Prevention Resource Center
Caveat re: Protective Factors

Protective factors are an important aspect of a complete suicide risk assessment. However, do not be lulled – protective factors may have little impact on a person in an acute suicidal state (that is, when warning signs are prominent).
CBT and Suicide

- Early Phase of Treatment: The practitioner (a) conducts an assessment of the presenting problem; (b) develops a safety plan with the patient; (c) develops a cognitive case conceptualization that involves identifying and characterizing the patient’s dispositional vulnerability factors, early experiences, beliefs (core, anticipatory, relief oriented, and permissive), key automatic thoughts, and suicide-relevant cognitive processes; and (d) establishes treatment goals with the patient.
- Intermediate Phase of Treatment: The practitioner helps the patient (a) increase the number of reasons for living; (b) develop coping strategies; (c) increase compliance with other services; and (d) improve social resources.
- Late Phase of Treatment: The practitioner and the patient (a) work to consolidate the skills learned in treatment; (b) work on relapse prevention; (c) review progress toward treatment goals; (d) and prepare for termination of the acute phase of treatment.

Finding Purpose

• Without a purpose, change does not occur.
  – Joy
  – Pleasure- Freud- “man lives for pleasure.”
  – Developing interests
Self-Care

• Acknowledge the intensity of your feelings
• Seek support from colleagues, de-brief
• Share your feelings with family/friends
• Avoid over – involvement
• Know that you are not responsible for another person’s choice to end their life
Advancing treatment. Transforming lives.

Resources

- https://www.suicidology.org/
- https://afsp.org/
- https://suicidepreventionlifeline.org/
- https://www.sprc.org/
Snapshots at jasonlove.com

"I'm having trouble finding myself."