



Substance Use Disorders and Suicidality: What Everyone Needs to Know

GEOFF WILSON, LCSW, LCADC
THE OFFICES OF PAUL DALTON

Agenda

- ▶ Review the prevalence of suicide and substance use in the United States and explore the link between the two.
- ▶ Discuss the importance of completing a thorough screening and assessment to determine risk level for suicide with the clients you are treating.
- ▶ Review the more common co-occurring disorders that pose a greater risk for suicide and discuss important implications for intervention and treatment.
- ▶ Discuss unique aspects for working with veterans and those actively serving in the military for addressing substance use and suicidality.


The Silent Epidemic

- ▶ Suicide is the leading cause of death among people with substance use disorders (SUDs).
- ▶ Comorbidity—or co-occurring mental illness and substance abuse disorders—increases the risk even further
- ▶ Compared to the general population, people treated for alcohol abuse or dependence are at about ten times greater risk for suicide.
- ▶ Alcohol is present in about 30 to 40 percent of suicides and suicide attempts

The Silent Epidemic


- ▶ **Suicide** is the SECOND leading cause of death for ages 10-24. (2013 CDC WISQARS)
- ▶ **Suicide** is the SECOND leading cause of death for college-age youth and ages 12-18. (2013 CDC WISQARS)
- ▶ More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease, COMBINED!!
- ▶ Each day in our nation there are an average of over 5,400 attempts by young people grades 7-12.
- ▶ Four out of Five teens who attempt suicide have given clear warning signs

The Silent Epidemic



- ▶ Drug-related suicide attempts rose 41% between 2004 and 2011.
- ▶ Over 200,000 emergency department visits resulted from drug-related suicide attempts in 2011

The Silent Epidemic



- ▶ 20.7 million adults had an SUD.
- ▶ 43.7 million adults had a mental health disorder
- ▶ 8.4 million had comorbidity: SUD and MH

Percent with Suicidal Thoughts in the Past Year among Adults Aged 18 or Older, by Past-Year Use:

▶ Nonmedical Users of Sedatives	20.9%
▶ Nonmedical Users of Stimulants	18.1%
▶ Nonmedical Users of Tranquilizers	14.0%
▶ Nonmedical Users of Pain Relievers	13.0%
▶ Users of Marijuana	9.6%
▶ Users of Any Illicit Drug	9.4%
▶ All Adults	3.9%

▶ NSDUH 2012

Percentage of Suicides, by Precipitating Circumstances

- ▶ **No alcohol dependence or substance use: 67%**
- ▶ **Alcohol Dependence: 18%**
- ▶ **Other substance Abuse Problem: 15%**
- ▶ National Violent Death Reporting System, 17 states, 2011

What do the Statistics tell us!!

- ▶ For every completed suicide by youth , it is estimated that 100 to 200 attempts are made
- ▶ Based on the 2015 Youth Risk Behavior Surveillance Survey:

14.5% of students had seriously considered attempting suicide in the past 12 months.

11.3% of students had made a plan for how they would attempt suicide.

6.9% of students had attempted at least one time during the 12 months prior to the survey.

What We Have to Keep in Mind

- ▶ **Suicide knows no boundaries; it occurs across all age, economic, social, and ethnic boundaries.**
- ▶ **Females attempt suicide more than three times as often as males; however, males die by suicide more than four times as often as the females.**
- ▶ **In the age 10 to 24 group, 81% of the suicide deaths were males and 19% were females.**

High Risk Groups



- ▶ LGBTQ youth are often considered to be at higher risk for suicide than their heterosexual peers.
- ▶ 81.9% of LGBT students have experienced harassment at school because of their sexual orientation
- ▶ 63.5% have felt unsafe at school
- ▶ 60.4% of LGBT students never reported an incident of harassment or assault to school personnel.

High Risk Groups



- ▶ Cultural variations also exist in suicide rates.
- ▶ Native American/Alaskan Native youth have the highest rates of suicide-related fatalities.
- ▶ Caucasian youth have the second highest rates of suicides.
- ▶ African-American youth have the third highest rates of suicides.
- ▶ Hispanic youth are more likely to report having attempted suicide than their black and white, non-Hispanic peers.

Alcohol Use Amplifies Suicide Risk

- ▶ **Between 40-60% of those who die by suicide are intoxicated at the time of death**
- ▶ **18-66% who die by suicide have some alcohol in their blood at the time of death**
- ▶ **Middle- or older-aged alcoholics at greater risk than younger alcoholics**
- ▶ **Alcohol use disorders are a significant risk factor for “medically serious” suicide attempts**
- ▶ **Conner; SAMHSA, 2010**

Why the Link

- ▶ Intoxication by drugs or alcohol may:
 - ▶ Decrease Inhibition
 - ▶ Increase Aggressiveness
 - ▶ Impair Judgment
- ▶ Specifically, alcohol intoxication plays a proximal risk factor for suicide
- ▶ Alcohol also increases the lethality of some medications, making an attempt via overdose more likely lethal

Alcohol as a Pre-disposing Risk Factor

- Depressionogenic effect
- Depressive illness may be co-morbid or independent of alcohol abuse
- Promotion of adverse life events
- Negative affect
- Impaired problem-solving skills
- Aggravation of impulsive personality traits
- Loss of social networks or isolation
- Genetic Predisposition

Brady, 2006

Alcoholics with a History of Suicide Attempts

- ▶ More likely to be severely impaired because of comorbid psychiatric problems and other substance use disorders
- ▶ More severely impaired due to alcohol-dependence characteristics
- ▶ Have stronger family history of suicide attempts (first degree relatives)
- ▶ “Alcohol dependence is a type of chronic suicide”

Alcohol and Depression

- ▶ **Alcoholic suicide attempters = more likely to be depressed than non-alcoholic attempters (Chignon et al., 1998)**
- ▶ **Between substance induced depression and independent depression: 41% alcoholics had a depressive episode (26% substance induced; 15% independent) (Schuckit et al., 1997)**
- ▶ **In autopsy studies, 89% alcohol-dependent suicides demonstrated history of other psychiatric illness (Foster et al., 1997)**
 - ▶ **25% had unipolar depression**
 - ▶ **22% had major depression (Henriksson et al., 1993)**

Alcoholism and Personality Disorders

- ▶ **376 pts in treatment for alcohol use disorders**
- ▶ **55% had a personality disorder**
 - ▶ **3 clusters: A (paranoid, schizoid, schizotypal); B (histrionic, narcissistic, borderline, antisocial); C (avoidant, dependent, obsessive-compulsive, depressive, negativistic)**
- ▶ **25% attempted at least once**

Suicide Risk Greater

- ▶ Add known risk factors such as depression, marital status, aggression and impulsive traits.
- ▶ Individuals with borderline personality disorder and who live alone are at highest risk for suicide
- ▶ Alcohol dependent + borderline personality disorder = high intent to die
- ▶ High risk for attempts = high risk for completion

Violent Means



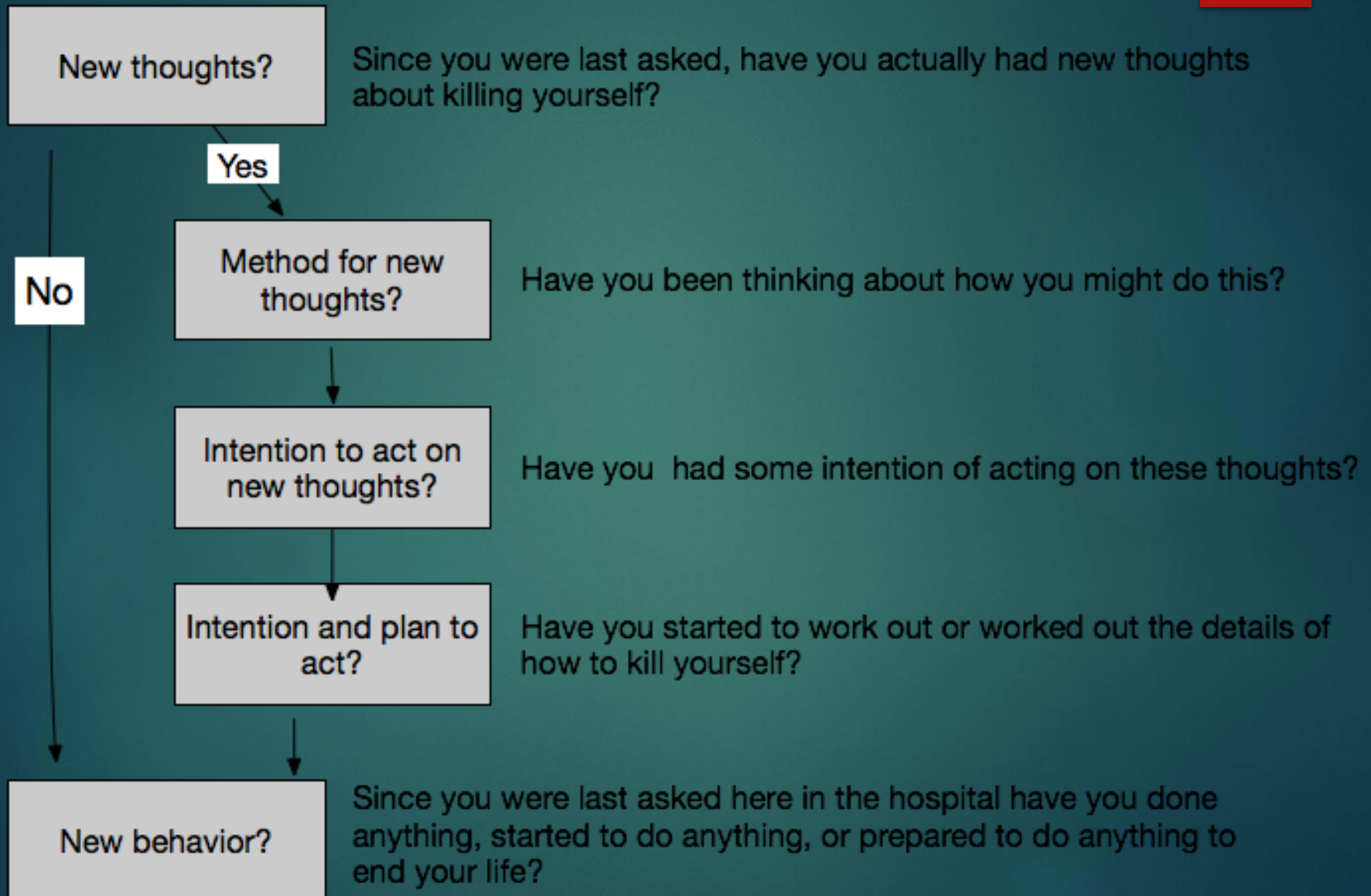
- ▶ Vets diagnosed with mental disorders (e.g., PTSD, depressive disorders) are at increased risk of committing suicide by violent and non-violent means
 - ▶ More severe/chronic generally non-violent means
- ▶ Vets diagnosed with a SUD who commit suicide are more likely to do so by violent methods

The Importance of On-going Screening

- ▶ **Clients in substance abuse treatment should be screened for suicidal thoughts and behaviors routinely at intake and at specific points in the course of treatment.**
- ▶ **Screening for clients with high risk factors should occur regularly throughout treatment**

Routine Repeat Screening

(C-SSRS Frequent Re-Screener, 2-5 items)



10 Points to Keep us on Track

- ▶ **Point 1: Almost all of your clients who are suicidal are ambivalent about living or not living.**

Explanation: Wishing both to die and to live is typical of most individuals who are suicidal, even those who are seriously suicidal (see, e.g., Brown, Steer, Henniques, & Beck, 2005). For example, hesitation wounds are commonly seen on individuals who have died by suicide (e.g., hesitation scratches before a lethal cut, bruises on a temple indicating that a gun had been placed there several times before pulling the trigger).

- ▶ Addressing Suicidal Thoughts And Behaviors in Substance Abuse Treatment-TIP 50 (U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment)

10 Points to Keep us on Track

- ▶ **Point 2: Suicidal crises can be overcome.**
- ▶ Explanation: Fortunately, acute suicidality is a transient state (Shneidman, 1985). Even individuals at high, long-term risk spend more time being nonsuicidal than being suicidal. Moreover, the majority of individuals who have made serious suicide attempts are relieved that they did not die after receiving acute medical and/or psychiatric care.

10 Points to Keep us on Track

- ▶ **Point 3: Although suicide cannot be predicted with certainty, suicide risk assessment is a valuable clinical tool.**
- ▶ Explanation: Substance abuse counselors work with many high-risk clients. Determining with accuracy who will die by suicide using tests or clinical judgment is extremely difficult, if not impossible (Pokorny, 1983).

10 Points to Keep us on Track

- ▶ **Point 4: Suicide prevention actions should extend beyond the immediate crisis.**
- ▶ Explanation: Clients in substance abuse treatment who have long-term risk factors for suicide (e.g., depression, child sexual abuse history, marital problems, repeated substance abuse relapse) require treatment of these issues, whether or not they show any indication of current risk for suicide.

10 Points to Keep us on Track

- ▶ **Point 5: Suicide contracts are not recommended and are never sufficient.**
- ▶ Explanation: Contracts for safety are often used as a stand-alone intervention, but they are never sufficient to ensure the client's safety. Contracts for safety are widely used to reduce legal liability, but the consensus panel is aware of no significant evidence that such contracts offer any protection from litigation

10 Points to Keep us on Track

- ▶ **Point 6: Some clients will be at risk of suicide, even after getting clean and sober.**
- ▶ Explanation: Abstinence should be a primary goal of any client with a substance use disorder and suicidal thoughts and/or behaviors (Weiss & Hufford, 1999). Indeed, risk will diminish for most clients when they achieve abstinence. Nonetheless, some individuals remain at risk even after achieving abstinence

10 Points to Keep us on Track

- ▶ **Point 7: Suicide attempts always must be taken seriously.**
- ▶ Explanation: There is often a mismatch between the intent of the suicidal act and the lethality of the method chosen (Brown, Henriques, Sosdjan, & Beck, 2004). Therefore, clients who genuinely want to die (and expect to die) may nonetheless survive because their method was not foolproof and/or because they were interrupted or rescued. Indeed, a prior suicide attempt is a highly potent risk factor for eventually dying by suicide (Kapur, Cooper, King-Hele, Webb, Lawlor, Rodway, et al., 2006)

10 Points to Keep us on Track

- ▶ **Point 8: Suicidal individuals generally show warning signs.**
- ▶ Explanation: Fortunately, suicidal individuals usually give warning signs. Such warning signs come in many forms (e.g., expressions of hopelessness, suicidal communication) and are often repeated. The difficulty is in recognizing them for what they are

10 Points to Keep us on Track

- ▶ **Point 9: It is best to ask clients about suicide, and ask directly.**
- ▶ Explanation: Available data do not support the idea that asking about suicide will put this idea in an individual's mind (Gould et al., 2005). A counselor's power is limited and does not include the ability to place the idea of suicide in a client's head or to magically remove such an idea. You may never know about a client's suicidality unless you ask

10 Points to Keep us on Track

- ▶ **Point 10: The outcome does not tell the whole story.**
- ▶ Explanation: Suicide deaths have a much lower base rate than many other deleterious outcomes that counselors encounter (e.g., relapse, treatment dropout). A client at significant risk may survive despite never being screened, assessed, or offered intervention for suicide simply because of the relatively low base rate of suicide. Therefore, a good outcome (survival) does not, by itself, equate to proper treatment of suicidal thoughts and behaviors. On the other hand, a clinical team may do a solid job of screening, assessing, and intervening with a high-risk client. Despite these efforts, a high-risk client may eventually die by suicide. Therefore, a tragic outcome (death) does not, by itself, equate to improper treatment of suicidality.

Counselor Best Practices

- ▶ Counselors should be prepared to develop and implement a treatment plan to address suicidality and coordinate the plan with other providers.
- ▶ If a referral is made, counselors should check that referral appointments are kept and continue to monitor clients after crises have passed, through ongoing coordination with mental health providers and other practitioners, family members, and community resources, as appropriate.
- ▶ Counselors should acquire basic knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.

Counselor Best Practices

- ▶ Counselors should be empathic and nonjudgmental with people who experience suicidal thoughts and behaviors.
- ▶ Counselors should understand the impact of their own attitudes and experiences with suicidality on their counseling work with clients. •
- ▶ Substance abuse counselors should understand the ethical and legal principles and potential areas of conflict that exist in working with clients who have suicidal thoughts and behaviors.

Warning Signs



- ▶ Increased use over time/Preoccupation
- ▶ Increased tolerance for the substance
- ▶ Difficulty controlling use
- ▶ Withdrawal symptoms
- ▶ Consequences (family, work, social, legal)
- ▶ Continued use in spite of problems
- ▶ Co-Occurring with other Disorders

Risk Factors for Suicide

- ▶ **Negative Personal History**
- ▶ **Psychopathology and Negative Personality Attributes**
- ▶ **Social and Interpersonal Isolation & Alienation**
- ▶ **Parent/Family Psychopathology**
- ▶ **Family Dysfunction**
- ▶ **Availability and Accessibility**

Risk Factors for Suicide

- ▶ **Suicide Threats: Either Direct or Indirect Statements**
- ▶ **People who talk about suicide, threaten suicide or call suicide crisis lines are 30 times more likely than average to kill themselves. Take suicide threats seriously.**
- ▶ **“I’d be better off dead.”**
- ▶ **“I won’t be bothering you much longer.”**
- ▶ **”You’ll be better off without me around.”**
- ▶ **“I hate my life.”**
- ▶ **“I am going to kill myself.”**
- ▶ **Suicide threats are not always verbal. •Text messages**
- ▶ **Social networks**
- ▶ **Twitter** (Jason Foundation, 2016)

Warning Signs of Suicide

- ▶ A previous suicide attempt.
- ▶ Current talk of suicide, or making a plan.
- ▶ Strong wish to die or preoccupation with death.
- ▶ Increase alcohol and/or drug use.
- ▶ Recent suicide attempt by a friend/family member.

Family and Interpersonal Stress

- ▶ **Interpersonal conflict/loss is most common precipitant of completed suicide (Martunnen et al., 1993).**
- ▶ **Interpersonal conflict/loss and legal/disciplinary problems relate to suicide attempts.**
- ▶ **Family loss/instability is nonspecific predictor of suicidality**

Protective Factors

- ▶ **The following are known and likely protective factors:**
- ▶ **Reasons for living.**
- ▶ **Being clean and sober.**
- ▶ **Attendance at 12-Step support groups.**
- ▶ **Religious attendance and/or internalized spiritual teachings against suicide.**
- ▶ **Presence of a child in the home and/or childrearing responsibilities.**

Protective Factors

- ▶ Intact marriage/partner.
- ▶ Trusting relationship with a counselor, physician, or other service provider.
- ▶ Employment.
- ▶ Trait optimism (a tendency to look at the positive side of life).

The "What" of Getting the Right Information: Information to Gather for Suicide Risk Assessment

Long-term risk factors

Impulsivity/Self control
(incl. subst. abuse)

Past suicidal behavior

Recent/present suicidal ideation, behavior

Identifiable Stressors/
Precipitants

Clinical Presentation
(Dynamic Factors)

Engagement and Reliability

Background factors that increase vulnerability

Suicide ideation, intent, plans, and behaviors. Includes preparatory behavior.

Dynamic factors that can change or intensify rapidly, contributing to acute risk.

Relationship with the provider and treatment team and patient's ability/willingness to report accurately.

Collaborative Discussion of Suicide Risk: From Clinicalese to Plain Language

Long-term risk
factors

All you've been
through

Impulsivity/Self
control
(incl. subst. abuse)

Things that make it
hard to stick with
plans

Past/present suicide
ideation, behavior

Thoughts and actions
that threaten your life
and safety

Identifiable
Stressors/
Precipitants

Stress you're under/
Stress gets you
desperate

Clinical Presentation
(Dynamic Factors)

Changes I've noticed
lately

Engagement and
Reliability

Our relationship and
how accurately you
can say what's going
on for you

Potential Triggers

Specific contingency plans

(Pisani et al, 2012)



Plan in case of Trigger 1

Plan in case of Trigger 2

Safety planning

(Brown & Stanley, 2012)

Warning signs

+

Internal coping strategies

Social situations and people to distract me

People to ask for help

Professionals or agencies to contact in crisis

+

Making the environment safe

Unique Aspects of Veterans

- ▶ “The most important challenges in suicide prevention are stigma surrounding mental illness, negative perceptions of treatment, and other barriers (including confidentiality concerns in the military setting) that result in the majority of service members and veterans not accessing care when needed or dropping out prematurely.”
- ▶ The stresses of deployment during wartime and the unique culture of the military account for some of these differences. Zero-tolerance policies and stigma pose difficulties in identifying and treating substance use problems in military personnel, as does lack of confidentiality that deters many who need treatment from seeking it.

Unique Aspects of Veterans

- ▶ In one study, one in four veterans returning from Iraq and Afghanistan reported symptoms of a mental or cognitive disorder; one in six reported symptoms of post-traumatic stress disorder (PTSD).
- ▶ These disorders are strongly associated with substance abuse and dependence, as are other problems experienced by returning military personnel, including sleep disturbances, traumatic brain injury, and violence in relationships. (Drugabuse.gov)

Unique Aspects of Veterans

- ▶ **The 2010 report of the Army Suicide Prevention Task Force found that 29 percent of active duty Army suicides from fiscal year (FY) 2005 to FY 2009 involved alcohol or drug use; and in 2009, prescription drugs were involved in almost one third of them. (NIDA, 2013)**

Unique Aspects of Veterans

- ▶ A 2012 report prepared for the DoD by the Institute of Medicine (IOM Report) recommended ways of addressing the problem of substance use in the military, including increasing the use of evidence-based prevention and treatment interventions and expanding access to care. The report recommends broadening insurance coverage to include effective outpatient treatments and better equipping healthcare providers to recognize and screen for substance use problems so they can refer patients to appropriate, evidence-based treatment when needed. It also recommends measures like limiting access to alcohol on bases.
- ▶ The IOM Report also notes that addressing substance use in the military will require increasing confidentiality and shifting a cultural climate in which drug problems are stigmatized and evoke fear in people suffering from them. (NIDA, 2013)

Case Example

Overview:

Leon, age 24, is an African American veteran of the Iraq War who is currently a college sophomore. He delivers pizza in the evenings. He has exhibited symptoms of posttraumatic stress disorder (PTSD) such as flashbacks, startle reactions, general apprehension, and intrusive images. He also shows symptoms of depression (sadness, sleep disturbance) since he returned from Iraq. He was discharged from the military when his 4 years were up, but the symptoms persisted. About a year ago he went to a Veterans Affairs (VA) clinic and received prescriptions for depression and sleep disturbance along with instructions to follow through with mental health counseling. He was in counseling with a psychologist and took the prescribed medication for about 6 months, at which point he discontinued treatment because he was feeling better.

Case Example

- ▶ Leon's drinking rapidly escalated after he started college last year, and his alcohol abuse continues. He drinks a fifth, sometimes two fifths, of vodka a week. Mostly he drinks after he gets off work around 11 p.m. and finds that "a couple" of drinks help him get to sleep around 2 a.m. Then he sleeps until around 7 a.m. When he doesn't sleep he gets restless, irritable, and startles easily. Last night he had his usual two or three drinks of straight vodka in his apartment after he got off work. He was found in a stuporous state the next morning around 9 a.m. and was rushed by ambulance to the local hospital. They kept him for several hours at the emergency department (ED), determined that he had not been drinking enough to warrant a detoxification admission, and eventually released him after he provided assurances that he would participate in alcohol counseling at the college alcohol and drug program. The ED staff made an appointment for him at the college alcohol and drug program this afternoon.

Case Example

- ▶ Leon denied any suicidal thoughts or behaviors when questioned in the ED. The ED personnel ordered a urine toxicology to assess for any drugs that may have contributed to his stuporous state prior to arrival, but when he quickly became alert and responsive, they released him before obtaining the results of his urine tests. They also mentioned ruling out suicidal ideation in their referral to the college counseling center. The emergency room personnel were not aware that Leon had been treated for depression at a VA facility last year.

Take Home Points

- ▶ SCREEN for Substance Use
- ▶ SCREEN for Psychiatric Illness
- ▶ SCREEN for Family History of Suicide
- ▶ TREAT Substance Abuse and Mental Illness CONCURRENTLY
- ▶ Limit access to lethal means

Potential Malpractice Issues

- ▶ Maris et al. (2000b) points out three common malpractice “failures” for work with suicidal clients.
- ▶ **1.Failure in assessment.** For substance abuse treatment programs, this means failure to (1) gather information (such as the standard screening questions noted in Part 1, chapter 1), (2) consider that information in treatment planning, (3) recognize warning signs or risk factors as they emerge in treatment, or (4) obtain records from other sources (e.g., previous substance abuse or psychiatric treatment) that would have indicated a significant risk of suicidality.

Potential Malpractice Issues



2.Failures in treatment. For substance abuse treatment programs, this might mean failure to (1) consider the impact of an intense substance abuse treatment environment on a client's suicidality, (2) prepare a client for treatment transitions, including administrative discharges, (3) make appropriate referrals for clients with suicidal thoughts and behaviors, and (4) follow up on referrals.

Potential Malpractice Issues

- ▶ **3. Failure to safeguard:** Substance Abuse Treatment programs have an obligation to clients to create a physically and psychologically safe environment. Creating this safe environment means observation procedures for clients in inpatient or residential settings who are potentially suicidal, efforts toward weapon removal for both inpatient and outpatient clients, and an awareness of medication use by clients who are potentially suicidal. Informed consent documentation should include an explanation of the limits of confidentiality (i.e., the duty to warn in specific situations). In addition, you should implement a policy and procedure for obtaining a release from clients who are at
 - ▶ significant risk or have warning signs of suicide to contact a family member or significant other if the counselor, with appropriate clinical supervision, feels the client may be at significant risk of attempting suicide. While the client must have an opportunity to revoke the release, it gives the agency some option with a client who is actively suicidal.

References

- ▶ Substance Abuse and Mental Health Services (SAMHSA): <http://www.samhsa.gov>
- ▶ Centers for Disease Control and Prevention (CDC) Preventing Suicide: Program Activities Guide http://www.cdc.gov/ncipc/dvp/Preventing_Suicide.pdf
- ▶ National Institute on Drug Abuse: <http://www.nida.nih.gov>
- ▶ National Institute on Alcohol Abuse and Alcoholism: <http://www.niaaa.nih.gov>
- ▶ Suicide Prevention Resource Center (SPRC): <http://www.sprc.org>
- ▶ Suicide Prevention Lifeline: <http://www.suicidepreventionlifeline.org>

Resources

- ▶ Stop Youth Suicide - SYS
- ▶ National Action Alliance for Suicide Prevention
- ▶ The Jason Foundation
- ▶ www.suicidepreventionlifeline.org
- ▶ 1-800-SUICIDE
- ▶ www.suicidology.org



Questions, comments, concerns!

- ▶ Thank You!!
- ▶ Geoff Wilson, LCSW, LCADC
- ▶ The Offices of Paul Dalton
- ▶ 501 Darby Creek Rd., Suite 11
- ▶ Lexington, KY 40509
- ▶ Geoffwilson914@gmail.com
- ▶ 859.229.5722