Webinar - Addressing the Intersection of Substance Use and Suicide: Strategies for Prevention, Intervention, and Treatment

Questions from Participants and Answers from the Presenter

Q: What is the Stanley-Brown Safety Plan?

A: The Stanley-Brown Safety Plan is a specific, evidence-based safety planning intervention that is developed collaboratively with a trained provider and used by an individual when having thoughts of suicide to stay safe until the urge passes.

Q: Is the Stanley Brown app and My3 app for professionals or consumers?

A: The app is to be used by consumers. Professionals should be aware of the app and encourage their clients to enter the information they come up with during the intervention into the app during the appointment or prior to discharge.

Q: On slide 18, why is there no more data after age 65 for American Indians?

A: Numbers are too small so the data are not publicly available.

Q: Is there any recent data on number of suicides in this time of COVID?

A: Unfortunately there are not any recent data because there is a two year data lag. This information may be obtained locally from county medical examiners or coroners. Meadows Mental Health Policy Institute did recently release a report about how increases in unemployment will lead to increases in suicide and substance use disorders, providing estimates per state. See this link:

https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts.pdf

Q: How well are screening competencies for MH, SUD, and suicide built into the required curriculum for doctors, nurse practitioners, physician assistants, and social workers for both those entering the field and as continuing education?

A: I don't think it's built in very well. There are specific screens that each of these fields recommend but often single questions are used or larger health assessments are used to assess suicide risk. A tool like the C-SSRS should be used for suicide risk because it asks about method, plan, intent, and behavior rather than just ideation.

Q: How are medical examiners and coroners trained to differentiate accidental vs intentional overdose, especially among youth/teens?

A: Deeming an overdose a suicide typically requires the presence of a suicide note or some other clear indicator that it is a suicide. That is why suicide by overdose is typically underreported.

Q: For providers that complain about limited time, how can we screen for both SUD and suicide? Are there joint screening tools that are reliable, valid, and quick?

A: Using prescreens is the best way to address the issue of limited time. In general medical settings, the number of positive suicide risk screens will be low so completing a full suicide screen will not happen very frequently. I suggest using the PHQ-3 along with another substance misuse prescreen like the AUDIT-C and DAST-1. Seven total questions. And of course highlighting the problem of substance use and suicide and the importance of screening.

Q: Can you share about HCPCs codes for screening for both suicide and SUD? Are they billed separately?

A: Here is some information about codes for substance use screening and intervention.

https://www.samhsa.gov/sbirt/coding-reimbursement

Here is some information about suicide risk screening.
http://zerosuicide.edc.org/sites/default/files/Suicide%20Care%20Pathway%20Coding%20for%20Primary%20and%20Behavioral%20Health%20Care.pdf

Q: What are the thoughts behind why the USA suicide rate is so much higher than other countries?

A: For one, we live in an individualistic society in the US. There is also often a greater stigma around mental health than in other countries. Access to services is another due to lack of insurance. Last, those in rural areas with a high school diploma or less are struggling most in the US. They are not doing as well as their parents' generation economically – failing businesses and farms.

Q: Has the suicide rates for trans people been considered/represented?

A: Yes. The rates are very high. Unfortunately the data are not readily available but are often obtained from research studies. The data I presented during the webinar came from the CDC Youth Risk Behavior Survey and they do not ask about whether a student transgender, only LGB.

Here is a link to a recent study. https://pediatrics.aappublications.org/content/142/4/e20174218

Q: Is there data for suicide rate for ages 40-49? It looks like that is missing from the chart.

A: One chart covers that age range but it's broken into two separate categories. The other was just highlighting youth vs. the 50-59 age category so was not intended to have 40-49. I ran the data just now, and the suicide rate for 40-49 in the US in 2018 (most recent data available) was 18.7 per 100,000 population.