Webinar: Integrating Suicide Prevention into the SBIRT Model

Questions from Participants and Answers from the Presenter

Q: What are your recommendations for a clinician administering the SBIRT and subsequent screenings alone? Should this be done with a colleague as best practice?

A: The screenings and brief interventions are typically performed alone. It is recommended that screening scores and notes from the brief intervention be entered into the patient's medical record so that other colleagues at the practice may access this information when working with the patient.

Q: What special considerations should be made when applying SBIRT with an older adult at risk for suicide?

A: Access to lethal means is a special consideration. Older adults typically have more prescription medications at their disposal, so it is important to ensure that the medication is only being taken at the amount prescribed and that it is safely stored away at other times. Prescribing physicians and pharmacists should be aware of suicide risk and connect them to care when appropriate.

Q: I haven't heard you emphasizing the importance of integration with the person's PRIMARY CARE TEAM! Suicide prevention and substance use care will not be successful if kept within the behavioral health community! INCLUDE THE PCP ON THE SAFETY PLAN POCs!

A: You are correct. This is very important. My apologies if this was not emphasized. I strongly believe in the importance of routine screening in primary care settings, not just in the behavioral health community. Thank you for this comment.

Q: Where is suicide by cop accounted for? Other or firearm?

A: Those aren't typically counted as a suicide. As I mentioned, medical examiners and coroners usually rely on a suicide note to determine that suicide was the intent. Thus the underreporting of suicides. In New York State we are beginning to develop a suicide fatality review process with the goal of better identifying and reporting suicides so that we have accurate information to inform suicide prevention efforts at a local level.

Q: What information do you have to support the suicide by poisoning and SUD overdose association made? If correct, what are the implications for ensuring mental health professionals are trained not just in suicide safety, but SUD/OUD overdose risk prevention?

A: Here is a recent article in the NEJM that I cited in my presentation: https://www.nejm.org/doi/10.1056/NEJMp1801417. I also referenced the SAMHSA Nexus brief that

provides guidance for collaboration between substance use and suicide prevention fields. It is essential that state agencies for substance use and mental health collaborate to ensure that their provider systems are trained in the other's specialty area. In New York State, we are working towards this. We are providing suicide prevention training and suicide safer care protocols to SUD providers and are working on developing SUD/OUD consultation for mental health providers. We also have many dually certified providers. Last, we're assembling a training that combines SUD/OUD overdose risk, naloxone administration, and suicide prevention.

Q: How is the BNI different from MI?

A: The BNI incorporates MI. MI is used in the BNI to encourage the patient to share during the BI and to develop a self-directed action plan.

Q: Do you recommend that the family and friends that a person includes on their list be notified, in advance that they are a contact?

A: It depends on where they are listed. I do not think that family and friends that are listed as contacts for distractions should be notified. If they are listed as contacts who they can reach out to for help, then often times those individuals should be engaged in the patient's treatment. So I would recommend asking the patient for permission to engage those family members/friends.

Q: Just wondering if you have experienced providers (especially schools) be hesitant to use screeners due to not knowing how to respond. Any thoughts/suggestions?

A: Yes, I think that is pretty common for suicide risk as well as for alcohol and drug screens. It is important to train providers in what to do after the screen and to have a protocol set up. The screeners come with guidance on how to proceed based on screening score. Providers will find it helpful to know the process following the screen and that there are interventions that can help the patient following the screening.

Q: Is there a requirement to inform the parents of a minor of a positive screen?

A: There is not a requirement. It is good practice for the provider to conduct an assessment without the parent present so that they can gain more information without the parent influencing the response. Once risk level is determined and an action plan devised, it is good practice to engage the parent in the child’s care plan.

Q: How do these numbers of drug use change with the legalization of marijuana?

There have a been a few studies looking into the increase in marijuana use following legalization of recreational marijuana. The most recent article in JAMA included 838,600 participants and found that odds of past year and past month marijuana use were greater after legalization than prior among Hispanic and non-Hispanic White populations as well as those ages 21 and above. There was no difference for non-Hispanic Black individuals or those 12-20 years old (Martins et al., 2021).

Q: How do you handle individuals who refuse to answer these questions related to suicide?

They do have a right to refuse to respond to the screening questions. The best way to get around this is to make sure your lead in to asking the questions is appropriate and empathic. You want to

introduce the subject, discuss why you are asking these questions, and ask permission to move forward with the screening. It is also important to ensure confidentiality while making it known when confidentiality would have to be broken.