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.