InforMed
Continuing Medical Education
By Colibri Healthcare

State Specific Continuing Medical Education

2023 Wisconsin Medical Licensure Program

- **2 Credits**
  BOARD APPROVED
  Responsible Opioid Prescribing*

ACCME ACCREDITED

*Opioid CME Requirement

2 Credit hours of board-approved education on responsible opioid prescribing.

CME FOR: *AMA PRA CATEGORY 1 CREDITS™* MIPS MOC STATE LICENSURE

WI.CME.EDU

CONTENTS

2023 WISCONSIN

CME that counts for MOC

Participants can earn MOC points equivalent to the amount of CME credits claimed for designated activities (see page iii for further details). InforMed currently reports to the following specialty boards: the American Board of Internal Medicine (ABIM), the American Board of Anesthesiology (ABA), the American Board of Pediatrics (ABP), the American Board of Ophthalmology (ABO), the American Board of Otolaryngology–Head and Neck Surgery (ABOHNS), and the American Board of Pathology (ABPath). To be awarded MOC points, you must obtain a passing score, complete the corresponding activity evaluation, and provide required information necessary for reporting.

$55.00	$50.00
ENTIRE PROGRAM	COURSE 1

DATA REPORTING: Federal, State, and Regulatory Agencies require disclosure of data reporting to all course participants. InforMed abides by each entity's requirements for data reporting to attest compliance on your behalf. Reported data is governed by each entity's confidentiality policy. To report compliance on your behalf, it's mandatory that you must achieve a passing score and accurately fill out the learner information, activity and program evaluation, and the 90-day follow up survey. Failure to accurately provide this information may result in your data being non-reportable and subject to actions by these entities.

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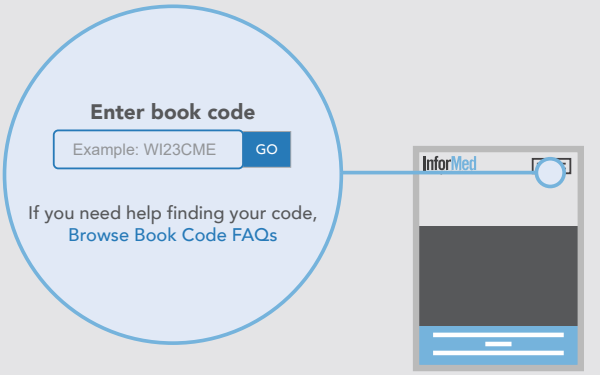

Program Options	Code	Credits	Price
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Course 1	WI23CME-50	2	$50.00

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- Fill out the answer sheet and evaluation found in the back of this booklet. Please include a check or credit card information and e-mail address. Mail to **InforMed, PO Box 2595, Ormond Beach, FL 32175-2595**.
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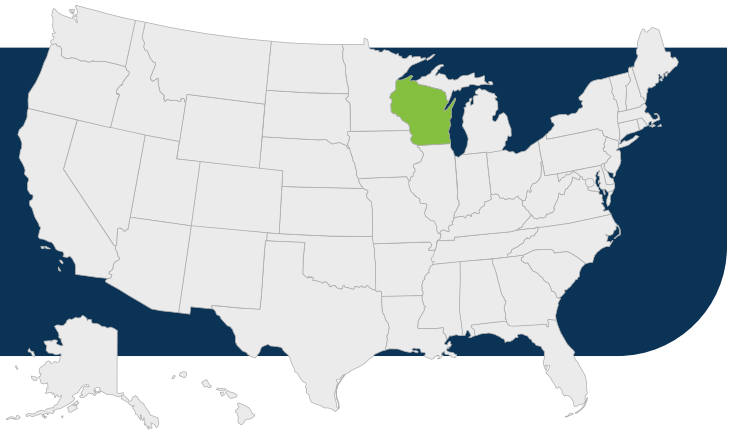

Wisconsin Professional License Requirements

PHYSICIANS MANDATORY CONTINUING MEDICAL EDUCATION REQUIREMENT FOR LICENSE RENEWAL

The Wisconsin Medical Examining Board requires all physicians (MD/DO) maintaining a current license to complete thirty (30) credit hours of continuing medical education (CME) during the current two (2) year CME cycle (1/1/2022 to 12/31/2023) which are *AMA PRA Category 1 Credits*™ or equivalent.

MANDATORY CME ON PRESCRIPTION OF OPIOID MEDICATION

All physicians (MD/DO) licensed by the Wisconsin Medical Examining Board that have a current DEA registration to prescribe controlled substances must earn a minimum of two (2) *AMA PRA Category 1 Credits*™ or equivalent via a board-approved course on opioid prescribing.

What This Means for You:

If you are licensed by the Wisconsin Medical Examining Board as a physician (MD/DO), and have a current DEA registration to prescribe controlled substances, then you must earn two (2) credit hours on opioid prescribing through a board-approved course. These credits earned will also count toward your overall CME requirements for license renewal.

We are a nationally accredited CME provider.
For all board-related inquiries please contact:

Wisconsin Medical Examining Board
DSPS
PO Box 8366
Madison, WI 53708-8366
P: (608) 266-2112

COMPLETION DEADLINE:
12/31/2023

LICENSE/TYPES
MD/DO

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MOC/MIPS CREDIT INFORMATION

In addition to awarding *AMA PRA Category 1 Credits*™, the successful completion of enclosed activities may award the following MOC points and credit types. To be awarded MOC points, you must obtain a passing score and complete the corresponding activity evaluation.

Table 1. MOC Recognition Statements		
Successful completion of certain enclosed CME activities, which includes participation in the evaluation component, enables the participant to earn up to the amounts and credit types shown in Table 2 below. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting MOC credit.		
Board Programs		
MOCA®	**ABA**	American Board of Anesthesiology's redesigned Maintenance of Certification in Anesthesiology™ (MOCA®) program, known as MOCA 2.0®
ABIM CME MOC ACCREDITED	**ABIM**	American Board of Internal Medicine's Maintenance of Certification (MOC) program
	ABO	American Board of Ophthalmology's Maintenance of Certification (MOC) program
ABOHNS	**ABOHNS**	American Board of Otolaryngology – Head and Neck Surgery's Continuing Certification program (formerly known as MOC)
CME for ABPath CC	**ABPath**	American Board of Pathology's Continuing Certification Program
PART 2 MOC THE AMERICAN BOARD of PEDIATRICS	**ABP**	American Board of Pediatrics' Maintenance of Certification (MOC) program.

Table 2. Credits and Type Awarded							
Activity Title	***AMA PRA Category 1 Credits*™**	**ABA**	**ABIM**	**ABO**	**ABOHNS**	**ABPath**	**ABP**
Best Practices for Treating Pain with Opioid Analgesics	2 *AMA PRA Category 1 Credits*™	2 Credits LL	2 Credits MK	2 Credits LL & SA	2 Credits SA	2 Credits LL	2 Credits LL+SA
Assessment and Prevention of Suicide	6 *AMA PRA Category 1 Credits*™	6 Credits LL & PS	6 Credits MK & PS	6 Credits LL, SA & PS	6 Credits SA & PS	6 Credits LL	6 Credits LL+SA
Legend: LL = Lifelong Learning, MK = Medical Knowledge, SA = Self-Assessment, LL+SA = Lifelong Learning & Self-Assessment, PS = Patient Safety							

Table 3. CME for MIPS Statement
Completion of each accredited CME activity meets the expectations of an Accredited Safety or Quality Improvement Program (IA PSPA_28) for the Merit-based Incentive Payment Program (MIPS). Participation in this Clinical Practice Improvement Activity (CPIA) is optional for eligible providers.

BEST PRACTICES FOR TREATING PAIN WITH OPIOID ANALGESICS

COURSE DATES:	MAXIMUM CREDITS:	FORMAT:
Release Date: 10/2021 Exp. Date: 9/2024	*2 AMA PRA Category 1 Credits*™	Enduring Material (Self Study)

TARGET AUDIENCE

All health care professionals who participate in the management of patients with pain.

HOW TO RECEIVE CREDIT:

- Read the course materials.
- Complete the self-assessment questions at the end. A score of 70% is required.
- Return your customer information/ answer sheet, evaluation, and payment to InforMed by mail, phone, fax or complete online at program website.

COURSE OBJECTIVE

To provide the fundamentals of acute and chronic pain management and a contextual framework for the safer prescribing of opioid analgesics that includes consideration of a full complement of non-opioid treatment options.

LEARNING OBJECTIVES

Completion of this course will better enable the course participant to:

1. Discuss pain and comorbidity assessments as appropriate to the individual patient and pain type and duration.
2. Discuss an individualized treatment plan utilizing or considering a full range of medication and non-medication options.
3. Identify risk or presence of OUD before initiating or continuing opioid therapy for pain.
4. Recognize signs and symptoms of OUD, strategies for optimal management, and when to refer to a specialist.

ACCREDITATION STATEMENT

InforMed is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

DESIGNATION STATEMENT

InforMed designates this enduring material for a maximum of 2 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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InforMed

DISCLOSURE OF INTEREST

In accordance with the ACCME Standards for Commercial Support of CME, InforMed implemented mechanisms, prior to the planning and implementation of this CME activity, to identify and resolve conflicts of interest for all individuals in a position to control content of this CME activity.

COURSE SATISFIES

WISCONSIN SPECIAL APPROVAL

This activity is approved by the Wisconsin Medical Examining Board and satisfies the education requirement in responsible opioid prescribing.

The Wisconsin Medical Examining Board requires all physicians (MD/DOs) with a current DEA registration to complete a minimum of 2 *AMA PRA Category 1 Credits*™ or equivalent on opioid prescribing through a board approved course.

FACULTY/PLANNING COMMITTEE DISCLOSURE

The following faculty and/or planning committee members have indicated they have no relationship(s) with industry to disclose relative to the content of this CME activity:

- Beth Dove
- Michael Brooks

The following faculty and/or planning committee members have indicated they have relationship(s) with industry to disclose:

- Melissa B. Weimer, DO, MCR, FASAM has received honoraria from Path CCM, Inc. and CVS Health.

STAFF AND CONTENT REVIEWERS

InforMed staff, input committee and all content validation reviewers involved with this activity have reported no relevant financial relationships with commercial interests.

DISCLAIMER

The Challenge of Treating Pain

The experience of pain brings great physical and emotional suffering as well as significant societal costs. Some 50 million U.S. adults live with chronic daily pain, and 19.6 million experience high-impact pain that interferes with daily life and work.[1] Pain is even more common in military veterans, particularly those who have served in recent conflicts: 66% reported pain in the previous three months, and 9% had the most severe pain.[2] The national cost of pain is estimated at between $560 billion and $635 billion annually.[1]

Pain that is unremitting and without adequate treatment can lead to a multitude of problems for the person who suffers, including anxiety, depression, disability, unemployment, and lost income.[1] Certain populations are more vulnerable than others to developing more severe chronic pain and disability, including women, older adults, and individuals from minoritized racial and ethnic backgrounds,[3] who are also at risk for having their pain undertreated.[3] People who lack access to optimal pain care experience more complications in medical and psychiatric conditions.[1] Failure to give adequate care for pain from injury or surgery can prolong recovery times, leading to hospital readmissions and transition to chronic pain.[1]

The challenge of managing acute and chronic pain is complicated by an ongoing public health crisis related to opioid overdose, a category that includes prescription opioids, heroin, and illicitly-produced fentanyl and its analogues.[4] Numerous families have endured tragedy in the form of opioid-related overdose deaths, which doubled from more than 21,000 in 2010 to more than 42,000 in 2016.[4] As of 2019, of the approximately 71,000 drug-related overdose deaths in the United States, close to 50,000 of them involved opioids, more than 14,000 of which involved prescription opioids (Figure 1).[5] Over the past decade, the fatalities have been strongly driven by a proliferation of illicitly-produced high-potency synthetic opioids, but prescription opioids and other sedating medications, particularly benzodiazepines, also contributed to fatal overdoses.[6] In all, more than 136 Americans die every day from overdoses that involve a prescription or illicit opioid. Moreover, overdose deaths spiked during the COVID-19 pandemic, particularly deaths involving synthetic opioids.[7]

These grim statistics illustrate how important it is to keep potential public health consequences in mind when prescribing any type of controlled substance, including opioids. The economic burden of opioid misuse reaches $78.5 billion a year in healthcare, lost productivity, addiction treatment, and criminal justice costs.[8] As of 2018, more than 2 million Americans had an opioid-use disorder (OUD) involving prescription or illicit opioids. Of people age 12 or older in 2019, there were:[4]

- 1.6 million new individuals who misuse prescription pain relievers
- 949,000 new individuals who misuse prescription sedative-hypnotics
- 901,000 new individuals who misuse prescription stimulants

Many people who misuse opioids are not receiving regular medical care or prescribed opioids. Indeed, most people who are prescribed opioids for pain treatment do not misuse their medications. However, roughly 21% to 29% of patients prescribed opioids for chronic pain do misuse them, and between 8% and 12% of them develop an OUD.[9] Furthermore, an estimated 4% to 6% of people who misuse prescription opioids transition to non-prescribed opioid and/or illicit opioid use.[10-12] Approximately 75% to 80% of people who use heroin misused prescription opioids first.[10,11]

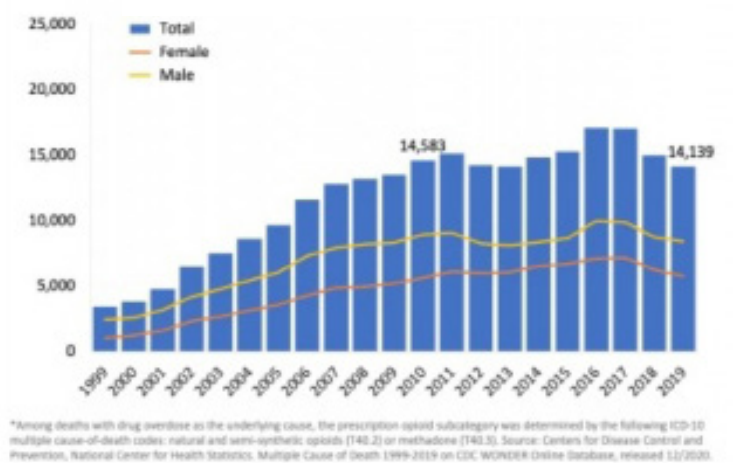
Health care practitioners (HCPs) play a key role in facilitating appropriate use of opioids and other sedating medications when prescribed for acute and chronic pain. Pain care is most effective when it combines multiple disciplines and utilizes a broad range of evidence-based pharmacologic and nonpharmacologic treatment options.[13,14] Opioids are associated with small improvements in pain and function versus placebo when used up to six months; however, evidence of longer-term effectiveness is limited, whereas increased harms from use beyond six months appear to be dose dependent.[4] Moreover, non-opioid options may bring equivalent or better patient outcomes with less risk: a comparative effectiveness review of evidence performed by the Agency for Healthcare Research and Quality found no difference in improvement in pain, function, mental health status, sleep, or depression when opioids versus non-opioid medications were used up to six months.[4]

At the same time, there is a recently recognized potential for harm in suddenly discontinuing or rapidly tapering doses in patients who have been on long-term opioids or in forcing patients who have been stable on higher doses to reduce to a set threshold dose.[1,15-17] It is also critical that HCPs recognize and optimally manage OUD when present. Distressingly few people who need treatment for substance-use disorder (SUD) are able to access it, and far more people need treatment for OUD than receive it. In 2012, the treatment gap was nearly a million people, with about 80% of opioid treatment programs nationally operating at 80% capacity or greater.[18] Solutions will include more accessibility of OUD treatment, including greater access to medications to treat OUD, and measures to prevent prescription and illicit drug misuse from developing in the first place.[19]

For acute pain and for some chronic pain, unresponsive to non-opioid therapies, opioids may form part of a customized treatment plan. A subset of patients may benefit from treatment with opioids long term, for example, during severe exacerbations of pain during the course of chronic conditions.[20] More than ever, HCPs are called on to optimize a range of available therapies and reserve opioids for when the benefits are expected to outweigh the risks and non-opioid options are inadequate.

This educational activity is built on core messages of the U.S. Food and Drug Administration's (FDA's) Blueprint for the Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS). It provides guidance on safely prescribing opioid analgesics, including all extended-release and long-acting (ER/LA) and immediate-release/short-acting (IR/SA) formulations. It is targeted to all HCPs who treat and monitor patients with pain, not prescribers alone. It stresses the importance of competence in considering and using a broad range of pharmacologic and nonpharmacologic therapeutic options for managing pain as well as in recognizing and managing OUD when indicated. The goal is to equip HCPs to recognize and manage any adverse events that may arise when a trial of potentially long-term opioids is part of a comprehensive treatment plan.

Figure 1. National Drug Overdose Deaths Involving Prescription Opioids* Among All Ages, 1999-2019[5]



*Among deaths with drug overdose as the underlying cause, the prescription opioid subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2) or methadone (T40.3). Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2019 on CDC WONDER Online Database, released 12/2020.

Pain Definitions

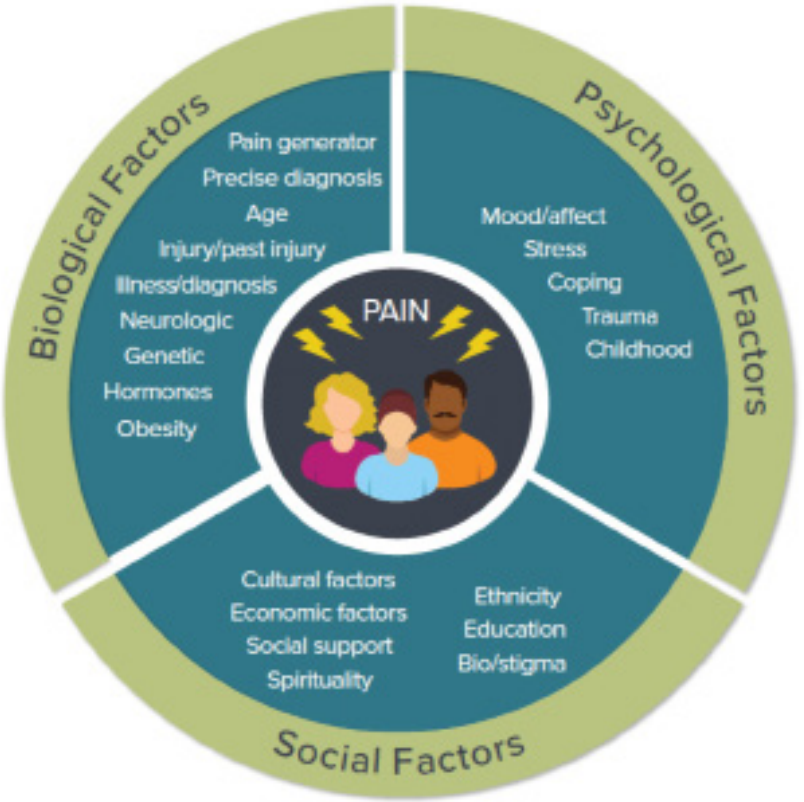
The International Association for the Study of Pain (IASP) revised its pain definition in 2020 to better convey pain's nuances and complexities and to improve its assessment and management. The IASP defines pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage."[21] The IASP further describes pain as follows:[21]

- As a personal experience that is influenced to varying degrees by biological, psychological, and social factors
- As a separate phenomenon from nociception that cannot be inferred solely from activity in sensory neurons
- As a concept learned through the life experiences of individuals
- As an experience that should be respected
- As serving an adaptive role that may, nonetheless, have adverse effects on function and social and psychological well-being
- As existing independently of the ability to express its presence verbally, i.e., verbal description is only one of several behaviors to express pain, and inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain

There are no precise clinical markers for pain, which is experienced by the individual as a constellation of biological, psychological, and social factors that include race and ethnicity (Figure 2).[1] This biopsychosocial model is now preferred to an earlier era's biomedical model of pain care, which primarily aimed medical, procedural, and surgical treatments at a presumed biological pain generator in an attempt to fix or numb pain.[20] Given pain's complexity, it is important to perform a thorough patient evaluation so that the presumed or differential diagnosis is accurate in order to select the best therapeutic option.[1]

Pain is protective and essential for survival when understood as a warning signal that something has gone wrong in the body. However, when pain persists indefinitely the central nervous system (CNS) begins to sense, transmit, modulate, and interpret the pain experience differently.[14] When the nociceptors, or sensory receptors, become sensitized, they discharge more frequently. In peripheral sensitization, this state of heightened neuron excitability occurs at the site where the pain impulse originated in the body; in central sensitization, it occurs in the spinal neurons, which begin to fire spontaneously, resulting in pain that intensifies and lasts far longer than the stimulus applied.[14] Sensitization can result in hyperalgesia, where response to pain-causing stimuli is intensified, and allodynia, a pain response to stimuli that normally are not painful.[14] Therefore, the resulting pain comes not just from an injury site but from neural impulses. The pathologies created by central sensitization can persist and continue to generate pain impulses indefinitely, far outlasting pain's usefulness as a warning signal.

Figure 2. The Biopsychosocial Model of Pain[1]



Pain Classifications

Pain can be categorized in several ways, including by type, duration, etiology, and pathophysiology.

- ***Acute pain*** is a physiologic response to noxious stimuli with a sudden onset and expected short duration.[1] It commonly occurs as a result of burn, trauma, musculoskeletal and neural injury, and after surgery or other procedures in the perioperative period.[1,20] Acute pain flares may also occur periodically in the course of chronic pain and medical conditions.[1] Anxiety and distress may exacerbate the acute pain experience.[22]
- ***Chronic pain*** lasts longer than normal healing and is generally diagnosed after persisting or recurring for longer than three-to-six months.[14]
  - Chronic pain's many possible causes include injuries, malignancies, chronic diseases, medical treatments or surgeries, or inflammation that appears as a result of injury or chronic disease.
  - Chronic pain may occur in the absence of a defined injury or cause.
  - Anxiety, depression, and stress are known to complicate the chronic pain experience.[1]
  - Certain neuropathic pain conditions may be diagnosed as chronic pain before the three-month mark. [23]

New Diagnostic Categories for Chronic Pain

Accurately diagnosing a pain condition can be challenging, particularly when the etiology or pathophysiology of the pain is not clearly understood. However, identification and treatment of the underlying condition causing pain should be considered of utmost importance . To systematically gather together all relevant codes for the management of chronic pain, new diagnostic categories in the International Statistical Classification of Diseases and Related Health Problems (ICD-11) take effect in January 2022.[24] These diagnostic categories are intended to assist HCPs in reaching an accurate diagnosis to better create an optimal treatment plan.

Per ICD-11, chronic pain is considered primary when pain has persisted for more than three months, is associated with significant emotional distress and/or functional disability, and is not better accounted for by another condition. Thus, in chronic primary pain, the pain is the chief complaint and disease in itself.

Chronic pain is secondary when it may, at least initially, be a symptom of an underlying disease. A diagnosis may be made independent of biological or psychological contributors, unless another diagnosis better fits the symptoms.

Although it is clinically useful to speak of chronic pain, it is important to remember that pain is a dynamic experience whose onset, maintenance, and exacerbation is not confined to set temporal categories.[25]

Thus, patients who experience significant pain that lasts beyond typical healing periods or the three-month diagnostic period for chronic pain may improve with conservative measures. Conversely, some types of neuropathic pain or sudden onset pain from injury or disease does not require three months before treating the condition as chronic as the pain is likely to persist or recur indefinitely.[23] Because pain can be both a symptom and a disease, an accurate diagnosis is vital to treating the biologic source of pain when it is known and to expediting timely management of pain of uncertain origin.[25] It is important to reinforce to patients that treatment of the underlying cause when known, should be the primary objective, rather than only concentrating on the addressing of their pain. All subtypes of chronic pain should be understood to have multiple biological, psychological, and social factors that contribute to the individual's pain experience, in keeping with the biopsychosocial framework.

Barriers to Effective Pain Care

The multimodal, multidisciplinary treatment approach is recognized as optimal for pain care; nevertheless, barriers to accessing this type of care for patients are numerous and entrenched in the health-care delivery system. It should be fully recognized that HCPs are asked to provide optimal pain care and lessen the risks from opioids in an environment that frequently provides inadequate support for practitioners and scant access for patients. A task force of health care associations convened by the American Medical Association to study and make recommendations to improve patient pain care described evidence-based care as "ensuring patients have access to the right treatment at the right time without administrative barriers or delay."[26]

Insurance barriers to providing optimal patient care are present in the policies of public and private payers and pharmacy chains as well as pharmacy benefits managers. These barriers include delays and denials from prior authorization, step therapy, treatment quantity limits, high cost-sharing, coverage limits and restrictive access for non-opioid and nonpharmacologic treatments for pain, and strict opioid limits enforced without regard to individual patient need.[26]

Barriers to the provision of nonpharmacologic therapies in particular include coverage that is absent or inadequate, unreceptive attitudes of HCPs and patients, and shortages of pain and behavioral health care specialists.[27] An Inter-agency Task Force convened by the Department of Health and Human Services (HHS) to recommend best practices in pain care proposed several ways of addressing gaps:[1]

- Create clinical practice guidelines to better incorporate evidence-based complementary and integrative therapies into practice
- Improve insurance coverage and payment for different modalities on the basis of the best practices identified in new guidelines
- Improve coverage and payment for multidisciplinary team care coordination
- Expand access to treatment and geographical coverage via the use of telemedicine and other technological delivery methods for psychological and behavioral health interventions
- Increase the number and training of qualified practitioners in behavioral health and other evidence-based complementary and integrative disciplines
- Provide better education as well as time and financial support for primary care practitioners who give patients the sole available pain care in many parts of the country

Another barrier to pain care is the stigma in living with chronic pain, which is often cited by patients and their caregivers as a difficulty worsened by lack of objective biomarkers for pain, the invisible nature of the disease, and societal attitudes that equate acknowledging pain with weakness.[28] Compassion, empathy, and trust within a practitioner-patient relationship are key to navigating these challenges. It can help to offer education to the patient regarding the underlying disease processes of pain and to encourage them to seek help early for pain that persists beyond the expected time frame. When opioids are indicated, it is strategic to counsel patients that opioids are an appropriate part of their pain treatment plan so that the stigma of the societal opioid crisis does not interfere with appropriate treatment and good outcomes for the patient regarding opioid use.[20]

Treatment Options for Managing Pain

The HHS Inter-Agency Task Force on best practices in pain management categorizes options for pain treatment as medication, restorative, interventional, behavioral health, and complementary and integrative.[1] Medications include opioid and non-opioid pharmacologic treatments. What follows are examples of each (not an exhaustive list) and a brief discussion of the evidence base underpinning these options.

Nonpharmacologic Options for Pain

A number of evidence-based nonpharmacologic treatments are recommended, either used alone or in combination with other modalities within a treatment plan that is individualized and draws from multiple disciplines (Table 1) and can include restorative, complimentary/ integrative or behavioral health training.[1,29,30] Nonpharmacologic options should not necessarily be considered "alternatives" to opioids but are encouraged as part of a comprehensive pain plan in keeping with the evidence base, patient access to competent practitioners, and adequate insurance coverage and reimbursement.

Frequently covered modalities for chronic pain include cognitive behavioral therapy (CBT), physical therapy, certain injections, exercise, and electrical stimulation.[29] Patients may find it helpful to combine approaches that include nutritional support, healthy lifestyle changes, patient education, sleep hygiene instruction, and relaxation and visualization techniques. The noninvasive nature and low side effect profile of nonpharmacologic treatments suggest they should be used first and preferentially.

Non-Opioid Pharmacologic Options for Pain

Numerous non-opioid pharmacologic therapies are available for pain, and these should be tried or considered, alone or in combination, before initiating long-term opioid therapy.[1]

Acetaminophen (ACET) is used to treat mild-to-moderate pain without inflammation. All ACET products carry an FDA-required black box warning highlighting the potential for severe liver damage and potential for allergic reactions.[31] HCPs and patients should be aware of the dose levels from all prescribed and over-the-counter medication sources to avoid exceeding the recommended daily dosage.

Table 1. Noninvasive, Nonpharmacologic Approaches to Pain Management[1]

Restorative	Behavioral Health	Complementary and Integrative
• Physical therapy • Occupational therapy • Physiotherapy • Therapeutic exercise • Transcutaneous electric nerve stimulation • Massage therapy • Traction • Cold and heat • Therapeutic ultrasound • Bracing • Chiropracty	• Cognitive behavioral therapy • Acceptance and commitment therapy • Mindfulness-based stress reduction • Emotional awareness and expression therapy • Self-regulatory/psychophysiological approaches: ° Biofeedback ° Relaxation training ° Hypnotherapy	• Acupuncture • Massage, manipulative therapies • Mindfulness-based stress reduction • Spirituality • Tai chi • Yoga • Reiki

Nonsteroidal anti-inflammatory drugs (NSAIDs) include aspirin, ibuprofen, naproxen, and cyclooxygenase-2 (Cox-2) inhibitors and are used to treat mild-to-moderate pain and inflammation. Indications are numerous and include arthritis, bone fractures or tumors, muscle pains, headache, and acute pain caused by injury or surgery.[1] Nonselective NSAIDs are those that inhibit the activity of both COX-1 and COX-2 enzymes and can be associated with gastritis, gastric ulcers, and gastrointestinal (GI) bleeding.[1] COX-2 inhibitors have fewer GI adverse effects.[1] Risks are elevated with NSAIDs for heart attack, stroke, GI bleeding or perforation, and renal and cardiovascular abnormalities, particularly at higher doses and longer duration of use.[32]

Anticonvulsants , such as gabapentin and pregabalin, have mild-to-moderate benefit for neuropathic pain syndromes, including postherpetic neuralgia and peripheral neuropathy and are also commonly used to treat migraine and as part of a multimodal approach to treating perioperative pain.[1] Adverse effects include drowsiness, cognitive slowing,[29] and a risk of misuse, particularly in people with a history of misusing opioids.[33] Gabapentin dose should be adjusted in chronic kidney disease.

Antidepressants, including selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), and tricyclic antidepressants, are used in low doses for insomnia and neuropathic pain. Doses are typically lower for analgesia than those required to treat depression. SSRIs (e.g., fluoxetine, sertraline, citalopram, and paroxetine) have less analgesic effect compared with other antidepressant classes.[1] SNRIs (e.g., venlafaxine, duloxetine) are effective for a variety of chronic pain conditions, including musculoskeletal pain, fibromyalgia, and neuropathic pain, and are associated with less drowsiness, memory impairment, and cardiac conduction abnormalities than tricyclic antidepressants. Tricyclics (e.g., desipramine, nortriptyline, amitriptyline) are initiated at low doses and gradually titrated to effect. Depending on class, risks and adverse effects may include dry mouth, dizziness, sedation, memory impairment, orthostatic hypotension, urinary retention, cardiac conduction abnormalities, sexual dysfunction, weight gain, emotional blunting, and suicidal thoughts.[1,29] Second-generation tricyclic antidepressants (e.g., nortriptyline) tend to be better tolerated than first generation (e.g., amitriptyline). Withdrawal reactions are possible when antidepressants are suddenly stopped.

Musculoskeletal agents for pain and muscle spasm are for short-term use with sedation being a common adverse effect. Common medications used in pain treatment include baclofen, tizanidine, and cyclobenzaprine. Particular risks are notable with carisoprodol (toxicity, unclear therapeutic benefit) and benzodiazepines (SUD, respiratory depression leading to overdose) when prescribed in combination with opioids.[29] Considering the risks with carisoprodol and benzodiazepines and the availability of other agents, these medications are not recommended to treat pain from muscle spasm.[1]

Topical medications include lidocaine, ketamine, capsaicin, and anti-inflammatory drugs such as ketoprofen and diclofenac. Anti-inflammatory topicals are proven beneficial for musculoskeletal pain, as is capsaicin for neuropathic pain.[29]

Cannabis remains a Schedule I drug in the United States, defined by the Drug Enforcement Administration (DEA), as having no currently accepted medical use and a high potential for abuse.[1] Rigorous studies are lacking on the safety and efficacy of any specific cannabis product as a treatment for pain.[1] Expert views and systematic reviews[34,35] differ regarding the strength and quality of evidence for cannabis use, and the IASP does not endorse general use of cannabinoids for pain, citing lack of high-quality research. The evidence remains inconclusive to recommend the general use of cannabis for pain.

Little is known about the safety, efficacy, dose, and routes of administration of available cannabis products. Epidiolex (cannabidiol) [CBD] oral solution has been approved for the treatment of seizures associated with two rare and severe forms of epilepsy, Lennox-Gastaut syndrome and Dravet syndrome, in patients age 2 and older.[36] (It is THC that has the primary psychoactive component of marijuana, not CBD).

Importantly, the FDA has not approved cannabis for the treatment of chronic pain.[34] However, a number of patients with pain appear to be replacing opioids with cannabis. Marijuana is legal for medical use in several states, and public interest in cannabis and cannabis-derived products for pain treatment is rising.[34]

Adverse events reported with cannabis use include psychotomimetic effects, anxiety and psychosis, cognitive dysmotivational syndrome, and learning deficits in adolescents.[37] Cannabis can also have hyperemesis effects, impair driving safety, and is linked to vascular events.[37]

Opioids for Pain

Opioid analgesic effects are principally achieved by the opioid binding to and activating mu, kappa, and delta receptors in the endogenous opioid system. Drugs are classified according to their action at these receptors as full agonists, mixed agonist-antagonists, or antagonists (Table 2). Full mu-agonists bind selectively to the mu-opioid receptor. When an antagonist occupies the receptor, it displaces the agonist and causes opioid withdrawal. Partial agonists, such as buprenorphine, have high receptor occupancy, some antagonistic effects, and low intrinsic activity at the site. Kappa opioid receptor agonists (including levorphanol, pentazocine, and butorphanol) have been used clinically but are associated with such side effects as dysphoria and hallucinations.

Buprenorphine has a reduced potential for respiratory depression and is considered safer than full agonists such as morphine, hydrocodone, and oxycodone.[1] Buprenorphine also acts as an antagonist at the kappa receptor, which is shown to reduce anxiety, depression, and the unpleasantness of opioid withdrawal.[1] Tapentadol and tramadol have dual modes of action as agonists at the mu receptor and SNRIs.[1]

Table 2. Opioid Analgesic Classifications

Type	Generic Name	Notes/Cautions
Pure agonists	Codeine Dihydrocodeine Fentanyl Hydrocodone Hydromorphone Levorphanol Meperidine* Methadone Morphine Oxycodone Oxymorphone Propoxyphene	*Meperidine not recommended for long-term treatment or in patients with renal compromise due to toxicity risks
Agonist-antagonists	Partial agonist: Buprenorphine Mixed agonist-antagonists: Butorphanol Dezocine Nalbuphine Pentazocine	May produce withdrawal if started while patient receiving full opioid agonist
Pure antagonists	Naloxone Naltrexone	Administered to reverse opioid effects
Other	Tramadol Tapentadol	Dual action mu-agonist and serotonin–norepinephrine reuptake inhibitor Dual action mu-agonist and norepinephrine reuptake inhibitor

Considerations with dual-mechanism opioids include lowering of seizure threshold in susceptible patients and the risk of serotonin syndrome due to concomitant serotonin activity.[20]

Opioid delivery systems include oral, buccal, sublingual, spray, intravenous, intramuscular, intrathecal, suppository, and transdermal routes.[1] Administration includes ER/LA and IR/SA formulations. IR/SA opioids typically have a rapid onset from 10 to 60 minutes and a duration of action of 2 to 4 hours. In contrast, ER/LA opioids have a relatively slow onset of action of 30 to 90 minutes and longer duration of action from 4 to 72 hours. ER/LA opioids are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate for patients with existing opioid tolerance. The class of ER/LA opioids are not for use "as needed," not for mild pain, and not for acute pain or pain that not expected to persist for an extended duration:[38,39]

Opioid risks, warnings, and side effects include an FDA boxed warning about the serious risks for misuse, abuse, addiction, overdose and death that apply to all IR/SA and ER/LA prescription opioids.[40] These risks are present whenever opioids are misused but apply even at prescribed doses. The labels for opioid combination products containing ACET also warn of the potential for severe liver damage.[31] An FDA boxed warning details the risks of prescribing opioids and benzodiazepines together, a combination of medications that has increased in recent years but which is associated with extreme sleepiness, respiratory depression, coma, and death.[41] In addition, patients may suffer serious harm, including serious withdrawal symptoms, uncontrolled pain, and suicide, if opioids are suddenly discontinued or tapered too rapidly.[42,43] Concomitant drugs that act as inhibitors or inducers of various cytochrome P450 enzymes can result in higher or lower than expected blood levels of some opioids. Dosages should be reduced in the presence of hepatic or renal impairment.[39]

Certain cautions apply to specific opioid types, formulations, and delivery systems. Some opioids (e.g., methadone, buprenorphine) can prolong the QTc interval. Relative potency to oral morphine is intended as a general guide with additional conversion instructions included in each product's PI.[39] ER/LA opioid tablets should be swallowed whole, never crushed, chewed, broken, cut, or dissolved. Altering them in such ways may result in rapid release and absorption of a potentially fatal dose.[38,39] When necessary, some products may be sprinkled as pellets on applesauce and swallowed without chewing. Transdermal systems and buccal films should not be cut, torn, or damaged before use. Transdermal dosage forms should not be chewed or swallowed, and exposing patches to heat may lead to fatal overdose.

Possible opioid side effects include but are not limited to:[1,32]

- Lightheadedness
- Dizziness
- Sedation
- Nausea and vomiting
- Drowsiness
- Mental clouding
- Constipation
- Hormonal deficiencies
- Pruritis
- Myoclonus
- Irritability
- Respiratory depression

Drug-Drug interactions are possible with opioids.[39] Co-ingesting CNS-depressants that include alcohol, benzodiazepines, sedatives, hypnotics, tranquilizers, and tricyclic antidepressants can potentiate the sedation and respiratory depression caused by opioids . Alcohol can cause rapid release of ER/LA opioid formulations leading to an increased drug level. Combining opioids with monoamine oxidase inhibitors (MAOIs) can increase respiratory depression and cause serotonin syndrome with certain opioids. Opioids induce the release of antidiuretic hormone, reducing the efficacy of diuretics. Initiating CYP 3A4 inhibitors or discontinuing CYP 3A4 inducers can result in higher than expected opioid blood levels leading to overdose.

Opioid contraindications. There are some absolute contraindications for initiating a trial of long-term opioid therapy that include:[20]

- Known hypersensitivity to active ingredients or other components of opioid analgesics
- Significant respiratory depression or compromise
- Acute or severe bronchial asthma
- Known or suspected paralytic ileus and gastrointestinal obstruction
- Evidence for or history of diversion of controlled substances (e.g., forged prescriptions, pharmacy robberies, selling own prescription drugs, theft of others' drugs)

Although the combination is sometimes used, the Department of Veterans Affairs/Department of Defense (VA/DoD) practice guideline lists concomitant use of benzodiazepines as a contraindication to initiating a trial of long-term opioid therapy.[20] The Centers for Disease Control and Prevention (CDC) recommends avoiding prescribing opioids and benzodiazepines concurrently whenever possible but allows for rare instances when the combination may be indicated (e.g., severe acute pain in the presence of long-term, stable, low-dose benzodiazepine therapy). [32] The combination can increase risk of respiratory depression, and a clear rationale necessitating their simultaneous use must be documented when these agents are combined.

Methadone for pain presents special clinical challenges due to a long and variable half-life, risk for toxicity due to accumulation in plasma concentrations during the several days necessary to achieve steady-state, and risk for cardiac toxicities due to prolongation of the QTc interval.[44-46] Methadone-related deaths have occurred in disproportionate numbers relative to the frequency with which it is prescribed for pain.[32] Methadone is only for patients whose severe pain is unrelieved by other opioids. Close monitoring is critical when initiating methadone and during dose changes, and caution is needed in patients with heart disease or taking medications with concurrent QTc interval effects. Patients should be assessed for cardiac health ahead of being prescribed methadone, and an initial ECG may be advisable, particularly if the patient has cardiac disease or risk factors. It is important to withhold methadone if there is evidence of sedation and could reflect an accumulation of the medication. [47]Bear in mind that pain relief from a methadone dose lasts only 4 to 8 hours, but methadone remains in the body much longer (8 to 59 hours).[46] Thus, the 44risk for respiratory depression may be higher than other agents. Patients should be counseled never to exceed the prescribed dose, not to mix with alcohol or other unauthorized substances, and to take methadone doses only as scheduled, not as needed. HCPs without experience and knowledge of methadone should seek expert consultation before prescribing it.[44]

Oxycodone use for pain is discouraged except in specific circumstances. It was initially suggested that oxycodone was less habit-forming than other opioids, and it became one of the most frequently prescribed opioids. However, it has not proven to possess improved efficacy compared with other opioids, and may in fact possess characteristics that increase it's likeability and risk for addiction.[48] It is considered to possess pleasurable effects, and few negative effects. Also, it has been suggested that it played a large role in the curretnt opioid crisis through it's misuse and abuse. Pills were crushed for nasal insufflation, and liquified for intravenous use – both in order to facilitate an immediate burst release.[48] Risk of overdose is also high with oxycodone, particularly when used in combination with other substances such as alcohol, benzodiazepines or other sedatives.[48] For all of these reasons, use should be limited and only considered for individuals at lower risk for addiction and who are unable to tolerate other pain medications.

Definitions Related to Opioid Use and Misuse

The HHS Inter-Agency Task Force on best pain management practices endorsed a set of definitions to guide conversations and understanding of frequent terms related to opioid use and misuse.[1] These definitions are shown in Table 3.

Table 3. Definitions Related to Opioid Use and Misuse[1]	
Term	**Definition**
Physical dependence	• Not the same as addiction • Occurs because of physiological adaptations to chronic exposure to opioids • Withdrawal symptoms occur when medicine or opioid is suddenly reduced or stopped or when antagonist is administered • Symptoms can be mild or severe and can usually be managed medically or avoided through slow opioid taper
Tolerance	• Same dose of opioid given repeatedly produces reduced biological response • Higher dose of opioid is necessary to achieve initial level of response
Misuse	• Taking medication in a manner or dose other than as prescribed • Taking someone else's prescription, even if for a medical complaint like pain • Taking medication to feel euphoria (i.e., to get high) • Nonmedical use of prescription drugs refers to misuse
Addiction	• Primary, chronic medical disease of brain reward, motivation, memory, and related circuitry • Dysfunction in circuits leads to characteristic biological, psychological, social, and spiritual manifestations as individual pathologically pursues reward and/or relief by substance use and other behaviors • Characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and dysfunctional emotional response • Involves cycles of relapse and remission • Without treatment or recovery activities, is progressive and results in disability or premature death
Opioid-use disorder	• A problematic pattern of opioid use leading to clinically significant impairment or distress • Defined by 11 criteria in the DSM-5* over a 12-month period • Previously classified as "opioid abuse" or "opioid dependence" in DSM-4 • Severe opioid-use disorder also referred to as "opioid addiction"
*DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition;[49] diagnostic criteria given later in this activity	

Diversion

Most people who misuse prescription opioids are given them freely by friends or family members, though some people buy or steal them.[50] About a third of people who misuse opioids get them by prescription from one doctor.[50] Many misused opioids became available in the community because they were left over from prescriptions for acute pain.[51] It is incumbent on the HCP to remember that, although most people who are prescribed opioids for pain do not misuse them, it is possible that some people who visit a medical facility for pain are instead seeking opioids to divert for misuse or illegal sale.

Creating Pain Treatment Plans

All pain management begins with identifying the cause or causes of pain and the biopsychosocial mechanisms that contribute to its severity and associated disability.[1] An effective treatment plan is built out of a full evaluation to establish diagnosis and emphasizes individualized patient-centered care. When persistent pain pertains to a specific disease condition or patient population, HCPs are advised to seek out evidence-based practice guidelines that are relevant.[1] The patient's pain type and previous treatments should be evaluated to see if opioid therapy is likely to be effective. The HCP should consider whether medical comorbidities, such as sleep apnea, may increase risk of respiratory depression, whether other available therapies have better or equal evidence, and whether thorough patient evaluation indicates the patient is likely to adhere to the treatment plan.

Treatment plans should be revisited and adjusted frequently to ensure goals are being met and any adverse effects of therapy are addressed. The success of a pain management plan is highly dependent on the therapeutic alliance established between the patient and the HCP.

Managing Acute Pain

For acute pain, non-opioids may offer effective management and should be utilized preferentially, alone or in combination with opioids (when indicated) to increase pain control and spare opioid doses.[22] Much acute pain is manageable with rest, over-the-counter medications, or a short course of opioids and resolution of the underlying cause (e.g., trauma, surgery, illness). Objective signs of an acute, painful medical condition (e.g., bone fracture or imaging that reveals kidney stones) are examples for when opioids are likely indicated. Prompt management of acute pain is necessary to prevent progression to a chronic state.[22]

When opioids are indicated, the therapeutic goal is to prescribe the lowest dose that controls pain for a duration lasting only as long as the acute phase. Leftover pills from acute pain prescriptions may later become a chief source of diverted and misused opioids. A systematic review found that 42% to 71% of opioids obtained by surgical patients went unused.[51] Prescriptions beyond three days are usually unnecessary, [32] while more severe episodes rarely need more than 7-14 days, although there are exceptions.[32,52] Be aware that localities and states may have strict regulations governing maximum duration of prescriptions for acute pain. In nearly all cases, HCPS should not prescribe ER/LA opioids for acute pain. It is worth considering that long-term opioids typically are not recommended for nonspecific back pain, headaches, or fibromyalgia, if the HCP should see a patient experiencing acute pain flares occurring with these conditions.[20]

Be aware also that patients who seek opioids to misuse may utilize emergency departments or urgent care for this purpose. The American College of Emergency Physicians (ACEP) has identified acute low back pain and exacerbations of chronic pain as common presenting complaints in the emergency department and recommends assessing whether non-opioid therapies would be adequate pain treatment, reserving opioids for severe pain that would be unresponsive to other therapies.[53] If opioids are indicated, the ACEP recommends prescribing the lowest practical dose for the shortest duration, considering the patient's risk for opioid misuse or diversion.[53] Checking the state prescription database ahead of prescribing opioids for acute pain can help ensure the patient is receiving the appropriate quantity of opioids for the pain.[1] If pain from surgery or trauma persists beyond the expected healing period, HCPs should reevaluate the diagnosis and treatment plan.

Assessing the Risk of Transition from Acute to Chronic Pain

Most cases of chronic pain begin as acute pain, and evidence suggests that prolonged exposure to pain leads to CNS changes that can transform the experience to a chronic syndrome.[22] Studies suggest that one-third of patients have progressively worsening pain intensity postoperatively,[22] and most research on risk factors for transitioning from acute to chronic pain takes place in surgical settings. Established risk factors include younger age, female gender, catastrophizing, low socioeconomic status, preoperative pain, impaired diffuse noxious inhibitory control, type and duration of surgery, injury to specific nerves, severity of acute pain, and, possibly, prior exposure to radiation therapy and chemotherapy.[22]

The high association of pain severity with subsequent chronic pain development boosts the rationale for comprehensive pain assessment and treatment in the perioperative setting.[22]

It is clear that psychological factors contribute to the pain experience overall and pose risk for chronicity. Depression after injury is an important predictor associated with reduced odds for recovery.[54] In people recovering from musculoskeletal trauma, catastrophic thinking (a psychological factor that responds to CBT) predicted pain intensity and disability at five-to-eight months post-injury.[34] Psychological interventions, following proper evaluation and diagnosis, can play a central role in reducing disability. When delivered before surgery, psychological interventions are shown to reduce postsurgical pain and opioid use[55,56] and may help prevent progression from acute to chronic pain. Use of opioids prior to surgical intervention for pain relief is discouraged, and non-opioid treatments should be maximized. It has been found that those individuals prescribed opioids prior to procedures have higher rates of complications, lower satisfaction scores and require higher doses of opioid medications post-operatively.[55,56]

A systematic literature review found support for two screening tools that may be useful in helping HCPs predict the likelihood of a transition from acute or subacute to chronic low back pain.[57] These tools are the STarT Back Screening Tool and the Örebro Musculoskeletal Pain Questionnaire, which stratify patients in into low-, medium-, and high-risk categories and were found to be valid, reliable and to have predictive value. Intense widespread pain (especially when it is increasing) and fear avoidance were found to predict the transition to chronic pain. Incorporating one of these tools or evaluating common predictors in acute pain can help HCPs identify patients at risk in order to treat them early or refer them for specialist management to prevent the trajectory to chronic pain.

Managing Chronic Pain

Managing Cancer-Related Pain

More than 14 million cancer survivors live in the United States.[1] An estimated 40% of cancer survivors experience persistent pain as a result of treatments such as surgery, chemotherapy, and radiation therapy.[1] All HCPs who treat patients with active cancer or with cancer-related pain should assess for, recognize, and treat pain at every encounter. Remember that the CDC guideline for opioid prescribing affirms the use of opioids when benefits outweigh risks and warns against opioid tapering or discontinuation when opioid use may be warranted, such as in treatment of cancer pain or at the end of life.[43]

With cancer-related pain, HCPs are encouraged to look beyond narrow treatment choices and incorporate multimodal treatments in a multidisciplinary treatment plan.[1] Cancer survivors should be evaluated for a recurrence or secondary malignancy with any new or worsening pain symptoms.[52]

Managing Pain in Palliative Care and at End of Life

Persistent, significant pain is common in patients with a limited prognosis, such as those in hospice and palliative care environments. The goal in palliative care is to keep the patient comfortable. HCPs should assess and address pain at every encounter, using multimodal and multidisciplinary care as part of the care management plan as indicated.[1]

In end-of-life care, pain control may be balanced against meaningful priorities the patient may have such as mental alertness and maximal interactions with loved ones. Pain assessment may be challenging in the context of reduced consciousness. Signs of discomfort include more rapid breathing or heart rate. Rectal and transdermal routes can be especially valuable at the end of life when the oral route is precluded because of reduced or absent consciousness, difficulty swallowing, or to avoid nausea and vomiting.[58]

Managing Chronic Noncancer Pain

To apply best practices in chronic noncancer pain treatment, HCPs should recognize and treat pain promptly, involve patients in the pain care plan, reassess and adjust the pain care plan as needed, monitor patient progress toward treatment goals, monitor patient adherence to any treatment agreements, and document all pain management outcomes in the patient medical record.

Use of opioids in patients with chronic pain should be considered on a trial basis with well defined goals of therapy established prior to beginning treatment. The goals of treatment should be meaningful to the patient and contain measurable outcomes of improvement that include pain relief, functionality, quality of life, and activities of daily living.[20,32,52]

Even patients with pain conditions or injuries that make complete cessation of pain unlikely can set goals such as sleeping through most nights, returning to work, walking a set distance, or participating more fully in family activities. The self-efficacy involved in collaborating on these goals can help patients gain greater control over their pain and their lives.

Prior to initiating treatment with opioids, non-opioid medications and other treatment modalities should be attempted and maximized. ACET and NSAIDs are considered first-line and second-line medications for pain associated with degenerative musculoskeletal disorders, respectively, and many guidelines recommend NSAIDs and ACET as first-line therapies for low-back pain.[32] Corticosteroid injections are generally recommended for hip and knee osteoarthritis.[59] Expert guidelines usually now recommend against ongoing opioid therapy for nonspecific back pain, headaches, and fibromyalgia.[20] Nonpharmacologic therapies and self-management strategies should be optimized.[27] Noninvasive interventions in specific conditions that have sustained small improvements in pain and function for one month or longer post treatment without serious harms are shown in Table 4.[30] A trial of opioids, when indicated, should be part of a comprehensive treatment approach, typically in combination with one or more treatment modalities.[20]

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 1 ON THE NEXT PAGE.

Assessing Pain

A patient's initial visit for evaluation of a pain problem should include a physical exam and a patient interview to gather and document their current medical history and pain assessment. One should obtain a complete personal and family history of current and past substance use and misuse to include prescription drugs, illegal substances, alcohol, and tobacco. Social history is also relevant and includes employment, marital history, and family status.[45] Women should be screened for contraceptive use and pregnancy or breastfeeding status or intent.[32] Previous treatment records, including any pertinent clinical notes of treatments tried and their efficacy, and laboratory and imaging results should be reviewed whenever possible and retained in the current patient record.

Table 4. Noninvasive, Nonpharmacologic Treatments for Specific Pain Conditions[30]

Pain Condition	Treatment
Chronic low back pain	Exercise, psychological therapies (primarily cognitive behavioral therapy), spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, acupuncture, multidisciplinary rehabilitation, tai chi
Chronic neck pain	Exercise, low-level laser, Alexander Technique, acupuncture
Knee osteoarthritis	Exercise, ultrasound
Hip osteoarthritis	Exercise, manual therapies
Fibromyalgia	Exercise, cognitive behavioral therapy, myofascial release massage, tai chi, qigong, acupuncture, multidisciplinary rehabilitation
Chronic tension headache	Spinal manipulation

Case Study 1

Instructions: Spend 5–10 minutes reviewing the case below and considering the questions that follow.

Rachel, 22, has had neck pain for 2 months. The pain first appeared after a car accident and has been nearly always present as dull and aching. The pain is localized in the upper neck and non-radiating. She cannot turn her head well because of the pain and has been unable to work her job on the wait staff of a busy restaurant on several occasions. She has tried over-the-counter ACET and ibuprofen and has slowly increased her dosage of both medications to the maximum allowed on the labels. She drinks several glasses of wine in the evening as a means to relax. She reports no other substance use. She does not exercise regularly, being busy with work in the evenings and college classes during the day. She has begun to worry excessively. She has begun to stay in bed more often to cope with the pain and her feelings of anxiety.

1. **Is Rachel a good candidate for an IR/SA opioid? Why or why not?** _____

2. **Is Rachel a better candidate for an ER/LA opioid plus a musculoskeletal agent? Why or why not?** _____

3. **What non-opioid pharmacologic treatment(s) for pain might be considered helpful?** _____

4. **What nonpharmacologic treatment(s) for pain and anxiety might be offered?** _____

5. **What additional warnings or counseling might be advisable?** _____

Pain should be assessed by its severity (to include pain intensity, pain-related distress, and interference with daily activities), its temporal characteristics (to include onset, duration, whether it is continuous, has recurrent episodes with painless intervals, or is continuous with times of pain exacerbation). Psychological and social factors can contribute to the pain experience, which is why these issues should be included in the patient interview and documented in the record. Recording these factors will assist with documenting what special pain management needs a patient has as well as what level of disability.[23] Good questions to ask the patient include what relieves or increases the pain, how it affects their daily lives and functioning, and what goals they have for pain relief and improved function.

A number of evidence-based, pain assessment tools are available for clinical practice:

- The Visual Analogue Scale (VAS) and Numerical Rating Scale (NRS) are quick tools to measure pain severity that are sensitive, validated, and widely-used.[60]
- The Brief Pain Inventory (BPI) has good sensitivity, reliability, and validity for pain severity and interference-with-function items, including assessments of mood and sleep.[61,62]
- The Pain, Enjoyment of Life, and General Activity Scale (PEG) was created to assist management of chronic pain in primary care settings.[63] It is based on the BPI and has rating scales to measure past-week pain, pain interference, functional components, and quality of life.
- The McGill Pain Questionnaire (MPQ) assesses pain descriptors (sensory, evaluative, and affective).[60] With good validity and reliability, the MPQ is useful for helping patients describe their subjective pain experience but requires a good vocabulary when self-administered. The MPG is also available as a short form.
- The Multidimensional Pain Inventory has been validated for multiple chronic pain conditions for categorizing how well patients cope with chronic pain as adaptive, dysfunctional, or interpersonally distressed.[64,65]

The PEG scale can be very useful in primary care or busy practices to assess pain, functioning, and quality of life.

Assessing Mental Health

HCPs should also screen and monitor patients for factors associated with poor outcomes and substance abuse, such as sleep disturbance, mood disorder, and stress. Screening tools to assess patients with pain for mental health disorders ahead of prescribing opioids include:

- Patient Health Questionnaire-2 (PHQ-2), a two-item screen for depressive disorder that leads to more detailed assessment if either item is positive.[66] The PHQ-2 is available at the following link: https://www.hiv.uw.edu/page/mental-health-screening/phq-2
- Patient Health Questionnaire-9 (PHQ-9), this nine-item screen for depressive disorder may be used initially or as a follow-up to the PHQ-2.[67] This tool and its variations are brief, reliable, valid, and easy to score. The PHQ-9 is available at the following link: https://www.hiv.uw.edu/page/mental-health-screening/phq-9
- The reliable and valid Beck Depression Inventory-II (BDI-II) is a self-report measure of depression severity.[68] This 21-item tool is available here: http://www.hpc-educ.org/Files/Danz/BDII.pdf
- Suicidal ideation is addressed by items on the PHQ-9 and BDI-II. This is an important assessment for patients with chronic pain.
- The Beck Anxiety Inventory (BAI) emphasizes somatic components of anxiety[69] and can be found here: https://www.gphealth.org/media/1087/anxiety.pdf
- The Generalized Anxiety Disorder-7 (GAD) and GAD-2 are validated and recommended to assess for generalized, panic, and social anxiety disorders, and PTSD.[70-72] These tools are available here: PMID: 325824585

Newer systems such as the Stanford-developed and implemented Collaborative Health Outcomes Information Registry offer more in-depth pain assessment through the use of item banks that capture many physical, psychological, and social functioning domains.[73]

Assessment for Poor Outcome of opioid therapy

A number of risk factors are associated with poorer outcomes in opioid therapy.[74] These factors include:[75]

- Nonfunctional status (e.g., severe physical debility) due to pain
- Exaggeration of pain
- Unclear etiology for pain
- History of rapid opioid dose escalation
- Young age (<30 years)
- Tobacco use
- Poor social support
- Personal history of SUD
- Family history of SUD
- Psychological stress
- Psychological trauma
- Psychological disease
- Psychotropic substance use
- Focus on opioids
- Sexual trauma
- History of legal problems
- History of SUD treatment
- Craving for prescription drugs
- Mood swings/disorders
- Childhood adversity, adverse childhood experiences
- Social environments that encourage illicit substance use

The HHS Inter-Agency Task Force on best practices in pain management emphasizes sleep disturbances, mood disorders, and stress as factors that put patients at risk for poorer outcomes and substance use.[1]

HCPs may identify risk factors from patient and family history and current biopsychosocial evaluation.

Other red flags to consider that indicate a patient may not be an appropriate candidate for opioid treatment includes those who are unwilling to undergo definitive treatment for their painful disorder, or unwilling to attempt treatment with non-opioid therapies .[76]

Assessing for Risk of Overdose

Respiratory depression leading to fatal or nonfatal overdose is a chief risk with opioids. Risk factors for overdose in people taking opioids medically or nonmedically include:[77-81]

- Middle age
- History of SUD
- Comorbid mental and medical disorders
- High opioid dose (>90 mg morphine equivalents, although risk is present at any dose)
- Recent upward titration of opioids (within the first 2 weeks)
- Recent opioid rotation
- Methadone use
- Benzodiazepine use
- Antidepressant use
- Unemployment
- Use of non-prescribed illicit substances
- Recent release from jail or prison
- Recent release from substance treatment program
- Sleep apnea
- Heart or pulmonary complications (e.g., respiratory infections, asthma)
- Pain intensity

Higher dose adds risk for opioid-related overdose but other risk factors contribute, and no dose is completely safe.[124] Although the CDC guideline identified a dose limit of 90 morphine milligram equivalents (MMEs) daily after which caution is advised, another study involving 2.2 million North Carolinians did not show evidence of a distinct risk threshold and found much of the risk at higher doses to be associated with co-prescribed benzodiazepines.[80] Evidence is strong that prescribing opioids together with benzodiazepines increases risk for overdose,[20] and evidence suggests that co-prescription of opioids and gabapentinoids also may increase overdose risk.[20]

Screening for Opioid Misuse Risk

Several screening tools are available to help HCPs detect current opioid misuse or risk that a patient may develop misuse or OUD during the course of opioid therapy. None has been associated with a high degree of predictive accuracy;[1,32] however, they are generally recommended in expert guidelines for their clinical utility (Table 6). Most of the tools in Table 5 are specific to opioid-treated patients with pain. The HHS Inter-Agency Task Force has also cited the Drug Abuse Screening Test[82] and the Alcohol Use Disorders Identification Test[83] as validated tools.[1]

HCPs should select the tool that fits best into their clinical practice, treating assessment as routine and encouraging patients to share information honestly. Even single questions, such as, "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" can be effective means of screening for drug use if implemented consistently.[84] An answer to the single question of one or more is considered positive and was found in a primary care setting to be 100% sensitive and 73.5% specific for the detection of a drug-use disorder compared with a standardized diagnostic interview.[32,84]

Table 5. Screening Tools for Risk of OUD in Opioid-Treated Patients

Tool	# of Items	Administered	Approximate Time to Complete
For Use Prior to Initiating Opioid Therapy			
Opioid Risk Tool (ORT)[85]	5	Health-care practitioner	1 min
Revised Screener and Opioid Assessment for Patients with Pain (SOAPP-R)[86]	24*	Patient	5 min
Diagnosis, Intractability, Risk, Efficacy (DIRE)[87]	7	Health-care practitioner	2 min
Pain Medication Questionnaire (PMQ)[88]	26	Patient	10 min
For Use During Opioid Therapy			
Current Opioid Misuse Measure (COMM)[89]	17	Patient	10 min
Patient Version Prescription Drug Use Questionnaire (PDUQp)[90]	31	Patient	20 min
Brief Initial Drug Screenings Not Specific to Pain Population			
CAGE-AID (Adapted to Include Drugs)[91]	4	Health-care practitioner	1 min
Drug Abuse Screening Test (DAST)[82]	10	Health-care practitioner or patient versions	5 min
Alcohol Use Disorders Identification Test[83]	10	Health-care practitioner or patient versions	5 min
*4- and 12-item SOAPP formats available			

The information gained from screening is documented in the patient record and used to assist selection of the best treatments, including medication classes and delivery systems, to facilitate ongoing monitoring to help mitigate potential opioid misuse, and to inform whether SUD treatment and mental-health referrals are warranted.

A baseline urine drug test (UDT) should take place before opioids are prescribed or continued.[20,32,77] Usefulness of a UDT includes identifying the presence of prescribed medications as well as unauthorized prescription and illegal drugs, helping to guide clinical decisions, and serving as an alert to potential drug-drug interactions. Immunoassay testing done at the point of care (POC) can help quickly establish whether a new patient has recently ingested illegal drugs or other opioid and prescription drugs but typically cannot isolate specific opioids.[92] If POC test results are inconsistent with medical direction, the next step is a quantitative evaluation, usually via gas chromatography/mass spectrometry (GC/MS) technology or liquid chromatography dual mass spectrometry (LC/MS/MS). These tests can detect actual drugs and their metabolites. Some laboratories offer definitive testing via LC-MS/MS that may be given as the initial test; however, most guidelines still suggest immunoassay ahead of confirmatory testing due to cost concerns.[92]

A query of the state prescription drug monitoring program (PDMP) should also take place before opioids are initiated or continued.[20,32,77] These importance checks of the patient's past and present opioid prescriptions are done at initial assessment and during the monitoring phase. PDMP data can help to identify patients who have had multiple practitioner episodes or potentially overlapping prescriptions that place them at risk of a misuse or drug interaction problem. The use of an PDMP is also aimed at stopping the spread of opioid misuse and diversion as a public health problem.

If baseline UDT and PDMP checks indicate unauthorized prescriptions or there are other signs suggestive of opioid misuse, the results should be discussed with the patient and, if OUD or another substance-use issue is suspected, treatment should be offered and/or a specialist referral can be given. More will follow on using UDT and PDMP checks for periodic monitoring during the course of opioid therapy.

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 2.

Guidelines and Regulations Governing Long-Term Opioid Therapy

If, after a risk-benefit analysis, a trial of opioid therapy for chronic pain is warranted, HCPs have access to numerous guidelines developed by professional medical societies, states, and federal agencies to assist in setting and executing treatment plans .

Common recommendations include: [20,32,77,52,93]

- Start patients on the lowest effective dose
- Conduct UDT at baseline and on follow-up as appropriate
- Check PDMP at baseline and on follow-up as appropriate
- Monitor pain and treatment progress with documentation, using greater vigilance at higher doses
- Pay close attention to drug-drug and drug-disease interactions
- Recognize special risks with fentanyl patches and methadone
- Titrate slowly and cautiously
- Consider using an opioid-specific risk assessment
- Use safe and effective methods for discontinuing opioids (e.g., tapering, making appropriate referrals to substance abuse treatment or other services)

The CDC issued has a practice guideline for using opioids to treat patients who have chronic pain and do not have an active malignancy or need palliative or end-of-life care.[32] The guideline defines long-term opioid therapy as use of opioids on most days for greater than three months.

Authors of the guideline state that its strictures should not be used to deny clinically appropriate opioid therapy to patients but, rather, to help HCPs in primary care consider all treatment options with an eye to reducing inappropriate opioid use.[94]

Initiating or Continuing Long-Term Opioid Therapy

The HCP may consider a trial of long-term opioid therapy as one therapeutic option if the patient's pain is severe and ongoing or recurs frequently, diminishing function or quality of life, and is unrelieved or likely to be unrelieved by non-opioid therapies.[77] To initiate a trial or continue opioid therapy, the HCP should complete the initial exam and diagnostic procedures and assess pain, mental-health, social, substance, and opioid risk as previously described. A list of items to document in the patient record is shown in Table 6.[20,32,77,52,93,95]

Case Study 2

Instructions: Spend 5–10 minutes reviewing the case below and considering the questions that follow.

Jonathan, 42, presents looking anxious and in considerable pain. A year ago, while moving furniture, he experienced sudden piercing mid-low back pain that radiated down his left leg. The patient had an L4/5 microdiscectomy that appeared at first to relieve radicular symptoms, but the symptoms returned six weeks afterward. His pain intensity at rest is 6 out of 10 on the VAS, but movement brings on back spasms, which causes his pain level to spike to 9 out of 10. Walking and bending at the waist are excruciating, and he finds it hard to find a comfortable position when lying down. He reports that ACET and ibuprofen bring no relief and admits that he would like to receive an ER formulation of oxycodone because he already knows it works for the pain, having occasionally used the same prescription belonging to a friend. Jonathan is now estranged from his parents, both of whom drank to excess and used illegal drugs when he was a child. He reports a history of panic attacks and nightmares ever since his time spent serving in the armed forces. He smokes approximately 30 cigarettes a day. He has no cardiopulmonary, gastrointestinal, endocrine, or neurologic diseases.

1. **How might Jonathan's pain type, intensity, duration and treatments tried inform the creation of a treatment plan for him?**_____

2. **What mental health screening tool(s) would be helpful?**_____

3. **What risk factors for opioid misuse are present and how might they influence treatment choices?**_____

Table 6. Items to Perform and Document in the Patient Record When Prescribing Opioid Therapy for Chronic Pain[20,32,77,52,93,95]

1. Signed informed consent
2. Signed opioid treatment agreement(s)
3. Pain and medical history
   - Chief complaint
   - Treatments tried and patient response
   - Past laboratory, diagnostic, and imaging results
   - Comorbid conditions (e.g., medical, substance-use, psychiatric, mood, sleep)
   - Social history (e.g., employment, marital, family status, substance use)
   - Pregnancy status or intent, contraceptive use
4. Results of physical exam and new diagnostic and imaging tests
   - Review of systems
   - Pain intensity and level of functioning
   - One or more indications for opioid treatment
   - Objective disease/diagnostic markers
5. Results of opioid risk assessment prior to prescribing opioids
   - Clinical interview or any screening instruments
   - Personal history of SUD, mental health disorder
   - Family history of SUD, mental health disorder
   - Co-management or treatment referral for patients at risk for SUD
   - Treatment or referral for patients with active OUD
   - Treatment or referral for patients with undiagnosed depression, anxiety, other mental health disorders
6. Treatment goals for pain relief, function, quality of life
7. Treatments provided
   - With risk-benefit analysis after considering available nonpharmacologic and non-opioid pharmacologic op&ons
   - All medications prescribed (including the date, type, dose, and quantity)
   - All prescription orders for opioids and other controlled substances whether written or telephoned
8. Prescription of naloxone, if provided, and rationale
9. Results of ongoing monitoring toward pain management and functional goals

SUD = substance-use disorder OUD = opioid-use disorder; PDMP = prescription drug-monitoring programs; UDT = urine drug testing

Medical records should be kept up-to-date and be legible so as to be easily reviewed.

Informed Consent

Patients started on opioid therapy for chronic pain should be informed of the potential risks and benefits. The most serious risk with any opioid is respiratory depression leading to death.

Patients who have never taken opioids or whose medications or doses will be changed should be counseled to expect sedation or other cognitive effects.

An informed consent form should be signed by the HCP and the patient and retained in the medical record. Items recommended in informed consent include:[20,77,95]

- Potential risks and benefits of opioid therapy
- Risks of OUD, overdose, and death even at prescribed doses
- That evidence is limited for benefit of opioids in chronic noncancer pain
- A mention of nonpharmacologic and non-opioid therapeutic options for pain treatment
- Potential short- and long-term side effects, such as cognitive impairment and constipation
- The likelihood that tolerance and physical dependence will develop
- Risks of drug interactions
- Risks of impaired motor skills affecting driving, operating machinery, and other tasks
- Signs and symptoms of overdose
- Risks when combining opioids with other CNS-depressants, including benzodiazepines and alcohol
- The importance of the patient disclosing all medications and supplements
- How to handle missed doses
- Any important product-specific risks, such as the dangers of chewing an ER formulation

Opioid Treatment Agreements

Opioid treatment agreements that spell out patient and HCP expectations and responsibilities are recommended by most opioid guidelines.[77,52]

Consider including:[95]

- Treatment goals in terms of pain management, restoration of function, and safety
- Patient's responsibility for safe medication use, such as agreement not to take more than prescribed, alter pills, or combine with alcohol, unauthorized prescriptions, or illicitly-obtained drugs
- Patient's responsibility to obtain prescribed opioids from only one HCP or practice
- Patient's responsibility to fill prescriptions at only one pharmacy
- Patient's agreement to periodic UDT or other drug tests
- Instructions for secure storage and safe disposal of prescribed opioids
- HCP's prescribing policies, including handling of early refills and replacing lost or stolen medications
- Reasons for which opioid therapy may be changed or discontinued, including violation of the treatment agreement
- Statement that treatment may be discontinued without the patient's agreement
- HCPs availability policy, including responsibility to provide care for unforeseen problems and to prescribe scheduled refills
- Education that the patient should not expect complete elimination of pain
- Understanding that patient should not receive additional intravenous or intramuscular pain medications in Emergency Department or Urgent Care settings
- The patient's signature

The forms for informed consent and treatment agreements may be combined into one document and adapted to the HCP's needs and preferences. It is advisable to have a strategy to manage opioid misuse by the patient should it occur and to know and discuss with the patient indications for which opioid therapy may be discontinued.

In general, opioid therapy in patients with untreated OUD is unlikely to achieve therapeutic aims, and initiating it is not recommended.[20] Similarly, opioid therapy should not be initiated in individuals currently using illicit substances. These individuals are at increased risk for misuse, abuse, overdose and death. A clear medical indication should be documented should opioids be prescribed.[1] HCPs may consider or continue opioids for patients with chronic pain and histories of drug abuse and psychiatric issues only if they are able to implement more frequent and stringent monitoring parameters.[32] In such situations, HCPs should strongly consider consultation and co-management with a pain, mental-health, or addiction specialist or else refer the patient for specialist management.[32,77] Prescription of opioids may not be appropriate until the comorbidity has been addressed.[77]

For patients exhibiting active OUD who are already on opioids, oftentimes at high doses, HCPs should provide or refer for addiction management and treatment with medications such as buprenorphine or methadone via an opioid treatment program.[43]

Treatment of pain with full agonist opioids in patients with OUD would need a careful evaluation of the risks versus benefits to determine management. It is unlikely that a patient with OUD and pain will have adequate pain control in the absence of treatment of OUD.[20] Taper of opioids may be considered in addition to initiation of OUD treatment. Sudden discontinuation or tapering of opioids in the absence of treatment of OUD with buprenorphine or methadone will put patients with OUD at risk for serious adverse outcomes (see subsequent sections on tapering opioids and managing OUD).[15,16,43]

Dosing and Titration Considerations

Opioids are best when used at the lowest effective dose and combined with non-medication and/or non-opioid medication modalities of treatment.[32,77] When opioids are initiated, the goal is to select the lowest effective dose for shortest duration possible to achieve therapeutic goals.[19,32] The risk of overdose increases with the dose, but the therapeutic window varies considerably from patient to patient.

In pain management, IR/SA opioids, are indicated for pain severe enough to need opioid treatment and for which non-opioid treatments are ineffective or not tolerated.[40] These short-acting opioids are preferred and considered safer when initiating a therapeutic trial of opioids for both acute and chronic pain and are often prescribed for use as needed every 4 to 6 hours.[40,77] Commonly prescribed IR/SA opioids include morphine, hydromorphone, oxymorphone, codeine, fentanyl, hydrocodone, and oxycodone.[142] Codeine, hydrocodone, and oxycodone are also available in combination with ACET or an NSAID, which limit daily dose due to risk for liver and GI toxic effects.[96] Patients with no or limited exposure to opioids should be initiated at the lowest available dose and titrated slowly to minimize adverse effects.[77] Dual-mechanism opioids may control pain with less opioid, and opioid-sparing techniques, such as combining therapeutics should be considered.

If patients require long-term maintenance and pain is severe enough to require around-the-clock analgesia that is not adequately relieved by IR/SA opioids or other therapies, consider a transition to ER/LA opioids with scheduled dosing.[97] ER/LA opioids are primarily intended to be taken once or twice a day, are not indicated for acute pain, and are for use only in patients who are already tolerant to opioids.[39] It is critical also that HCPs be aware that all transdermal and transmucosal fentanyl and hydromorphone ER products are for use only in opioid-tolerant patients and never for acute or short-term pain.[39]

Because patient response varies, titrating to a therapeutic dose should be individualized with close attention to efficacy, tolerability, and presence of adverse effects. The CDC recommends reassessing risk vs. benefit at ≥50 MME per day, avoiding increasing dosages to ≥90 MME per day, or carefully considering the rationale, as efficacy above this level is questionable with an increase in risks of potentially serious side effects.[32] Authors of the CDC guideline subsequently clarified that the guideline does not support sudden dismissal of patients or hard limits on dosage and treatment durations.[15] These circumstances particularly affect patients who are already receiving long-term opioid therapy and who seek continuation of care after losing access elsewhere.[98] It must be reemphasized that recommended threshold doses do not remove the necessity of exercising caution at any dose or the importance of individualizing the dose.

Particular care is essential, not only during opioid dose initiation but also whenever doses are increased, changed to a different opioid, or when CNS-depressant medications are added to the regimen. Patients should be monitored carefully, particularly within 24 to 72 hours of opioid initiation or upward titration. Studies show that patients are particularly vulnerable to respiratory depression at these times.[77,78]

Naloxone Prescription

Naloxone can be used to save lives during overdose from a prescribed or illicit opioid, and its presence increases safety for the patient and others who live in or visit the home.[32] Strong evidence shows that providing naloxone to patients reduces opioid-related emergency-department visits.[50]

Take -home naloxone can be easily prescribed and is generally recommended for all patients who receive an opioid prescription. It is particularly recommended with the presence of opioid overdose risk factors, such as history of overdose, history of SUD, clinical depression, opioid dosages ≥50 MME/day, concurrent benzodiazepine use,[32] or with evidence of increased risk by other measures. Two easily administered products are an auto-injection device and a nasal spray that requires no assembly, and family members may be instructed in the use. Patients given naloxone should keep it available at all times.[77]

Naloxone administration can cause withdrawal symptoms, and people who have been administered it should have follow-up medical care. Laws vary by state regarding immunity for physicians or laypeople administering naloxone and can be checked here: http://www.pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139.

Patients and their caregivers and other family members should be instructed on the signs of overdose and counseled to do the following if an opioid overdose is suspected:[99]

- Call 911 immediately
- Administer naloxone if available
- Try to keep the person awake and breathing
- Lay the person on their side to prevent choking
- Stay with the person until emergency workers arrive

Signs of an opioid overdose include:[44,99]

- Small, constricted "pinpoint pupils"
- Sedation or loss of consciousness
- Slow, shallow breathing
- Choking or gurgling sounds
- Limp body
- Pale, blue, or cold skin
- Snoring heavily and cannot be awakened
- Periods of ataxic (irregular) or other sleep-disordered breathing
- Trouble breathing
- Dizziness, confusion or heart palpitations

HIPAA Compliance

In a Fact Sheet published by the US Department of Health and Human Services, guidance is provided in sharing patient health information with family members when a patient is incapacitated or experiencing an emergency situation. Health professionals are permitted to discuss health related issues with family members without violating the Health Insurance Portability and Accountability Act (HIPAA) when faced with serious or health crises that pose an imminent threat to the patient, particularly in the setting of an unconscious or incapacitated patient.[100]

Periodic Monitoring of Long-Term Opioid Therapy

Follow-up with patients being treated with opioids is aimed at preventing potential misuse and tracking progress toward goals of pain control and function. Items to evaluate and document include analgesia, daily activities, adverse effects, aberrant drug-related behaviors, cognition, function, and quality of life. Similarly, patients should be reassessed for the development of tolerance and consideration of adjunctive therapies, opioid rotation, tapering, or discontinuation.[1] Tools available to assist with frequent reassessment and documentation include the Pain Assessment and Documentation Tool[101] and the COMM.[134] Ongoing periodic monitoring should incorporate checks of the PDMP and UDT.[92] When counseling patients, it is best to present UDT, PDMP data, and other monitoring measures to patients as a routine, consensual part of medical care using nonjudgmental language.

The CDC guideline states that patients on opioid therapy should be reevaluated within one-to-four weeks of initiation or dosage change and at least every three months thereafter to ensure benefits outweigh risks.[32] Monitoring measures should be ongoing with every patient prescribed opioid therapy.[20] Risk and benefit assessment should be performed regularly with ongoing opioid therapy. Patients with more comorbidities or higher misuse risk require more stringent monitoring measures, such as pill counting, and more frequent follow-up than patients with less risk for harm.[19] Some expert guidance recommends using risk stratification to set clinic visit frequency and other monitoring measures as determined by patient risk category (low, moderate, or high risk) during initial screening and clinical follow-up.[45]

The recommended frequency for periodic review of PDMP data ranges from every prescription to every three months.[32] A consensus-based recommendation for UDT frequency is to test every patient at least once annually and higher-risk patients from two-to-three times annually.[92]

It is very important to check local and state regulations and the recommendations of state medical boards in the area of practice, as many of these bodies set expectations for the timing and other particulars regarding UDT and PDMP checks.

Interpreting UDT results requires caution as the tests have limitations.[32] These include:[92]

- Cross-reactivity with other drugs or substances
- Potential for false positives (e.g., poppy seeds positive for opiates)
- Potential for false negatives
- Variable drug metabolism
- Laboratory error

Unexpected results, such as the absence of prescribed medications that could indicate diversion, should be discussed with the patient and documented in the record along with plans to address the results.

Reassessment of any comorbid mental health disorders is also part of ongoing opioid therapy. Tools used for initial assessment of anxiety, depression, and somatic symptoms may also be used for monitoring of these conditions and reevaluating the treatment plan.[102]

PLEASE COMPLETE CASE STUDY 3.

Seeking Expert Referrals

Knowing when to seek specialist care is part of treatment with opioids. In general, the HCP should consult with a pain, addiction, or mental-health specialist or refer the patient for specialist care whenever:

- Pain continues to worsens with treatment
- OUD is suspected or identified
- Worsening of any mental health disorder is observed, including any SUD

Uncontrolled or increasing pain severity despite attempts to optimize the medication regimen and in the absence of a clear explanation is a signal that pain specialist consultation or referral is advisable.

In the presence of ongoing or severe behaviors suggestive of opioid misuse, HCPs should consider that patient may be suffering from OUD or other substance-use or mental-health disorders. When an active OUD or a recent OUD history is present, HCPs should strongly consider referral for medication treatment of addiction (unless this is provided in your clinic), specialist pain management, and/or tapering opioids and managing pain with non-opioid therapies.[32] Criteria of an OUD are described later in this activity. Signs and symptoms seen in a clinical scenario include:[103]

- Taking opioids compulsively and long term for no legitimate medical purpose
- If pain is present, taking opioids in excess of prescription
- Obtaining opioids from unauthorized sources
- Falsifying or exaggerating medical problems to receive opioids
- Significant tolerance and physical dependence (although these may also occur in patients without OUD)
- Conditioned responses of craving that persist after cessation

Other life circumstances that may accompany OUD but are not always seen include:[102]

- Marital problems, including divorce
- Unemployment and irregular employment
- Financial insecurity
- History of drug-related crimes

SUDs involving alcohol or any other drug may threaten the success of opioid therapy and introduce safety risks. SUD should be suspected when the recurrent use of alcohol or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. The coexistence of both a mental health and an SUD is referred to as co-occurring disorders. The National Institute for Mental Health's Mental Health Information website has information about specific mental conditions and disorders as well as their symptoms: https://www.nimh.nih.gov/health/topics/.

Case Study 3

Instructions: Spend 5–10 minutes reviewing the case below and considering the questions that follow.

Diane, 57, has a diagnosis of sickle cell disease and has been stable on her opioid dose for nearly a decade. Her pain is generally well controlled. She still experiences acute exacerbations of pain but has learned to live with and manage them. Her hydromorphone ER dose of 32 mg daily is only one pain management strategy she utilizes. Others include NSAIDs, positive visualization and meditation techniques, remaining physically active, and regular visits with a behavioral therapist. Her therapy helps her cope with the stigma she often feels from friends and certain family members who do not support her use of opioid therapy because of its societal association with misuse. She has long-standing mild depression that is controlled with a low dose of an SSRI and is helped by her regular therapy sessions. She has considered ketamine treatment in the past but fears possible cognitive side effects and has good quality of life and function with her current pain regimen. She has never increased opioid doses on her own or engaged in other aberrant drug-related behaviors. After shifting insurance coverage due to a job loss, Diane visits a new HCP who proposes to reduce her opioid dose gradually to 50 MMEs daily so as to reduce opioid exposure and thus increase safety.

1. **What considerations are present with the management of pain from sickle cell disease?** _____

2. **How are practice guidelines or insurance coverage policies that set thresholds for opioid dose to be incorporated into individualized treatment plans?** _____

3. **How would one go about conducting a risk-benefit analysis for opioid therapy in this patient, and what documentation is advised?** _____

The presence of a psychiatric or substance-use condition does not mean the patient is not experiencing real pain. The many contributing factors from the biological, psychological, and social domains as well as chronic pain's adverse impact on relationships, work, sleep, function, overall health, and quality of life explain why a comprehensive approach to pain management is optimal.[14] These complexities also explain why patients often respond better to a combination of therapeutic modalities rather than a unimodal medication regimen.

Tapering or Discontinuing Opioid Use

Before initiating opioid therapy, HCPs should have an exit strategy in place to humanely taper opioids whether the goal is dose reduction or to discontinue opioid therapy. Indications for discontinuing opioid therapy may include:[43]

- Failure to achieve sufficient analgesia
- Intolerable side effects
- Resolution of pain
- Development of OUD or serious misuse
- Higher doses without evidence of benefit
- Presence or warning signs of an impending serious event (e.g., confusion, sedation, slurred speech)
- Concurrent medications (e.g., benzodiazepines) that increase risk for a serious outcome
- Concurrent medical condition(s) (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age) that increase risk for a serious outcome
- A pattern of ongoing failure to adhere to the treatment plan to which the patient agreed

Signs of serious nonadherence that may indicate opioids are unsafe for the patient include:[45]

- Repeatedly increasing dose without HCP knowledge
- Sharing medications
- Unapproved opioid use
- Use of illicit drugs
- Obtaining opioids from unauthorized sources
- Prescription forgery
- Multiple episodes of losing prescriptions
- Polysubstance use

One must beware of abrupt opioid discontinuation and know that treatment is individualized.[1,15-17,20] The CDC guideline is meant to advise HCPs to avoid increasing doses above 90 mg MME daily but is not meant to circumscribe individualizing treatment or to justify abrupt reduction from high doses.[43] Nor is the guideline meant to justify reducing or discontinuing opioids that may be medically indicated and when benefits outweigh risks.[43]

Patients who are candidates for taper should be treated with alternatives to opioid therapy for pain. HCPs should avoid dismissing patients from care and should ensure whenever possible that patients continue to receive coordinated care.[43] Referral should include, as indicated, treatment of OUD or management of psychiatric illnesses.[77] In an outpatient setting, taper should be done so as to avoid opioid withdrawal in physically-dependent patients. Taper may be accomplished in a detox setting if the patient is unable to reduce opioid dose.

An expert consensus guideline offered the following recommendations regarding tapering opioids:[20]

- Evaluate comorbidities, the patient's psychological condition, and other relevant factors before beginning the taper
- Educate the patient and family about the taper protocol
- Manage withdrawal symptoms (e.g., nausea, diarrhea, muscle pain, myoclonus) using non-opioid analgesics and adjuvant agents
- For complicated withdrawal symptoms, refer the patient to a pain specialist or chemical dependency center
- Refer for counseling or other support during the taper if there are significant behavioral issues

Diversion of opioids or other controlled substances is a contraindication for continuing opioid therapy.[20] With confirmed diversion, the best practice is to monitor for withdrawal symptoms, offering necessary support and treatment of SUD, if present.[20]

Managing OUD

Methadone and buprenorphine are used to treat OUD, a process known as medication treatment for OUD (MOUD) when combined with behavioral therapy.[40] Buprenorphine works by suppressing and reducing opioid cravings. Methadone reduces cravings and withdrawal and also blunts the effects of opioids. Buprenorphine is widely used and encouraged for treating patients with OUD.[1,18] One reason is buprenorphine's antagonistic action at the kappa receptor, as this effect is associated with reducing opioid withdrawal symptoms along with helping to attenuate anxiety and depression.[1]

HCPs should treat OUD with buprenorphine/naloxone if authorized by the DEA Drug Addiction Treatment Act of 2000 waiver or should refer the patient for addiction treatment.[98] Recent practice guidelines released by the Substance Abuse and Mental Health Services Administration within HHS are available here: https://www.samhsa.gov/newsroom/press-announcements/202104270930. Approaching OUD as a chronic illness can help patients to stabilize, achieve remission of symptoms, and establish and maintain recovery.[18]

Patients with OUD should have access to mental health services, medical care, and addiction counseling to supplement treatment with medication.[18] Individualized psychosocial supports may include supportive counseling, recovery coaching, recovery support services, and other services that may be needed by particular patients.

Patients who present with or develop OUD or mental health disorders or both and who also have persistent pain require multidisciplinary care.[1] Patients with co-occurring pain and OUD should be offered MOUD.[18,19]

For any population with trouble accessing treatment for OUD, including poorer urban areas and rural areas with limited treatment options, expanding the number of qualified HCPs able to treat OUD with buprenorphine in an office-based setting leads to more ready diagnosis and treatment. Because OUD medication is best combined with evidence-based psychological and behavioral therapies, the growing popularity and feasibility of accessing telehealth sessions is another possible means of expanding access to currently underserved communities.

The Basics of Addiction Medicine

Definitions and terms used to discuss addiction have evolved over time. Certain phrasing that is potentially stigmatizing has fallen out of usage, and more accurate terminology has been introduced. For example, patients with SUD, including OUD, should not be referred to as "addicts." The disease of OUD is diagnosed using DSM-5 criteria (Table7).[49] A minimum of two-to-three criteria are required for a mild SUD diagnosis, while four-to-five is moderate, and six or more is severe;[49,103] OUD is specified if opioids are the substance of use. Addiction, while not a DSM-5 diagnosis, is a frequently used term and typically describes severe SUD. The presence of tolerance and physical dependence does not necessarily mean that an OUD has developed, particularly if the medication is taken as prescribed.

Conclusions

All HCPs who treat pain with the use of opioids need up-to-date competencies to manage potential opioid-related harms. This includes a familiarity with the full complement of nonpharmacologic and pharmacologic options to create an individualized treatment plan, reserving opioids for when other strategies are not effective. An optimal multimodal approach to pain management consists of using treatments from one or more clinical disciplines incorporated into comprehensive plan.[1]

For select patients who benefit from opioids long term, HCPs should reduce risk and optimize benefits by patient education, screening of high-risk patients for OUD, continuous monitoring, combining treatments with non-opioid options when indicated, referral and co-management of comorbid conditions, and an exit strategy to ensure careful tapering when indicated. It is important for patient outcomes and for regulatory and legal requirements to document every aspect of opioid therapy within the medical record and to follow all federal, state, and local regulations regarding opioid therapy. HCPs should know the signs and symptoms of OUD and be prepare to treat or refer for treatment with the understanding that medications for OUD are essential to save lives.

See the Wisconsin Prescribing Opioid Guidelines (https://dsps.wi.gov/Documents/BoardCouncils/MED/MEBGuideline.pdf) at the back of this course for Wisconsin specific information related to opioid prescribers.

Table 7 Criteria for Opioid-Use Disorders from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
• Opioids are often taken in larger amounts or over a longer period of time than was intended
• There is a persistent desire or unsuccessful efforts to cut down or control opioid use
• A great deal of time is spent in activities to obtain the opioid, use the opioid, or recover from its effects
• Craving, or a strong desire or urge to use opioids
• Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home
• Continued opioid use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of opioids
• Important social, occupational, or recreational activities are given up or reduced because of opioid use
• Recurrent opioid use in situations in which it is physically hazardous
• Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that's likely to have been caused or exacerbated by the substance
• Tolerance,* as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect b. A markedly diminished effect with continued use of the same amount of an opioid
• Withdrawal,* as manifested by either of the following: a. The characteristic opioid withdrawal syndrome b. The same—or a closely related—substance is taken to relieve or avoid withdrawal symptoms
*This criterion is not met for individuals taking opioids solely under appropriate medical supervision. Severity: mild = 2–3 symptoms; moderate = 4–5 symptoms; severe = 6 or more symptoms.

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APPENDIX A. Wisconsin Medical Examining Board Opioid Prescribing Guidelines - *January 16, 2019*

https://dsps.wi.gov/Documents/BoardCouncils/MED/MEBGuideline.pdf

Scope and purpose of the guideline:
To help providers make informed decisions about acute and chronic pain treatment -pain lasting longer than three months or past the time of normal tissue healing. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. Although not specifically designed for pediatric pain, many of the principals upon which they are based could be applied there, as well.

Opioids pose a potential risk to all patients. The guideline encourages providers to implement best practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients.

Identify and treat the cause of the pain, use non-opioid therapies
Use non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and non-opioid pharmacologic therapies (such as acetaminophen and anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

Start low and go slow
When opioids are used, prescribe the lowest possible effective dosage and start with immediate-release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

Close follow-up
Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

What's included in the guideline?
The guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, treating the cause of the pain, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the guideline include:

1. **Determining when to initiate or continue opioids**
- -Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
- -Establishment of treatment goals
- -Discussion of risks and benefits of therapy with patients

2. **Opioid selection, dosage, duration, follow-up and discontinuation**
- Selection of immediate-release or extended-release and long-acting opioids
- Dosage considerations
- Duration of treatment
- Considerations for follow-up and discontinuation of opioid therapy

3. **Assessing risk and addressing harms of opioid use**
- Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
- Review of prescription drug monitoring program (PDMP) data
- Use of urine drug testing
- Considerations for co-prescribing benzodiazepines
- Arrangement of treatment for opioid use disorder

Prescription Opioid Guideline

1. Pain is a subjective experience and at present, physicians lack options to objectively quantify pain severity other than by patient reported measures including pain intensity. While accepting the patient's report of pain, the clinician must simultaneously decide if the magnitude of the pain complaint is commensurate with causative factors and if these have been adequately evaluated and addressed with non-opioid therapy.

2. It is best practice for a practitioner to consider guidelines within their specialty when prescribing opioids.

3. In treating acute pain, if opioids are at all indicated, the lowest dose and fewest number of opioid pills needed should be prescribed. In most cases, less than 3 days' worth are necessary, and rarely more than 5 days' worth. Left-over pills in medicine cabinets are often the source for illicit opioid abuse in teens and young adults. When prescribing opioids, physicians should consider writing two separate prescriptions for smaller amounts of opioids with specific refill dates, rather than a single large prescription. Most patients do not fill the second prescription, thus limiting opioid excess in a patient's home and potential misuse.

4. A practitioner's first priority in treating a patient in pain is to identify the cause of the pain and, if possible, to treat it. While keeping the patient comfortable during this treatment is important, it is critical to address to the extent possible the underlying condition as the primary objective of care.
   a. Patients unwilling to obtain definitive treatment for the condition causing their pain should be considered questionable candidates for opioids. If opioids are prescribed to such patients, documentation of clear clinical rationale should exist.
   b. Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid. For conditions where this is questionable, use of other treatments instead of opioids should be strongly considered.
   c. Consultation should be considered if diagnosis of and/or treatment for the condition causing the pain is outside of the scope of the prescribing practitioner.

5. Opioids should not necessarily be the first choice in treating acute or chronic pain.
   a. Acute pain: Evidence for opioids is weak. Other treatments such as acetaminophen, anti- inflammatories, and non-pharmacologic treatments should be attempted prior to initiating opioid therapy. Although opioids could be simultaneously prescribed if it is apparent from the patient's condition that he/she will need opioids in addition to these. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.
   b. Acute pain lasting beyond the expected duration: A complication of the acute pain issue (surgical complication, nonunion of fracture, etc.) should be ruled out. If complications are ruled out, a transition to non-opioid therapy (tricyclic antidepressant, serotonin/norepinephrine re-uptake inhibitor, anticonvulsant, etc.) should be attempted.
   c. Chronic pain: Evidence for opioids is poor. Other treatments such as acetaminophen, anti- inflammatories, and non-pharmacologic treatments (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) should be utilized. Multiple meta-analyses demonstrate that the benefits of opioids are slight, while annualized mortality rates dramatically increased.

There are few if any treatments in medicine with this poor a risk/benefit ratio, and there should be adequate clinical indication to indicate why chronic opioid therapy was chosen in a given patient. Note: There is no high-quality evidence to support opioid therapy longer than 6 months in duration. Despite this fact, it is considered acceptable although not preferable to continue patients on treatment who have been on chronic opioid therapy prior to this Guideline's release and who have shown no evidence of aberrant behavior.

d. Patients unwilling to accept non-pharmacological and/or nonnarcotic treatments (or those providing questionably credible justifications for not using them) should not be considered candidates for opioid therapy.

6. Patients should not receive opioid prescriptions from multiple physicians. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored. Physicians should avoid prescribing controlled substances for patients who have run out of previously prescribed medication or have had previous prescriptions lost or stolen.

7. Physicians should avoid using intravenous or intramuscular opioid injections for patients with exacerbations of chronic non-cancer pain in the emergency department or urgent care setting.

8. Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. As of April 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.

9. Pain from acute trauma or chronic degenerative diseases can oftentimes be managed without opioids prior to surgery. Surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery.

10. Prescribing of opioids is strongly discouraged in patients taking benzodiazepines or other respiratory depressants. Benzodiazepines triple the already high increases in respiratory depression and annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

11. The use of oxycodone is discouraged. There is no evidence to support that oxycodone is more effective than other oral opioids, while there are multiple studies indicating that oxycodone is more abused and has qualities that would promote addiction to a greater degree than other opioids. As a result, oxycodone should not be considered first-line and should be used only in patients who cannot tolerate other opioids and who have been evaluated for and found not to demonstrate increased risk of abuse.

12. Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:
    a. Medical history and physical examination targeted to the pain condition.
    b. Nature and intensity of the pain.
    c. Current and past treatments, with response to each treatment.
    d. Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, chronic obstructive pulmonary disease (COPD), etc.).
    e. Effect of pain on physical and psychological functioning.
    f. Personal and family history of substance abuse.
    g. History of psychiatric disorders associated with opioid abuse (bipolar, attention deficit disorders (ADD/ADHD), sociopathic, borderline, untreated/ severe depression).
    h. Medical indication(s) for use of opioids.

13. Initiation of opioids for chronic pain should be considered on a trial basis. Prior to starting opioids, objective symptomatic and functional goals should be established with the patient. If after a reasonable trial these goals are not met, then opioids should be weaned or discontinued.

14. Practitioners should always consider the risk-benefit ratio when deciding whether to start or continue opioids. Risks and benefits should be discussed with patients prior to initiating chronic opioid therapy and continue to be reassessed during that therapy. If evidence of increased risk develops, weaning or discontinuation of opioids should be considered. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be discontinued, and the patient should be treated for withdrawal, if needed.
    a. Exceptions to this include patients with unstable angina and pregnant patients, especially in the 3rd trimester (withdrawal could precipitate pre-term labor).
    b. Components of ongoing assessment of risk include:
        i. Review of the Prescription Drug Monitoring Program (PDMP) information.
        ii. Periodic urine drug testing (including chromatography) – at least yearly in low risk cases, more frequently with evidence of increased risk.
        iii. Violations of the opioid agreement.
        iv. Periodic pill counts may also be considered for high risk patients.

15. All patients on chronic opioid therapy should have informed consent consisting of:
    a. Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death. It is also recommended practitioners discuss with patients the effect opioid use may have on the ability to safely operate machinery or a vehicle in any mode of transportation.
    b. Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects.

16. Initial dose titration for both acute and chronic pain should be with short-acting opioids. For chronic therapy, it would be appropriate once an effective dose is established to consider long- acting agents for a majority of the daily dose.

17. Opioids should be prescribed in the lowest effective dose. This includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients. If daily doses for chronic pain reach 50 morphine milligram equivalents (MMEs), additional precautions should be implemented (see #14.b. above). Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is strongly discouraged, and appropriate documentation to support such dosing should be present on the chart.

18. The use of methadone is not encouraged unless the practitioner has extensive training or experience in its use. Individual responses to methadone vary widely; a given dose may have no effect on one patient while causing overdose in another. Metabolism also varies widely and is highly sensitive to multiple drug interactions, which can cause accumulation in the body and overdose. For a given analgesic effect, the respiratory depressant effect is much stronger compared to other opioids. Finally, methadone can have a potent effect on prolonging the QTc, predisposing susceptible patients to potentially fatal arrhythmias.

19. Prescribing of opioids is strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be present.

20. During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.

21. Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:
    a. History of overdose (a relative contraindication to chronic opioid therapy).
    b. Opioid doses over 50 MMEs/day.
    c. Clinical depression.
    d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.).

The recommended dose is 0.4 mg for IM or intranasal use, with a second dose available if the first is ineffective or wears off before EMS arrives. Family members can be prescribed naloxone for use with the patient.

22. All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner, when possible, should assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an appropriate treatment center or provider willing to accept the patient. Discharging a patient from the provider's practice solely due to an opioid use disorder is not considered acceptable.

23. Discontinuing Opioid Therapy
    a. If lack of efficacy of opioid therapy is determined, safe discontinuation of opioid
    b. therapy should be performed.
    c. If evidence of increased risk develops, safe discontinuation of opioid therapy should be considered.
    d. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be immediately discontinued, and the patient should be treated for withdrawal, if needed.

Exceptions to abrupt opioid discontinuation include patients with unstable angina and pregnant patients. These patients should be weaned from the opioid medications in a gradual manner with close follow-up.

24. Current HIPAA Guidance for the Sharing of Protected Health Information with a Patient's Family Members and Loved Ones Irrespective of Patient Wishes.

Interpretive guidance from the US Department of Health and Human Services Office of Civil Rights, indicates that HIPAA regulations allow health professionals to share health information with a patient's loved ones in emergency or dangerous situations such as opioid overdose. HIPAA allows health care professionals to disclose some health information without a patient's permission under certain circumstances, including: in cases where the patient is incapacitated or unconscious, or where a serious and imminent threat to a patient's health or safety exists. For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if the doctor informs family, friends, or caregivers of the opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge.

Resources

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BEST PRACTICES FOR TREATING PAIN WITH OPIOID ANALGESICS

Self-Assessment

Choose the best possible answer for each question and mark your answers on the self-assessment answer sheet at the end of this book. There is a required score of 70% or better to receive a certificate of completion.

1. What is one way to reduce the stigma for patients living with chronic pain?

A. Counseling patients in whom opioids are indicated that opioids are appropriate for them.
B. Urging patients to self-manage moderate-to-severe pain.
C. Optimizing use of non-steroidal anti-inflammatory drugs.
D. Ensuring that individuals from minoritized racial and ethnic backgrounds have greater access to opioid therapy.

2. Gabapentin has mild-to-moderate benefit in the treatment of:

A. Insomnia that commonly accompanies chronic pain.
B. Short-term inflammation associated with acute pain caused by injury or surgery.
C. Muscle spasm in low-back pain as an alternative to more sedating medications.
D. Neuropathic pain syndromes.

3. Spinal manipulation has demonstrated improvements in pain and function when used:

A. In combination with opioids in pain lasting longer than 3 months.
B. For chronic tension headache.
C. For fibromyalgia.
D. In patients with chronic neck pain and concomitant opioid-use disorder (OUD).

4. Which is a true statement about factors to record in the patient record?

A. Psychological and social factors should be included as these can contribute to the pain experience.
B. Objective clinical markers for pain must be present before pain treatment is given.
C. The primary objective of pain treatment is to document a reduction in the patient's self-reported pain scale number.
D. Diagnosis of chronic pain is made if pain is continuous.

5. Which of the following tools assess pain, pain interference, functional components, and quality of life, and was created to assess management of chronic pain in primary care settings?

A. McGill Pain Questionnaire (MPQ).
B. Pain, Enjoyment of Life, and General Activity Scale (PEG).
C. Revised Screener and Opioid Assessment for Patients with Pain (SOAPP-R).
D. The Visual Analogue Scale (VAS) combined with the Numerical Rating Scale (NRS).

6. Which is a true statement about screening patients for potential opioid misuse?

A. Only the Drug Abuse Screening Test has been associated with a high degree of predictive accuracy.
B. Brief screening tools are regarded to have clinical utility in diagnosing OUD.
C. Single screening questions may be used.
D. There is no evidence to support screening for risk ahead of opioid prescription.

7. Patients who are already being prescribed opioids for chronic pain who exhibit an active OUD should be:

A. Discontinued immediately from opioids and treated with nonpharmacologic pain therapies.
B. Engaged in collaborative taper and treated or referred for treatment with medications to manage OUD.
C. Tapered rapidly from opioid doses and encouraged to seek psychiatric counseling.
D. Rotated to a dual-mechanism opioid with less misuse potential and sent for detoxification from high-dose opioids.

8. **Which of the following is an example of an opioid-related risk factor appropriately influencing a treatment choice?**
   A. Pain duration lasting longer than 6 months is a contraindication for carisoprodol co-prescribed with opioids.
   B. Patients without previous exposure should be initiated at the lowest possible dose of an extended-release opioid and titrated slowly to minimize adverse effects.
   C. Cardiac toxicities due to QTc prolongation suggest morphine should be carefully evaluated or should not be used.
   D. Take-home naloxone is advised in the presence of concurrent benzodiazepines.

9. **One sign of an active OUD is:**
   A. Craving that persists after cessation.
   B. Combining opioids with alcohol.
   C. Persistent failure of analgesia despite optimal doses.
   D. Chronic insomnia with opioid therapy for pain.

10. **Which of the following statements is true regarding a diagnosis of OUD using DSM-5 criteria?**
   A. A minimum of four criteria are required for a mild OUD diagnosis.
   B. The preferred term for problematic opioid usage that does not meet criteria for OUD is “abuse”.
   C. The presence of tolerance and physical dependence does not necessarily mean that an OUD has developed.
   D. Patients cannot develop an OUD if they take medication as prescribed.

ASSESSMENT AND PREVENTION OF SUICIDE

COURSE DATES:	MAXIMUM CREDITS:	FORMAT:
Release Date: 2/2023 Exp. Date: 1/2026	*6 AMA PRA Category 1 Credits*™	Enduring Material (Self Study)

TARGET AUDIENCE

This course is designed for all physicians (MD/DO) and other health care practitioners.

HOW TO RECEIVE CREDIT:

- Read the course materials.
- Complete the self-assessment questions at the end. A score of 70% is required.
- Return your customer information/ answer sheet, evaluation, and payment to InforMed by mail, phone, fax or complete online at program website.

COURSE OBJECTIVE

The purpose of this course is to provide learners with the background and statistical data of suicide within the US, etiology of suicide, suicide risk, assessment, treatment, and management. Additional topics include the risk of imminent harm, communication strategies, and a special focus on the veteran population.

LEARNING OBJECTIVES

Completion of this course will better enable the course participant to:

1. Understand terminology and concepts related to suicide.
2. Understand risk factors associated with suicide.
3. Describe strategies for conducting a suicide assessment.
4. Discuss appropriate treatment and management options for patients at risk of suicide.

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COURSE SATISFIES

6

AMA PRA Category 1 Credits™

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DISCLAIMER

Introduction

The U.S. Centers for Disease Control [CDC] (2019) has identified suicide as one of the top ten leading causes of death in the 10-65 age group. According to the Suicide Prevention Resource Center (SPRC), suicide acts take a tremendous emotional and economic toll on the families and loved ones of those who engage in suicidal behaviors. Not only does the suicidal behavior of a loved one cause an emotional toll on family members and place others within the family unit at risk of dying by suicide, but it also results in increased medical costs for individuals and families, lost income for families, and lost productivity for employers and the community. This topic must be addressed throughout the healthcare community to prevent further avoidable loss of life.[1]

The financial benefits of implementing suicide preventative measures will, hopefully, convince policymakers and lawmakers that suicide prevention is not only the "right" thing to do, morally speaking, but is also an investment that has a financial benefit in addition to saving lives. A recent study by Shepard et al., in 2015 found that the total cost of suicide acts in 2013 was $93.5 billion, with an estimated average cost of $1,329,553 for a single suicide. Approximately 97% of this cost was attributed to lost wages from productivity, whereas the remaining 3% went to medical treatment. The study also estimated that every $1 spent on psychotherapeutic interventions and interventions that promoted linkages between different care providers saved $2.50 in suicides.[1]

Primary care providers may be able to prevent suicide due to their frequent interactions with suicidal patients. According to Schreiber and Culpepper,[2] 80% of individuals who die by suicide have had at least one contact with their primary healthcare provider within one year of suicide, whereas only 25 to 30% had contact with a mental health professional within that same period. And although it cannot be determined that routine screening for suicide has prevented any death, one behavioral healthcare program saw a 65% reduction in suicide rates 20 months after implementing a routine screening protocol.[3] Nevertheless, primary care providers are more likely to see patients experiencing suicidality than mental health professionals. A screening approach sensitive to risk factors, current stressors, and the presence of ideation, plan, intent, and preparatory behaviors, especially for patients experiencing depression, may alert providers to patients who may be at acute risk for suicide.[2]

Lastly, individuals discharged from a psychiatric facility have a suicide rate 300 times higher in the first week and 200 times higher in the first month compared to the general population.[4] Medical and allied healthcare professionals in emergency, behavioral health, and primary care settings thus, have a critical role in identifying patients at elevated suicide risk.

Suicide Terminology

In recent years, the societal vernacular on suicide has changed. Clinicians and researchers are encouraged not to say that an individual "tried to commit suicide" or "committed suicide" because the word "commit" has negative connotations. Instead of "committed" or "completed," it is currently recommended to use the phrase "died by suicide". Furthermore, suicide attempts are no longer categorized as "failed," "unsuccessful," or "successful."[5]

The following definitions are adapted from the CDC, and the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults:[5]

- **Aborted or self-interrupted attempt:** When a person begins to make steps towards making a suicide attempt but stops before the actual act.
- **Affected by Suicide:** All those who feel the impact of suicidal behaviors, including those bereaved by suicide, friends, community, or the actions of celebrities.
- **Bereaved by Suicide:** Family members, friends, co-workers, others affected by the suicide of a loved one. They can also be referred to as survivors of suicide loss.
- **Interrupted Attempt:** When a person is interrupted from carrying out a self-destructive act by another person or outside circumstances.
- **Means/Methods:** The instrument, material, or method used to engage in self-inflicted injurious behavior.
- **Non-Suicidal Self Injury (NSSI):** The intentional injury of one's own body tissue without suicidal intent and for purposes not socially sanctioned, such as carving, cutting, or burning oneself, banging or punching objects or oneself, and embedding objects under the skin.
- **Protective Factors:** Factors that reduce the likelihood that an individual will engage in suicidal behavior.
- **Risk Factors:** Factors that increase the likelihood that an individual will engage in suicidal behaviors.
- **Safety Plan:** A collaborative plan between patient and clinician that contains a written list of warning signs, coping responses, supports, and emergency contacts that an individual may use to avert thoughts, feelings, or impulses or behaviors related to suicide.
- **Suicidal Behaviors or Preparatory Actions:** Acts or preparation toward making a suicide attempt that includes any evidence of intent to die.
- **Suicidal Ideation:** Thoughts of engaging in suicidal behaviors or serving as the agent of one's own death (active ideation), or preoccupation with death or being dead (passive ideation).
- **Suicidal Intent:** Expectation and desire for a self-injurious act to end in death.
- **Suicidal Plan:** Plan of the method, means, time, place, or other details for engaging in self-inflicted injurious behavior with any intent to die because of the behavior.
- **Suicidal Thoughts:** General nonspecific thoughts of wanting to end one's life.
- **Suicide:** Death caused by intentional self-directed injurious behavior with any intent to die.
- **Suicide Attempt:** A non-fatal, self-directed, potentially injurious behavior with any intent to die because of the behavior with or without injuries.

Healthcare Professional Consideration:
Healthcare professionals need to talk about suicide in a non-judgmental way and avoid stigmatizing terms. Hopefully, learning how to talk about suicide can encourage people to seek help.

Myths about Suicide

In society, there are many myths surrounding suicide that may prevent people from getting the help they need. Addressing common myths associated with suicide can help clinicians, researchers and the general population understand the importance of helping others address their mental health challenges by seeking treatment (see Table 1 on the next page).

Healthcare Professional Consideration:
Be prepared to hear suicide myths from patients or the general public. Addressing common myths surrounding suicide can help patients and others realize the importance of seeking treatment to address their mental health challenges.

Epidemiology

Global Suicide Data

The World Health Organization (WHO) recognizes suicide as a top health priority globally. However, it is estimated that more than 700,000 people die by suicide every year in the world. Suicide is the fourth leading cause of death among 15–29-year-olds globally in 2019. Given the sensitivity of suicide and the illegality of suicidal behavior in some countries, there is likely underreporting and misclassifications of deaths, making the availability and quality of suicide data poor.[7]

Suicide does not just occur in high-income countries but is a global phenomenon in all regions. Over 77% of suicides occurred in low and middle-income countries in 2019. Approximately 20% of global suicides result from self-poisoning with pesticides, most of which occur in low and middle-income countries. Other top methods are hanging and firearms.[7]

Table 1. Myths and Facts about Suicide	
Myth	**Fact**
Suicide only affects individuals with a mental health condition.	Many individuals with mental illness are not affected by suicidal thoughts and not all people who attempt or die by suicide have mental illness. Relationship problems and other life stressors such as criminal/legal matters, persecution, eviction/loss of home, death of a loved one, a devastating or debilitating illness, trauma, sexual abuse, rejection, and recent or impending crises are also associated with suicidal thoughts and attempts.
Once an individual is suicidal, he or she will always remain suicidal.	Active suicidal ideation is often short-term and situation-specific. Studies have shown that approximately 54% of individuals who have died by suicide did not have a diagnosable mental health disorder. And for those with mental illness, the proper treatment can help reduce symptoms.
Most suicides happen suddenly without warning.	Warning signs—verbally or behaviorally—precede most suicides. Many individuals who are suicidal may only show warning signs to those closest to them. These loved ones may not recognize what is going on, which may seem like the suicide was sudden or without warning. Therefore, it's essential to learn and understand the warning signs of suicide.
People who die by suicide are selfish and take the easy way out.	Typically, people do not die by suicide because they do not want to live—people die by suicide because they want to end their suffering. These individuals are suffering so deeply that they feel helpless and hopeless. Individuals who experience suicidal ideations do not do so by choice. They are not simply "thinking of themselves," but rather they are going through a severe mental health symptom due to either mental illness or a difficult life situation.
Talking about suicide will lead to and encourage suicide.	There is a widespread stigma associated with suicide, and as a result, many people are afraid to speak about it. Talking about suicide reduces the stigma and allows individuals to seek help, rethink their opinions, and share their story with others. We all need to talk more about suicide.[6]
Note. From Fuller, K. (2020, September 30). 5 Common myths about suicide debunked. National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/September-2020/5-Common-Myths-About-Suicide-Debunked[6]	

United States Suicide Data

The American Foundation for Suicide Prevention (AFSP) similarly proposes that suicide is underreported, and there are challenges in collecting accurate data regarding the number of individuals who die by suicide each year.[8] The National Violent Death Reporting System (NVDRS) is a state-based surveillance system that gathers more than 600 unique data elements from death certificates, coroner/medical examiner reports, law enforcement reports, and toxicology reports.[9]

The AFSP estimates that 47,511 Americans die from suicide each year, making it the tenth leading cause of death in the U.S. This amounts to 130 suicides per day.[8] Suicide is the second leading cause of death in ages 10-24; the third leading cause of death in ages 35-44; and the fourth leading cause of death in ages 45-54. Over seven times as many people died by suicide in 2019 than in alcohol-related motor vehicle accidents.[10]

White, middle-aged males die by suicide at a greater rate than any other population. Males are 3.63 times more often to die by suicide than women. Females are 1.66 times more likely to attempt suicide.[8]

The number of people who think about or attempt suicide is even higher. In 2019, 12 million American adults seriously thought about suicide, 3.5 million planned a suicide attempt, and 1.4 million attempted suicides.[8,11]

The most common means of suicide in the United States is a firearm, followed by suffocation and poisoning. In 2019, up to 50% of suicides involved a firearm, 28% involved suffocation, and 13% involved poisoning.[12] Approximately 75% of firearm deaths were suicides, and 50% of all suicides were caused by firearms.[10] In men and women, firearms are the most common means of suicide. Firearms are the most common method of suicide used by men of all ages, and this is especially true among men aged 65 years and older.[12]

Suicide Risk Factors

Most suicides occur with individuals experiencing depression, substance use disorders, and psychosis.[13] Although research has identified that multiple factors can increase one's risk for suicide, no studies show that one factor or a set of factors is predictive of suicide. Factors that are positively associated with suicide risk include specific demographics, psychiatric illness and comorbidity, suicide-specific symptoms and attitudes, family history, personality disorder/traits, substance use/abuse, severe medical illness, life stressors, suicidal behavior, psychological vulnerability, and access to weapons.[5] Table 2 briefly outlines these risk factors.

Table 2. Risk Factors for Suicide			
Individual	**Relationship**	**Community**	**Societal**
• Previous attempts. • Mental illness, particularly clinical depression. • Social isolation • Criminal problems. • Financial problems. • Impulsive or aggressive tendencies. • Job problems or loss (relational, social, work, or financial). • Serious illness. • Substance use disorder.	• Adverse childhood experiences, such as child abuse or neglect. • Bullying. • Family history of suicide. • Relationship problems, such as a break-up, violence, or loss. • Sexual violence.	• Local epidemics of suicide. • Barriers to accessing mental health treatment. • Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal problem.	• Easy access to lethal methods (firearms, medications). • Stigma associated with mental illness or help-seeking. • Unsafe media portrayals of suicide.
Note. Adapted from U.S. Centers for Disease Control.[14]			

Demographics

Children

A well-characterized risk factor for death by suicide is exposure to early-life adversity, generally defined as parental neglect or childhood physical, sexual, or emotional abuse. Early-life adversity might also be transmitted through families, partly explaining the familial aggregation of suicidal behavior. Young people who die by suicide often have a high burden of adversity and a history of childhood abuse or neglect.[15]

Children are most vulnerable to influences that may eventually lead to suicide. The Adverse Childhood Experiences (ACE) study, first conducted in the mid-1990s, examined the long-term health effects of trauma exposure, violence, and loss during childhood. The higher the person's ACE score, the greater chance of a wide range of chronic health problems, including depression, anxiety, suicide, and PTSD.[16] A study of ACE data showed that ACEs were positively associated with reported suicide ideation and attempts, and the occurrence of at least three ACEs increased the likelihood of suicidal ideation and attempts threefold.[17]

Elderly

Eighty percent of suicide deaths in the U.S. are among men and women aged 45-54. However, the highest rate of suicides occurs among men aged 85 years and older[18] Death by suicide exists among the elderly and is directly linked to symptoms of depression and anxiety.[19] The developmental aspect of older Americans is often overlooked and considered a "natural part" of life; however, it is suspected that isolation, loss of loved ones, and untreated depression contribute to an increased risk of death by suicide in this age group.

Cultural and Geographic Factors

Immigrants

It is essential to recognize that immigrants are at a higher risk for suicide. Risk factors include language barriers, worrying about the family at home, and separation, often leading to hopelessness, depression, and anxiety. Additionally, the lack of information on the way the healthcare system works, loss of status, loss of social networks, as well as acculturation challenges are identified as other potential contributing factors.[13]

American Indian and Alaskan Native populations and Rural Areas

The U.S. suicide rate is highest amongst American Indian and Alaskan Native populations.[5] These ethnic groups tend to live in rural areas where suicide rates are higher compared to urban areas.[20] Rural areas often have lower availability of mental health services because of clinician shortages and social barriers, including stigma and lack of culturally competent care.[21] Geographic origin as a source of variation in the incidence of suicide underscores the importance of implementing suicide prevention strategies in rural areas.

Economic Factors

Suicide and suicide attempts are relatively equal in low-income and high-income countries, with some variance among gender and age groups. In high-income countries, such as the United States, suicide is most common among adults over the age of 45.[18]

Economic crises

Economic crises (e.g., unemployment and decreased personal income) have been positively associated with suicide. Poverty rates have been found to have a strong association with suicide death rates among men and women above the age of 20 years. While initial unemployment has been identified as a risk factor for suicide, it should also be noted that the subsequent poverty and reduced or persistent limited access to resources also contribute to the risk of death by suicide.[23]

Other studies have found that U.S. suicide rates are associated with economic cycles, with the rate decreasing during periods of economic expansion and increasing during contraction. These findings are supported by a study that found that, after controlling for depression, change in financial status was a more significant correlate of suicidal ideation than chronic poverty.[23]

Industry and occupation

Interestingly, suicide rates are also correlated with industry and occupation. The industry groups that have a higher rate of suicide are listed in Table 3.[24]

PLEASE COMPLETE CASE STUDY 1 ON THE NEXT PAGE.

Family and Home Factors

According to the Washington State Department of Health (WA DOH),[15] the emotional toll of a suicide within the family increases the risk of death by suicide in the surviving family members. The data also supports that the risk of suicide attempts is higher in relatives of people who have died by suicide, and that the risk of dying by suicide is higher in relatives of people with a history of suicide attempts.[21] Further, family conflicts, abuse, violence, lack of family connectedness and parents' mental health disorders can also increase an individual's suicide risk. Lastly, a history of foster care or adoption is also linked to higher suicide risk.[25]

Mental Health Factors

Depression and substance use disorders are the most common diagnoses among suicide victims. While depression is a strong risk factor for suicidal ideation and attempts, it lacks specificity as a predictor, and little is known about the specific characteristics that increase this risk. Comorbid psychiatric disorders also correlate with high suicide risk. A study examined comorbid disorders and suicide risk in severe depression/melancholia and found that the most common comorbidity was obsessive-compulsive behaviors, anxiety, and schizophrenia.[17]

Impulsivity is a tendency to act without thinking through a plan or its consequences. It has been linked to suicidal behavior because of its association with mental health disorders and/or substance abuse. Impulsivity also has been associated with aggression and other violent behaviors, including suicide.[26] Multiple other factors, such as alcohol- and drug-related disorders, are common in people who die by suicide and exacerbate underlying risks or interact with depression to increase suicidal behavior.[18]

Patients recently discharged from inpatient psychiatric units are at elevated risk for subsequent completed suicide, especially within the first week of discharge. Although rates decline relative to time after discharge, they do remain higher compared to the non-hospitalized population even several years after discharge, which provides a case for ongoing suicide safety assessments at discharge and several years after a discharge.[27]

Previous studies have shown that 90 to 95% of individuals who die by suicide also suffer from at least one severe psychological problem[5]; consequently, seeking and receiving psychological help is presumed to be a protective factor against suicide.

Table 3. Suicide Rates by Industry and Occupation Groups

Industry	Male	Female
Mining, Quarrying, and Oil and Gas Extraction	54.2	-
Construction	45.3	-
Other Services (such as automotive repair)	39.1	-
Agriculture, Forestry, Fishing, and Hunting	36.1	-
Transportation and Warehousing	29.8	10.1
Construction and Extraction	49.4	25.5
Installation, Maintenance, and Repair	36.9	-
Arts, Design, Entertainment, Sports, and Media	32.0	-
Transportation and Material Moving	30.4	12.5
Protective Service	-	14.0
Healthcare Support	-	10.6

Note. Numbers in Male/Female columns indicate suicide rates per 100,000.

Case Study 1

Instructions: Spend 5-10 minutes reviewing the case below and considering the question and discussion that follows.

You are working in a free clinic dedicated to a largely immigrant population. Your patient, Juan, is a 45-year-old construction worker who recently arrived from Mexico for work opportunities. He left Mexico due to financial hardship, and initially secured financial stability with his local construction position. Juan came in today in hopes of refilling a prescription for his anti-hypertensive medications since he has not yet established care in your area, and he does not have health insurance.

As you speak with Juan during his visit, he tells you that he is learning English, but for the most part, understands very little of the language and feels "lost" in his new surroundings so far. He has strong family and social bonds in Mexico but is alone here. He explains that he had been sending most of his salary back home and had taken great pride in his ability to provide for his family with this position. But, recently the housing market in the area has taken a steep downturn, with a significant decline in the number of new projects and Juan lost his job. Juan expresses dismay that he is having difficulty supporting not only himself in this new environment, but also that he is no longer able to support his family, and becomes tearful when discussing his situation. While Juan has no prior diagnosis of anxiety or depression, he admits to feelings of hopelessness since losing his job.

1. **Although you have just met Juan, take a moment to consider his current risk factors for suicide.** _____

_____

Discussion: While Juan has a strong network of friends and family at his home, his isolation in this country as an immigrant increases his suicide risk. In addition, his age and his profession, construction, have been associated with suicide risk. His recent, sudden, job loss also adds to the risk Juan faces. The feelings of hopelessness are concerning symptoms that warrant further exploration.

Those who do not receive adequate support are at increased risk for continued psychological problems, thereby increasing their risk of suicide.

Evidence-Based Practice:

In 2018, the Australian Rural Mental Health Study investigated the relationship between depression and suicidal behavior. Out of 1051 participants, 364 reported depression in their lifetime. Of these, 48% reported lifetime suicidal ideation, and 16% reported a lifetime suicide attempt. The severity of depression was a significant correlate of suicidality in both men and women, but suicide attempts were significantly more common among females with a younger age of depression onset and with a higher number of psychiatric comorbidities. No additional factors were found for males, making prediction difficult for men.[17]

Social Factors

Social isolation can be a significant risk factor for suicide.[15] Social isolation can occur for certain groups in specific geographic regions. For instance, in a small rural community, the LGBTQIA+ population may be isolated or marginalized, placing these individuals at a greater risk for death by suicide. In another example, questioning youth who are not connected with their family have a significantly higher suicide attempt rate than peers who have a supportive family.[15]

In a broader view, several social factors are associated with an increased risk of suicide: living alone, a high degree of introversion, traumatic events that had occurred in adulthood, and interpersonal stressors. Extreme hopelessness, helplessness, and worthlessness, which may or may not result from depressive disorders, have also been shown to contribute to increased risk.

Sexual Orientation

Sexual orientation has been shown to affect suicide risk. In the 2015-2019 National Surveys on Drug Use and Health, lesbian, gay, and bisexual adults are three to six times more likely than heterosexual adults to have suicidal thoughts, plans, or attempts. This demonstrates the importance of suicide prevention services that address the specific needs of lesbian, gay, and bisexual adults.[28]

Emotional Factors

Bereavement or loss of a close friend or relative, or a loved one can cause a significant amount of emotional distress, which can, in turn, lead to hopelessness and loneliness.[29] Within bereavement groups, those that are bereaved by suicide contribute to the highest risk for suicide.[30]

Physical Factors

Physical Health Conditions

While it is established that mental health disorders are risk factors for suicide, the relationship between poor physical health and suicide risk is unclear.[31] It is known that there is a close relationship between physical and mental health. Individuals with multiple physical health conditions tend to have a lower quality of life and a higher likelihood of a mental health disorder. Numerous studies have suggested that the type and number of physical illnesses are associated with suicide. However, most of the studies are based on small, non-representative samples of the population (e.g., U.S. military veterans).

A recent population-wide study of over one million people in Northern Ireland examined the relationship between physical health and suicide.[31] It showed that activity limitation is a significant factor for suicide risk, even after adjusting for chronic poor mental health. The effect of activity limitation was more pronounced for younger ages.

Sleep Disturbances

For a long time, experts believed that sleep disturbances were risk factors for suicidal ideations and suicidal behaviors.[32] However, a recent study published in 2020 showed that while sleep disturbances (insomnia, poor sleep quality, nightmares) are statistically significant risk factors for suicidal ideation, attempts, and death, these effects only weakly predict suicide. This finding is consistent with a growing body of evidence demonstrating this same relationship.

Traumatic Brain Injury

Athletes and veterans who have sustained multiple traumatic brain injuries (TBI) are vulnerable to suicidal behaviors and suicidal ideations. Regardless of gender, age or comorbidities, studies show that those with TBIs have more suicide attempts, and the risk of attempted suicide increases with the severity of the TBI.[33]

Stigma Surrounding Suicide

Public stigma is a social phenomenon in which members of society have negative attitudes about people with devalued characteristics. Stigma is a term that usually contains three elements: problems of knowledge (i.e., "ignorance"), attitudes (i.e., "prejudice"), and behavior (i.e., "discrimination"). Characteristics associated with suicide include emotional weakness, attention-seeking, selfishness, malingering, and immorality. Those who attempt or die by suicide are perceived to be impious (i.e., "not praying enough") or as betraying family and friends through a cowardly or selfish act.[34] The result of public stigma surrounding suicide can result in fewer observed help-seeking behaviors, and those that have survived suicide may internalize feelings of shame.[35]

Stigma also affects those bereaved by suicide. Research shows that those bereaved by suicide have higher rejection, shame, and blame levels than other bereaved people. This may partly be due to friends and family avoiding or feeling uncertain about approaching someone about their grief and loss. People bereaved by suicide may also find themselves avoiding the conversation about the cause of death due to anticipated stigmatized responses.[35]

Protective Factors in the General Population

According to the Center for Disease Control, there are several factors that can mitigate the risk in a person with a moderate to low risk for suicide. These include[14]:

- Effective coping and problem-solving skills.
- Self-esteem and a sense of purpose and meaning in life.
- Cultural and religious beliefs that discourage suicide.
- Connections to family, friends, and community support.
- Supportive relationships with care providers.
- Availability of physical and mental healthcare services.
- Limited access to lethal means among people at risk.

Healthcare Professional Consideration:
Safety planning and assessment of patients at increased risk for suicide should also include an examination of that patient's protective factors that serve to reduce suicidal acts.

Suicide Warning Signs

Since suicide is a relatively rare event, it is challenging to predict suicide based on risk factors. A recent meta-analysis found that predicting suicide is no better than chance and has not significantly improved over the last fifty years. The goal of identifying warning signs or clinical situations that warrant a suicide assessment is not a prediction but rather to determine an individual's suicide risk (i.e., "low", "medium", or "high") and to plan for informed interventions.[5]

Examples of clinical situations that warrant a suicide assessment include[5]:

- Crisis evaluations in the emergency department.
- Intake evaluations for all patients, especially those with severe mental illness.
- Patients with depression; someone who is either anticipating or experiencing significant loss or stress.
- Patients with certain physical illnesses, especially if life-threatening or associated with severe or chronic pain or loss of function.
- Significant clinical change (increase in suicide ideation, suicidal behavior, change in mental status, unstable mood, impulsiveness, trauma victimization)
- Regarding inpatient care settings, a change in privilege level, when there is a deterioration in mental status, and before discharge.

Warning signs are verbal expressions, changes in behaviors, or new behaviors that may indicate that a person is suicidal. The more of these warning signs a person displays, the greater the risk of suicide.[36]

Adult warning signs include[5]:

- Talking about wanting to die.
- Looking for a way to kill oneself.
- Talking about feeling hopeless or having no purpose.
- Talking about feeling trapped or being in unbearable pain.
- Talking about being a burden to others.
- Talking about great guilt or shame.
- Increasing the use of alcohol or drugs.
- Acting anxious, agitated, or reckless.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Daring or risk-taking behavior.
- Experiencing severe mental pain.
- Depression.
- Severe anxiety, panic attacks.
- Displaying extreme mood swings.
- Showing rage or talking about seeking revenge.
- Giving away prized possessions.
- Saying a final goodbye to family and friends.
- Putting affairs in order.
- Lack of interest in future plans.

Youth warning signs include[5]:

- Talking about or making plans for suicide
- Expressing hopelessness
- Displaying severe emotional pain or distress
- Showing worrisome behavioral cues or marked changes in behavior, such as:
  - Withdrawal from or change in social connections, including extracurricular activities and school performance
  - Changes in sleep
  - Anger or hostility that is out of character or out of context
  - Recent increased agitation or irritability
  - Risk-taking behavior or alcohol/drug use

Healthcare Professional Consideration:
It is important to note that the risk of suicide is greater if the warning sign is new, has increased, is after a perceived or experienced emotionally challenging event, or is associated with the acute onset of mental illness[5].

PLEASE COMPLETE CASE STUDY 2.

Case Study 2

Instructions: Spend 5-10 minutes reviewing the case below and considering the question and discussion that follows.

While seeing patients in your primary care office, you are happy to see that Laura is your next patient. She has recently returned to the area - you had been her physician for several years in the past. Laura is a veteran who recently was discharged from the military after serving for the last 10 years. During a training exercise, she suffered a traumatic brain injury for which she currently receives partial disability. You know from your previous relationship with Laura that she identifies as lesbian, and you have also cared for her partner in the past.

As you enter the room, you are somewhat surprised by Laura's appearance. She appears slightly disheveled, which is out of character for her. She tells you that recently, a close friend from her previous unit committed suicide. Laura does have a history of depression and recently has been having difficulty sleeping.

1. Which of Laura's risk factors is least likely to predict suicidal behavior?_____

Discussion: Research has shown that insomnia is only weakly associated with suicide risk. Veterans, those with history of traumatic brain injuries, lesbian, gay, and bisexual, and those with a history of depression are shown to be at increased risk. Finally, those that are bereaved by suicide contribute to the highest risk for suicide among bereavement groups.

Suicide Screening

"Screening" and "assessment" are not synonymous. "Screening" is a method to identify those at increased risk for a specific condition or disorder and who could benefit from further evaluation[5]. "Suicide screening" is often a quick and standard procedure to identify individuals at risk for suicide. The method may be a standard form in a clinic, provider office, or the emergency department triage area. Often, suicide screening takes 15 minutes or less to conduct.

On the other hand, "assessment" is more comprehensive than screening and provides a more thorough conceptualization of an individual.[5] Assessments may include screenings, but these screening measures are used with other information to form an assessment or evaluation of the patient.

U.S. Preventive Task Force Recommendations

The U.S. Preventive Services Task Force (USPTF)'s most current recommendation for suicide screening is from 2014. As of September 2022, the USPTF is updating its current recommendation statement for suicide risk screening in adolescents, adults, and older adults. The existing recommendation states that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in a primary-care setting. It is important to note that this recommendation applies to individuals who do not have an identified psychiatric disorder.[37]

Joint Commission Recommendations

As of July 2019, the Joint Commission suggests that screening in some select environments for individuals with certain presenting complaints may indicate standard screening. The details of the recommendation are as follows[38]:

- Conduct an environmental risk assessment to identify features that could be used to attempt suicide.
- Screen all patients for suicide ideation using a brief and standardized screening tool.
- Use an evidenced-based process to perform a suicide risk assessment of those who have screened positive for suicidal ideation.
- Document an individual's overall level of risk for suicide and a plan to mitigate the risk.
- Follow policies and procedures regarding the care of individuals identified at risk for suicide. At a minimum, these should include:
    - Training and competence assessment of staff who care for patients at risk for suicide.
    - Guidelines for reassessment.
- Follow policies and procedures for counseling and follow-up care at discharge for patients identified at risk for suicide.
- Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide.

Suicide Risk Assessment Model

Individuals within the healthcare team must understand their role in suicide assessment and prevention within their organization. While each organization will differ, healthcare professionals should consider their role within the organization related to the Suicide Risk Assessment Model. The best practice would be for each role to flow to the following individual in the organization. As part of the routine screening, a behavioral health questionnaire should be given to each patient who presents to their primary healthcare provider to collect data regarding their psychological well-being.

A typical clinical protocol involves a healthcare team member deciding whether the Patient Health Questionnaire-9 (PHQ-9) or other behavioral health screening is indicated for a particular patient. Upon receiving the patient into the office, if they are identified as needing this screening, the medical assistant will ensure it is completed and scored. If the suicidality question on the PHQ-9 is positive, then the medical assistant will administer the Columbia-Suicide Severity Rating Scale (C-SSRS) questionnaire. Both assessment documents are then placed in the electronic medical record.

The primary healthcare provider will review the results with the patient and discuss the patient's present symptoms. The provider should contact a behavioral healthcare provider and, in the interim, conduct any needed safety planning and consider restricting access to lethal means. The primary healthcare provider will also engage the patient regarding strategies for managing depression symptoms. It is also vital to always encourage participation and facilitate a warm hand-off to the integrated behavioral health provider.

A licensed behavioral health provider needs to be available for urgent consultation of an acutely suicidal patient. The role of the behavioral health provider is to see patients for treatment or to determine if the patient is appropriate for specialty behavioral treatment. An integrated approach to behavioral health is imperative for the successful outcome of the patient who presents with depression symptoms or suicidal ideations.

Suicide Screening Tools

Screening an individual for suicidal risk involves several equally important factors:

1. Establishing rapport with the individual to determine an honest assessment.
2. Using an evidence-based screening tool that is appropriate for the individual and the situation.
3. Knowing what to do with the information collected.

Suicide screening tools are standardized and brief. Screening personnel may administer them and take less than 15 minutes to complete. The screener needs to ask all questions in a screening tool precisely. Should an individual show "at-risk scores or indicators," they require a full suicide assessment by a behavioral health provider.

ASQ – A Suicide Risk Screening Tool

The Ask Suicide-Screening Questions (ASQ) is a free resource for emergency departments, inpatient medical/surgical units, and outpatient clinics or primary care units by the National Institute of Mental Health (NIMH). This four-question tool takes about 20 seconds to administer[39]:

1. *In the past few weeks, have you wished you were dead?*
2. *In the past few weeks, have you felt that you or your family would be better off if you were dead?*
3. *In the past week, have you been having thoughts about killing yourself?*
4. *Have you ever tried to kill yourself? If yes, how?*

In addition to the screening tool, the NIMH designed a script for nursing staff that introduces the screening tool as well as what to say if a risk for suicide is identified. The script is located along with the tool on the following website: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

The Patient Health Questionnaire 2

The Patient Health Questionnaire 2 (PHQ-2) is designed to screen as a first step approach for depression in the primary healthcare setting. The PHQ-2 is a simple tool containing two questions, enhancing routine inquiry about depression, the most prevalent and treatable mental disorder in the primary care setting. The PHQ-2 questions are the first two questions of the PHQ-9 tool[40]:

"*Over the past 2 weeks, how often have you been bothered by any of the following problems?*

1. *Little interest or pleasure in doing things?*
2. *Feeling down, depressed, or hopeless?*"

The patient indicates the frequency in which they experience these prompts on a 4-point scale of 0 ("Not at all"), 1 ("Several days"), 2 ("More than one-half of the days"), and 3 ("Nearly every day")[40]. One concern about this approach is that a patient may answer 'no' to the two questions but still have suicidal thoughts. Organizations should consider adding an additional question to the PHQ-2 assessing suicide risk, such as "Over the past 2 weeks, have you been bothered by: Thoughts you may want to kill yourself or have you attempted suicide?" Individuals who screen positive on the PHQ-2 need to be further evaluated with the PHQ-9 to determine their risk for a depressive disorder[40]. View the PHQ–2 at https://www.med-iq.com/files/noncme/material/pdfs/LI042%20IG%20tools.pdf

The Patient Health Questionnaire 9

The Patient Health Questionnaire 9 (PHQ-9) is a multipurpose tool for screening, diagnosing, monitoring, and measuring the severity of a patient's depression in the primary healthcare setting[41]. The tool rates the frequency of symptoms and then factors into the scoring severity index. The survey asks nine questions about depression and suicidal ideation over the past two weeks.

Question 9 on the tool screens for the presence and duration of suicide ideation. A follow-up questionnaire on the PHQ-9 assigns weight to the degree that the depressive problems are affecting the patient's level of function. The PHQ-9 is easily completed by the patient and quickly scored by the healthcare provider. It can be used repeatedly to determine improvement or worsening of depression in response to treatment.[41] View the PHQ -9 at https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf.

Suicide Assessment Five-Step Evaluation and Triage

The Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) interview contains more extensive items that may yield more detailed information about a patient's suicide risk.[40] This screening tool may be more useful in an outpatient behavioral health setting. It consists of the following five steps[42]:

1. Identify risk factors (suicidal behavior, current/past psychiatric disorders, key symptoms, family history of suicide, stressors, change in treatment, access to firearms)
2. Identify protective factors (both internal and external factors)
3. Conduct suicide inquiry

- Ideation: frequency, intensity, duration in the last 48 hours, past month, and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals, non-suicidal self-injurious actions
- Intent: extent to which the patient expects to carry out the plan and believes the plan to be lethal versus self-injurious. Explore ambivalence of reasons to die versus reasons to live.

4. Determine the risk level of suicide with the appropriate intervention
5. Document the risk level, rationale, treatment plan, and a follow-up plan.

View the SAFE-T Pocket Card at https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432

Patient Safety Screener 3

The Patient Safety Screener 3 (PSS-3) is a three-item screening tool used in acute care settings where patients remain under constant care (Table 4).[43] It has been validated for use in the emergency department for patients 18 years and older and can be administered to all patients, not only those with a risk of suicide.

The PSS-3 is interpreted as follows[43]:

- Yes to question 1. This indicates depressed mood.
- Yes to question 2. This indicates active suicidal ideation.
- Yes to question 3. This indicates a suicide attempt.

Table 4. Patient Safety Screener

Over the past two weeks,	
…have you felt down, depressed, or hopeless?	— Yes. — No. — Patient unable to complete. — Patient refused.
…have you had thoughts of killing yourself?	— Yes. — No. — Patient unable to complete. — Patient refused.
In your lifetime,	
…have you ever attempted to kill yourself?	— Yes. — No. — Patient unable to complete. — Patient refused. — If yes, when did this happen? — Within the past 24 hours (including today). — Within the last month (but not today). — Between one and six months. — More than six months ago. — Patient unable to complete. — Patient refused.

View the Patient Safety Screener 3 (PSS-3) at https://sprc.org/micro-learning/the-patient-safety-screener-a-brief-tool-to-detect-suicide-risk

Columbia-Suicide Severity Rating Scale (C-SSRS)

The C-SSRS is one of the most used screening tools. This tool assists the screener in determining whether someone is at risk for suicide, the severity or imminence of that risk, and what level of support the individual needs. The screener will ask the individual if and when they have thought about suicide; which actions they had taken to prepare for suicide and when; and if and when they attempted suicide (whether it was interrupted or if they stopped on their own). Individuals and organizations establish criteria or thresholds that determine what steps need to be taken following the screening. A crisis plan and referral options are a part of the follow-up. The scale, as well as training on how to use the tool, is available free of charge for use in the community and healthcare settings and is available in 140 languages.[44] View the Columbia-Suicide Severity Rating Scale (C-SSRS) tool at https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

Beck Depression Inventory-II (BDI-II)

The BDI-II depression screening evaluates the individual's characteristic attitudes and symptoms of depression over the previous two-week period.[45] The tool is widely used and has been validated for use with both adults and adolescents.

Beck Scale for Suicidal Ideation (SSI)

The SSI tool measures active and passive suicide desires and preparation steps that may have been taken.[45] Any positive responses indicate the need for further detailed questioning.

Beck Hopelessness Scale (BHS)

The BHS tool takes about five minutes to complete and is based on pessimism, hopelessness, and suicidal risk.[45] Hopelessness is a strong predictor and is a stronger indicator than the severity of depression. If the screening indicates a risk for hopelessness, the provider should conduct a more detailed suicide assessment. Unlike a screening, a full suicide assessment requires a skilled professional who has additional training for assessing at-risk individuals.

Using a tool is only half the assessment process. The evaluator must use the information from the screening and assessment tools, as well as the words, gestures, and non-verbal behavioral information from the individual, to evaluate the information and determine the individual's level of risk for carrying out the suicide action.

Suicide Assessment

A suicide assessment is a more comprehensive evaluation than screening and is performed by a clinician to confirm suspected suicide risk, estimate the imminent danger to the patient, and decide on a course of treatment. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a patient and/or friends and family to gain insight into the patient's thoughts and behaviors (e.g., related to depression, suicide), risk factors (e.g., access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.

Establishing rapport

Establishing rapport with the at-risk individual may be the most challenging part of the assessment process. Being skilled and focused is an essential factor for the evaluator. It is important that the assessor gives the individual privacy, shows them concern, and makes them aware that they want to know what is currently happening. The act of asking about suicide can be therapeutic and can make a person feel understood, accepted, and connected to their clinician.[5]

The evaluator should use active listening and make eye contact with the individual (Table 5). Active listening is an important skill that requires time and practice. It is an essential component of a productive discussion because it allows for the respectful exchange of ideas.[46]

Here are some recommendations to improve active listening skills[46]:

- Listen to fully understand what is being said to you.
- Rephrase what you heard the person say so you can be sure you heard correctly.
- Ask questions that help you get more information (e.g., "What did you mean when you said ...?")
- Offer encouragement and support.
- Ask how the person feels. Be careful not to assume that you know how the person feels.

Structuring the assessment interview

If significant risk factors are present or any suicide warning signs are evident, the healthcare worker must conduct a suicide assessment. It is important to ask patients directly about suicide and obtain additional information from family members, friends, other clinicians, EMS personnel, and appropriate others. When conducting a suicidal inquiry, healthcare professionals must use a non-judgmental, non-condescending, matter-of-fact approach.

Individuals at elevated risk for suicide may be guarded during an interview or may respond with vague language prompting the interviewer to probe and inquire further. See Table 6 for examples of these statements as well as possible responses.

Healthcare Professional Consideration:

When assessing a patient for suicide, healthcare professionals need to demonstrate self-awareness of their emotional reactions, attitudes, and beliefs related to suicide.

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Understanding Levels of Suicide Risk

It is estimated that in 2019, 12 million Americans seriously thought about suicide (CDC, 2021d). Unfortunately, there is no specific way to predict who will attempt suicide, although we try and identify prognostic factors. According to the American Psychological Association (APA) , while the elderly makes up only 13% of the population, they account for 20% of individuals who die by suicide. In addition, 75% of older adults who die by suicide have seen their physician within the last month.[19]

Table 5. Active Listening Techniques[47]

Communication Blockers	Communication Enhancers
Blaming and attacking.	Asking for more information and problem solving together.
Being distracted or using other body language that is not-attentive.	Making eye contact, leaning toward the other person, giving full attention.
Dismissing or making light of someone's problems.	Showing empathy, validating the other person's feelings.
Interrupting.	Staying silent until the person is finished speaking.
Lecturing / memorializing.	Withholding judgment.
"Yes…but" statements.	"Yes…and" statements.

Note. Adapted from Tutu and Franklin: A Journey Toward Peace. (2000). PBS. https://www.pbs.org/journeytopeace/meethope/index.html[47]

Table 6. Common Individual Statements and Appropriate Responses[48]

The Individual's Statement	Possible Responses
Everyone will be better off without me.	Who would be better off? What would be better for those people? Where are you planning to go?
I just can't bear it anymore.	What is so hard to bear? What would make your life better? When did you begin to feel this way?
I just want to go to sleep and not deal with anything again.	What do you mean by "sleep?" What is it that you don't want to deal with anymore?
I want it to be over.	What is it that you want to be over? How can you make it be over?
I won't be a problem much longer.	How are you a problem? What is going to change in your life so that you won't be a problem any longer? When will you no longer be a problem?
Things will never work out.	What can you do to change that? What, then, do you propose to do?
It is all so meaningless.	What would make life more meaningful? What are some aspects of your life that make it worth living? What is happening in your life that makes it so meaningless?

Note. Adapted from Videbeck, S. L. (2017). Psychiatric-mental health nursing (7th ed.). Philadelphia, PA: Wolters Kluwer.[48]

Case Study 3

Instructions: Spend 5-10 minutes reviewing the case below and considering the question and disscusion that follows.

While working an evening shift in the Emergency Department, your next patient, Cindy, presents with a chief complaint of "Headache". While reviewing the chart, you noticed that during the suicide screening done at triage, the patient answered "Yes" to the question, "Over the past two weeks have you had thoughts of killing yourself?" Upon review of Cindy's records, you note that she has had a dozen visits for non-specific complaints like "weakness", "back pain", and "headache." Entering Cindy's room, you notice that she maintains little eye contact.

1. **What are some elements of Cindy's case that would increase your concern about her? Consider ways you might approach her to adequately evaluate her risk for suicide.** _____

Discussion: After evaluating her headache complaint, you ask "What did you mean when you stated you had thoughts of killing yourself?" You sit down, giving her your full attention. Although initially reluctant to explain, your empathetic yet persistent tone reassures her that assistance is available. She shares that she is severely depressed and has planned in the past to hang herself because she cannot bear the pain any longer. You persuade her that speaking with a mental health professional will help her start healing, and contact the psychiatrist on duty to perform a suicide assessment.

In recognizing the risk to all age groups, it is imperative that healthcare workers accurately assess for suicidal ideation. To do this, healthcare workers must:

- Identify individual risk factors.
- Use appropriate screening and/or assessment tools to determine suicide risk.
- Identify levels of risk.

Healthcare workers must be aware of risk factors that make a person vulnerable to suicidal ideation (SI). Suicidal thoughts and behaviors are linked to many different circumstances, including illness and life stressors—notably periods of crises, such as illness, chronic pain, financial stress (particularly sudden financial stress or loss, compared to chronic poverty), and relationship breakups.[15,19]

According to the WHO, the strongest predictor of suicide is one or more previous attempts.[7] Suicide and mental disorders, such as depressive disorders and substance use disorders, have been well-established as linked to death by suicide, particularly in high-income countries. Alcohol consumption is a significant risk factor associated with suicide and has been identified as the fifth-leading worldwide risk for disability-adjusted life year (DALY), a time-based measure that combines years of life lost due to premature mortality and disability. It remains the leading risk factor for suicide among individuals between the ages of 14 and 49 years.[15]

Often, patients who have attempted suicide are discharged with no community support or appropriate follow-up, making them vulnerable to reattempting suicide. In low-resource settings, geographic inaccessibility to healthcare facilities and the absence of trained professionals have been identified as potential obstacles.[15]

Evidence-Based Practice

A history of a previous suicide attempt places an individual at high risk for suicide and is the strongest predictor of suicide. A study examining medical records from 1987 to 2007 identified 1490 individuals with a first suicide attempt reaching medical attention. More than 59% died immediately from the first suicide attempt, and amongst those who survived, 85% killed themselves within one year.[2]

Classifying risks

There are various ways of classifying specific levels of risk. Zero Suicide identifies three levels of risk within the two categories of acute and chronic: low, intermediate, and high. The following algorithm to help clinicians identify and understand levels of risk based on acute or chronic SI (Table 7).[49]

Appropriate actions for different levels of risk

Zero Suicide offers the following guidelines for specific actions according to their respective levels of risk (See Table 8 on the next page).[49]

PLEASE COMPLETE CASE STUDY 4 ON THE NEXT PAGE.

Table 7. Levels of suicide risk

Acute	Chronic
High risk: Patients have suicidal ideation with the intent to die by suicide. They are unable to maintain safety without external support.	**High risk:** Patients with chronic suicidal ideation and an increase or change in baseline mood, behavior or talk about suicide/dying.
Intermediate risk: Patients have suicidal ideation, but no intent based on identified reasons for living (ie children) and ability to follow a safety plan and maintain safety. Preparatory behaviors are likely absent.	**Intermediate risk:** Patients with chronic suicidal ideation but have protective factors, coping skills, reasons for living and psychosocial stability suggesting the ability to endure future crisis without resorting to suicide.
Low risk: Patients are identified to be at low risk if they have suicidal ideation, but do not currently have a plan for suicide or suicidal behaviors. Another feature is collective high confidence (from patient, care provider, family member) in the ability of the patient to maintain safety independently.	**Low risk:** Patients with chronic suicidal ideation but have abundant strengths and resources. The following is generally NOT present: history of self-directed violence; chronic SI; highly impulsive; risky behaviors; marginal psychosocial functioning.

Note. Adapted from Zero Suicide. (2019). Therapeutic risk management – Risk stratification table.[49] https://zerosuicide.edc.org/sites/default/files/Risk%20Stratification%20Table%20MCHGM.pdf

Table 8. Actions according to level of suicide risk	
Acute	**Chronic**
High risk: Requires psychiatric hospitalization to maintain safety. These patients need to be observed on a secure unit and kept in an environment with limited access to lethal means.	**High risk:** These individuals require a calculated risk assessment; routine mental health follow ups; a safety plan; routine suicide risk screening; coping skills building; management of co-occurring psychiatric disorders, and evidence-based treatment for suicide.
Intermediate risk: Consider psychiatric hospitalization if related risk factors are responsive to inpatient treatment (i.e., psychosis). If patients are treated in an outpatient setting, there should be increased contact; regular re-assessment of risk; a safety plan in place.	**Intermediate risk:** These individuals require routine mental healthcare to maintain or enhance coping skills and protective factors; a safety plan; management of co-occurring psychiatric disorders, and evidence-based treatment for suicide.
Low risk: Outpatient treatment should include behavioral health services and a well-articulated safety plan.	**Low risk:** These individuals may seek treatment on a regular or an as needed basis. Some may be managed in primary care.
Note. Adapted from Zero Suicide. (2019). Therapeutic risk management – Risk stratification table.[49] https://zerosuicide.edc.org/sites/default/files/Risk%20Stratification%20Table%20MCHGM.pdf	

Case Study 4

Instructions: Spend 5–10 minutes reviewing the case below and considering the questions and discussion that follow.

(Rationale and discussion is displayed at the bottom of this exercise)

Mrs. B. is a 35-year-old married woman with two children (ages 10 and 15). She presents for an annual checkup at her primary care physician. She appears uncomfortable and refuses to make eye contact with the front desk nurse, with whom she is usually friendly. She has been seeing Dr. Duke, but she is scheduled to see his partner, Dr. Cook, this afternoon because Dr. Duke is on vacation. Dr. Cook's nurse, Joan, notices that Mrs. B. is not her usual self and appears "out of it" today and is somewhat irritable. She seems to have burn marks on her arms but is wearing a long-sleeved shirt and dismisses the marks saying: "I burned myself on the oven." When asked by the nurse, Mrs. B denies suicidal ideation; however, there was no additional follow-up with a screening or assessment tool to determine the appropriate level of risk. Mrs. B reports to the nurse that she has not been sleeping, doesn't have much appetite, and is struggling to get her husband to understand her needs "since he is so busy with his job and an affair" and her parents have moved 500 miles away. Mrs. B. has a history of depression diagnosed as postpartum depression after her second child was born. Her second child is now 10 years old, and she has no documented depressive symptoms. Of note, during the postpartum period, she had one suicide attempt. Dr. Cook is extremely busy today, and when Joan brings up Mrs. B.'s apparent depressed mood to his attention, he is extremely dismissive and remarks that her history of depression and prior suicide attempt was a thing of the past. Two weeks later, Mrs. B. is found by her older son after attempting to hang herself. She was admitted to the intensive care unit at the local hospital.

1. **Based on the information provided, Mrs. B. falls into the following category of risk:**
   - A. Low risk.
   - B. Moderate risk.
   - C. High risk.
   - D. None of the above.

2. **Which of the following is the strongest predictor of Mrs. B.'s current suicide attempt?**
   - A. Postpartum depression.
   - B. Previous suicide attempt.
   - C. Isolation.
   - D. Being married.

3. **Mrs. B. came to see her primary healthcare provider for her annual checkup. Based upon the previous reading, what percentage of individuals see their primary healthcare provider within one year of a suicide attempt?**
   - A. 80%.
   - B. 55%.
   - C. 65%.
   - D. 35%.

Rationale for Question 1: Patients at high risk most likely have a suicide plan with preparatory or rehearsal behavior.

Rationale for Question 2: While her history of postpartum depression and isolation are concerns that she may attempt suicide, the previous suicide attempt is the strongest predictor for the current suicide attempt.

Rationale for Question 3: According Schreiber and Culpepper2, 80% of individuals who die by suicide have had at least one contact with their primary healthcare provider within one year of dying by suicide.

Case Study 4 (Continued)

Discussion: Upon reviewing Mrs. B.'s history, the attending physician noted that she had reported that her husband had been engaged in an extramarital affair three months earlier. Mrs. B provided several "hints" in her discussion with the nurse, which were not included in her chart, and they included: her parents' relocation, lack of time spent with husband /affair of her husband, isolation, lack of sleep, and poor appetite. She had tried to cope with these stressors on her own, and although she saw a counselor monthly, she intentionally kept that information from the counselor at her last visit two months prior. Also, she had canceled her last two counseling sessions but did call a suicide hotline three weeks before her attempted suicide. The suicide hotline tried to follow up and check in with her, but she was dismissive and refused to take their calls. In addition to her primary care physician, she saw her gynecologist four weeks before her suicide attempt. Her gynecologist noticed that she was not her usual self, but when she pressed her, Mrs. B. reported that her therapist was adjusting her antidepressant dose and that she would be fine in a few weeks.

In conclusion, Mrs. B. had four interactions with healthcare professionals within the three months leading up to her suicide attempt. Although two of those providers recognized a change in her presentation, they did not fully appreciate the severity of her distress. The challenge with caring for patients who see multiple providers is that communication among providers in different health systems can be highly challenging. Often, providers have to rely on the patient's self-report for accurate communication of updates and pertinent findings.

In retrospect, her son—who knew that his mother had previously attempted suicide —was aware that she had contacted the suicide hotline before her second attempt, but he did not want to betray her confidence by reporting his suspicion to anyone who could have potentially intervened. Clearly, there is a need for continued education regarding mental illness and how it affects families. Also, patients with children who are old enough should be encouraged to share their diagnosis with families and encourage their families to use a support system as much as they feel comfortable.

Lastly, the nurse could have been more proactive and screened Mrs. B. for suicidal ideation and intent during her last visit. She had some context and a better understanding of Mrs. B.'s history than the physician filling in. She chose to defer to Dr. Cook's authority and failed to act on her clinical judgment. In addition, she could have reported her suspicions to Dr. Duke when he returned from his vacation four days after her visit.

Documentation

Careful documentation of assessing and managing a patient's illness is part of legal and ethical psychiatric care.[50] It also allows communication about changes of a patient's risk level that can inform their treatment plan.[5]

Documentation of Risk Assessment

Documentation must be thorough and objective. Healthcare providers should never express opinions or make judgments, such as, "Patient is completely irrational." Instead, inputting the patients' exact words in quotation marks (e.g., Patient states, "You are the ones who are crazy, and I am going to kill myself to get away from everyone and everything.") is recommended.

Sadek details the important components of documentation, which includes[50]:

- The date of an assessment.
- The reasons for the assessment.
- Risk factors for suicide.
- Protective factors that may reduce suicide risk.
- The patient's suicide risk level.
- Basis for the risk level and plan.
- Action taken regarding firearms and other means of suicide.
- The steps put in place given the patient's specific constellation of risk and protective factors.
- Contact details for the patient, relatives, and treating professionals.

Documentation is a clinical tool critical to the initial assessment and periodic reassessment informed by the patient's risk level. Because risk fluctuates over time, suicide assessment should not be seen as a one-time, isolated event. If an individual is determined to be at elevated risk for suicide, appropriate consultation, referral, and follow-up is important to continue to monitor across time.

Healthcare Professional Consideration:

When documenting a patient's risk for suicide, the healthcare professional should also document their communication to the treatment team and appropriate persons (i.e., on-duty doctor, nursing supervisor).

Treatment and Management of Suicide

The treatment and management of suicide are complex, and clinicians must develop a biopsychosocial treatment plan which is critical for the appropriate management of patients at elevated risk for suicide. A thorough biopsychosocial assessment can help inform the healthcare worker's conceptualization and facilitate a discussion on social support resources available to the patient. Under some circumstances, it can be beneficial for the healthcare worker to include family members or other supportive resources in the patient's treatment plan.

Patients seen in any medical setting who present as imminent harm to themselves or others must be immediately referred to a psychiatrist, psychologist, or other qualified healthcare provider. As an example, first responders and emergency room staff should be appropriately trained to care for patients at elevated risk for suicide. An empathic approach is indispensable in this case. Emergency room staff and first responders must be aware of any biases toward persons living with suicidal thoughts or behavior, including religious or philosophic beliefs, lack of formal psychiatric training, or limited resources, including time or staffing shortages. The challenge is identifying patients safe enough to be discharged without hospitalization in an emergency setting. Some emergency departments have mental health professionals on call to help evaluate patients identified as at risk of suicide and determine those safe enough to return home.[51]

When an individual attempts suicide, medical stabilization at a hospital is the priority. If the patient experiences physical trauma, the appropriate surgical service should be contacted. If the attempt involves drug ingestion, the patient must undergo detox and receive antidotes.[5]

Levels of Care

There are four levels of care for a patient with varying levels of suicidality as it pertains to ideation, plan, intent, preparatory behaviors, and previous attempts[5]:

- Outpatient.
- Intensive outpatient program.
- Partial hospital program.
- Inpatient hospitalization.

Outpatient Treatment

The appropriateness of outpatient treatment is contingent on a thorough assessment of a patient endorsing suicidality to include current stressors in a safety plan. Patients who are eventually discharged from the inpatient setting must have an appropriate outpatient follow-up with mental health providers.[51] Follow-up should be set up as soon as possible, within a few days of discharge. Given that compliance with follow-up appointments may be low, family members' use in helping patients comply is greatly encouraged. Family members and friends can also be engaged to help reduce a patient's access to lethal means of suicide. Particular attention should be paid to the patient's documented suicide plan, and appropriate interventions should be implemented. These strategies include removing potential means of suicide from the home—guns, medications, or other toxic substances—as appropriate. Finally, proper documentation of the patient's progress in the inpatient setting will help guide and inform decisions in the outpatient setting.[51]

Treatment of patients at risk for suicide should be chosen based on their underlying mental illness and the manifestation of suicidal behaviors.[51] For example, chronic suicidal behaviors should be treated with interventions based on psychotherapy, whereas acute suicidal behaviors should be treated with more aggressive interventions (i.e., increased frequency of therapy and/or psychopharmacologic medications).

Partial Hospitalization and Intensive Outpatient Care

Partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs) are structured mental health treatment programs that are a step down from 24-hour care in an inpatient hospital. The main difference between PHPs and IOPs is the length of time. Partial hospitalization programs are at least four hours a day and at least five days a week; IOPs are a few hours per day and a few days per week. Patients who have an elevated risk of suicide that is not imminent but require aggressive treatment would benefit from these programs.[51]

Inpatient Hospitalization

Any patient at imminent risk for suicide, including a recent suicide attempt, should be referred to psychiatric inpatient hospitalization. Inpatient care offers medically supervised care in a hospital setting 24 hours a day, seven days a week, and an average stay for a patient usually ranges from 48 hours to ten days.[4] The goal of inpatient hospitalization is to conduct an evaluation, initiate therapy and/or medications, and stabilize the patient until they are safe and eligible for a lower level of care.[2]

Factors that can place a patient at high risk of suicide include[2]:

- Suicide attempt with a highly lethal method (firearm or hanging).
- Suicide attempt that includes steps to avoid detection.
- Ongoing moderate-severe suicidal ideation or disappointment that a suicide attempt was not successful.
- Inability or reluctance to honestly discuss the suicide attempt and what precipitated it.
- Inability or reluctance to openly discuss safety planning.
- Lack of alternative interventions for monitoring and treatment.
- Agitation.
- Hopelessness.
- Impulsivity.
- Poor social support.
- Psychiatric disorders: anxiety disorders, bipolar disorder, personality disorder, PTSD, psychotic disorders, and substance use disorders.

If a patient cannot be immediately hospitalized in a psychiatric inpatient unit, they should be kept in a room where all sources of potential harm are removed, and a staff member should be providing constant supervision.[2] Patients identified with suicidal thoughts and behaviors in most clinical settings are assigned a dedicated "safety attendant" to watch them. This intervention often decreases the need for restraints for most patients. The use of family members is highly discouraged because family members may connive with patients to make plans to leave against medical advice or violate a legal hold, or if they see a patient leaving, they may not try to stop them.[53] Security staff may be necessary if the patient insists on leaving.[2]

Mechanical and chemical restraints should be used judiciously in suicidal patients. The use of restraints should be minimized when possible. However, the use of restraints may be essential and potentially lifesaving for situations wherein the patient is combative or otherwise uncooperative. All restrained patients must be assessed per hospital protocol. Often, documentation of the neurovascular status of the restrained patient must be performed. Finally, a re-evaluation of the need for restraints should be performed per hospital protocol.[51]

If the patient needs to be transferred to a hospital on a psychiatric hold, an ambulance should be used, and the paramedics should be aware of the suicide risk.[2]

Involuntary Hospitalization

If a patient refuses to be hospitalized despite being a risk to themselves or others, involuntary hospitalization may be necessary. The process of committing a patient to hospitalization varies from state to state in the U.S.[2] If a patient is admitted involuntarily, they maintain autonomy to consent for treatment. The only medications that can be administered without consent are those that are required to stabilize the patient during a behavioral crisis. If other medications are deemed necessary, a clinician must obtain court-ordered treatment.[2]

Transition from Inpatient to Outpatient Care and Continuity of Care

In the U.S., one out of seven people (or 14%) who died by suicide had contact with inpatient mental health services in the year before their death (National Action Alliance for Suicide Prevention, 2019). The transition from inpatient to outpatient behavioral care is a critical time for patients who are at risk for suicide. In the month after a patient is discharged from inpatient care, the suicide death rate is 300 times higher (in the first week) and 200 times higher (in the first month) than the general population. The suicide risk remains high for up to three months, and sometimes up to a year, after discharge.[4]

The following evidence-based recommendations guide care for an individual with elevated suicide risk during the transition from inpatient to outpatient care[4]:

- **Work as a collaborative team.** Both inpatient and outpatient teams should work as a unified team and employ a patient-centered approach that involves the providers, the patient, and the family. This collaboration can help patients navigate the gap between care settings.
- **Cultivate human connection.** Encourage contact between the outpatient provider and the patient prior to discharge. Make use of certified peer specialists and others who have lived experiences to support both the patient and the family.
- **Build bridges.** Establish and follow protocols to triage appointments and arrange for rapid referrals for patients. Write formal agreements between inpatient and outpatient provider organizations to clarify their roles, responsibilities, and commitments to rapid referrals. Develop strategies for narrowing the gap in the care transition. Lastly, maintain good communication between organizations to provide optimal patient care.

Recommendations for Inpatient Providers

Due to the nature of increased suicide risk following an inpatient discharge, it is crucial that patients receive an outpatient appointment or other mental health services as soon as possible after discharge. Prior to discharge, inpatient providers should do the following[4]:

1. **Develop relationships, protocols, and procedures for safe and rapid referrals.**
   - **Begin discharge planning upon admission.** Discharge planning begins within 24 hours of admission and sets an expectation that hospitalization is a brief period of treatment, and that post-discharge care will be needed.
   - **Develop collaborative protocols.** Work with outpatient organizations to ensure a safe and rapid referral post-discharge.
   - **Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA).** Partner with an outpatient organization and write a formal agreement detailing care coordination expectations. These partnerships are the key to developing a smooth transfer with minimal barriers.
   - **Electronically deliver copies of essential records.** Send the following information to the outpatient provider: current course of illness and treatment; transition/discharge plans; treatment plans; medication list; crisis/safety plan; release of information; and emergency contacts list. Send the records at the time of discharge.
2. **Involve family members and other supports.**
   - **Encourage family participation.** Family members and other individuals (relatives, spouses, partners, friends) can provide a source of support for the patient upon discharge. Providing education to these supports can increase the efficacy of the support network for the patient.

- **Include peer specialists.** Certified Peer Specialists offer unique support due to their own personal experience with managing their own mental health challenges and can connect with the patient and provide additional social and emotional support, answer questions about post-discharge life, and offer hope for recovery.
- **Engage school and community support.** For children, reach out to the school counselor or school psychologist to discuss support resources and safety needs at school.

3. Collaboratively develop a safety plan.
   - **Work collaboratively.** Work with the patient and their family members and supporting community to develop a patient safety plan. Ensure that staff has the training to develop safety plans with the patient. Specific to children, with consent, share the safety plan with the school counselor.
4. Connect with the outpatient provider.
   - **Schedule an outpatient appointment.** Secure an outpatient appointment ideally within 24-72 hours after discharge, but no later than seven days after discharge. Identify any potential barriers to attending the appointment prior to discharge (e.g., transportation, childcare, housing, insurance, additional time away from work).
   - **Offer step-down care.** Some patients may benefit from an intermediate level of care in a less restrictive environment but with more frequent services than offered in outpatient care (e.g., IOPs and PHPs).
   - **Partner with the outpatient provider.** Complete any necessary release documents and speak directly to the outpatient provider. Provide background on the patient's presenting problem, course of treatment, details of the safety plan. A short conversation with the outpatient team prior to discharge can build a bridge across services. This initial contact can be in-person, over the phone, or via videoconferencing.
   - **Connect the patient with the outpatient provider.** Arrange an in-person meeting or a video conference to allow a therapeutic alliance to begin prior to discharge.

After discharge, inpatient providers should follow up with the patient and outpatient provider. A recently discharged patient should receive a phone call within 24 hours to assess the patient's recovery, and communication should be maintained until the patient's first outpatient appointment to ensure bridge support.[4]

Recommendations for Outpatient Providers

A patient discharged from a psychiatric inpatient unit may be referred to a clinic, mental health center, day treatment program, or private practice. Before discharge from the inpatient setting, the provider should connect with the patient to build a therapeutic alliance. This pre-discharge contact triples the odds of a patient engaging in outpatient services post-hospitalization. The following are steps an outpatient provider should follow prior to their patient being discharged[4]:

1. Develop relationships, protocols, and procedures that allow for safe and rapid referrals.
   - **Establish relationships through effective communication.** Cultivate a relationship with inpatient facilities to ensure smooth transitions for future patients.
   - **Establish policies and procedures.** Review policies and procedures for referral acceptance and triage appointments. A patient's heightened risk for suicide in the first week after discharge prioritizes them for an intake appointment.
   - **Accept shared responsibility.** Work with the inpatient facility, the patient, and their family to coordinate a safe and effective care transition.
   - **Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA).** Work with inpatient facilities to ensure timely communication and promote the release of records for care continuity.
   - **Obtain copies of essential documents.** Obtain releases of information, transition plan, treatment plans, medications, and collaborative crisis/safety plan
   - **Arrange a conference call.** Schedule a call with the inpatient providers in order to gather as much information as possible prior to your patient intake.
   - **Train all staff.** Staff members can influence a patient's impression of the outpatient office. Greeting patients with compassion and warmth will help the patient feel more comfortable and can influence the patient's willingness to engage in treatment.

2. **Reach out to their family members or other supports**
   - Meet the patient and family members at the inpatient psychiatric setting. If an in-person meeting with the patient is not feasible, consider connecting through telemedicine. At a minimum, call the patient prior to discharge to begin fostering a therapeutic alliance.

After discharge, an outpatient provider may contact the patient by phone if the initial appointment is not within 24 hours. Following up by phone following discharge can be helpful to confirm the intake appointment, re-assess suicide risk, and build rapport. It is also important to involve family members and other supports by providing psychoeducation and community resources. A healthy family support system improves the health and well-being of the patient.[4]

Pharmacotherapy

Each patient should be individually assessed to evaluate the discharge environment for safety. In these circumstances, psychopharmacologic interventions are often employed. If psychopharmacologic interventions are used for patients discharged home, the patient and family members must understand the possible side effects associated with the drugs being administered, especially the use of antidepressants in patients who are depressed and suicidal.[51]

Antidepressants

Several studies using randomized controlled trials have shown that the treatment of depression using drug therapy, such as antidepressants, has been associated with decreased suicidal ideation in individuals of ages 25 years and older.[51] Some studies suggest that the use of selective serotonin reuptake inhibitors (SSRIs) (i.e., Lexapro, Prozac) results in a more significant reduction of suicide ideation compared to selective serotonin and norepinephrine reuptake inhibitors (SNRIs) (e.g., Cymbalta, PRISTIQ) or norepinephrine-dopamine reuptake inhibitors (NRDIs) (e.g., Wellbutrin)[51]. Interestingly, in patients younger than 25 years old, antidepressant therapy has not been shown to decrease suicidal ideation and behaviors, although it does reduce signs and symptoms of depression.[51]

Black box warning of increased SI on antidepressants.

In 1999, concerns were raised about antidepressants causing suicidality (Rush, 2021). There were concerns about patients developing intense suicidal ideation while taking fluoxetine (Prozac) as prescribed. In response to these concerns, the manufacturer conducted a meta-analysis of 3,065 patients and found no significant difference in suicidal behavior in patients taking fluoxetine versus placebo.[52]

In 2003, similar concerns re-emerged as the United States Food and Drug Administration (FDA) issued a warning regarding the risk of increased suicidality associated with antidepressant use in young people under 26 years of age seen in clinical trials. In 2005, The FDA issued another warning about suicidality in adults being treated with antidepressants.

In 2007, the FDA did not advise withholding antidepressants for approved indications, but they did emphasize the following[52]:

- Individuals 18 to 24 years old should be informed of the risk of developing suicidality when initiating antidepressant treatment (usually in the first one to two months).
- Clinicians should monitor patients closely during antidepressant treatment.
- Depression and other psychiatric conditions are themselves associated with an increased risk of suicidality.

There is no clear evidence that antidepressant use in patients with depression symptoms increases the risk of suicidality in adults. Some trials show a negative association between antidepressant use and suicide attempts. On the other hand, evidence strongly suggests an age-specific effect of antidepressants and suicidality. Among young adults, adolescents, and children, the onset of suicidality is greater when compared to placebo, especially during the few weeks of psychopharmacological treatment. However, it is important to weigh the small risk of suicidality against the risk of suicidality with untreated depression.[52]

Lithium

For patients with unipolar depression or bipolar and related disorders, maintenance treatment with lithium has been shown to prevent suicide. The exact mechanism of action through which lithium works to reduce suicidal behaviors remains unknown; however, it has been theorized that it may function by reducing mood disorder episodes or by decreasing impulsive and aggressive behaviors.[2]

Evidence-Based Practice:

Buprenorphine, the treatment for opioid use disorder, is currently being investigated as a treatment for severe suicidal ideation. A four-week randomized trial compared adjunctive buprenorphine with a placebo in 62 patients with severe suicidal ideation. The patients had various diagnoses (unipolar major depression, borderline personality disorder, adjustment disorder) and were treated with antidepressants and/or benzodiazepines. The study found an improvement in suicidal ideation with adjunctive buprenorphine that was independent of treatment with antidepressants.[2]

Overdose Concerns with Medications

Of note, tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) may be lethal if taken in high doses and thus should be avoided in patients at risk for suicide. In addition, the SNRI venlafaxine may be dangerous in overdose and should be avoided. By contrast, SSRIs are generally safe in overdose and should be the first-line treatment in patients with thoughts and behaviors of suicide.[2] While acute toxicity is believed to be less severe in the setting of SSRI overdose compared to TCAs and MAOIs, fatal overdose and successful suicide attempts have been reported with SSRIs.[53]

Suicide management strategies include non-pharmacologic interventions, such as individual psychotherapy, behavioral therapy, family therapy, and cognitive therapy. The following are proven psychotherapies for treating patients with thoughts and behaviors of suicide: cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), collaborative assessment and management of suicidality (CAMS), and problem-solving therapy (PST), and attachment-based family therapy (ABFT).

Many psychotherapies are rooted in the principle that the therapist is an empathic partner who forms a strong alliance with the patient and acknowledges the patient's suicidal thoughts and behaviors as a response to pain or distress. The following components are necessary for any approach to treating suicidal thoughts or behaviors[54]:

- **Lethal means reduction:** This is one of the most important interventions to reduce suicide attempts. It is vital to assess a patient's access to firearms or other lethal means and to work with them to restrict access to those means.
- **Safety planning:** This strategy involves a plan to keep a patient safe until skills can be learned or other solutions put into place.
- **Developing reasons for hope**: Many treatments approach patients with thoughts and behaviors of suicide by managing hopelessness. The goal is to connect patients to core values and attachments that inspire them to manage their current pain.
- **Inspiring delay:** Generally, the impulse to engage in suicidal behaviors is fleeting. By having the patient delay action on the impulse, it could save their life. One strategy includes having the patient reflect on things they may miss if they die, year by year.

Psychotherapies

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) for Suicide Prevention (CT-SP) is an evidence-based cognitive-behavioral treatment for adults with suicidal ideation and behaviors. Although this protocol was initially developed for patients who had recently attempted suicide, it has applications for patients who are more acutely suicidal. The CT-SP treatment is based on the cognitive-behavioral theory that a person's biopsychosocial vulnerabilities can interact with suicidal thoughts and behaviors to produce a "suicide mode".[55] By targeting those suicide-related thoughts and behaviors, suicide risk can be decreased.

Dialectical Behavior Therapy

Dialectical Behavioral Therapy (DBT) was initially developed to treat patients diagnosed with borderline personality disorder who are also chronically suicidal. It is based on the biosocial theory of emotion dysregulation. Dialectical Behavioral Therapy promotes the belief in one's own ability to succeed, the ability to emotionally self-regulate, and interpersonal effectiveness.[56]

Its cornerstone is the idea that patients must build a life worth living, even if they have many problems in their life and wish to die.[54]

Collaborative Assessment and Management of Suicidality

Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based suicide-focused treatment that quickly reduces suicidal ideation in six sessions, lowers distress and hopelessness, improves hope, and improves clinical retention to care. The therapist and patient work closely to keep the patient stable and identify "drivers" that compel the patient to take their life.[57]

Problem-Solving Therapy

Problem-Solving Therapy (PST) is a brief, evidence-based approach that teaches and empowers patients to solve their here-and-now problems contributing to their depression and helps increase their self-efficacy. It is effective with a majority of the population, including people from different cultural backgrounds.[58]

Attachment-Based Family Therapy

Attachment-Based Family Therapy (ABFT) is a family therapy model designed to treat family and individual processes associated with adolescent suicide and depression.[59] Based on interpersonal theories, adolescents' depressive symptoms and suicidality can be exacerbated or buffered against by the quality of interpersonal relationships with families. Attachment-Based Family Therapy aims to repair attachment relationships or establish a secure base for adolescent development.

Other therapies

Non-pharmacological interventions for the treatment of suicide include electroconvulsive therapy (ECT). For severely suicidal patients, ECT provides a quick response that may be lifesaving in the short-term. The ECT treatment can be administered in an inpatient or outpatient setting but requires anesthesia and the delivery of an electric current to the brain.[10]

Some preliminary evidence has suggested that high doses of repetitive transcranial magnetic stimulation might rapidly decrease suicide ideation and suicidal behaviors. This intervention is potentially useful in emergency or crisis scenarios to expeditiously address a patient's ideations and intent[44].

Safety Planning Strategies

The first National Strategy for Suicide Prevention was put forth in 1999 by then-Surgeon General David Satcher, MD.[60] It was a landmark document that helped officially organize the strategies to prevent suicide across the country.

Since then, research and clinical evidence have continued to refine various approaches to protect at-risk individuals. Some well-known interventions are Crisis Hotlines and the use of the Safety Planning Intervention.

Crisis Hotlines

Crisis telephone helplines, or crisis hotlines, are a valuable resource in suicide prevention on a public health level. There is substantial information that helplines reduce distress and suicidal behaviors in many callers. Crisis lines, available 24 hours a day, provide immediate access to crisis intervention, particularly to those unwilling or unable to have a face-to-face interaction with a mental healthcare provider. Crisis lines, such as those in Washington State, are heavily used. Between October 1, 2014, and September 30, 2015, 46,633 calls to the National Suicide Prevention Lifeline came from individuals in Washington State. Of those 46,633 calls, 22,936 were from individuals who used the Veterans Crisis Line for help[15].

Raising awareness of such crisis resources needs to begin in K-12 schools and higher education and be displayed in multiple public locations, including billboards, public transportation, and media outlets.[15] In addition, crisis line information and materials should be available in primary health care, behavioral health care, and emergency department settings.

There are no randomized controlled trials of suicide crisis lines, partly due to the difficulty of conducting such studies ethically; however, an evaluation conducted in 2018 of the Substance Abuse and Mental Health Services Administration (SAMHSA) Lifeline found that 80% of callers interviewed six to twelve weeks after their initial call said the follow-up calls kept them from dying by suicide, provided them with hope, made them feel cared about, and connected them to other mental health resources.[61]

Crisis hotlines play a significant role in intervening during an individual's crisis. Hotlines, which provide 24-hour service with referrals and resources, have demonstrated reducing suicide attempts while connecting the individual with community resources for follow-up. Suicide hotlines provide the connectedness that research shows is an influential protective factor in preventing suicide.[15]

Safety Planning Intervention

The second highly effective approach to prevent suicide is implementing a Safety Planning Intervention (SPI). This plan is a brief 30-to-45-minute clinical intervention conducted when an individual is identified with a risk for suicide. It is a collaborative effort between a treatment provider and a patient and results in a written list of warning signs, coping strategies, and resources to use during a suicidal crisis.[62]

The premise of this intervention is that if individuals are provided tools that enable them to resist or decrease suicidal urges for brief periods, the risk for suicide is likely to decrease. The target population for an SPI evaluation is those at increased risk for suicide but do not need immediate rescue.

Patients at this level of risk may have[62]:

- History of suicidal behavior (e.g., plans/ preparations for suicide, suicide attempts, aborted attempts,).
- Recent history of SI.
- Otherwise determined to be at-risk for suicide.

This intervention aims to provide people who are experiencing suicidal ideations with a specific set of concrete strategies to use to decrease the risk of suicidal behavior. The safety plan includes a collaboratively identified coping strategy and a list of individuals or agencies that may be contacted during a crisis. It prioritizes relying on internal, individual resources and expands to include resources that include the participation of others or other external resources.[62]

In 2018, Stanley and Brown published an article in JAMA Psychiatry comparing SPI with follow-up versus usual care of a suicidal patient in the emergency department. They found that SPI with follow-up resulted in 45% fewer suicidal behaviors over a period of six months.[62]

See Table 9 for an in-depth review of each of the Safety Planning Intervention Steps.

Table 9. Safety Planning Intervention Steps

STEP	GOALS	COMMUNICATION
1. **Recognizing the warning signs of an impending suicidal crisis:**	• Identify warning signs that may indicate the beginning of worsening of a crisis. • Understand how identifying warning signs provides an opportunity to cope before acting on suicidal urges.	• Ask "What were the warning signs that you experienced during the crisis?" or "How will you know you are in a crisis and the safety plan should be used?" • If the warning signs are vague, ask the patient to be more specific so they are more likely to recommend the beginning signs of a crisis.
2. **Using your own coping strategies:**	• Explain the purpose of coping strategies is to: 1) help take the individual's mind off of their problems to prevent worsening of suicidal thoughts; and 2) prevent the individual from making a suicide attempt without contacting other people. • Help the individual recognize internal coping strategies. • Identify barriers and ways to overcome them.	• Ask "What have you done in the past to take your mind off your suicidal thoughts without contacting another person? What activities could you do by yourself to help take your mind off of your problems even if it is for a brief period of time?" • If the individual cannot think of any distracting activities, provide suggestions. • Ask "How likely do you think you would be able to do this during a time of crisis?" or "Is it feasible?" If there is doubt, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
3. **Contacting others in order to distract from suicidal thoughts:**	• Instruct the individual to use Step 3 if Step 2 does not lower risk. • Identify other people and social settings that provide distraction. • Obtain feedback from the individual about the likelihood of doing these activities. • Identify barriers and problem-solve ways to overcome them.	• Ask "Who can you contact who helps you take your mind off your problems or helps you feel better? You don't need to tell these people that you are feeling suicidal. We just want to identify people who can take your mind off your problems even for a brief time." • Ask, "What public places, groups, or social events help you to take your mind off your problems or help feel better?" • Ask, "Sometimes when people are feeling really upset, they don't want to talk to other people. However, sometimes just getting out and being in a place around other people can help. Can you think of places you could go where you wouldn't have to be alone?" • For each response, ask, "How likely do you think you would be able to talk with someone/go somewhere during a time of crisis?" "Is it feasible and safe?"

Table 9. Safety Planning Intervention Steps (continued)		
4. **Contacting family members or friends who may help to resolve the crisis:**	• Instruct the individual to use Step 4 if Step 3 does not resolve the crisis or lower risk. • Explain that this step involves contacting a trusted family member or friend for support. • Obtain feedback from the individual about the likelihood of doing these activities. • Identify barriers and problem-solve ways to overcome them.	• Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress or feeling suicidal?" • Ask, "How likely do you think you would be able to reach out to each person?" • If doubt is expressed about contacting others, ask, "What might get in the way of reaching out to this person?
5. **Contacting mental health professionals or agencies:**	• Instruct the individual to use Step 5 if Step 4 does not resolve the crisis or lower risk. • Explain that Step 5 consists of professionals who can provide assistance to the individual during a crisis.	• Ask "Who are the professionals and community workers that we should identify to be on your safety plan? • Ask, "What is the likelihood that you would contact these professionals or agencies?"
6. **Making the environment safe and reducing the availability of means to complete suicide:**	• Explain that having access to lethal means places the individual at greater risk for suicide and does not allow enough time to use the coping strategies or sources of support listed on the Safety Plan. • For each method that is identified, determine the individual's access to the lethal means and collaborate to find voluntary options that reduce access to the lethal method and make the environment safer.	• Express concern about the patient's safety and explain that making the environment safer will help to lower risk of acting on suicidal feelings. For some individuals who attempt suicide, the interval between thinking about and acting on suicidal urges is usually a matter of minutes. • For each lethal method, ask "What can we do to make the environment safer?" • Ask, "How likely are you to do this? What might get in the way? How can we address the obstacles?" • If doubt is expressed about limiting access, ask, "What are the pros of having access to this method and what are the cons? Is there an alternative way of limiting access so that it is safer?"

Note. Adapted from Stanley, & Brown (2018). The safety planning intervention to reduce suicide risk for people with SMI [PowerPoint slides]. Substance Abuse and Mental Health Services Administration.[62] *https://www.nasmhpd.org/sites/default/files/SAMHSA%20SPI%20SMI%20PPT%20final_2.pdf.*

The basic steps of SPI involve more tasks than simply completing a safety plan form. These include[62]:

- Identify and assess suicide risk.
- Obtain the patient's subjective crisis narrative.
- Provide psychoeducation around suicide and introduce safety planning.
- Identify warning signs that may indicate the beginning or escalation of a crisis and explain how to follow the steps that allow them to cope with the crisis before acting on suicidal thoughts.
- Complete the safety plan (see Figure 1 on the next page for the safety planning document).
- Implement the safety plan.
- Follow up with the patient to continuously assess their risk for suicide.

This plan should be developed collaboratively with the individual. Whenever possible, the patient should complete the form themself, and the healthcare professional should be available to provide clarification and ensure that the plan is achievable.

Once the safety plan is completed, review the entire plan with the patient.[62] Inform the patient that it is not necessary to follow all the steps before reaching out for help. The clinician should provide a copy of the safety plan to the patient and discuss its location. At follow-up visits, periodically review the safety plan.

Suicide Prevention Strategies

Suicide is preventable with early and timely low-cost interventions. Any efforts to thwart the daunting number of suicides worldwide must be thorough and multifaceted; suicide is complex and multifactorial in its etiology. Given that the etiology of suicide is multifactorial, combining multiple strategies to reduce risk and strengthen protective factors at the individual, relationship, community, and societal levels are required.[60] No single approach is impactful enough to decrease the incidence of suicide.

For any suicide prevention strategy to succeed and for the suicide prevention interventions to be appropriately tailored to address each individual's need, it is critical to fully understand the methods used to attempt suicide. All suicides are preventable. Appropriately implemented interventions at the state, community, and individual levels can help prevent suicides and suicide attempts. Some of these interventions include responsible media reporting, assessing the community for barriers to mental healthcare access, introducing alcohol policies to reduce the irresponsible consumption of alcohol, and educating various groups to reduce the stigma of the topic.[15]

Early identification of mental health and substance abuse disorders is critical to any suicide prevention strategy. Additionally, training non-specialized healthcare workers in the identification, assessment, and management of suicide is an effective strategy to prevent suicide.[15]

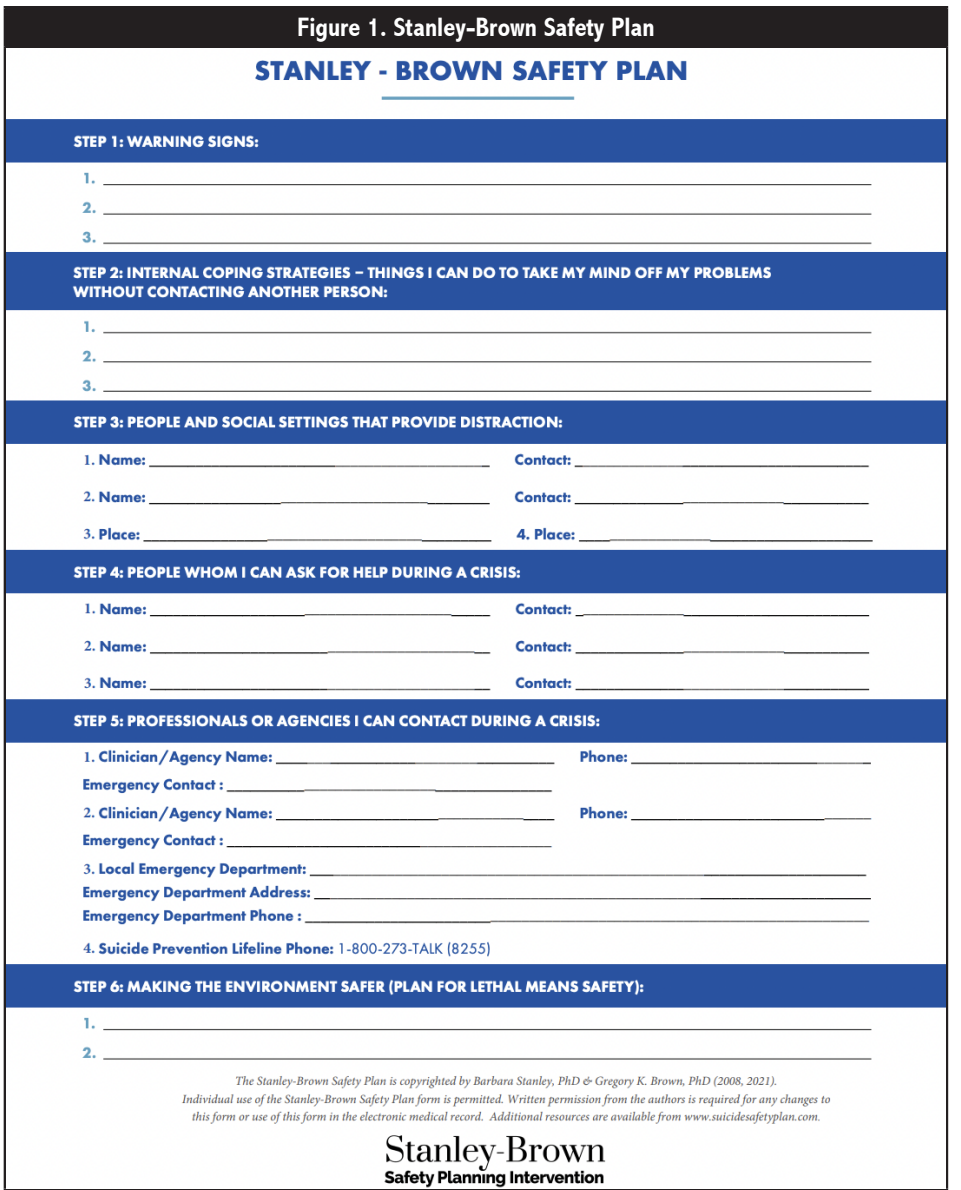
In many cultural and religious groups, mental illness is still considered taboo. Many people who contemplate taking their lives are too afraid to seek help for fear of being ostracized. The lack of public awareness concerning suicide in particular, and mental illness as a whole, only potentiates the problem.[15]

Suicide prevention strategies should be unique to the target population and should address differences in patient characteristics, methods of suicide, socioeconomic status, age, and gender. Given that suicide is a complex issue, multiple professionals must be involved in any applied strategies. These stakeholders include policymakers, professionals in health education and law, media, and community members.

Caring Contacts

One evidence-based intervention that has been shown to support individuals following a crisis event is the "Caring Contacts" program. Caring Contacts is an effective suicide prevention strategy that may be used post-discharge for high-risk individuals and may be scaled to the community's needs.[64] It is low-cost, and once established, volunteers can manage it. The program involves a clinician or other caring individuals who send eight or more messages of care, support, and connection to an individual with suicidal risk over a year. It may consist of postcards, letters, emails, or even text messages. It helps to keep patients engaged, provides a follow-up for individuals who are challenging to engage, and extends the connection between provider and patient after treatment has ended.[64]

Figure 1. Stanley-Brown Safety Plan



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

Note. From Stanley, B., & Brown, G. K. (2021, August 6). Stanley-Brown safety plan [Graphic]. Stanley-Brown Safety Planning Intervention. https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf[63]

Zero Suicide

Zero Suicide is a framework that takes a systemic approach to identifying suicide risk across healthcare and behavioral healthcare systems.[40] The foundational belief of Zero Suicide is that the suicide deaths of individuals under care within healthcare and behavioral health systems are preventable. The Zero Suicide website provides a wide variety of resources available to community leaders, including the Zero Suicide Toolkit, to help implementors put the Zero Suicide framework into practice.

Primary, Secondary, Tertiary Prevention

If a suicide act has not occurred, it is important to determine the best prevention strategies. Strategies range from referral to prevention resources to immediate hospitalization and prescribed interventions to keep the individual from self-harm. The public health model of primary, secondary, and tertiary prevention is a valuable model for suicide.

Primary Prevention

Primary prevention strategies for suicide are geared toward the general population and include activities and information that educate the community about strategies to decrease suicide. Primary prevention aims to reduce the number of new suicide cases in the general population.[65] These general suicide programs and information are appropriate for schools, homes, clinics, clubs, and social groups.

Secondary Prevention

Secondary prevention strategies for suicide aim to decrease the likelihood of a suicide attempt in high-risk patients.[66] This level of prevention includes the activities of crisis intervention programs and crisis hotlines. Secondary prevention comprises specific measures used to care for individuals in an active suicidal crisis. Crisis care is usually provided by hospitals, clinics, and hotlines.

Tertiary Prevention

Tertiary prevention strategies for suicide occurs in response to completed suicides and suicide attempts.[65] Tertiary prevention also provides interventions and care for individuals who had personal connections to someone who died from suicide. The goal of tertiary prevention is to help survivors grieve and to understand why the person killed him or herself.

Service Members and Veterans

Suicide is a national public health concern, and this claim is especially true among veterans and active military members. The U.S. Department of Veterans Affairs (VA) leads efforts to understand suicide risk factors for veterans, develop evidence-based prevention programs, and prevent veteran suicide by utilizing a public health approach.[67] The VA analyzes suicide data at the national and state levels to better guide these strategies.

The U.S. Department of Defense (DoD) also publishes quarterly and annual suicide reports presenting suicide data on service members and their families. It describes intentional efforts to combat suicide, reduce the stigma associated with seeking help, and share program evaluation and policy review.[67]

Service Member and Veteran Suicide Deaths in the U.S.

Service Members

According to the 2020 Department of Defense Suicide Event Report (DoDSER), 580 members died by suicide. Key findings included[67]:

- Active component: The suicide rate increased from 2015 to 2020.
- Reserve: There was no significant change in the suicide rate from 2015 to 2020.
- National Guard: There was no significant change in the suicide rate from 2015 to 2020.
- Service members who died were largely enlisted, male, and younger than 30 years old.

Table 10 shows the suicide counts and rates per 100,000 Service members in the military.

Veterans

According to the most recent National Veteran Suicide Prevention Annual Report, the Veteran suicide count and the rate decreased in 2019 from 2018 and 2017. There were 399 fewer Veteran suicides in 2019 than in 2018, reflecting the lowest raw count of Veteran suicide deaths since 2007. In 2019, the number of suicide deaths among the U.S. population was 45,861, of which 6,261 (13.7%) were Veterans[67].

Despite a decrease in Veteran suicide deaths in 2019, the Veteran population remains at a significantly higher risk for suicide than non-Veterans in the U.S.[67] The Veteran suicide rate is 52.3% (i.e., 1.5x) higher than non-Veterans.[67,69]

Table 10. Military Suicide Counts and Rates		
Military Population / Service	**2020 Count**	**2020 Rate**
Active Component	384	28.7
Army	175	36.4
Navy	66	19.3
Marine Corps	62	33.9
Air Force	81	24.3
Reserve	77	21.7
Army	142	22.2
Navy	13	-
Marine Corps	10	-
Air Force	12	-
National Guard	119	27.0
Army	103	30.9
Air Force	16	-

Note. Adapted from U.S. Department of Defense, Under Secretary of Defense for Personnel and Readiness. (2021). CY 2020 annual suicide report. https://www.dspo.mil/Portals/113/Documents/CY20%20Suicide%20Report/CY%202020%20Annual%20Suicide%20Report.pdf[68]

From 2001 to 2019, there were increases in the percentage of Veteran suicide deaths involving firearms and suffocation, as well as decreases for those due to poisoning or "other means". In 2019, firearms were used in 70% of male Veteran suicides and 50% of female Veteran suicides.[67]

Veteran Risk Factors

The Veteran population has unique risk factors that contribute to the higher suicide rates.[69] Multiple studies have shown that the following factors increase the risk of suicide for Veterans[69,71,72,73]:

- Anger, rage, mood swings, and episodes of anxiety and agitation.
- Expressing feelings of having no reason to live.
- Seven adverse social determinants of health are strongly associated with SI and suicide attempts in Veterans: violence, housing instability, financial or employment problems, legal problems, familial or social problems, lack of access to health care and transportation, and nonspecific psychosocial needs.
- A chart review conducted in 2012 found that approximately half of Veterans who died by suicide had a sleep disturbance such as insomnia.
- Sexual dysfunction is common in people with post-traumatic stress disorder (PTSD). In male Veterans, decreased sexual pleasure and frequency of sexual intercourse is linked to more suicidal thoughts. In female Veterans, increased sexual frequency is linked to increased suicidal thoughts.
- Mental health conditions like anxiety disorders, manic-depressive disorders, depressive disorders, and PTSD. Research at the Syracuse Medical Center found that 40% of Veterans with anxiety had at least one risk factor for suicide. They also found that Veterans with a positive depression screen were at high risk for suicide.
- Research has established links between TBIs and suicidality. Veterans who sustained a deployment-related TBI are at greater risk for suicide than those without TBI diagnoses.
- Substance abuse, especially heavy binge drinking. In general, individuals who abuse drugs or alcohol are more likely to be depressed, have financial or social issues and engage in impulsive and high-risk behaviors. In 2017, researchers found that Veterans who abuse drugs or alcohol are twice as likely to die by suicide than other Veterans.
- Veterans and Service Members who have been exposed to suicide are at elevated risk for suicide themselves.
- Over 40% of Veterans experience difficulty when transitioning from military life to civilian life. Studies show these individuals are five times more likely to experience SI.

Evidence-Based Practice:

A study in 2020 examining VA patient data determined that social determinants of health, including violence, housing instability, and financial problems, increased the risk of suicide in Veterans.67 Each adverse factor increased a Veteran's odds of suicidal ideation by 67% and a suicide attempt by 49%.

Protective Factors Related to Veterans and Military Personnel

Protective factors within a population reduce the probability amidst the increased risk. Protective factors are less frequently investigated and, therefore, lack empirical support as risk factors; however, several research studies report encouraging results.

Like in the general population, social support is a significant protective factor. Relationships with family and friends can prevent individuals from considering suicide to solve their problems. Studies show that Veterans who had good social support during and post-deployment had more positive mental health outcomes, including lower rates of SI. However, even with solid social support, individuals must have the social skills to ask for help when they need it. Given that social supports mitigate suicide risk, it is vital to assess Veterans for the presence of social connections.[74]

Research also shows that Veterans with a greater sense of purpose have more resilience, which reduces the odds of suicidality. In addition, engagement in religion or spirituality has also been associated with decreased risk for SI in Veterans. Other protective factors include employment, meeting basic needs, self-care, living stability, social support, resilience, and self-determination).[71]

An approach to clinical interviewing should include questions about protective factors. Not only do these questions carry less stigma than questions about suicide or self-harm behavior, but identifying protective factors for suicide in Veterans encourages the healthcare provider to focus on the individual's competence in various domains of basic functioning.[71]

Service Members and Veteran Intervention Strategies

As a healthcare worker, knowledge regarding available resources is important for referrals and resources to individuals we meet. The Veterans Administration Health Service Department has implemented several programs to aid Veterans at risk for suicide or who have attempted suicide previously. The VA's mission is to end Veteran suicide by implementing a public health approach that combines community-based and clinically based strategies across prevention, intervention, and postvention areas of focus.[68]

Suicide Prevention 2.0 (SP 2.0). Suicide Prevention 2.0 is comprised of a dual effort, intervening on the community level and in the clinical care setting. The community-based intervention component reaches Veterans inside and outside the VA system by collaborating with other agencies.[72] It aims to: 1) identify Service members, Veterans, and their families and screen everyone for suicide risk; 2) promote connectedness and improve care continuity; and 3) decrease lethal means and safety planning. The clinical approach focuses on disseminating evidence-based psychotherapies to Veterans in need. The VA is currently hiring over 100 clinicians across 140 healthcare systems to provide mental health services to Veterans.[68]

Now Initiative. The Now Initiative's goal is to initiate evidence-based interventions to impact Veterans most efficiently at high-risk of suicide within one year. Its areas of focus include 1) lethal means safety; 2) suicide prevention in medical populations; 3) outreach to prior Veteran Health Administration (VHA) users; 4) suicide prevention program enhancements; and 5) paid media.[67]

The President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS). On March 5, 2019, Executive Order 13861 was signed establishing a 3--year effort known as PREVENTS. Its three main areas of focus include: 1) National Suicide Prevention Campaign; 2) improving suicide prevention research, and 3) building partnerships.[68]

988 / Veterans Crisis Line. The Veterans Crisis Line is a confidential resource that connects Veterans in crisis and their family members with qualified and trained responders in the VA.[72]Veterans and loved ones can connect via phone by dialing 988 or via online chat through http://www.veterancrisisline.net. Alternatively, Veterans can send a text message through their cellphones to 838255. Once the crisis line is contacted, Veterans and family members can receive confidential support 24 hours a day, 7 days a week.[68] It is important to note that Veterans can seek help via this confidential resource even if they are not registered with the VA system. The responders on the crisis line are trained to assist veterans with mental health problems and those struggling with the transition to civilian life or relationships. Many of the responders are Veterans themselves and understand what Service members have been through and the challenges they and their families face.[68]

Hannon Act of 2019 (P.K. 116-171). In October 2020, the Hannon Act was signed into law. Section 201 of the Hannon Act established the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP), a $174 million, three-year program to enable VA to provide resources for community-based suicide prevention efforts. It also provides the VA with opportunities to expand suicide prevention efforts. One of its goals is to improve local community capacity to conduct outreach to Veterans and families, provide them with suicide prevention services, and connect them to resources within the community.[68]

The Veterans COMPACT Act of 2020 (P.L. 116-214). The Veterans COMPACT Act was signed into law in December 2020. It enables the VA to implement programs, policies, and reports related to transitioning Service members, suicide prevention, and crisis services; mental health education and treatment; and improvement of services for women Veterans.[68]

Veterans Benefit Administration. The suicide prevention efforts within this administration are focused on improved data sharing toward enhanced suicide risk prediction and identification; increased coordination for Veterans with financial insecurity; and implementation of suicide training for the Veterans Benefits Administration personnel.[68]

Domestic Policy Council. This interagency group creates and amplifies suicide prevention efforts across various agencies related to suicide prevention for Veterans.[68]

In summary, the VA believes that every veteran's suicide is a tragedy. The VA relies on multiple sources of information to identify deaths due to or are most likely due to suicide. It has undertaken the most comprehensive analyses of veteran suicide rates in the United States. The VA has examined over 50 million veteran records from 1979 to 2014 from every state. In addition, the VA has expanded current initiatives and developed new ones to help veterans and their families and reduce the rate of suicide among veterans. The ongoing collection of data and strategic initiative development, such as the #BeThere campaign, highlights the VA's ongoing commitment to the mental health and well-being of our veterans.

BEFORE MOVING ONTO THE NEXT SECTION, PLEASE COMPLETE CASE STUDY 5 ON THE NEXT PAGE.

Risk of Imminent Harm Through Self-Injurious Behaviors

Not every self-injury is a suicide attempt. Non-suicidal self-injuries (NSSI) are defined as "behaviors engaged in with the purposeful intention of hurting oneself without intentionally trying to kill oneself". Other terms used are self-injurious behavior, self-mutilation, cutting, deliberate self-harm, delicate self-cutting, self-inflicted violence, parasuicide, and auto aggression. Forms of NSSI include scratching, plucking hair, interfering with wound healing, cutting, burning, or hitting.[50]

Evaluating between Non-Suicidal Self-Injury and a Suicide Attempt

To accurately predict suicide risk and identify those at the highest risk for suicide is an important task. It is imperative to differentiate between Non-Suicidal Self-Injury (NSSI) and a Suicide Attempt (SA). While both behaviors are injurious to the body, it is necessary to determine the individual's injury intent. Clinicians must understand the distinction between NSSI and SA to make a sound decision regarding treatment and hospitalization.

An NSSI is not a suicide attempt. It is most often used to try to regulate emotional pain or self-soothe – not as a means of ending one's life.[75] Usually, NSSI behaviors are performed to feel better and/or deal with significant negative feelings. Other reasons for NSSI include tension reduction, emotion regulation, anger expression, self-punishment, or a decrease in dissociation. Suicidal behaviors, however, are more lethal (e.g., gunshot wounds, handing).[50]

Evidence-Based Practice:

A review of 22 empirical studies found that the adolescent lifetime prevalence of self-injury is 13 to 23%. The typical age of onset is between 12 and 14 years of age. Risk factors for NSSI include a history of sexual abuse, a higher number of adverse childhood events (ACEs), depression, anxiety, eating disorders, alexithymia, hostility, low self-esteem, antisocial behavior, smoking, and emotional reactivity.[52]

Tattoos and body piercings are not considered NSSI, unless they are created with the specific intention to self-harm. Often NSSI is inflicted on the hands, wrists, stomach, or thighs but can occur anywhere on the body.[76]

While self-injury is a risk factor for suicide, they differ in several important ways, including but not limited to[75]:

- Expressed intent: The expressed intent of NSSI is almost always to feel better, whereas for suicide, it is to end feeling (and subsequently, life) altogether.
- The method used: Methods for NSSI typically cause damage to the surface of the body only; suicide-related behaviors are potentially lethal. Notably, it is uncommon for individuals who engage in NSSI and who are also suicidal to identify the same methods for each purpose.
- Level of damage and lethality: NSSI is often carried out using methods designed to damage the body, but not to injure the body sufficiently enough to require medical intervention or to end life. Suicide attempts are always more lethal than standard NSSI methods.
- Frequency: NSSI can vary in frequency, often contingent on experience of stress and other difficult emotions; suicide-related behaviors are much rarer.
- Level of psychological pain: The amount of distress experienced when engaging in NSSI is often significantly lower than that which gives rise to suicidal thoughts and behaviors. Moreover, NSSI tends to reduce arousal for many of those who use it and, for many individuals who have considered suicide, is used as a way to avoid attempting suicide.
- Presence of cognitive constriction: Cognitive constriction is black-and-white thinking – seeing things as all or nothing, good or bad, one way or the other. It allows for little ambiguity. Individuals who are suicidal often experience high cognitive constriction; the intensity of cognitive constriction is less severe in individuals who use NSSI as a coping mechanism.
- Aftermath: The aftermath of NSSI and suicide can be strikingly different. Although unintentional death does occur with NSSI, it is not common. After a typical NSSI incident, well-being and functioning improve for a short amount of time. The aftermath of a suicide-related gesture or attempt is precisely the opposite.

Despite the different intentions associated with NSSI and suicidal thoughts and behaviors, it is important to note that they share common risk factors. These include but are not limited to[75]:

- History of trauma, abuse, or chronic stress.
- High emotional perception and sensitivity.
- Few effective mechanisms for dealing with emotional stress.
- Feelings of isolation (this can be true even for people who seem to have many friends or connections).
- History of alcohol or substance abuse.
- Presence of depression or anxiety.
- Feelings of worthlessness.

Case Study 5

Instructions: Spend 5–10 minutes reviewing the case below and considering the questions that follow.

(Rationale and discussion is displayed at the bottom of this exercise)

Jack is a 65-year-old retired Lieutenant Colonel in the Army. He was on active duty flying helicopters during the Vietnam War, airlifting casualties to medical centers. He enjoyed a 45-year marriage to his high school sweetheart. They have three grown children with a dozen grandchildren. Jack has enjoyed a post-military career as a consultant to the Department of Defense at the Fort Lewis military base in Tacoma, Washington. He retired 2 years ago so that he and his wife could enjoy traveling and visiting the children and grandchildren.

Jack's wife became ill last year and struggled with ovarian cancer that she succumbed to after a 6-month battle while undergoing chemotherapy. Jack's connectedness to social events was primarily through his wife. She was actively engaged in her church. When Jack's wife died, he withdrew and lost much of that connectedness. His daughters and friends attempted to get him into grief counseling or to attend a bereavement group with the Hospice who took care of her. He had participated in group meetings a couple of times and then brushed off any further contact. He had a couple of months where he seemed to "bounce back;" however, he has begun to struggle with nightmares and flashbacks since her death. He is barely sleeping. He has attempted to connect with his war buddies; however, that has stirred many memories from the long-ago war.

In addition to his wife's death, many of the repressed feelings from the war have begun to plague Jack, and he has become more despondent, reclusive, and depressed. His children live hundreds of miles away and do not realize the changes in their Dad. Based on their contact, they believe that he is still attending the bereavement group. His daughters call once a week. At the time of her weekly phone call, his oldest daughter could not get a hold of him…. She persists without an answer and calls the neighbor, who admits not having seen Jack for a few days. The police perform a welfare check and find Jack lying on the floor of his house with an apparent self-inflicted gunshot wound and a suicide note.

1. **Based upon the information provided, which of the following strategies would be least effective in Jack's scenario?**
   - A. Refer Jack to a behavioral health provider.
   - B. Direct Jack to the Veterans Crisis Hotline.
   - C. Connect Jack with a support group for veterans struggling with grief.
   - D. Report the situation to the local parish.

2. **Veterans with a _____ are at a greater risk of suicide.**
   - A. Traumatic brain injury.
   - B. Poor diet.
   - C. Back pain.
   - D. Migraine disorder.

3. **In Jack's case, considering the discussion regarding reducing access to lethal means, which action by family or friends may have been taken?**
   - A. Educating Jack regarding what to do when he has suicidal thoughts.
   - B. Call the police and have them do a welfare check.
   - C. Remove any firearms from the house.
   - D. Call the local parish for assistance.

Rationale for Question 1: The best option is D. The Veterans Crisis Hotline is available 24/7 for veterans who are in a crisis or struggling with depression, despondency, or feelings of suicide. Grief counseling and support groups both for veterans and in this case, Jack's loss of his wife is a critical intervention through a crisis moment. Grief counseling and support groups and the Veteran's Crisis Hotline can provide crisis intervention and mental healthcare support.

Rationale for Question 2: The best option is A. Studies support that traumatic brain injury coupled with other risk factors found in the general population (substance abuse, depression, etc.) can increase the veteran's risk of death by suicide.

Rationale for Question 3: The best option is C. Family members concerned with a veteran's safety can request a gunlock from their local VA suicide prevention coordinator. In addition, at minimum the weapon should be locked and unloaded and, if necessary, a temporary off-site storage may be advisable.

Discussion: While Jack's family may not have been fully aware of his severe depression, Jack had many risk factors for suicide. These included: his age (the elderly are at higher risk for suicide); the recent death of his wife and subsequent loneliness; social isolation; a history of trauma during his military career, and current symptoms of PTSD (nightmares, flashbacks); sleep disturbances; and untreated depression. All of these risk factors place Jack at a higher risk for suicide. In the aftermath of Jack's death by suicide, his friends and family members should receive grief to help them cope with the loss of their daughter.

Communication Strategies with Patients and Supporters about Lethal Means

The CALM (Counseling on Access to Lethal Means) program helps clinicians work with patients and families to reduce access to lethal means to prevent suicide. Highlights of this program include the following actions[77]:

- Speak with the patient and family, friends, or with other key persons in his/her support system. If the patient is an adult, be sure to obtain releases for permission to speak with members of the patient's support system.
- Discuss suicide risk and how escalation of such risks may lead to a suicide attempt.
- Ask the patient whether there are firearms in the home and if the patient has access to firearms outside the home as well.
- Recommend that all firearms be removed from the home and from patient's access until such time as the situation improves.
- If handling firearms is too dangerous for the patient, enlist the support of others to remove the firearms. Law enforcement may temporarily hold firearms and most will dispose of such weapons upon request.
- If the family is unwilling to remove firearms from the home, the firearms should be unloaded and locked in a place that is not easily accessible. Ammunition should be stored in a separate locked container.
- Potentially lethal prescription medications and alcohol should be removed from the home, and only left in small amounts, if at all.
- Monitor the patient's reactions to the reduction plan. Opposition may suggest a strong commitment to using lethal means to die by suicide. If the patient is overly eager to comply it may indicate that he/she has chosen another means (e.g., deliberate car accident) to attempt suicide.

Strategies to Reduce Access to Lethal Means

Limiting or reducing a person's access to lethal means effectively prevents suicides. The conceptual model of reducing access includes means restriction, which results in the individual either substituting or delaying the attempt. This substitution or delay results in fewer fatal attempts, and often the suicidal crisis may even pass, ultimately resulting in a drop in the overall suicide rate[15].

Individuals at risk for suicide need firearms, medications, means to hang themselves, or poisonous substances restricted or made less accessible. Statistically, an individual who does not have access to lethal means is more likely to delay the attempt, and fewer attempts with less lethal means will prove less fatal. The individual who attempts suicide generally does so during a crisis; if that attempt is delayed, generally, the crisis is averted, and 89-95% of attempters do not go on to die by suicide[15]. If lethal means are restricted, the suicide rate will decline over time.

Creating a safe environment within a healthcare facility is essential to reduce access to lethal means to suicidal patients. Hospitals, prisons, and detention facilities can prevent suicide by using collapsible shower heads, light fixtures, doorknobs, and specially designed bedding that does not tear.[78]

Healthcare providers should educate patients on how to make their family members and homes safer by reducing access to medications and firearms[78]:

Medications:

- Never keep lethal doses of any medication on hand.
- Consider keeping medications locked in a safe place.
- Properly dispose of medications that are no longer needed.

Firearms:

- Keep firearms locked and unloaded in a safe and ammunition stored in a separate location.
- Ask a friend or family member to store a firearm for a while.
- Unloaded firearms can also be secured with a gun-locking device making them unusable.

PLEASE COMPLETE CASE STUDY 6.

Case Study 6

Instructions: Spend 5-10 minutes reviewing the case below and considering the questions that follow.

(Rationale and discussion is displayed at the bottom of this exercise)

Ella is a 16-year-old high school student. She requests to see a school counselor after a difficult breakup with her boyfriend of three months. During her initial consultation with the counselor, she reports that she has had suicidal ideations and a plan and intent. She reports that she has a plan to swallow a bottle of Tylenol to "make the pain go away." When asked if she had access to Tylenol, she reported that she bought a bottle a few days ago and was waiting to find the right time. The school counselor promptly contacts Ella's parents, who come in to meet with her. Ella's mom reports that Ella tended to be dramatic and that she had made such threats after her previous three breakups and all Ella needed to do was stop being distracted by boys and focus on her future. At the counselor's insistence, the mother promised to report the counselor's findings to her pediatrician. The following week, Ella was found dead by her best friend on her bathroom floor.

1. **What was the trigger that led to the death by suicide in this case?**
   A. Ella's mom not listening.
   B. Romantic Breakup.
   C. Ella has always had suicidal ideations.
   D. School counselor's confrontation.

2. **Based on the information regarding restricting access to lethal means, which action could have been taken by an individual in the scenario to reduce the risk of suicide?**
   A. Notify the pediatrician.
   B. Meet with the parents and Ella together.
   C. Ask Ella to meet with her regularly.
   D. Remove access to the Tylenol.

3. **Based on the information provided regarding lethal means, who does not need education to raise awareness of Ella's risk for suicide?**
   A. Educators.
   B. Mother.
   C. Lay gatekeeper.
   D. The school counselor.

Case Study 6 (continued)

Rationale for Question 1: The best option is B. The stressor in Ella's life was the breakup with her boyfriend of three months.

Rationale for Question 2: The best option is D. Removing the bottle of Tylenol from Ella's possession and ensuring that she does not have access to other means of poisoning could have reduced the potential for follow-through by Ella.

Rationale for Question 3: The best option is D. Although there is no definitive means of absolutely ensuring that a suicide can be prevented, conducting an appropriate assessment, and developing a plan that includes patient and family is mandatory. In addition, ongoing follow-up is essential as well. Patients at risk for suicide must receive follow-up, as well as extensive education. Family members must also receive education and training on an ongoing basis.

Discussion: Managing and treating suicidal ideations can be challenging, especially in children whose parents are dismissive of the warning signs in their children. The counselor, in this case, reacted appropriately by promptly reporting her findings and suspicions to Ella's parents. However, Ella's mom's denial regarding the challenges her daughter faced was a particular hindrance in securing the right help for Ella.

Education regarding lethal means is imperative for all involved. Limiting or reducing Ella's access to lethal means (Tylenol) could have effectively prevented her death by suicide. This restriction to access may have resulted in her using a substitute or delaying the attempt. Either the substitution or delay would have provided time to pass and potentially the crisis to pass, which would have resulted in an unsuccessful attempt or no attempt at all.

The counselor should have tried to contact Ella's father and convey her sense of urgency regarding the immediacy of Ella's needs. This was especially important, given that her mother was so resistant to getting Ella the help she needed. After Ella's death, her friends and classmates should receive counseling. Additionally, Ella's parents should receive grief counseling to help them cope with the loss of their daughter.

Conclusion

Death by suicide is one of the top ten leading causes of death in the United States for people ages 10-65.[11]Suicidal behavior takes a huge emotional toll on family and friends and an economic toll on society. Therefore, suicide prevention and treatment must be addressed throughout the healthcare community to prevent the further loss of life. Healthcare professionals are in a unique position to prevent suicide due to their frequent contact with patients and should use a multi-factorial approach to screen patients for suicidality to assess their risk level, conduct a thorough assessment, and to appropriately refer patients to appropriate services.

Resources

Below is an extensive resource list borrowed from the National Action Alliance for Suicide Prevention of suicide-related resources filtered by topic[4]:

1. **Suicide Care**
   a. National Action Alliance for Suicide Prevention. This organization lists recommended standard care practices for people with suicide risk. https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf
   b. U.S. Department of Veterans Affairs (VA) /U.S. Department of Defense (DoD). The VA and DoD have created their own guidelines for the assessment and management of patients at risk for suicide. https://www.healthquality.va.gov/guidelines/MH/srb/
   c. Zero Suicide. This organization has created a toolkit to help transition individuals through care. https://zerosuicide.edc.org/toolkit/transition#quicktabs-transition=1
   d. Zero Suicide. Universal Health Services Inc, Behavioral Health Division has a detailed suicide care management plan template for inpatient hospital settings. https://zerosuicide.edc.org/sites/default/files/UHS%20Inpatient%20Suicide%20Care%20Management%20Plan%20Template.pdf
2. **Suicide-Specific Therapy Approaches**
   a. Dialectical Behavioral Therapy (DBT). https://behavioraltech.org/
   b. Cognitive Behavioral Therapy (CBT). https://sprc.org/event-training/cognitive-behavioral-therapy-for-suicidal-behavior/
   c. Collaborative Assessment and Management of Suicidality (CAMS). https://cams-care.com/
   d. Problem-Solving Therapy (PST). https://aims.uw.edu/training-support/behavioral-interventions/problem-solving-treatment-pst
   e. Attachment-Based Family Therapy (ABFT). https://drexel.edu/familyintervention/attachment-based-family-therapy/overview/
3. **Involving family and other supports**
   a. The Way Forward. https://theactionalliance.org/sites/default/files/the-way-forward-final-2014-07-01.pdf
   b. Family-to-Family Educational Program. https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Family-to-Family
   c. Suicide is Different. https://www.suicideisdifferent.org/
4. **Safety planning**
   a. Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version. https://sprc.org/online-library/safety-plan-treatment-manual-to-reduce-suicide-risk-veteran-version/
   b. Patient Safety Plan. https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
   c. Safety Planning Guide: A Quick Guide for Clinicians. https://sprc.org/online-library/safety-planning-guide-a-quick-guide-for-clinicians/
   d. SAMHSA Suicide Safe Mobile App. https://store.samhsa.gov/product/suicide-safe
5. **Lethal means counseling**
   a. Recommendations for Clinicians. https://www.hsph.harvard.edu/means-matter/recommendations/clinicians/
   b. Recommendations for Families. https://www.hsph.harvard.edu/means-matter/recommendations/families/
   c. Counseling on Access to Lethal Means (CALM). https://dev.sprc.org/resources-programs/calm-counseling-access-lethal-means
   d. Firearm Safety and Injury Prevention. https://www.acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention/
6. **Rapid referrals**
   a. HelpPRO Therapist Finder. https://www.onlinetherapy.com/
   b. Therapy Finder. https://suicidepreventionlifeline.org/help-yourself/
7. **Discharge planning**
   a. Strategy 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf
8. **Care transitions**
   a. Continuity of Care for Suicide Prevention and Research. https://sprc.org/wp-content/uploads/2023/01/ContinuityCare_Suicide_Prevention_ED.pdf
   b. Safe Care Transitions for Suicide Prevention. https://dsamh.utah.gov/pdf/ZS%20Docs/Safe%20Care%20Transitions%20DSAMH%202018.pdf
9. **Follow-up**
   a. Follow-Up Matters. https://followupmatters.suicidepreventionlifeline.org/#one-month
   b. Re-engineered Discharge (RED) Toolkit; Tool 5: How to Conduct a Post discharge Follow up Phone Call. https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html
10. **Caring contacts**
    a. Now Matters Now, Caring Contacts. https://www.nowmattersnow.org/wp-content/uploads/2020/04/Caring-Contacts-Text-and-Scripts.pdf
    b. Zero Suicide, Contact after Leaving Care. https://zerosuicide.edc.org/toolkit-taxonomy/contact-after-leaving-care

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ASSESSMENT AND PREVENTION OF SUICIDE

Choose the best possible answer for each question and mark your answers on the self-assessment answer sheet at the end of this book. There is a required score of 70% or better to receive a certificate of completion.

11. _____% of individuals who die by suicide have had at least one contact with their primary healthcare provider within one year of dying by suicide.

A. 10.
B. 80.
C. 45.
D. 60.

12. The American Foundation for Suicide Prevention estimates that suicide is the _____ leading cause of death in the U.S.

A. 2nd.
B. 5th.
C. 10th.
D. 12th.

13. Healthcare workers must accurately assess for suicidal ideation. To do this, they must do all of the following EXCEPT:

A. Identify individual risk factors.
B. Use appropriate screening tools.
C. Identify levels of risk.
D. Manage the patient's medications.

14. Warning signs of suicide could include all of the following, EXCEPT:

A. Talking about feeling trapped.
B. Talking about having no purpose.
C. Decreasing the use of alcohol.
D. Extreme mood swings.

15. Which of the following individuals would be most likely at risk for suicide?

A. Linda, a 20-year-old black female.
B. Jerry, a 45-year-old white male.
C. Victoria, a 15-year-old white female.
D. Carl, a 26-year-old Hispanic male.

16. Stigma is a term that contains the following elements EXCEPT for:

A. Tolerance.
B. Prejudice.
C. Ignorance.
D. Discrimination.

17. All of the following are protective factors for suicide EXCEPT:

A. Belongingness.
B. Sense of purpose or meaning in one's life.
C. A high yearly income.
D. Religiosity.

18. The practitioner needs to inquire of the patient regarding suicidal thoughts, ideations, and plans. Which of the following would be an appropriate way to word the question?

A. "You are not thinking about dying by suicide, are you?"
B. "Have you ever tried to kill yourself or thought about suicide?"
C. "People who are moody like you often think about hurting themselves; you aren't thinking that way, are you?"
D. "Have you ever tried to attempt suicide to get attention?"

19. The important components of documenting a patient's suicide risk includes all of the following EXCEPT:

A. Risk factors for suicide.
B. Protective factors for suicide.
C. A patient's occupation.
D. The patient's suicide risk level.

20. Restricting access to lethal methods can result in all of the following EXCEPT:

A. Provide more suicide options.
B. Substitute planned method for less lethal one.
C. Delay a suicide from occurring.
D. Reducing the number of suicides.

21. The following statements are true EXCEPT for the following:

A. The higher the person's Adverse Childhood Experiences (ACE) score, the greater chance of a wide range of long-term health problems.
B. Compared to individuals without ACEs, the odds of suicide ideation or attempts in adulthood increased more than tenfold among individuals with 10 or more ACEs.
C. The ACE study first conducted examined the long-term health effects of trauma exposure, violence, and loss during childhood.
D. The higher the individual's ACE score, the greater chance of developing depression, anxiety, suicide, and PTSD.

22. In the month after a patient is discharged from inpatient care, the suicide death rate is:

A. 5 times higher in the first week after discharge.
B. 50 times higher in the first week after discharge.
C. 100 times higher in the first week after discharge.
D. 300 times higher in the first week after discharge.

23. One of the goals of psychiatric inpatient hospitalization for a suicidal patient is to:

A. Initiate long-term therapy only.
B. Conduct a psychiatric evaluation and initiate therapy and/or medications.
C. Exclusively conduct a medical evaluation.
D. Immediately refer a patient to intensive outpatient care.

24. The basic steps for a safety plan intervention include all of the following EXCEPT:

A. Identify warning signs that may indicate the beginning or escalation of a crisis.
B. Obtain crisis narrative in which the individual can "tell their story" about a specific suicidal or personal crisis.
C. Provide psychoeducation and introduce safety planning.
D. Immediately provide psychopharmacological intervention for the patient.

25. The Beck Depression Inventory-II assessment evaluates which of the following:

A. An individual's feelings and behaviors over the past 2 weeks.
B. An individual's feelings and behaviors over the past 2 days.
C. Active and passive suicide desire.
D. Gestures and non-verbal behavioral information.

26. After a suicide attempt, the first priority for a patient should be:

A. Alerting family and friends.
B. Medical stabilization at a hospital.
C. Providing medication.
D. Providing therapy.

27. Involuntary hospitalization is necessary when:

A. A patient refuses to attend appointments consistently.
B. A patient discloses passive suicidal ideation.
C. A patient has missed their medication(s).
D. A patient is a risk to themselves or others and refuses to be hospitalized.

28. A patient with an acute and high-risk for suicide:

A. Is unable to maintain safety without external support.
B. Has chronic suicidal ideation and an increase or change in baseline mood, behavior or talk about suicide/dying.
C. Has suicidal ideation, but does not currently have a plan for suicide or suicidal behaviors.
D. Has protective factors, coping skills, reasons for living and psychosocial stability suggesting the ability to endure future crisis without resorting to suicide.

29. As a result of public stigma surrounding suicide, survivors of suicide may:

A. Internalize feelings of shame.
B. Discuss suicide freely and openly.
C. Seek help from a therapist.
D. Alert their family members during a mental health crisis.

30. In regards to suicide, the American Psychiatric Association defines the term "Aborted or self-interrupted attempt" as:

A. When an individual is interrupted from self-destructive behavior by another person or outside circumstance.
B. When an individual formulates a plan for self-inflicted injurious behavior.
C. When an individual takes steps towards making a suicide attempt but stops before the actual act.
D. A non-fatal, self-directed, potentially injurious behavior with any intent to die.

NOTES

NOTES

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Shade circles like this: ● Final exam questions are located at the end of each chapter.

Best Practices for Treating Pain with Opioid Analgesics

	A	B	C	D
1	○	○	○	○
2	○	○	○	○
3	○	○	○	○
4	○	○	○	○
5	○	○	○	○
6	○	○	○	○
7	○	○	○	○
8	○	○	○	○
9	○	○	○	○
10	○	○	○	○

Assessment and Prevention of Suicide

	A	B	C	D		A	B	C	D
11	○	○	○	○	21	○	○	○	○
12	○	○	○	○	22	○	○	○	○
13	○	○	○	○	23	○	○	○	○
14	○	○	○	○	24	○	○	○	○
15	○	○	○	○	25	○	○	○	○
16	○	○	○	○	26	○	○	○	○
17	○	○	○	○	27	○	○	○	○
18	○	○	○	○	28	○	○	○	○
19	○	○	○	○	29	○	○	○	○
20	○	○	○	○	30	○	○	○	○

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LEARNER RECORDS: EVALUATION

You must complete the program evaluation and applicable activity evaluation(s) in order to earn *AMA PRA Category 1 Credits*™, MOC points, or participation in MIPS. For each of the objectives determine if the activity increased your:

A Competence B Performance C Outcome D No Change

COURSE 1 - BEST PRACTICES FOR TREATING PAIN WITH OPIOID ANALGESICS:

		A	B	C	D
1.	Identify and employ a full range of therapeutic options when developing a pain treatment plan..	○	○	○	○
2.	Screen patients for presence or risk of OUD, assess and manage patients who demonstrate signs of OUD, or refer if necessary	○	○	○	○

3. Please identify a specific change, if any, you will make in your practice related to safe prescribing of opioid analgesics.

_____

_____

4. What do you see as a barrier to making these changes?

_____

_____

COURSE 2 - ASSESSMENT AND PREVENTION OF SUICIDE:

		A	B	C	D
5.	Identify risk factors and utilize appropriate screening tools for patients at risk of suicide	○	○	○	○
6.	Use appropriate strategies for the assessment and treatment of patients at risk of suicide	○	○	○	○

7. Please identify a specific change, if any, you will make in your practice related to assessment and prevention of suicide.

_____

_____

8. What do you see as a barrier to making these changes?

_____

_____

OVERALL PROGRAM:

		Yes	No	If no, please explain:
9.	The program was balanced, objective & scientifically valid	○	○	_____
10.	Do you feel the program was scientifically sound & free of commercial bias or influence?	○	○	_____

11. How can this program be improved? _____

_____

12. Based on your educational needs, please provide us with suggestions for future program topics & formats. _____

_____

13. For which activities would you like to use your participation as a clinical practice improvement activity (CPIA) for MIPS?

○ Course 1 ○ Course 2 ○ None

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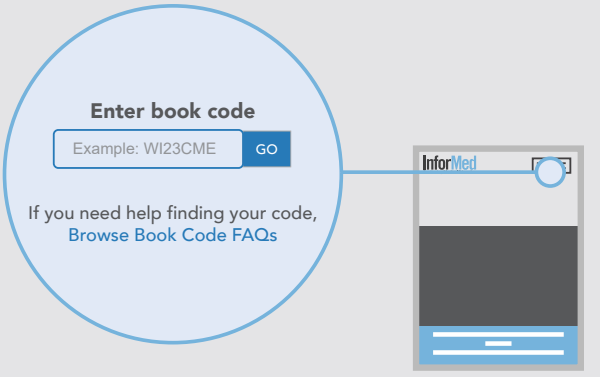

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