SUBSTANCE USE DISORDER AND SUICIDE PREVENTION

CENTRE FOR SUICIDE PREVENTION

INFORMATION • TRAINING • RESEARCH

RESOURCE TOOLKIT

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INTRODUCTION

The abuse of alcohol or drugs is second to depression as the most frequent risk factor for suicidal behaviour. The risks increase if **Substance Use Disorder (SUD)** co-occurs with **depression** (major depressive disorder) or other mental health disorders such as **Post Traumatic Stress Disorder (PTSD)**, **Anxiety Disorder, Bipolar Disorder, Schizophrenia** and some **personality disorders**. Those who experience depression or these other disorders often turn to drugs or alcohol as coping measures. Sometimes this use can evolve into SUD.

A substance can be defined as **prescription medication**, **over-the-counter preparations**, **alcohol, illegal drugs** (cannabis, cocaine, opiates, ecstasy, amphetamines, and hallucinogens), **steroids** or **inhalants** (Mood Disorders Canada, 2009).

Alcohol and some drugs can lead to suicidality through **loss of inhibition, impulsivity** and **impaired judgement.** SUD can also lead to changes in the brain that result in depression over time, and can be disruptive to relationships—causing alienation and a loss of social connection. Further, they can be a means to **ease the distress** associated with carrying out the act of suicide (NCIJ,2014; Pompilii, 2008).

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STATISTICS

- **40%** of all patients seeking treatment for alcohol/substance use disorder report at least one suicide attempt at some point in their lives (Pompilli, 2008).
- Acute alcohol intoxication is present in about **30–40**% of suicide attempts and suicides.

- Studies conducted in substance abuse rehabilitation programs typically reported that **50–75%** of clients had some type of co-occurring mental disorder.
- Studies in mental health settings reported that between **20–50%** of their clients had a co-occurring substance use disorder (SAMHAS, 2010).

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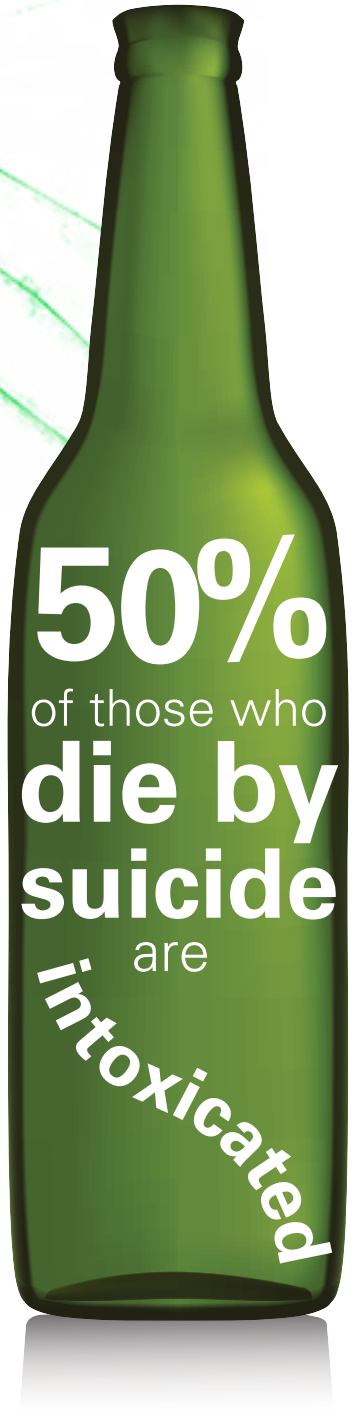
- While **95**% of individuals with a mental illness and/or substance use disorder will not die by suicide, **90%** of individuals who do die by suicide have either a mental or substance use disorder, or both (SAMHAS, 2008).
- Between **40–60%** of those who die by suicide are intoxicated at the time of death (NSSP, 2001).
- About **4.4%** of Canadians aged **15** and older met the criteria for a Substance Use Disorder in the past 12 months. The most common of these was Alcohol Use Disorder, at **3.2%** (Statistics Canada, 2012).
- For **4-12%** of the population in Canada and the United States, Alcohol and Substance Use Disorder can become a serious and life-threatening issue (Hasin, 830).



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DSM-5 Criteria for Substance Use Disorder

The American Psychiatric Association published the **Diagnostic and Statistical Manual of Mental Disorders (DSM)-5** in 2013. It has updated its criteria to define **Substance Use Disorder (SUD).**

Each specific substance is addressed as a separate use disorder (e.g., Alcohol Use Disorder, Stimulant Use Disorder, Opioid Use Disorder, etc.), but all substances are diagnosed based on the same overarching criteria. The following are the characteristics of **Alcohol Use Disorder (AUD):**

1. Alcohol is taken in **larger amounts** over a longer time period than intended;
2. Repeated **unsuccessful efforts to control** use;
3. **Significant time** spent in activities necessary to **obtain alcohol, use alcohol or recover** from effects;
4. **Craving** or having a strong desire or **urge to use** alcohol;
5. Recurrent use resulting in a **failure to fulfill obligations** at work, school or home;
6. Continued alcohol usage despite **social** or **interpersonal problems**;
7. Social, occupational or recreational **activities are eliminated or reduced** because of alcohol use;
8. Recurrent **use in physically hazardous situations**;
9. Continued use despite **knowledge of having a physical or psychological problem** caused or exacerbated by alcohol;
10. **Tolerance affected**: Increasing amounts of alcohol to achieve desired effects or intoxication, diminished effect

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with continued use of the same amount of alcohol;

11. **Withdrawal experienced**:

    a. **Withdrawal Symptoms**:
    - Reduction in heavy and prolonged alcohol use and at least two of the following:
        - » **Increased hand tremor, insomnia, nausea or vomiting, visual, tactile or auditory hallucinations or illusions, psychomotor agitation, anxiety and grand mal seizures**
    - The symptoms above cause significant stress in social, occupational, or other important areas of life
    - The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder

    b. **Alcohol or benzodiazepine** is taken to **relieve withdrawal symptoms**.

The presence of at least **2** of the above symptoms (1-11) indicates **Alcohol Use Disorder.**

Severity of AUD is defined as: **Mild- 2 to 3** symptoms; **Moderate- 4 to 5** symptoms; **Severe- 6** or more symptoms.

(American Psychiatric Association, 2013)

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RISK FACTORS FOR SUICIDE

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PROTECTIVE FACTORS

- **Identified reasons for living**
- **Being clean and sober**
- **A trusting relationship with a counsellor, physician, or other service provider**

- **Employment**
- **Presence of a child in the home and/or childrearing responsibilities**
- **Stable marriage**

- **Religious attendance and/or internalized spiritual teachings against suicide**
- **Attendance at SUD support groups**
  (eg. 12-step groups, Smart Recovery, Women in Sobriety)
- **Optimistic perspective on life**

(SAMHAS,2009)

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EXCERPT FROM iE13:

TRAUMA INFORMED CARE

TRAUMA, SUBSTANCE ABUSE AND SUICIDE PREVENTION

by Robert Olson, Librarian, Centre for Suicide Prevention

…trauma survivors often have a Substance Use Disorder. For example, among women with PTSD, **28%** meet the criteria for an alcohol use disorder, and **27%** for a substance use disorder. This is significant in that it is nearly **3** times the rate for women without PTSD. "The greater the trauma, the greater the risk (is) for alcohol abuse, illicit drug use, depression, suicide attempts, and other negative outcomes" (Rosenberg, 2011, p.428). **40–59%** of women in substance abuse rehabilitation have PTSD (Gatz, 2007), **50%** of women have a history of rape or incest, and up to **2/3** of men and women report childhood abuse and neglect (Desanto, 2012).

"The greater the trauma, the greater the risk for alcohol abuse and illicit drug use..."

The 12 Step model focuses on the abuse of the substance itself, not the underlying factors which may cause someone to drink or take drugs. In treatment centers that use this approach, The 12 Steps are the primary treatment in individual counseling as well as group therapy. This approach invites its participants to accept the idea that substance addiction is a disease that is progressive and incurable. The disease can only be controlled through ego-deflation, admittance of personal powerlessness, and the surrender of the individual will to a "higher power." According to this model, it is only by believing whole-heartedly and unquestioningly in these ideas that one has hope for recovery.

But for many–particularly trauma survivors and other vulnerable individuals–this 12 Step model can be a very ineffectual treatment. It is very common for someone who has been abused or victimized to develop an inherent belief in their own powerlessness. Thus, participating in a program that demands admitting and believing in their own powerlessness as its chief hallmark might ultimately be counterproductive to helping one regain power over their life. Further,

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to "trust" in a "higher power" for direction when all someone has known his or her entire life is betrayal, neglect, and abuse, might not be an objective easily achieved (White, 1998; Kasl, 1992; Apple, 2006).

A trauma survivor often turns to alcohol or drugs as a coping mechanism, and, in so doing, attempt to mask real pain that is not of their own making. With this in mind, there should be a thorough examination and treatment of the root causes–in this case, trauma– that drive an individual to become dependent on alcohol or drugs. This should be a main goal of a rehabilitation treatment program.

Non-12 Step rehabilitation centres, which are becoming increasingly common, try to adopt this approach. These alternative rehabilitation centres often employ an approach based on the "Bio/Psycho/Social" model of treatment, which purports a holistic and individualistic approach to recovery. They treat the "whole person", not just the symptoms. The creators of this model suggest that there are myriad reasons why someone becomes an addict or alcoholic. Thus, in practice, various methods are employed to address the individual's plight, while firmly stressing that each person's situation is unique. A facility that subscribes to this non-traditional philosophy and treatment model offers an option that has not often been seen before in the substance abuse rehabilitation industry. This option is, of course, choice. These alternative treatment programs emphasize the new idea that one size does not, in fact, fit all, and that each person should have their own "tailor-made" solution… It is a humanistic, client-centered philosophy that represents a major paradigm shift in the treatment of trauma.

"A trauma survivor often turns to alcohol or drugs as a coping mechanism... [an] attempt to mask real pain that is not of their own making."

Two examples include: Minnesota Alternatives in Spring Lake Park, Minnesota: http://mnalternatives.com/ and The Sunshine Coast Health Centre in Powell River, British Columbia: http://www.sunshinecoasthealthcentre.ca/ are two such programs that employ non-12 Step, alternative recovery models. Both institutions also specialize in working with trauma survivors with Substance Use Disorder.

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DEMOGRAPHICS

ADOLESCENCE

Co-morbid disorders such as depression are frequently exhibited in adolescents who misuse alcohol or other substances. Any adolescent who appears to be at risk for alcoholism/addiction or depression should always be screened for all other psychiatric disorders and for suicidality (Makija, 2007).

Poor impulse control is a key risk factor that often underlies suicidal and substance use behaviours.

Adolescent substance use may increase the risk for suicidal behaviour due to both acute and long-term effects.

Stressful life events, both traumatic and interpersonal, have been shown to contribute to suicide risk in adolescents (Dawes, 2008).

MIDDLE-AGED MALES

Middle-age and older men with alcohol dependence and mood disorders are at particularly high risk for suicide (Sher, 2006).

Instead of talking about stress or trying to seek help for their depression men will often mask their stress and deal with their depression through harmful behaviours and actions.

Most men do not like to admit that they feel vulnerable or uncertain, and so are less likely to talk about their feelings with their friends, loved ones, or doctors.

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Depression in men, at least in the early stages, often manifests as irritability, anger, hostility, aggression, abusive behaviour, risk taking, substance abuse, and escaping behaviours.

Data also reveal that men are far more likely to present to the emergency department than to general practice, and this relates to men's denial of illness, longer self-surveillance, and reliance on self-management strategies (Ogrodniczuk, 2011).

+65 AND OLDER

Those over 65 years of age abuse alcohol more than any other drug (Osgood, 1992).

25–50% of seniors have a substance abuse problem **and** a mental illness. (Mood Disorders Canada, 2009).

Early onset drinkers are those who have always had a dependence on alcohol but have "survived" into older age only to have their problems compounded. About 2/3 of older adults with drinking problems are early onset drinkers.

Reactive problem drinkers become dependent on alcohol in later life as an attempt to "self-medicate"(Osgood, 1992) and drink in response to recent losses because of stressors such as the **death of spouses, family or friends; retirement; changes in the family structure**; and **failing physical or mental health**.

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SELF-HELP AND PEER-TO-PEER SUPPORT

12 STEP GROUPS

Alcoholics Anonymous www.alcoholics-anonymous.org
"Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism."

Narcotics Anonymous www.na.org/

Cocaine Anonymous www.ca.org

A.A. Agnostica aaagnostica.org
A.A. for atheists and agnostics. A website meant to be a helping hand for the alcoholic who reaches out to Alcoholics Anonymous and finds that she or he is put off by the religious content of many AA meetings.

ALTERNATIVE GROUPS

Women in Sobriety www.womenforsobriety.org
A non-profit dedicated to helping women overcome alcoholism and other addictions through self-help programs which help achieve sobriety and sustain ongoing recovery.

Smart Recovery www.smartrecovery.org
Face-to-face meetings and online. "SMART (**S**elf **M**anagement **a**nd **R**ecovery **T**raining) recovery participants learn tools for addiction recovery based on the latest scientific research and participate in a worldwide community which includes free, self-empowering, science-based mutual help groups."

HAMS Network www.hamsnetwork.org
HAMS is a peer-led, free-of-charge support and informational group for anyone who wants to change their drinking habits for the better. The acronym HAMS stands for Harm reduction, Abstinence, and Moderation Support.

LifeRing lifering.org
"LifeRing is an abstinence-based, worldwide network of individuals seeking to live in recovery from addiction to alcohol or to other non-medically indicated drugs." Offers peer-to-peer support in ways that encourage personal growth and continued learning through personal empowerment.

Rational Recovery rational.org
"A worldwide source of counseling, guidance, and direct instruction on self-recovery from addiction to alcohol and other drugs through planned and permanent abstinence."

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REFERENCES

American Psychiatric Association.(2013). *Diagnostic and Statistical Manual of Mental Disorders, (DSM-5)*. Washington, D.C.: American Psychiatric Association.

Apple. (2006). What AA does for survivors of abuse or trauma. Retrieved from http://www.morerevealed.com/aadep/reclaim/whataadoes.html

Dawes, M., Mathias, C. and Richard, D. (2008). Adolescent suicidal behaviour and substance use: Developmental mechanisms.[HTML] *Substance Abuse: Research and Treatment*, 2, 13-28.

DeSanto, P. (2012). *Effective addiction treatment: The Minnesota alternative*. Spring Lake Park, MN. Minnesota Alternatives.

Hasin, D. S., et al. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States. *Archives of General Psychiatry*, 64(7), 830-842.

Kasl, C. (1992). *Many roads to recovery: Moving beyond the 12 steps*. New York: HarperCollins.

Makija, N. and Sher, L. (2007). Preventing suicide in adolescents with alcohol use disorders. *International Journal of Adolescent Medicine and Health*, 19(1), 53-59.

Mood Disorders Society of Canada. (2009). *Quick Facts: Mental illness and addiction in Canada*. Retrieved from http://www.mooddisorderscanada.ca/documents/Media%20Room/Quick%20Facts%203rd%20Edition%20Referenced%20Plain%20Text.pdf

National Center for Injury Prevention (NCIJ). (2010). *Suicides Due to Alcohol and/or Drug Overdose: National Center : A Data Brief from the National Violent Death Reporting System*. Retrieved from http://www.cdc.gov/violenceprevention/pdf/NVDRS_Data_Brief-a.pdf

Ogrodniczuk, John S. and Oliffe, John L. (2011). Men and depression. *Canadian Family Physician*,57(2),153-155.

Osgood, Nancy. (1992). *Suicide in later life: Recognizing the warning signs*. New York: Lexington Books.

Pompili, M. et al. (2010). Suicidal behaviour and alcohol abuse. *International Journal of Environmental Research and Public Health*, 7, 1392-1431.

Statistics Canada. (2012). *Canadian Community Health Survey: Mental Health, 2012*.Retrieved from http://www.statcan.gc.ca/daily-quotidien/130918/dq130918a-eng.htm

Rosenberg, L. (2011). Addressing trauma in mental health and substance use treatment. *The Journal of Behavioural Health Services & Research*, 38(4), 428-431.

Substance Abuse and Mental Health Services (SAMHSA). (2009). Addressing Suicidal Thoughts and Behaviours in Substance Abuse Treatment: TIP 50. Retrieved from http://store.samhsa.gov/shin/content/SMA09-4381/TIP50.pdf

Substance Abuse and Mental Health Services (SAMHSA). (2010). *SAMHSA News*, 17(1), 9. Retrieved from http://www.samhsa.gov/samhsanewsletter/Volume_17_Number_1/JanuaryFebruary2009.pdf

Substance Abuse and Mental Health Services (SAMHSA). (2008). *Substance Abuse and Suicide Prevention: Evidence & Implications*. Retrieved from http://www.samhsa.gov/matrix2/508suicidepreventionpaperfinal.pdf

Sher. L. (2006). Alcohol consumption and suicide. *Quarterly Journal of Medicine*, 99(1), 57-61. Suicide Prevention Resource Center (SPRC).

White, W. (1998). *Slaying the dragon*. Bloomington, IL.: Chestnut Health Systems.

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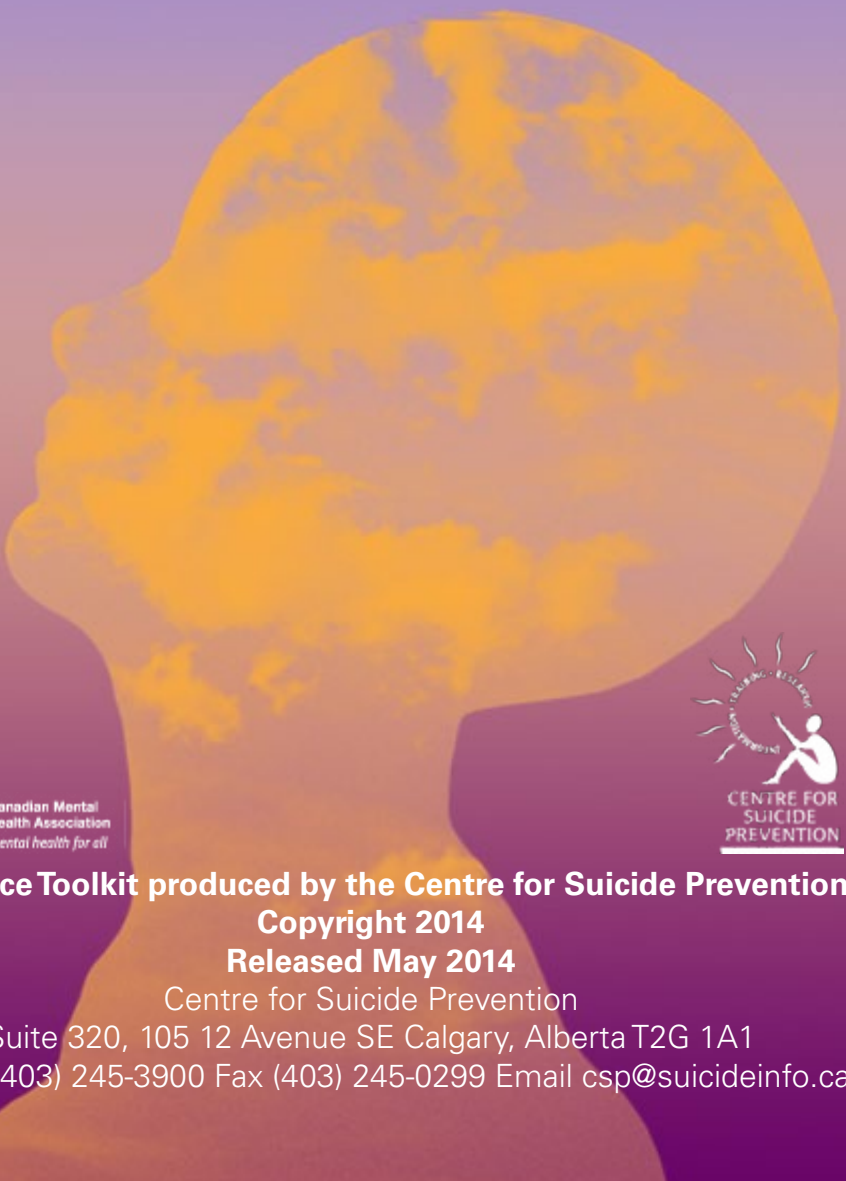

Canadian Mental Health Association
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Resource Toolkit produced by the Centre for Suicide Prevention

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Released May 2014

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