The Relationship Between Suicide and Alcohol Misuse

Dale Roberson, LCSW, CADC, C-DBT
(he/him)
Objectives

1. Discussion of research on associations of suicidal behavior (including suicide and suicide attempt) with acute use of alcohol and alcohol use disorder.
2. Unpack the complexity of suicide with its several psychological, social, biological, cultural, and environmental factors.
3. Discover potential risk-reduction, prevention, and clinical strategies we can employ to reduce this public health concern.
Why Are We Here?

This presentation summarizes the relationship between alcohol use and suicide, provides behavioral treatment and prevention professionals with information on the scope of the problem, an understanding of traditional barriers to collaboration and current programming, and ways to work on alcohol misuse and suicide prevention strategies.
The Link Between Alcohol Use & Suicide

- Suicide claims more than 800,000 lives each year worldwide and is the second-leading cause of death among people ages 15 to 29.
- For every suicide, at least 20 non-lethal suicide attempts have occurred, primarily by attempted overdose.
- These attempts are a leading cause of hospitalizations from injury and a potent risk factor for eventual suicide.
- Alcohol use may confer risk for these outcomes proximally through acute use of alcohol (AUA), which has been defined as the use of alcohol within 3 hours or within 6 hours of suicidal behavior, or as any blood alcohol concentration (BAC) in an individual who attempted suicide or died by suicide.

(Conner, KR. & Bagge, CL; page 1)
Current Information on Suicide-related Thoughts and Behaviors in Florida

In 2019 Suicide was the:

- 8th leading cause of death for all Floridians.
- 2nd leading cause of death for people ages 25-34 (Although the death rate by unintentional injury is four times higher than deaths by suicide, suicide remains the second leading cause of death followed by homicide, cancer, and heart disease.)
- 4th leading cause of death for people ages 5-14, 35-44, 45-54.
- 8th leading cause of death for people ages 55-64.

(Florida Vital Statistics Annual Report 2019)
Current Information on Suicide-related Thoughts and Behaviors in Florida

The 2019 Florida Youth Risk Behavior Survey results are below:

- 33.7% Felt sad or hopeless for two or more weeks in a row
- 15.8% Purposefully hurt themselves without wanting to die
- 15.6% Seriously considered attempting suicide
- 11.8 Made a plan to attempt suicide
- 7.9% Attempted suicide

(2019 Florida Youth Risk Behavior Survey)
Current Information on Suicide-related Thoughts and Behaviors in Florida

- In 2019, 3,427 Floridians died by suicide, representing a 3.5 percent decrease from the number of deaths in 2018.
- Over half of suicide deaths in 2019 involved a firearm. For non-fatal intentional self-harm injuries, a total of 8,370 hospitalizations occurred in Florida in 2019.
- Furthermore, there were 12,514 Emergency Department visits related to self-harm injuries.
- Of note, intentional self-harm includes incidents with and without intent to die, therefore, not all self-harm injuries represent suicide attempts.
- Nevertheless, non-suicidal self-injury may incur additional risk for future suicide attempts and potentially death.

(Florida Department of Health, Florida Bureau of Vital Statistics Suicide and Behavioral Health Profile)
Chart 1

Depicts a slight overall increase in the age-adjusted suicide death rate across genders and age groups across the previous decade.

White males continue to die by suicide at the highest rate (29.7 per 100,000), followed by Black males (10.0 per 100,000), White females (8.6 per 100,000), and Black females (2.0 per 100,000).

*(Florida Vital Statistics Annual Report [2020]*)
Chart 2

Depicts 722 individuals 55 – 64 years old died by suicide in 2019.

The age group with the second most deaths was 45 – 54, followed by those aged 25 – 34.

(Florida Vital Statistics Annual Report [2020])
Graph 1
Provides information on the estimated percentages for each method used to die by suicide in 2019.

Firearms represented the largest percentage, with about 53% of deaths caused by firearms, followed by hanging/suffocation, drugs and biological substances, other method, and jumping from a high place.

Importantly, firearms continue to be the most common used method in suicide deaths.

*(Florida Vital Statistics Annual Report [2020]*)
Symptoms of Alcohol Intoxication (DSM-5)

A. Recent ingestion of alcohol
B. Clinically significant problematic behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment) that developed during, or shortly after, alcohol ingestion.
C. One (or more) of the following signs or symptoms developing during, or shortly after, alcohol use:
   A. Slurred speech
   B. Incoordination
   C. Unsteady gait
   D. Nystagmus (rapid involuntary movements of the eyes)
   E. Impairment in attention or memory
   F. Stupor or coma
D. Signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.
Symptoms of Alcohol Withdrawal (DSM-5)

A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.

B. Two (or more) of the following, developing within several hours to a few days after cessation of (or reduction in) AU described in Criterion A:
   A. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100bpm)
   B. Increased hand tremor
   C. Insomnia
   D. Nausea or vomiting
   E. Transient visual, tactile, or auditory hallucinations or illusions
   F. Psychomotor agitation
   G. Anxiety
   H. Generalized tonic-clonic seizures

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. Signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.
Diagnostic Criteria for Alcohol Use Disorder (DSM-5)

- Alcohol is taken in larger amounts or over a longer period than was intended.
- Persistent desire or unsuccessful efforts to cut down or control alcohol use.
- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
- Craving, or a strong desire or urge to use alcohol.
- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued alcohol use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

- Recurrent alcohol use in situations in which it is physically hazardous.
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- Tolerance
- Withdrawal

**Mild:** 2-3 criteria met

**Moderate:** 4-5 criteria met

**Severe:** 6+ criteria met
Alcohol’s Contribution to Suicidality

- Alcohol use disorder (AUD) is the second-most commonly identified mental disorder among suicide decedents worldwide (the most common is mood disorder), suggesting that AUD is a major contributor to population-level rates of suicide.

- Key reasons that AUD is a major risk factor for suicide include its role in contributing to substance-induced depressive episodes, disruptions in interpersonal relationships (e.g., breakups), and repeated exposure to alcohol intoxication.

*(Conner, KR. & Bagge, CL; page 2)*
Alcohol’s Contribution to Suicidality

– The Centers for Disease Control and Prevention defines suicide as "death caused by self-inflicted injuries with the intention of dying from the result of such actions".

– Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10-14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication.

– For contrasts, one study found that opiates were present in 20% of suicide deaths, marijuana in 10.2%, cocaine in 4.6%, and amphetamines in 3.4%.

(Esang, M, & Ahmed, S.; page 1)
Alcohol’s Contribution to Suicidality

- Suicide risk is **highest** among patients living with bipolar disorder and unipolar affective disorder, followed by schizophrenia and anxiety disorders.
- Men with comorbid depression and alcohol use have the highest long-term suicide risk (16.2%).
- The prevalence of lifetime suicide attempts among patients with alcohol use disorder and bipolar disorder is reported to be between 21% and 42%.
- Similarly, patients with bipolar disorder and comorbid substance use disorder have earlier-onset mood symptoms, higher rates of anxiety disorders, more suicide attempts, and more frequent hospitalizations than patients with bipolar disorder alone.

*(Esang, M, & Ahmed, S.; page 1)*
AUA and Suicidal Behavior by Firearm

– Data shows that alcohol intoxication is most commonly present in suicide by firearm among young adult and middle-aged men.
– Such data provide a strong empirical rationale for the common clinical practice of holding intoxicated, suicidal patients in emergency settings to allow for a drop in BAC before assessing suicidal risk and considering discharge.

(Conner, KR. & Bagge, CL; page 2)
Acute Stabilization

- Clinical recommendations suggest inpatient care for individuals with alcohol misuse who present with suicidal plans or intent, preferably in a dual-diagnosis facility (i.e., treatment setting for AUD/SUD and comorbid mental illness).
- Evidence suggests that suicidal individuals with comorbid AUD significantly benefit from inpatient treatment relative to outpatient settings.
  - Additionally, acutely intoxicated individuals with suicidal urges appear to stabilize quickly in inpatient care.
  - However, relapse and suicidal behavior following discharge remain significant concerns.

(Rizk, Mina M., et al.; page 3)
Acute Stabilization

- Transfer to another inpatient setting following acute stabilization may decrease the risk of post-discharge suicide attempts, and longer treatment courses, whether inpatient or outpatient, may lower the post-treatment risk of suicidal behavior.
  - Notably, impulsive suicide attempts may be a strong indicator of relapse risk after discharge.
- Individuals with alcohol dependence who are hospitalized for an impulsive suicide attempt have higher rates of post-discharge relapse, and relapse faster, than those without an impulsive attempt.
  - This lends support to the clinical utility of targeting suicidality and alcohol misuse simultaneously in the acute stages of treatment.

(Rizk, Mina M., et al.; page 3)
Alcohol’s Behavioral Mechanism as a Catalyst for Suicide

Mechanisms responsible for alcohol’s ability to increase the proximal risk for suicidal behavior include alcohol’s ability to:

1. increase psychological distress,
2. increase aggressiveness,
3. propel suicidal ideation into action through suicide-specific alcohol expectancies (e.g., alcohol may supply the motivation to complete the action, the user may believe that alcohol will assist in completing suicide painlessly), and
4. constrict cognition, which impairs the generation and implementation of alternative coping strategies.

(SAMHSA.gov; page 4)
Risk Assessment and Management

– The goal of intervention is to treat acute, modifiable risk factors and to continuously ensure the individual's safety.
– Individuals at high risk for suicide should be hospitalized as a precaution, and detoxification treatment should be started immediately.
– Subsequently, it is crucial to make the individual aware of the process of rehabilitation.

(Esang, M, & Ahmed, S.; page 2)
At-Risk Populations for Suicide

The following populations are known to have an increased risk for suicidal behaviors:

– American Indians/Alaska Natives
– Individuals bereaved by suicide
– Individuals in justice and child welfare settings
– Individuals who engage in non-suicidal self-injury
– Individuals who have attempted suicide
– Individuals with medical conditions
– Individuals with mental and/or substance use disorders
– LGBTQIA+ individuals
– Members of the armed forces and veterans
– Men in midlife
– Older men

(SAMHSA.gov; page 4)
Warning Signs of Substance Misuse

– Has smell of alcohol on breath
– Slurs speech or stutters, is incoherent
– Has difficulty maintaining eye contact
– Has tremors (shaking or twitching of hands and eyelids)
– Exhibits impaired coordination or unsteady gait (e.g., staggering, off balance)
– Experiences wide mood swings (highs and lows)
– Appears fearful or anxious; experiences panic attacks
– Appears impatient, agitated, or irritable
– Is increasingly angry or defiant
– Behaves in an impulsive or inappropriate manner

(SAMHSA.gov; page 11)

– Denies, lies, or covers up
– Takes unnecessary risks or acts in a reckless manner
– Misses interviews, appointments, or meetings or arrives intoxicated
– Has difficulty concentrating, focusing, or attending to a task
– Appears distracted or disoriented
– Makes inappropriate or unreasonable choices
– Has difficulty making decisions
– Experiences blackout
– Needs directions repeated frequently
– Has difficulty recalling known details
Warning Signs of Suicide

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others

(SAMHSA.gov; page 11)

- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings
- Losing interest in things, or losing the ability to experience pleasure
Awareness of Shared Risk and Protective Factors

- Practitioners must be aware that individuals who make a suicide attempt are at considerable risk for repeat attempts and eventual suicide and that this risk may last many years.
- People at risk for suicide and substance misuse share a number of risk factors that include depression, impulsivity, and thrill-seeking/life threatening behaviors.
- Because risk and protective factors for the two can overlap, prevention professionals need to be aware of them and to implement prevention programming that reduces risk and enhances protective factors within the population and in communities.

(SAMHSA.gov; page 10)
### Dynamic and Static Risk Factors Associated with Suicide and Protective Factors

#### Dynamic and Acute Risk Factors
- Current suicidal ideation
- Current suicidal plan
- Preparation for suicide
- Acute symptoms of mental disorder
- Severe psychic anxiety
- Anxious ruminations
- Global insomnia
- Psychosis with delusions of poverty or doom
- Active or recent alcohol abuse

#### Static and Long-Term Risk Factors
- Family history
- Caucasian race
- Unmarried status
- Living alone
- Lack of social support
- Medical illness
- Unemployment
- Fall in social or economic status
- Rejection by spouse or partner
- Previous suicide attempts
- Anniversary of important losses

*(Esang, M, & Ahmed, S.; page 2)*
Protective Factors

- A trusting relationship with a counselor, physician, or other service provider
- An optimistic or positive outlook
- Childrearing responsibilities
- Coping and problem-solving skills
- Cultural and religious beliefs that discourage suicide
- Employment
- Involvement in community activities
- Perceiving that there are clear reasons to live
- Receiving effective mental and/or substance use disorder treatment/care
- Resiliency, self-esteem, direction, perseverance
- Sobriety
- Strong family bonds and social skills

(SAMHSA.gov; page 10)
Cuteness Pause
Temperature Check

How are we doing?

– Questions?
– Comments?
– Insights?
Why Focus on the Substance Misuse and Suicide Interconnection?

– Behavioral treatment and prevention professionals have the unique advantage of being in a position to promote a public health approach, supporting preventive interventions across the entire continuum from prevention to treatment to recovery supports.

– Focusing on alcohol consumption, population-based studies have begun to show that alcohol prevention is suicide prevention.

– For example, a study in Ontario, Canada, revealed that as alcohol consumption in a population rises, the suicide rate also rises by between 11 and 39 percent, suggesting that a population’s level of alcohol use may be correlated with the suicide rate.

(SAMHSA.gov; page 7)
Intervention: The Public Health Approach to Prevention

- The public health approach to preventing suicide and substance misuse includes universal, selective, and indicated strategies.

- What follows are some suggestions that behavioral treatment and prevention policymakers may implement to further promote this public health approach.

(SAMHSA.gov; page 7)
Problem Definition and Gap Analysis

– **Determine the extent of the problem.** Estimating the incidence of substance misuse and suicidal behaviors is a precursor to developing a strategy to reduce suicides linked to substance use.

– **Identify substance misuse and suicide prevention efforts already occurring.** An environmental scan for existing substance misuse and suicide prevention programs is the next step in developing a strategic plan to address the intersection between substance misuse and suicide.

  – An environmental scan should include assessing programs in clinical and community settings, including hospitals, primary care clinics, behavioral health settings, crisis intervention programs, the criminal and juvenile justice systems, schools, college campuses, community-based organizations, workplaces, and faith-based organizations.

(SAMHSA.gov; page 7)
Collaboration

– **Begin the dialogue.** Multi-disciplinary collaboration is a key attribute of public health. Therefore, a dialogue that emphasizes a public health approach and that engages all facets of the community—the general public, elected officials, schools, parents, first responders, religious communities, and many others—should be launched and maintained.

– **Translate the need for substance misuse/suicide prevention integration into distinct prevention funding initiatives.** Funding exists for a wide range of community partners. These partners collectively form a natural constituency for integrated funding initiatives.

*(SAMHSA.gov; page 8)*
Policy

- Develop, disseminate, and implement policies supporting prevention of substance misuse and suicide. Another area of policy development is screening and assessment. Further prevention goals by developing and promoting universal screening and assessment tools for substance use disorders and suicide risk.

- Seek guidance and direction from Florida’s Statewide Office for Suicide Prevention, Office of Substance Abuse and Mental Health, Florida Department of Children and Families
  
  - Suicide Prevention - Florida Department of Children and Families (myflfamilies.com)

(SAMHSA.gov; page 9)
Program Development

- **Program development.** Once information has been gathered about the prevalence of suicidal behaviors linked to substance use and available programs addressing these issues have been identified, select and implement evidence-based programs that meet the specific cultural, community, and developmental norms of the targeted population.
  - Community interventions must be able to deliver and, to some extent, integrate screening, primary prevention, assessment, diagnostic, and treatment services.

(SAMHSA.gov; page 9)
Organizational Barriers

- Organizational barriers to collaborating may exist due to each agency’s unique and distinct mission and the structures in place for addressing its mission.

- Using an interagency approach to develop a comprehensive suicide prevention strategy, state and tribal governments can bridge organizational barriers, build connections among agencies, and facilitate collaboration.

(SAMHSA.gov; page 5)
Funding Barriers

– Funding mechanisms are another potential barrier to collaboration. Federal funding, which includes Block Grants for both mental health and substance misuse and Partnerships for Success grants for substance misuse prevention (among others), is typically disbursed to a specific state agency or tribal government, which then provides sub-grants to community agencies or organizations, institutions of higher education, or tribal organizations.

– These funding streams may reinforce each agency’s unique way of operating and fulfilling its mission.

– Formation of suicide prevention councils, coalitions, or work groups that bring together stakeholders across agencies and organizations can help to coordinate funding from different sources and promote collaboration to tackle suicide prevention activities.

(SAMHSA.gov; page 5)
Philosophical Differences

– Previously, substance misuse preventionists thought of suicide as a mental health issue that was best addressed through clinical interventions, especially for depression.

– Those working in the substance misuse field left suicide prevention mainly to mental health professionals. At the same time, mental health professionals were not always trained to work with suicidal persons who had co-occurring mental and substance use problems.

– Working collaboratively across the mental health and substance misuse fields is therefore key to reducing suicide rates.

(SAMHSA.gov; page 5)
Lack of Information

– Reluctance to work collaboratively across agencies, departments, organizations, and professions may also be due to lack of information about the link between substance use and suicidal behavior.
– Prevention professionals should be informed about the connections between suicide and substance use—particularly underage alcohol use, binge drinking, and adult alcohol misuse—and be encouraged to work together on prevention strategies.

(SAMHSA.gov; page 6)
Actions for Prevention Professionals

What should substance misuse prevention professionals do?

– **Learn** who is responsible for suicide prevention in your state or tribal organization
– **Become** familiar with suicide prevention plans, strategies, and programs
– **Identify** public health goals that you have in common with agencies, organizations, and/or coalitions leading suicide prevention efforts
– **Leverage** each other’s strengths and ask to partner with suicide prevention agencies and coalitions
– **Plan** and implement cross-training on the link between substance misuse and suicidality and the risk factors and warning signs for substance misuse
– **Use** process and outcome data to evaluate and make the case that prevention works—use data to show that reducing substance misuse lowers suicidal behavior and suicide attempts

*(SAMHSA.gov; page 12)*
Actions for Prevention Professionals

What should suicide prevention professionals do?

– **Learn** who is responsible for substance misuse prevention in your state or tribal organization
– **Become** familiar with substance misuse prevention plans, strategies, and programs
– **Identify** public health goals that you have in common with agencies, organizations, and/or coalitions leading substance misuse prevention efforts
– **Leverage** each other’s strengths and ask to partner with substance misuse prevention agencies and coalitions
– **Plan** and implement cross-training on the link between suicidality and substance misuse, the different types of suicidal thoughts and behaviors, and the risk factors and warning signs for suicide
– **Use** process and outcome data from your substance misuse prevention colleagues to evaluate and make the case that substance misuse prevention is suicide prevention—suicide prevention programs that address substance misuse help to lower suicide rates

*(SAMHSA.gov; page 12)*
Clinical Interventions
Pharmacological Interventions

There are many FDA-approved medications for treatment of depression and primary among them are selective serotonin reuptake inhibitors (SSRIs). As yet, however, there are no FDA-approved medications specifically indicated for suicidal ideation, urges, or behavior.

A few pharmacotherapies have been approved for the treatment of alcohol misuse. They include disulfiram, which produces aversive symptoms following alcohol intake; acamprosate, thought to mitigate withdrawal-related symptoms; and naltrexone, a nonselective opiate receptor antagonist that reduces alcohol cravings.

These drugs primarily operate by targeting reinforcement mechanisms involved in alcohol misuse; however, extended-release naltrexone has also shown some benefits in reducing attendant anxiety and depressive symptoms.

(Rizk, Mina M., et al.; page 4)
Pharmacological Interventions

– **SSRIs** consistently produce a modest 15–20% reduction in alcohol consumption, however intra-individual reductions in alcohol intake range widely from 10 to 70%. In addition to SSRIs, **tricyclic antidepressants** are thought to mitigate depressive-like alcohol withdrawal symptoms and may be effective for co-occurring depression and AUD.

– Antidepressants may not be justified for treatment of alcohol misuse in the absence of major depressive disorder (MDD). To date, however, there are insufficient trials comparing one medication to another, and few that examine the effects of pharmacotherapy on suicidality in alcohol users.

*(Rizk, Mina M., et al.; page 4)*
Psychotherapeutic Interventions

- Brief interventions for suicidal crises (e.g., *Safety Planning Intervention [SPI]*) often implemented in healthcare settings typically involve a written compilation of suicidal thoughts and behaviors (STB) triggers, coping strategies, and sources of support.

- Similar variations may include a risk assessment component (e.g., *ED-SAFE*) or intermittent outreach (e.g., *SPI*).

- These interventions have shown success in reducing imminent suicide risk and may be potentially adapted to address simultaneous risk of alcohol misuse. *However, there is a dearth of research evaluating their effectiveness in co-occurring suicidality and AUD.*

*(Rizk, Mina M., et al.; page 4)*
Psychotherapeutic Interventions

- **Motivational enhancement therapy (MET)** is a time-limited intervention that utilizes **motivational interviewing (MI)** principles to resolve ambivalence about treatment engagement and clarify goals relating to alcohol use.

- **Cognitive behavioral therapy (CBT)** for co-occurring mood and AUD focuses on dysfunctional, distorted, or self-defeating schemas or beliefs that may be contributing, jointly or severally, to depressed mood, suicidality, and alcohol misuse.

- MI and CBT interventions have shown the greatest success among psychotherapeutic interventions used in populations with co-occurring alcohol misuse and depression and/or anxiety, even in brief interventions, and longer-term treatments produce still better outcomes.

*(Rizk, Mina M., et al.; page 4)*
Psychotherapeutic Interventions

– Other interventions, such as *relapse prevention therapy (RPT)* and *contingency management (CM)*, directly target the psychological reinforcement mechanisms that maintain addictive behavior.

– While they have been effective in populations with AUD/SUDs, there is limited evidence of their utility in co-occurring suicidality/depression and alcohol misuse.

– Psychotherapy in combination with psychopharmacological treatment may also benefit from the advantages of each of these modalities.

*(Rizk, Mina M., et al.; page 4)*
Clinical Practice and Research Implications

- Assessments of the role of AUA in suicide attempts should begin with establishing if AUA occurred and estimating the amount of alcohol consumed. Assessments may include determining an individual’s motivation for drinking before the attempt and a collaborative chain analysis with the individual.

- **Chain analysis** is a retrospective method for determining the sequence of events, thoughts (e.g., suicide premeditation and drinking motivations), and behaviors (e.g., drinking) that led up to a suicidal act.

- The information learned from a chain analysis can be used to develop a personalized distress safety plan that highlights high-risk periods and warning signs, and to devise strategies for avoiding alcohol. Overall, the goal of the plan is to prevent escalation of suicidal risk in the context of AUA.

- Future research directions include the study of real-time interventions via mobile applications, which could potentially coach individuals on adaptive strategies for suicidal thoughts, urges to drink, or distressing experiences.

*(Conner, KR. & Bagge, CL; page 3)*
Conclusion

– Further empirical research is necessary to differentiate the acute effects of alcohol intake on suicidality, separate from chronic or dependent use.
– Additionally, the gaps in intervention research on co-occurring suicidality and AUD are substantial, and pharmacological studies do not frequently account for the effects on suicidality, specifically, in addition to mood improvements in alcohol users.
– Given the high prevalence of alcohol use alongside escalating rates of suicide, there is a compelling need for attention to their co-occurrence.

(Rizk, Mina M., et al.; page 7)
Any...
Thank You!
References

*Pictures included are available for use in public domain.*

- 2019 Florida Youth Risk Behavior Survey
References

– Florida Department of Health, Florida Bureau of Vital Statistics Suicide and Behavioral Health Profile  

References


Resources

– Behavioral Health Treatment Services Locator http://findtreatment.samhsa.gov
– Centers for Disease Control and Prevention (CDC) Suicide Prevention (cdc.gov)
– Florida Certification Board (remote-learner.net) free online courses available for CEUs:
  – Assessing Suicide Risk
  – Suicide Prevention
  – Youth Suicide Prevention
– Suicide Deaths - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)
Resources

– Substance Use and Suicide Prevention
  – Suicide Prevention - Florida Department of Children and Families (myflfamilies.com)
– Suicide Prevention Suicide Prevention - Florida Department of Children and Families (myflfamilies.com)
– Suicide Prevention Hotlines
  – National Suicide Prevention Lifeline 1-800-273-TALK (8255)
  – www.SuicidePreventionLifeline.org
– Veterans Crisis Line
  – 1-800-273-TALK (8255) PRESS 1