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Research with Older Adult Methadone Clients: The Importance of Monitoring Suicide Ideation

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Introduction

Researchers confronted with study participants who are older adults and current MMT clients remain in need of an integrated, relatively rapid screening process to gauge suicide ideation. Suicide ideators are those who currently have plans and wishes to commit suicide but have not made any recent overt suicide attempt (Centers for Disease Control and Prevention, 2016). Among older adults in methadone maintenance treatment (MMT), comorbid psychiatric conditions, and psychosocial adversities present a special need to assess for suicide ideation (Choi, DiNitto, Marti, & Choi, 2016; Wu & Blazer, 2013). There is a preponderance of tools to assess risk for suicide in multiple contexts, e.g. adults in primary care, outpatient care, emergency departments, and high risk youth in clinical settings (Gaynes et al., 2004; Heilbron, Goldston, Walrath, Rodi, & McKeon, 2013; Linehan, Comtois, & Ward-Ciesielski, 2012; Randall, Colman, & Rowe, 2011; Simon et al., 2013). Furthermore, there exists a “gold standard” in the Columbia Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2011) which has been validated across three multisite studies in treatments for adolescents and adults. However, protocols for assessing suicide ideation among depressed older adults in methadone maintenance treatment (MMT) do not exist. Furthermore, despite the increasing numbers of older adult heroin users who are accessing opioid treatment, this highly marginalized group remains a scarcely studied population (Han et al., 2015; Rosen, Hunsaker, Albert, Cornelius, & Reynolds, 2011).

Screening Suicide Ideation Among Older Adult, Substance-using Study Populations

Researchers are confronted with the ethical necessity to intentionally monitor suicide ideation among study subjects whose behaviors can include a desire to detach from the “worries of life” (Kreek, LaForge, & Butelman, 2002), severe decision-making deficits (Biernacki, McLennan, Terrett, Labuschagne, & Rendell, 2016), and a decrease in sensitivity to future consequences (Ersche et al., 2005; Kreek et al., 2002; Terrett et al., 2017).

Additionally, contextual complexities of the lives of research subjects can further inform the need for suicide ideation monitoring. For example, opiate users lead lives that are risky in terms of medical complications, legal involvement, lessening of control over impulsive behavior, and suicide (Darke et al., 2007; Farabee, Joshi, & Anglin, 2001; Forman et al., 2004; Roy, 2010). Individuals with depression and drug dependence are also at an elevated risk for suicide ideation (Darke et al., 2007; Voss et al., 2013). Suicide ideation risk may also fluctuate with changes in the life situation of high-risk study participants. Both clinicians and clinical researchers are informed not to extend heightened clinical vigilance to distinguish between active and passive ideation of suicide given the dynamic status of ideation itself, and among older adults, thoughts of death are not uncommon and may reflect natural preparations for death (Szanto et al., 2013; Szanto et al., 1996). Instead, clinicians and clinical researchers should extend a similar vigilance to those participants whose ideation is “only” passive (Szanto et al., 1996) as studies have shown that inquiring among individuals on his/her desire for death has the same value as assessing suicidal ideation to examine risk for suicide attempt (Baca-Garcia et al., 2011). Among researchers of study populations with high risk of suicide ideation, the emphasis is placed on the research team’s ethical decision to monitor and assess suicide risk during the course of the research study.

Suicide Ideation Among Depressed Older Adults in MMT

The Current Study

This study describes our steps to actively monitor for suicide ideation among our study subjects who are older adults in methadone maintenance treatment (MMT) with comorbid psychiatric conditions. We draw on insights from our randomized controlled trial (RCT) that assessed the combined effect of Problem Solving Therapy (PST) plus Treatment as Usual (TAU) compared to TAU alone on decreasing depressive symptoms among opioid-addicted older adults. The research, conducted at a free-standing MMT clinic, offers a strong example to elucidate how suicide ideation was assessed over time within the context of a research study. Problem Solving Therapy (PST) is an empirically-tested, relatively brief, intervention for older adults with late-life mood disorders. Participants were randomized to PST+TAU and TAU groups; maintaining TAU ensured regular MMT treatments over the course of the study among all participants. For further information on the use of this intervention in the RCT, randomization procedures, and participant flowchart, please refer to Rosen, Engel, McCall, and Greenhouse (2017) and Rosen, Smith, and Reynolds (2008).

In the originating RCT study, a total of 132 potential participants comprised the subject pool. All 132 potential research participants were screened for depression symptom severity using the Patient Health Questionnaire (PHQ)-9 at baseline, every 4 weeks post-baseline until the treatment period was completed, a final treatment completion assessment which was conducted one month after the completion of the treatment period, and a subsequent posttreatment data collection phase at 3-months, 6-months, 9-months, and 12-months. The on-site RCT project coordinator conducted all interviews with participants to collect assessment data throughout the duration of the study. The MMT clinic provided separate offices on different floors to the study coordinator and the counselors providing PST to reduce barriers to participation in the study (Rosen et al., 2017). For example, for all study

participants, following his/her PHQ-9 assessment with the RCT study coordinator, participants were able to commence their PST+TAU or their TAU within the same sited building. A university-based institutional review board reviewed and approved the protocol throughout the duration of the study. Participants provided written informed consent prior to their enrollment in the study.

Study Site and Research Participant Characteristics

132 participants were assessed for depression severity symptoms and passive suicide ideation in an RCT sited at a free-standing urban MMT clinic. At the time of the study, the clinic served approximately 640 clients per day with 65 staff members, including drug and alcohol counselors, outreach workers, medical personnel, and other support staff. Approximately one third of the clinic's patient population were 50 years of age or older.

Integrating Suicide Ideation Monitoring into Research Design

We adapted and strengthened an existing suicide risk action plan to address suicide ideation in a sample of older adult methadone clients who were depressed. This enhanced protocol could be implemented within the existing structure of the clinic and included adaptations such as additional training for study staff on 1) risk for suicide among a substance abusing older adult population, 2) access concerns to legal and illegal substances to cause potential harm, and 3) treatment of comorbid disorders in later-life. The RCT study used three key research design components that were integrated into the data collection of the study to ensure regular monitoring of participants' depression and suicide ideation. First, when individuals were consented to participate in their research study, the RCT study coordinator reviewed the consent form and emphasized that all information was confidential—except if study staff were alerted to participants' self-harm or harming of others. It was further highlighted, both verbally and visually within the consenting document, that if participants were reported for self-harm or harming of others, study confidentiality would be breached. Second, the study design included weekly staff meetings that discussed study participants' progression in treatment and the monitoring of suicide risk. Finally, a suicide risk assessment (Figure 1) and decision-making protocol to be used by the research study coordinator (Figure 2) were developed to use alongside regular monitoring of depression as measured by the Patient Health Questionnaire (PHQ)-9. Participants were also given a Suicide Referral Card to place in their wallet or purse which informed of important phone numbers and contacts to access help at all times of the day.

Given the research study's design, the participant's randomized study group (PST+TAU or TAU) remained blinded to the RCT study coordinator at all times. Only the principal investigator and two therapists delivering the experimental condition were aware of a participant's identity and baseline depression symptom severity. With any endorsement of the PHQ-9 suicide ideation item, the RCT study coordinator initiated the decision-making discussion to the principal investigator who continued with the appropriate escalation for decision-making which could have involved the participants' therapist or any member of the methadone leadership team (e.g. Executive Director, MMT Senior Clinical Staff, and clinical Director) (Figure 2). This communication protocol enabled the immediate alert from the RCT study coordinator to the principal investigator who was able to quickly deliver suicide

ideation assessment results directly to the study therapist without compromising the RCT study procedures.

Patient Health Questionnaire (PHQ)-9

In the RCT study, the research team selected the PHQ-9 for its use as a brief scale to identify a depressive disorder, summarize the severity of depressive symptoms, and to assess suicidal ideation. The PHQ-9 is a 9-item scale used to identify a depressive disorder or to summarize the severity of depressive symptoms. It was administered at multiple time points throughout the study by the clinically-trained RCT study coordinator. In the PHQ-9, participants rated the frequency of each item in the last two weeks on a four-point scale (0 = not at all, 1 = several days, 2 = more than half the days, and 3 = nearly every day). Depressive symptom severity was reflected in the sum of the nine items with a range of 0 to 27. A score of 10 or higher suggests major depression. The PHQ-9 has demonstrated reliability, validity, and good measures of sensitivity and specificity with a variety of different clinical populations (Kroenke, Spitzer, & Williams, 2001; Meader, Moe-Byrne, Llewellyn, & Mitchell, 2014). This tool has been used to assess depression severity among older adults (Sirey et al., 2008). The PHQ-9 has demonstrated internal consistency and convergent validity with outpatients who abuse substances (Dum, Pickren, Sobell, & Sobell, 2008) and identified mild depression in residential clients with substance abuse diagnoses (Hepner, Hunter, Edelen, Zhou, & Watkins, 2009). Sensitivity and specificity were 88% and a cut-off score is recommended to be 10 or greater for major depression (Kroenke & Spitzer, 2002; Kroenke et al., 2001).

Of particular interest within the PHQ-9 instrument is item #9 which screens for the presence and duration of suicide ideation: *“Over the last 2 weeks, how often have you been troubled by thinking that you would be better off dead, or that you would want to hurt yourself in some way?”* Studies have found that item #9 in the PHQ-9 identifies individuals who are at increased risk of suicide attempt or death (Bauer, Chan, Huang, Vannoy, & Unützer, 2012; Simon et al., 2013). For Simon et al. (2013), suicide ideation was an “enduring vulnerability rather than a short-term crisis” as suicide risk grew over the course of several months.

The RCT study coordinator administered the PHQ-9 to all participants, including item #9, at baseline, the acute treatment phase (4 weeks, 8 weeks, 12 weeks, and 16 weeks), and then once every three months for twelve months, which was the end of the study period. If a study participant responded affirmatively to item #9 on the PHQ-9, the RCT study coordinator would engage the participant in a sequential series of probing questions to assess for suicide risk (Figure 1) such as, *“Do you have current thoughts about harming yourself?”*, *“Have you had any previous attempts to hurt yourself?”*, *“Do you have a plan to hurt yourself?”*, *“Have you previously attempted to commit suicide?”* Then, based on participants’ responses, the RCT study coordinator would refer to a decision-making guideline (Figure 2) to follow up with action steps (which could include notification to appropriate clinical or research study personnel) and providing clinical documentation.

Findings

In the RCT case example, a total of 132 study participants were assessed for depression severity symptoms. More than half of the participants identified as African American, 70% of the sample were male, over 80% of the sample self-identified as unemployed, nearly 75% had attained at least a high school diploma, nearly 70% reported incomes less than \$10,000 per year, and 66% reported living with others (Table 1), and age averaged 57 years across the sample (Standard Deviation = 5.19). Across the study's duration, a total of 16 individuals (12% of the study participants) incurred 41 instances where item #9 in the PHQ-9 suggested suicide ideation due to participants' response of "1-several days," "2-more than half the days," or "3-nearly every day." (Table 2). Among the 41 instances, 7 were unduplicated and 9 were repeat responders.

The following excerpts from the RCT study documentation offer examples of three participants' risk situations following the affirmative response to the PHQ-9 item within a research study context. Participant A and Participant B had relatively lower total depression severity symptoms as per the PHQ-9 scores, and an affirmative response to item #9 on the PHQ-9; Participant C has a relatively higher total depression severity symptom score as per the PHQ-9 and an affirmative response to item #9 on the PHQ-9. These examples demonstrate the heightened communication among RCT study coordinator, study therapists, MMT Executive Director, and principal investigator to initiate the decision-making guidelines and escalate the action steps to ensure participant safety.

Participant A

Participant A reported "1-several days" to the PHQ-9 suicide ideation question. The RCT study coordinator assessed the risk level of the participant, noted a "low risk" level, and documented to the principal investigator:

I followed up with the questions that are in the protocol--*how often do you think about this? Specifically, what are your thoughts? Have you thought of how you would do it?* He said that he just sometimes feels bad about himself or things in his life and thinks that it would be better if he wasn't here, but that he would never actually hurt himself. He had no plan for suicide and no intentions of going through with anything. He just sometimes thinks the world would be better off without him during those times when he is feeling down. Overall, his total PHQ-9 score was a 7. I encouraged him to talk to his counselor about his feelings.

At this stage, the protocol has moved beyond the research coordinator, and it was the principal investigator who, upon receiving this communication, contacted the PST+TAU therapist. The following excerpt is the follow-up documentation from the participant's PST+TAU therapist who gave a clinical judgment of the case:

I saw this client this morning for session... He states that these thoughts are brief and that he feels he has control over them. Affirmed that they are "nothing to worry about" and says that he has had these frequently in his life. Denies specific plans or intentions to harm himself. He agreed to call the emergency phone numbers if he should feel overwhelmed. This client has a trial scheduled... He was in a hurry to

conclude today and most of the session was a motivational approach to activate him to take whatever positive action is possible on his goals.

For Participant A, the ideation risk was originally flagged by the RCT study coordinator who documented and escalated the subject to the principal investigator who then informed the PST+TAU therapist. Ultimately, the participant's PST therapist gave the clinical judgment of his case and did not see "an imminent threat to harm himself given his presentation and report." Afterwards, Participant A returned to the study coordinator on the regularly scheduled assessment date. The study coordinator resumed her responsibilities in collecting appropriate study information, which includes PHQ-9 scores. If Participant A were to affirm a response to item #9 on the PHQ-9, the research coordinator would activate the suicide protocol once more.

Participant B

Participant B reported "1-several days" to the PHQ-9 suicide question. The RCT study coordinator assessed the risk level of the participant, noted a "medium risk" level, and documented to the principal investigator:

When I asked him about his thoughts, he said that he takes care of his granddaughter because her mother has been in jail. The mother just got out and she has not been very involved in her daughter's life. He wonders if he were to die or go away, what would happen. He has no plans to do this and does not want to die. He wants to be there for his granddaughter. His PHQ-9 score was 10.

Similar to Participant A, this participant was alerted to the study's principal investigator who also quickly informed the participant's PST+TAU therapist. The following is an excerpt from the participant's PST+TAU therapist who gave a clinical judgment of the case:

Client endorsed recent suicidal ideation without plans or intentions that occur about 3 times per week and last from 10 to 15 minutes. Client states these are in response to the behavior of his daughter who is recently out of prison, in her active addiction and has left the care of her child with the client as primary caretaker. Client says that he has no intentions of harming himself and feels he is able to reject these feelings when they come. Client reports strong desire to live, no desire to commit suicide, reasons for living are greater than reasons for dying, has no desire to make a suicide attempt and reasons for living outweigh reasons for dying. Client has strong deterrents, i.e., would not leave his children and grandchildren, doubts his competence, "I'm afraid of doing that [committing suicide], I don't think I could do that." Client accepted the emergency phone numbers. He was glad to hear that he could get a quick response without having to go through an intake but does not expect to have to use it.

Participant B's ideation was first escalated to the principal investigator by the RCT study coordinator then from the principal investigator to the PST+TAU therapist. In this example, it was ascertained that further escalation to the MMT's Executive Director was recommended. Ultimately, the MMT Executive Director agreed that the patient was safely managed in an outpatient setting and concurred with the PST+TAU therapist to inform the TAU therapist on the ideation issues that were raised by this patient. Similar to Participant A,

afterwards, Participant B returned to the study coordinator on the regularly scheduled assessment date. The study coordinator resumed her responsibilities in collecting appropriate study information, which includes PHQ-9 scores. If Participant B were to affirm a response to item #9 on the PHQ-9, the research coordinator would activate the suicide protocol once more.

Participant C

Participant C reported “2-more than half the days” to the PHQ-9 suicide ideation question. The RCT study coordinator assessed the risk level of the participant, noted a “low risk” level, and documented to the principal investigator:

Participant scored 13 on the PHQ-9. When asked about thoughts of suicide he stated, “I don’t want to kill myself but sometimes I wish I was dead. I don’t have a plan but dying would solve my problems.” He was very clear that he didn’t want to hurt himself or kill himself but didn’t want to lie about his thoughts given his current life. He isn’t using any drugs or alcohol. Denied any previous attempts [of suicide]. We talked for a few minutes and I was able to determine that he was low risk. I gave him the helpline card.

When meeting with the RCT study coordinator at the following data collection assessment, Participant C escalated the response to item #9 as “3-nearly every day”. The RCT study coordinator assessed the risk level of the participant, noted a “high risk” level, and documented to the principal investigator:

This person said “nearly every day” to the suicide question in the PHQ-9. His score was 20, which was significantly higher than last time. He still did not have plans to commit suicide, but said that he often thinks he’d be better off dead. He has to move out of his house and has nowhere to go. He did have a plan for how he would commit suicide--he said that he would take a lot of dope and Xanax. He did say that he doesn’t have any plans or intention to actually go through with it, but he is going through a rough time and doesn’t see it getting any better. No previous attempts [of suicide]. He has a good relationship with his counselor and I encouraged him to talk to his counselor about these thoughts. He also talks to his brother who has been clean for 17 years.

This client verbalized his passive suicide ideation “*he still did not have plans to commit suicide...*” but importantly, this documentation noted the means by which a suicide could be attempted, “*He did have a plan for how he would commit suicide... a lot of dope and Xanax.*” Given the higher risk posed by this client, immediately following this communication, the principal investigator contacted the senior clinical staff person at the MMT clinic to discuss the client. This client’s situation warranted a discussion between the senior clinical staff person at the MMT clinic and the RCT study coordinator. This was documented by the RCT study coordinator to the principal investigator in the following:

After we discussed this and determined that this person is “medium risk” I spoke with [the senior staff person at the MMT clinic]. I explained that [the client’s] score on the depression scale was increasing and that he had increasingly been mentioning suicide. I gave him a brief overview of my discussion with the client

today. He agreed to talk to the client's counselor and make sure that the counselor follows up with the client.

For Participant C, the ideation risk was flagged and discussed among the RCT study coordinator, the senior staff of the MMT clinic, and the principal investigator. Appropriate and timely escalation of risk was noted and a judgment of the case was made for the participant's safety. Again, afterwards, Participant C returned to the study coordinator on the regularly scheduled assessment date. The study coordinator resumed her responsibilities in collecting appropriate study information, which includes PHQ-9 scores. If Participant C were to affirm a response to item #9 on the PHQ-9, the research coordinator would activate the suicide protocol once more.

Conclusion

This paper reported on the findings from the implementation of a research team's deliberate plan to monitor RCT study participants' possible suicide ideation. The suicide assessment (Figure 1) and decision-making guidelines with action steps (Figure 2) allowed for thoughtful clinical consideration at all levels of suicidal risk among our risky older adult research population. Excerpts from the experiences of these three participants illuminate the importance of assessing for suicide ideation, understanding the context of the lives of the older adult research subjects who were also current clients in MMT, and the value of documentation within a research study of a clinical population.

The affirmative responses to item #9 of the PHQ-9 among an older adult MMT study population support the notion that research investigators need to include a suicide ideation assessment protocol which can also facilitate next steps to ensure participant safety, maintain overall study benefit, and assist in the clinical training of study staff. Ensuring that an action plan is part of the overall research protocol helps to safeguard the safety of research participants and allow research investigators to remain cognizant of participants' needs over the course of the study period. In addition, critical to the successful implementation of the suicide protocol was the coordination between research and clinical staff. Given the complex life situations experienced by this clinical population of aging adults, the protocol reinforced the importance of professional responsibilities to these study subjects and the commitment of research staff to ensure the safety and well-being of study participants.

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- **Ask directly if the client has thoughts of suicide.**

- "Have you thought of committing suicide?"
- "Are you thinking of killing yourself?"

Here, we emphasize use of direct words, for use by the study coordinator, such a "kill yourself" or "wanting to die" as opposed to "hurt yourself" because when assessing the severity of suicide ideation, subtlety can be counterproductive.

- **Assess whether there have been previous attempts.**

- Have you ever tried to commit suicide before?

- **If attempts were made, ask about method and situation.**

- "When?"
- "How many times?"
- "What happened?"
- "What was going on in your life at the time?"

- **Reduce participant access to means of suicide.**

- Is there a plan? What are the details of the plan? How extensive is the plan?
- "Do you have a plan?"
- "When would you carry out the plan?"
- "Do you have a date and time?"
- "Where would you be?"
- "Who would you want to find you?"

- **What is the lethality of the means/method? Is there access to the identified means?**

- "Do you have the pills?" "Where are they?" "What type of pills would you take?"
- "What type of gun?" "Where would you get the gun?" "Do you have bullets?" "Where is the gun? The bullets?"
- "Do you have a rope/cord?" "Where would you hang yourself?"

- **What are the risk and protective factors for the participant:**

- Is the participant using drugs or alcohol?
- What are the participant's social supports?
- Does the participant have a religious or spiritual affiliation?
- How is the participant discussing suicide and potential aftermath? Do fantasies seem to be positive or painful?
- Is the participant able to see any alternatives to suicide?
- Has the participant had a recent stressful life event?

Figure 1.

Conducting a suicide assessment.

Figure 2.
Decision-making guidelines and action steps taken by research study coordinator.

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Table 1

Study sample characteristics (n=132)

Characteristic	% (#)
Race	
African American	64.4 (85)
White	35.6 (47)
Gender	
Male	71.2 (94)
Female	28.8 (38)
Employment Status	
Unemployed	84.8 (112)
Employed	15.2 (20)
Education	
< High school grad	25.0 (33)
High school grad or more	74.2 (98)
Income	
< \$10,000	67.4 (89)
\$10,000 +	32.6 (43)
Living Arrangement	
Alone	34.1 (45)
With Other	65.9 (87)

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Table 2
Number of times suicide ideation protocolactivated for study participants (n=132)

Treatment Phase		Follow Up Phase							
Baseline	4-week	8-week	12-week	16-week	1-mo	3-mo	6-mo	9-mo	12-mo
7	4	2	2	2	5	4	4	6	5