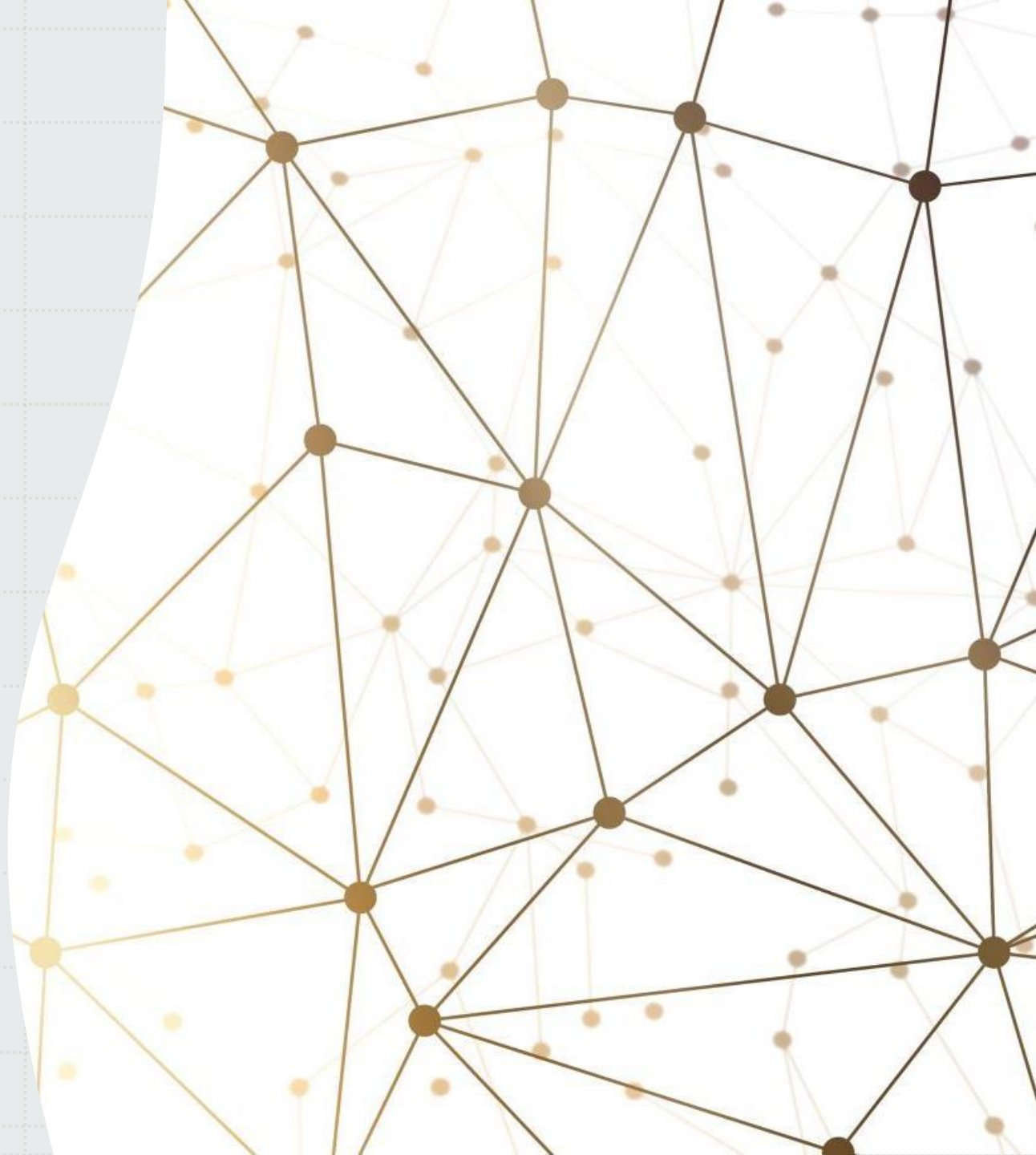


Culturally Responsive Integrated Harm Reduction Screenings:

A Community-based Participatory Research Approach

Traci Norman,
Addiction Treatment in the Black Community



Training Takeaways:

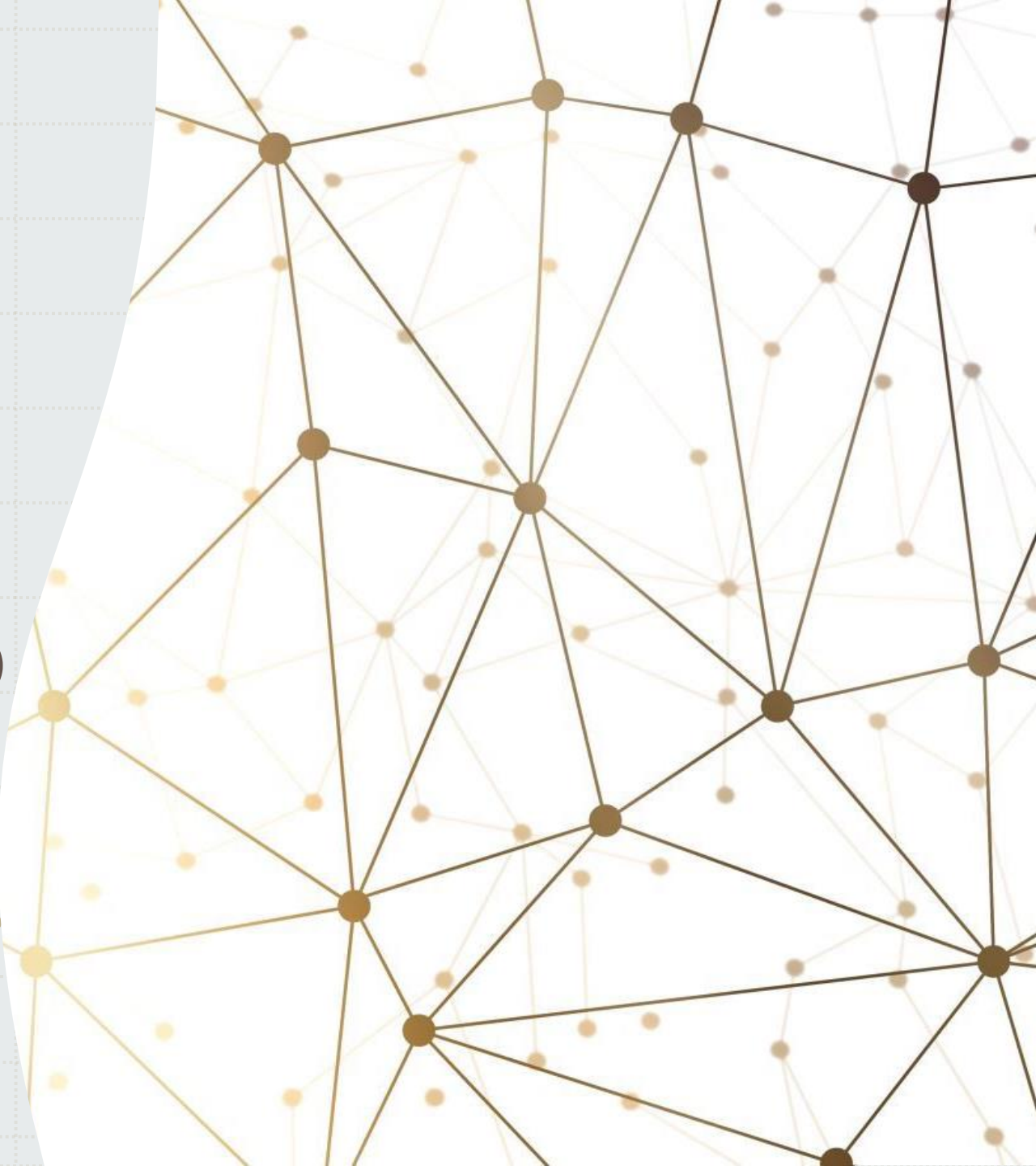
- ❑ IHRI Study Inclusion/Exclusion Criteria
- ❑ Participant Assessment Tools
 - SCID Tool
 - ASQ Screening Tool
- ❑ Notable Observations
- ❑ Next Steps for Screened Individuals
- ❑ Self Care



But First...😊

Please Share:

- Name, Pronouns
- Role on JWC Team
- Highlight of '23 (or favorite ice cream)
- Apprehension Related to Screenings?



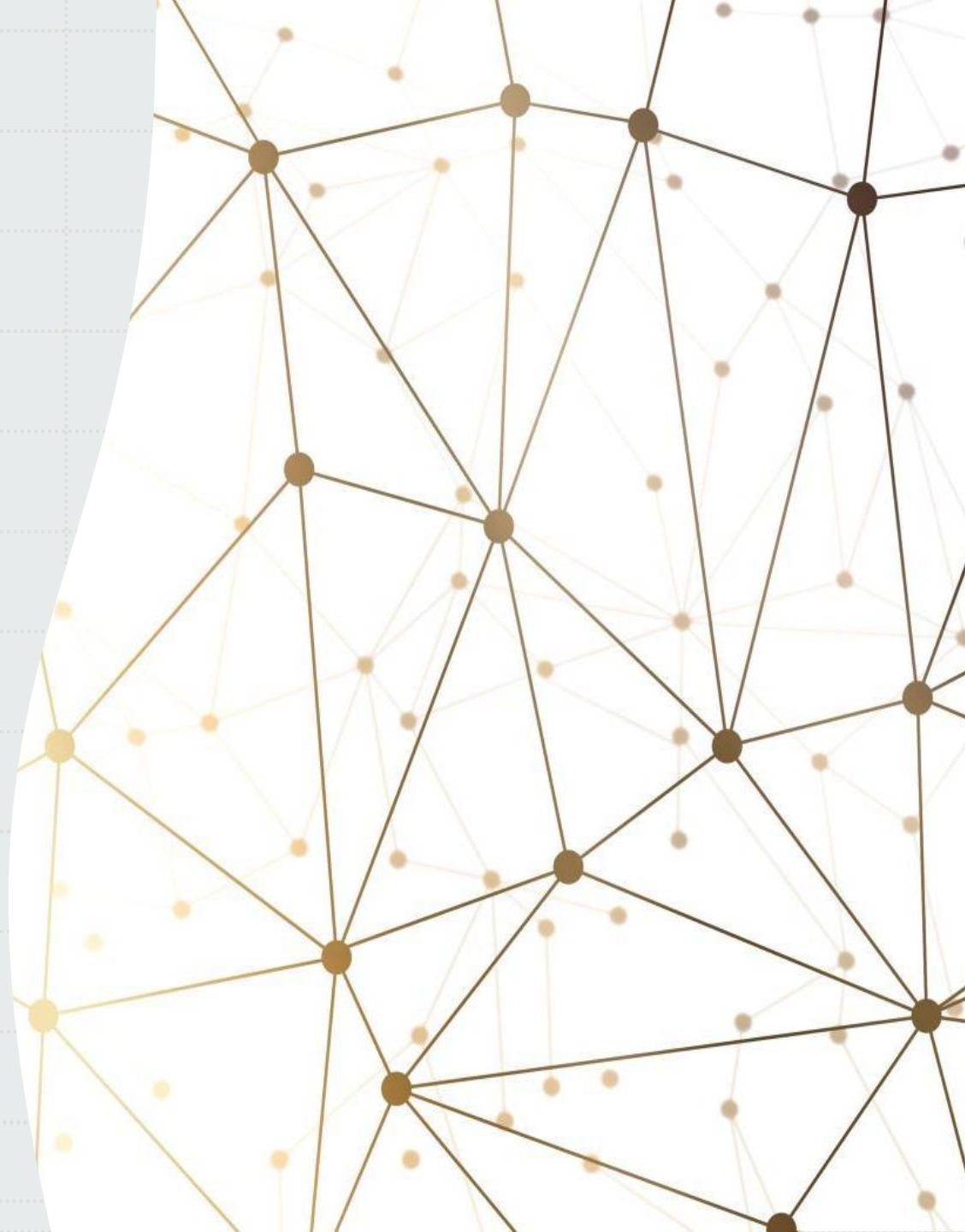
IHRI Inclusion Criteria:

1. 18 Years Old
2. **Self-identified** as misusing opioids in the past 30 days (can have co-occurring substance use)
3. Ability to Consent
 1. Consent Quiz
 2. **Comprehension** Ability
 3. ..."but they just used an hour ago?!"



IHRI Exclusion Criteria:

- inability to provide informed consent or participate in the study procedures as proposed in the consent
- active suicidal or homicidal ideation or an **unstable** psychotic disorder (schizophrenia, schizoaffective disorder) or mood disorder (bipolar disorder, severe major depressive disorder)
- an unwillingness to be randomized.



General Definitions

Suicidal Ideations:

- Thoughts about self harm, with deliberate consideration or planning of possible techniques of causing one's own death-DSM5

Homicidal Ideations:

- Thoughts about ending or making plans to end another's life - NIH

Psychotic Disorder:

- Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions; Disconnected from Reality

Mood Disorder:

- Category of illnesses that describe a serious change in mood; impacts emotional state

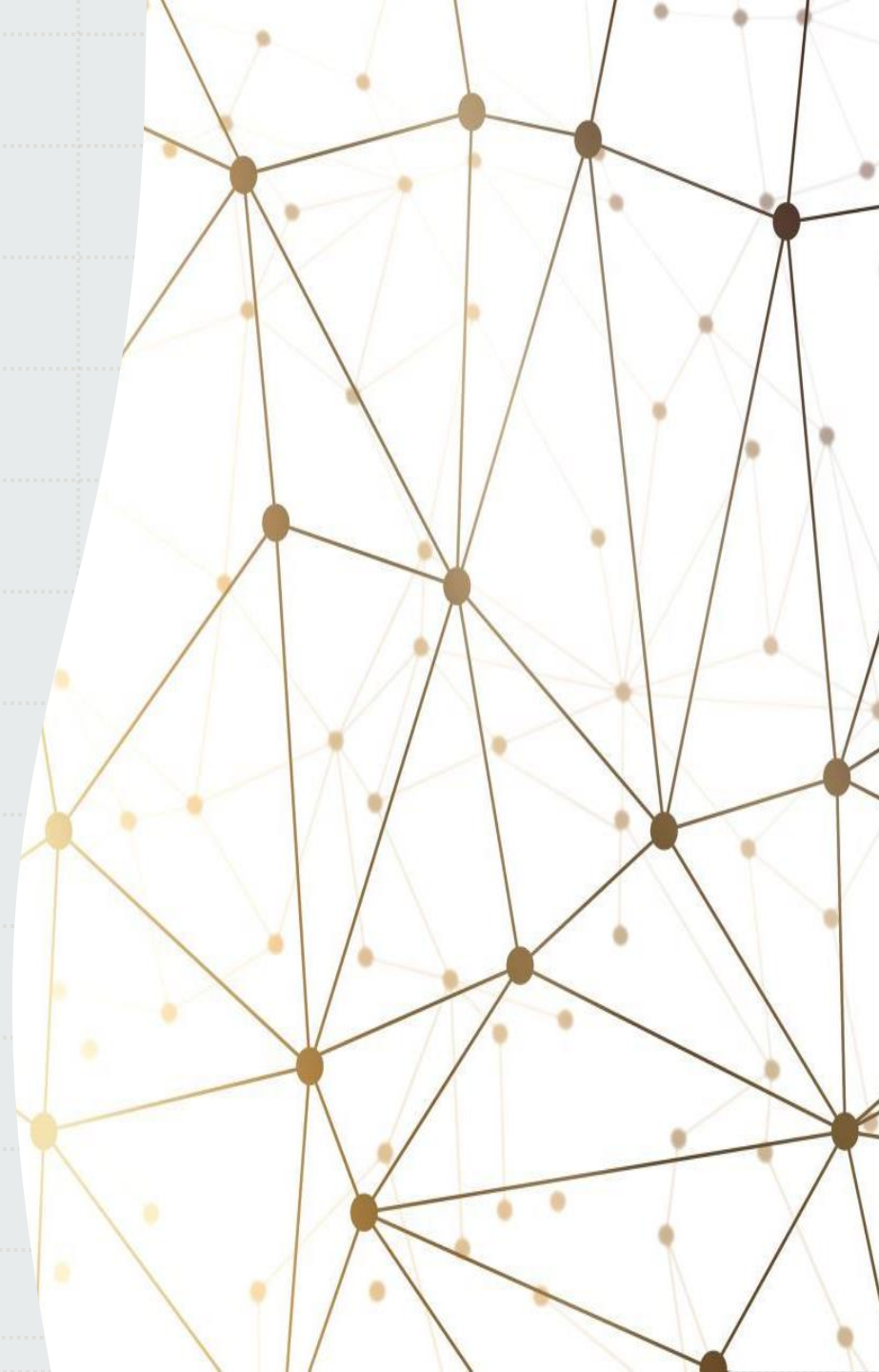


Case Example 1:

John is a 35 year-old man who shares that he has used 'her'on' intravenously for 3 years. His use has increased to 1 bundle a day from 4 bags weekly.

You explain the IHR study to John and he agrees to be screened. Prior to consenting, he takes the consent quiz and scores 10%.

What do **YOU** Do?



SCID Sections - IHRI

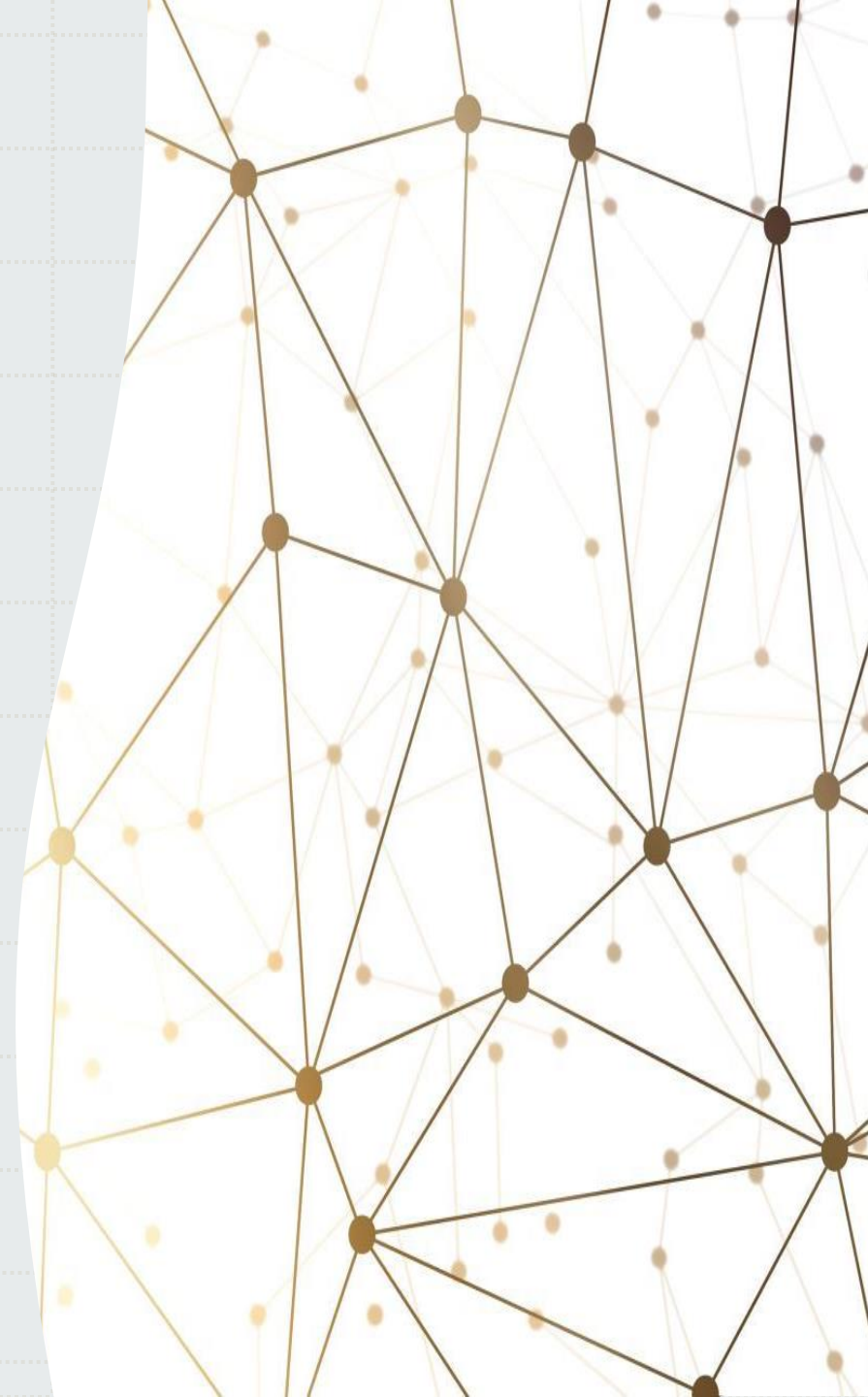
Structured Clinical Interview for DSM-5 Disorders

1. Psychotic Screening Module
2. Hallucinations

Scoring SCID (1=Absent; 3=Threshold/True)

Importance of PROBING

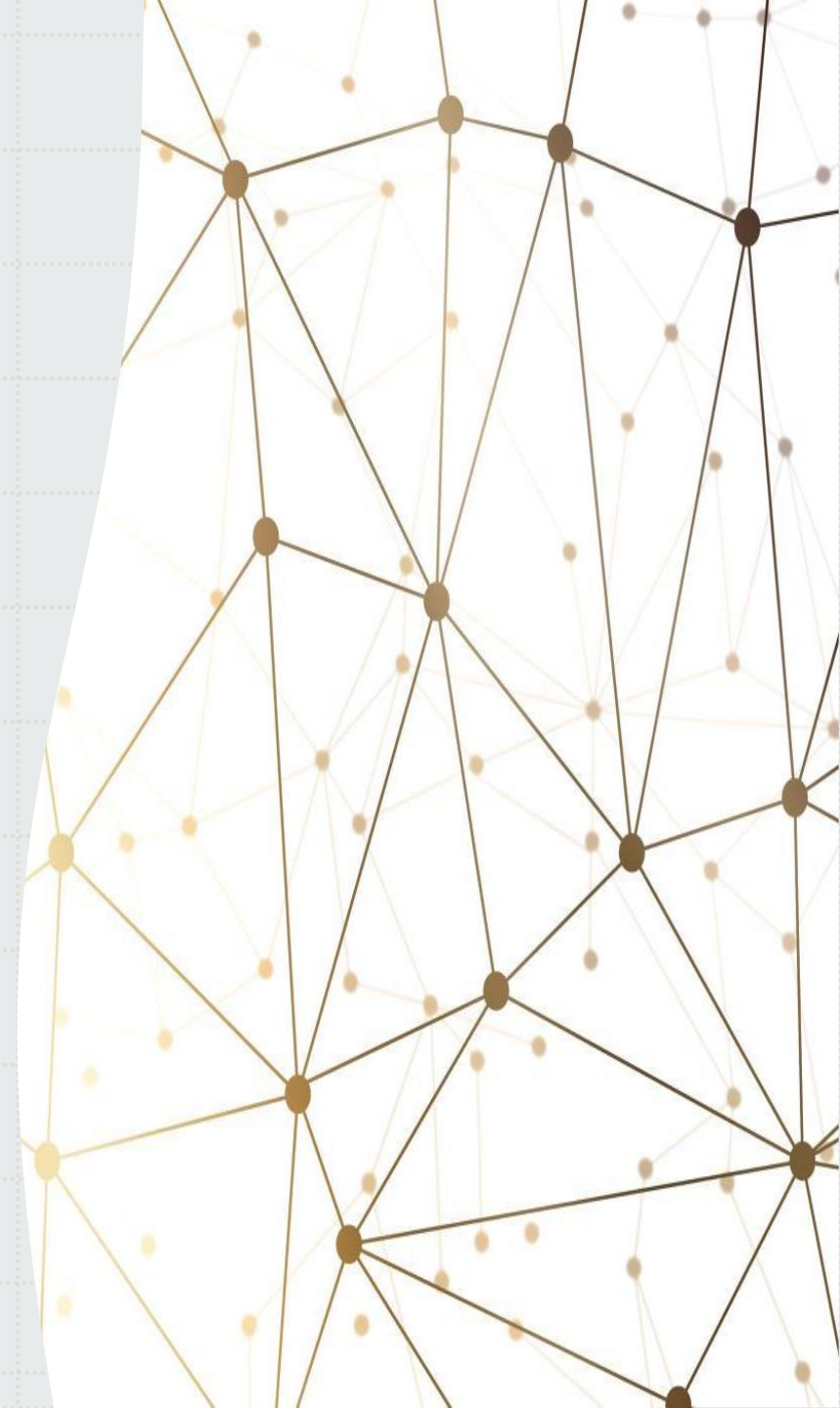
- Cultural Inclusion (i.e. "have you felt that GOD has communicated directly with you")



Case Example 2:

Nicole is a 46 year old woman who has used “crack” [cocaine] for the past 20 years. Her fiancé’ fatally overdosed when they were using together 2 years ago; she does not want the same fate. She has consented and is excited to engage with the study. During the SCID, Nicole expresses she communicates directly with her deceased fiancé and feels she is to blame for his death. She is distracted very easily and you have to repeat/redirect several times. As the assessment concludes, she reveals she wants to hurry home so she can have dinner with her fiancé’.

What do YOU do?





Ask Suicide-Screening Questions

NIMH TOOLKIT

Suicide Risk Screening Tool

Ask the patient:

1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No

If yes, how? _____

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **STAT** safety/full mental health evaluation.
 - Patient cannot leave until evaluated for safety.
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
 - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. Patient cannot leave until evaluated for safety.
 - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741



Homicidal Ideations Screening Tool

In the past month, did you think/wish (even momentarily) that someone would be better off dead or that they needed to be killed?

In the past month, did you think (even momentarily) about harming or hurting someone else with the awareness that they might die as a result?

In the past month, did you intend to act on these thoughts?

In the past few weeks, did you have someone else or people in mind that you wanted to kill?

In the past month, did you injure someone on purpose without intending to kill them?

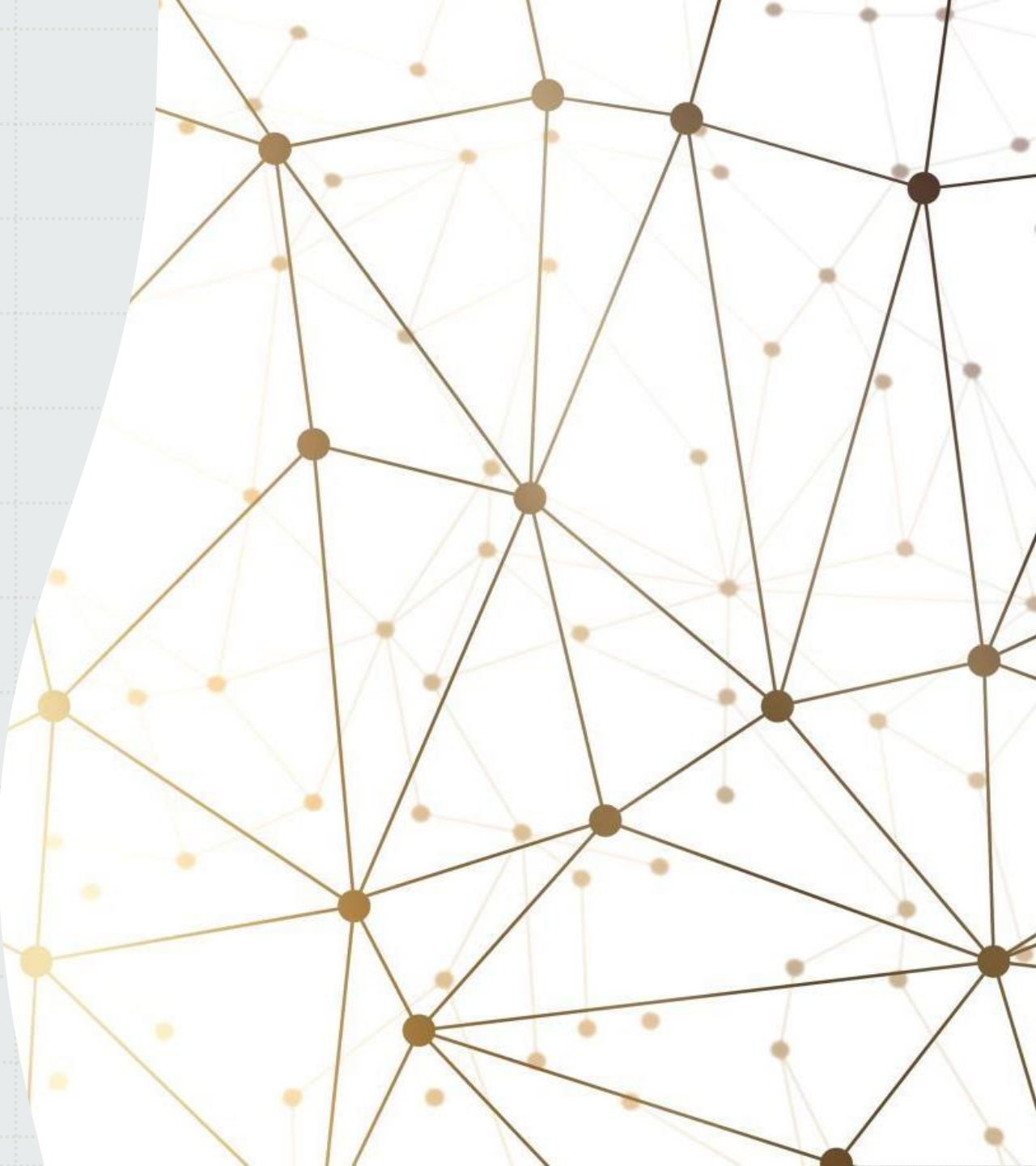
PROBE if yes to ANY question to determine if there is a plan in place.

* How many times have they had these thoughts in the past month?

*Who do you intend to hurt?

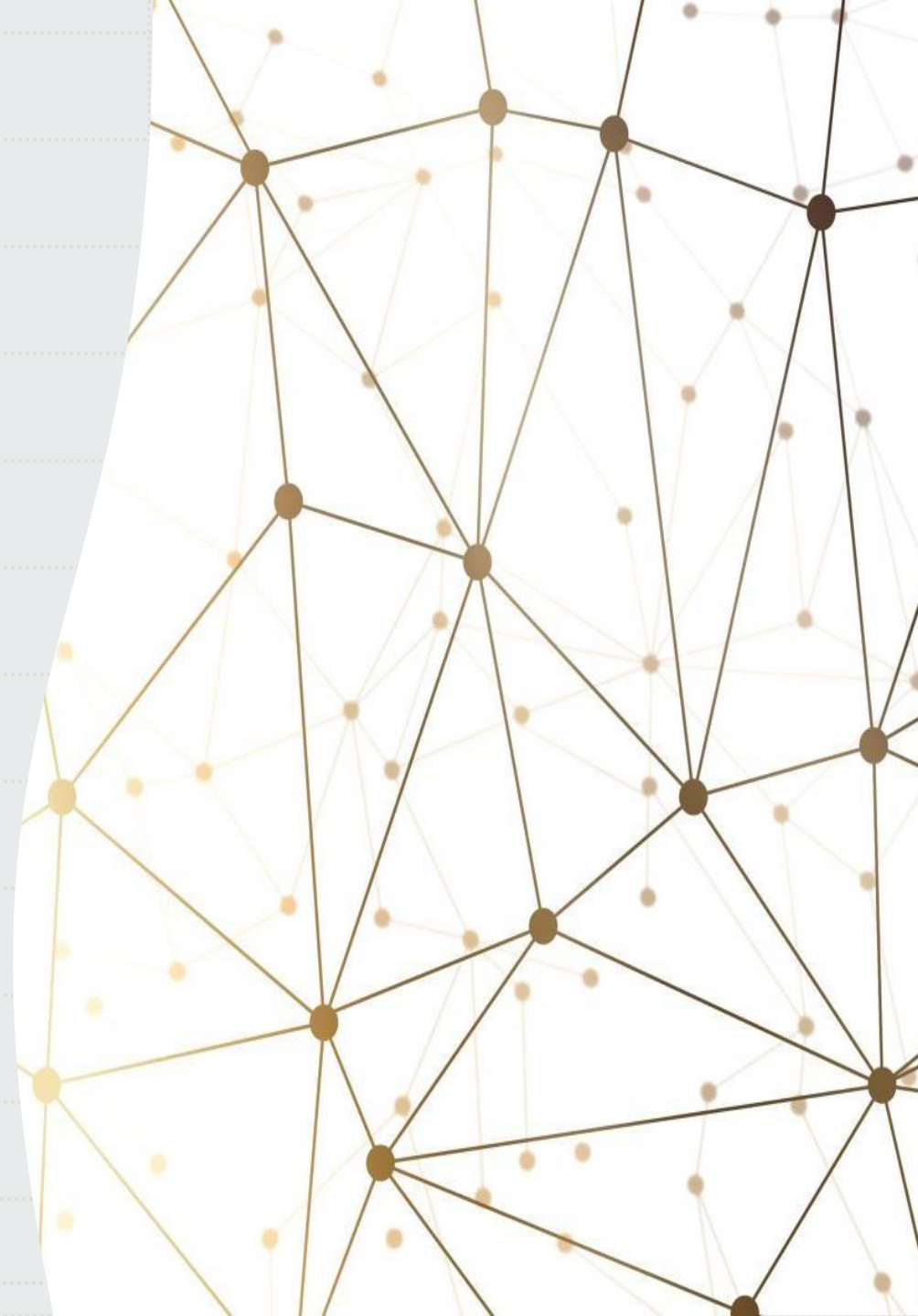
*Do you have a method or means to kill someone?

*Have you set a date/timeframe?



Observations for Potential Violent Behavior

1. Staring and prolonged eye contact
2. Tone and voice volume
3. Anxiousness
4. Mumbling
5. Pacing



Your Turn...

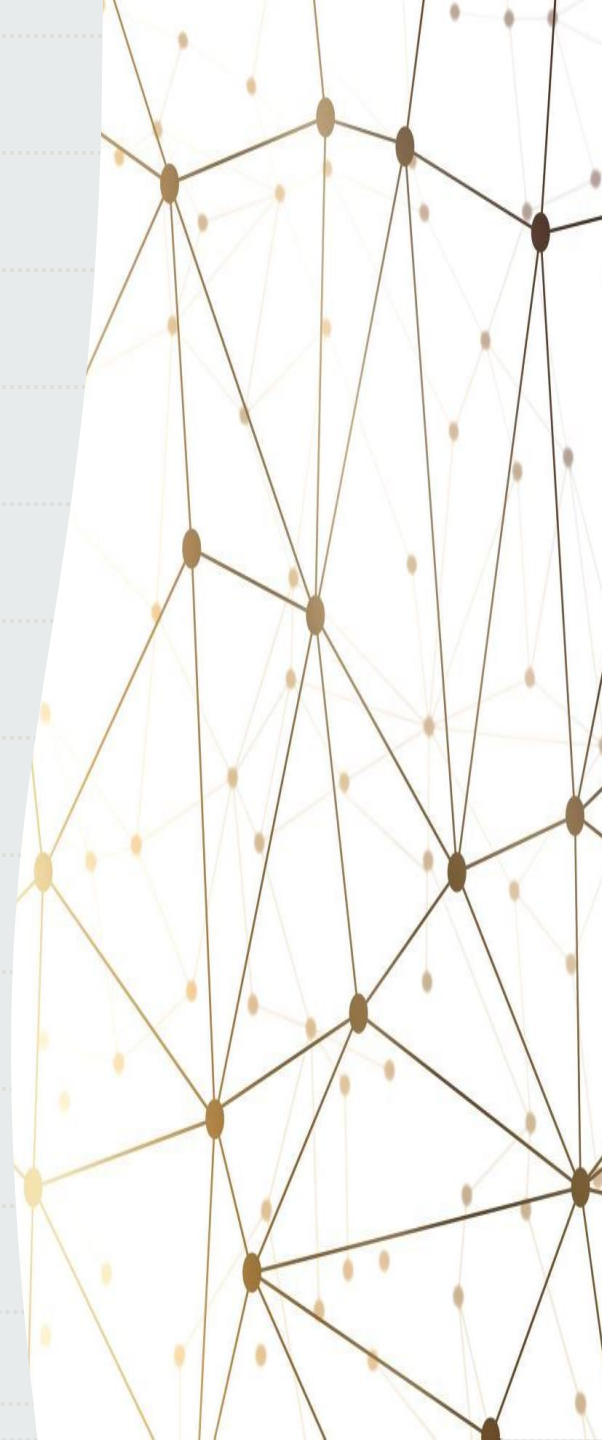
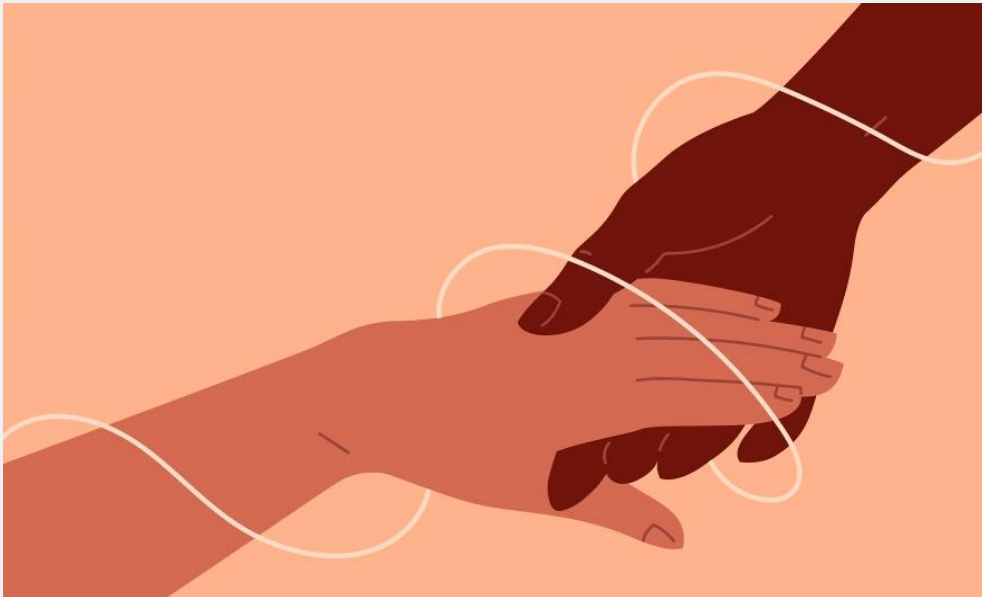
1. 18 year old trans-woman suicidal Ideations
1. Pregnant 21 year old woman states she wants an abortion
1. Participant expresses homicidal Ideations



Keep In Mind...

Harm Reduction

"Meeting Individuals Where They [Currently] Are To Get Them Where THEY Want To Be!"



Also Keep In Mind...

Dr. Jordan/Dr. Sue/PIs are available for psych/med issues that you are unsure of!

I am also available if you have any screening questions/concerns!

- Traci.Norman@nyulangone.org
- (860)205-1324 (personal cell so please don't share)

