

Current Prescription Opioid Misuse and Suicide Risk Behaviors Among High School Students

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abstract

BACKGROUND AND OBJECTIVES: In previous studies, researchers have reported that youth with a lifetime history of prescription opioid misuse (POM) are at an increased risk for suicidal ideation, planning, and attempts. In this study, we investigate whether the association between youth POM and suicide outcomes differs by recency of POM (ie, none, past, or current misuse).

METHODS: In this report, we use data from the 2019 Youth Risk Behavior Survey to examine associations between recency of POM (current POM, past POM, and no POM) and suicide risk behaviors among US high school students.

RESULTS: After controlling for demographics, alcohol, and other drug use, both current POM and past POM were significantly associated with all suicide risk behaviors compared with no POM. Students who reported current POM had the highest adjusted prevalence ratios (aPRs) for suicidal ideation (aPR: 2.30; 95% confidence interval [CI] 1.97–2.69), planning (aPR: 2.33; 95% CI 1.99–2.79), attempts (aPR: 3.21; 95% CI 2.56–4.02), and feeling sad or hopeless (aPR: 1.59; 95% CI 1.37–1.84). Students who reported current POM also were significantly more likely than youth who reported past POM to report that they had seriously considered attempting suicide, made a suicide plan, and attempted suicide.

CONCLUSIONS: Although POM, particularly current POM, is associated with increases in the risk for suicide-related behaviors and experiences of youth, comprehensive prevention approaches that address the intersections between suicide and POM provide a promising path forward for addressing these public health challenges among youth.



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Dr Wilkins conceptualized the study, drafted the abstract, introduction, results, and discussion sections of the initial manuscript, reviewed and revised the entire manuscript, and led all revisions from internal clearance review processes; Dr Clayton conceptualized and designed the study, led all analyses, drafted the methods section of initial manuscript, and reviewed and revised the manuscript; Dr Jones interpreted study data, drafted parts of the introduction, results, and discussion sections, and reviewed and revised the manuscript critically for important intellectual content; Dr Brown interpreted study data, drafted parts of the discussion section, and reviewed and revised the manuscript; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

DOI: <https://doi.org/10.1542/peds.2020-030601>

Accepted for publication Dec 4, 2020

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WHAT'S KNOWN ON THIS SUBJECT: Suicide and opioid overdose contribute to substantial morbidity and mortality each year in the United States. In previous studies, researchers have reported that youth with a lifetime history of prescription opioid misuse (POM) are at increased risk for suicidal ideation, planning, and attempts.

WHAT THIS STUDY ADDS: In this study, we investigate whether the association between youth POM and suicide outcomes differs by recency of POM (none, past, or current misuse). Youth POM, particularly current POM, was associated with increased risk for suicide-related outcomes.

To cite: Wilkins NJ, Clayton H, Jones CM, et al. Current Prescription Opioid Misuse and Suicide Risk Behaviors Among High School Students. *Pediatrics*. 2021;147(4):e2020030601

The intertwined public health challenges of suicide and opioid overdose contribute to substantial morbidity and mortality each year in the United States. During 2018, suicide was the second leading cause of death for youth aged 10 to 19 years.¹ During 1999 to 2016, opioid-related overdose death rates among youth aged 10 to 14 years increased 150%, and rates among youth aged 15 to 19 years increased 250%.² In previous studies, researchers have reported that youth with a lifetime history of prescription opioid misuse (POM), defined as taking a prescription opioid without a doctor's prescription or differently from how a doctor prescribed it, are at an increased risk for suicidal ideation, planning, and attempts.³ Studies among adults have also revealed links between POM and suicidal ideation^{4,5} and suicide planning and attempts.⁶ In addition, among adults, more frequent POM has been linked with suicidal ideation,⁷ as have both past and current POM.⁸ There is some evidence to suggest that current substance use (including use of analgesics, broadly defined) is more strongly associated with suicide attempts among adults than past use, although this difference in suicide risk by current and past use does not appear to hold true for illicit opioids (heroin) specifically.⁹ These findings suggest that unlike other substances, the association between at least illicit opioid use and suicide risk behaviors may not vary by recency of opioid use. However, it is important to note that previous research on recency of POM and suicide risk behaviors is still limited among adults and even more so among youth populations. This paucity of evidence has implications for clinical, community, and school-based suicide prevention approaches because it remains unclear whether individuals (youth in particular) who report current POM should be considered priority for suicide

interventions or if those reporting any POM, regardless of recency of use, should be prioritized for these interventions and services. In this article, we use data from the 2019 National Youth Risk Behavior Survey (YRBS) to examine associations between recency of POM, defined in this article as current POM only; past POM only (not inclusive of current misuse [and referred to for the rest of the article as past misuse]); and no misuse of prescription opioids, and suicide risk behaviors among US high school students.

METHODS

Prevalence estimates were calculated overall and by demographic groups for recency of POM and past 12-month suicide risk behaviors (persistent feelings of sadness or hopelessness, serious consideration of suicide attempt [ie, suicidal ideation], suicide planning, and suicide attempt).

Data are from 13 677 US high school students participating in the 2019 YRBS. The 2019 YRBS was used to collect data from a nationally representative sample of public and private school students in grades 9 to 12 in the 50 US states and the District of Columbia. Additional information about YRBS sampling, data collection, response rates, and processing is available elsewhere.¹⁰ The exposure of interest was recency of POM. This variable is a 3-level composite variable (categories included none, past but not current, and current use) that was created by combining responses to the following questions: "During your life, how many times have you taken prescription pain medicine without a doctor's prescription or differently from how a doctor told you to use it?" and "During the past 30 days, how many times did you take prescription pain medicine without a doctor's prescription or differently from how a doctor told you to use it?"

Respondents were instructed to count drugs such as codeine, Vicodin, OxyContin, hydrocodone, and Percocet. Outcomes of interest included suicidal ideation, suicide planning, suicide attempts, and depressive symptoms (ie, felt sad or hopeless), which were ascertained by responses to the following questions, respectively: (1) "During the past 12 months, did you ever seriously consider attempting suicide?"; (2) "During the past 12 months, did you make a plan about how you would attempt suicide?"; (3) "During the past 12 months, how many times did you actually attempt suicide?" (dichotomized to 0 and ≥ 1); and (4) "During the past 12 months, did you ever feel so sad or hopeless almost every day for ≥ 2 weeks in a row that you stopped doing some usual activities?" (referred to from here on as feeling sad or hopeless).

Descriptive analyses included prevalence estimates and associated 95% confidence intervals (CIs) for each recency of POM group and for each suicide-related outcome. These were calculated overall and by demographic groups: sex (male or female), race and/or ethnicity (non-Hispanic white, non-Hispanic Black, or Hispanic), school grade level (9th and 10th or 11th and 12th), and self-reported sexual identity (heterosexual; gay, lesbian, or bisexual; or not sure). Statistically significant differences were determined with the χ^2 test, with *P* values $< .05$ considered significant. Unadjusted and adjusted prevalence ratios (aPRs) and corresponding 95% CIs were calculated; estimates were considered statistically significant if the 95% CI did not include 1.0. Adjusted models included the following covariables: sex, race and/or ethnicity, grade, sexual identity, current alcohol use, current marijuana use, and lifetime use of illicit drugs. Statistically significant pairwise differences between demographic groups for each

TABLE 1 Prevalence of POM and Suicide Risk Behaviors Among High School Students, by Demographic Characteristics (YRBS, United States, 2019)

Characteristic	Total Population		POM Status			Suicide			Felt Sad or Hopeless ^a , % (95% CI)
	Unweighted No.	% (95%CI)	Never POM ^b , (n = 7362), % (95% CI)	Past POM ^c , (n = 638), % (95% CI)	Current POM ^d , (n = 661), % (95% CI)	Seriously Considered Attempt ^e , (n = 1684), % (95% CI)	Made a Plan ^f , (n = 1395), % (95% CI)	Attempted ^g , (n = 703), % (95% CI)	
Total	8661	—	85.3 (85.5–86.9)	7.4 (6.6–8.4)	7.2 (6.3–8.3)	19.0 (17.6–20.4)	16.1 (14.8–17.3)	8.9 (8.0–9.8)	37.4 (35.6–39.3)
Male	4222	50.4 (48.6–52.3)	87.5 (85.9–89.0)	6.3 (5.4–7.4)	6.1 (5.3–7.1)	13.3 (12.0–14.7)	11.4 (10.2–12.6)	6.5 (5.5–7.6)	27.7 (26.0–29.5)
Female	4371	49.6 (47.7–51.4)	82.9 (80.3–85.3)	8.7 (7.3–10.3)	8.4 (7.1–9.9)	24.6 (22.3–27.0)	20.6 (18.8–22.5)	11.2 (9.7–12.7)	47.2 (44.5–49.9)
Non-Hispanic white	4158	52.4 (46.8–57.9)	86.8 (84.4–88.9)	7.6 (6.4–9.0)	5.6 (4.4–6.9)	19.6 (17.9–21.4)	16.2 (14.5–18.1)	7.9 (6.8–9.3)	36.5 (34.2–38.7)
Non-Hispanic Black	1087	9.8 (7.4–12.8)	84.9 (81.7–87.6)	6.4 (4.7–8.5)	8.7 (6.5–11.6)	16.6 (14.2–19.3)	14.0 (11.9–16.4)	11.3 (8.8–14.5)	31.9 (27.956.2)
Hispanic	2267	27.8 (22.5–33.7)	83.0 (80.3–85.4)	7.2 (6.0–8.6)	9.8 (8.2–11.6)	17.2 (15.0–19.7)	15.1 (13.1–17.3)	8.9 (7.2–11.0)	40.5 (38.1–42.9)
9th and 10th grade	4586	52.5 (50.8–54.1)	86.1 (84.1–87.8)	6.9 (5.9–8.0)	7.0 (5.8–8.4)	18.3 (16.3–20.3)	15.4 (13.7–17.2)	8.9 (7.9–10.0)	36.1 (33.8–38.4)
11th and 12th grade	4006	45.9 (45.9–49.2)	84.5 (82.3–86.5)	8.2 (6.9–9.6)	7.3 (6.1–8.8)	19.8 (18.2–21.4)	16.7 (15.2–18.3)	8.7 (7.5–10.1)	38.9 (36.5–41.4)
Heterosexual	6856	84.8 (83.7–85.9)	86.8 (84.9–88.5)	6.8 (5.9–7.9)	6.4 (5.4–7.5)	14.5 (13.3–15.9)	12.1 (11.0–13.2)	6.4 (5.6–7.3)	32.8 (31.2–34.6)
Gay, lesbian, or bisexual	927	11.0 (10.2–12.0)	75.5 (70.8–79.7)	12.5 (9.7–15.8)	12.0 (9.6–14.9)	49.6 (45.3–53.9)	43.8 (40.0–47.7)	23.9 (20.4–27.9)	68.7 (64.2–73.0)
Not sure	345	4.1 (3.5–4.8)	81.2 (75.9–85.6)	7.3 (5.0–10.6)	11.5 (8.2–15.9)	30.8 (24.8–37.4)	24.4 (19.8–29.6)	14.5 (10.1–20.3)	49.1 (41.3–57.0)

—, not applicable.

^a Felt sad or hopeless every day for ≥ 2 weeks in a row and stopped doing some usual activities in the past 12 mo.

^b Never taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed.

^c Taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed ≥ 1 time during lifetime but not during the past 30 d.

^d Taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed ≥ 1 time during the past 30 d.

^e Seriously considered attempting suicide during the 12 mo before the survey.

^f Made a plan about how to attempt suicide ≥ 1 time during the 12 mo before the survey.

^g Attempted suicide ≥ 1 time during the 12 mo before the survey.

outcome were determined by linear contrast analyses; differences were considered significant if the *P* value was <.05. All analyses were conducted with Statistical Analysis System-callable SUDAAN (version 11.0.1) to account for survey weights and the YRBS complex sample design.

RESULTS

During 2019, an estimated 7.4% of students reported past POM, and 7.2% reported current POM (Table 1). An estimated 37.4% of students reported they had felt sad or hopeless; 19% reported that they had seriously considered a suicide attempt; 16.1% had made a suicide plan; and 8.9% had attempted suicide. As shown in Table 1, prevalence of past POM, current POM, and suicide risk behaviors varied across demographic groups. Female high school students reported higher prevalence of both past POM (8.7%; 95% CI 7.3–10.3) and current POM (8.4%; 95% CI 7.1–9.9) and all suicide risk behaviors, including seriously considering suicide (24.6%; 95% CI 22.3–27.0), making a suicide plan (20.6%; 95% CI 18.8–22.5), attempting suicide (11.2%; 95% CI 9.7–12.7), and feeling sad or hopeless (47.2%; 95% CI 44.5–49.9) than male

TABLE 3 aPRs of Suicide Risk Behaviors Among High School Students, by POM Status (YRBS, United States, 2019)

POM Status	Seriously Considered Attempting Suicide ^a		Made a Suicide Plan ^b		Attempted Suicide ^c		Felt Sad or Hopeless ^d	
	aPR	95% CI	aPR	95% CI	aPR	95% CI	aPR	95% CI
None ^e	1.0	—	1.0	—	1.0	—	1.0	—
Past ^f	1.70 ^g	1.46–1.99	1.78 ^g	1.43–2.21	1.91 ^g	1.43–2.56	1.39 ^g	1.23–1.56
Current ^h	2.30 ^{g,i}	1.97–2.69	2.33 ^{g,i}	1.99–2.79	3.21 ^{g,i}	2.56–4.02	1.59 ^g	1.37–1.84

Model covariates included sex, race and/or ethnicity, grade, sexual identity, current alcohol use, current marijuana use, and lifetime use of illicit drugs. —, not applicable.

^a Seriously considered attempting suicide during the 12 mo before the survey.

^b Made a plan about how to attempt suicide ≥1 time during the 12 mo before the survey.

^c Attempted suicide ≥1 time during the 12 mo before the survey.

^d Almost every day for ≥2 weeks in a row and stopped doing some usual activities during the 12 mo before the survey.

^e Never taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed.

^f Taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed ≥1 time during lifetime but not during the past 30 d.

^g Significantly different from none at *P* value <.05.

^h Taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed ≥1 time during the past 30 d.

ⁱ Significantly different from past POM at *P* value <.05.

high school students (past POM: 6.3% [95% CI 5.4–7.4]; current POM: 6.1% [95% CI 5.3–7.1]; seriously considered suicide: 13.3% [95% CI 12.0–14.7]; made a suicide plan: 11.4% [95% CI 10.2–12.6]; attempted suicide: 6.5% [95% CI 5.5–7.6]; and felt sad or hopeless: 27.7% [95% CI 26.0–29.5]). Students who identify as gay, lesbian, or bisexual also reported higher prevalence of both past POM (12.5%; 95% CI 9.7–15.8) and current POM (12.0%; 95% CI 9.6–14.9) and all suicide risk

behaviors (seriously considered suicide: 49.6% [95% CI 45.3–53.9]; made a suicide plan: 43.8% [95% CI 40.0–47.7]; attempted suicide: 23.9% [95% CI 20.4–27.9]; and felt sad or hopeless: 68.7% [95% CI 64.2–73.0]) than high school students who identify as heterosexual (past POM: 6.8% [95% CI 5.9–7.9]; current POM: 6.4% [95% CI 5.4–7.5]; seriously considered suicide: 14.5% [95% CI 13.3–15.9]; made a suicide plan: 12.1% [95% CI 11.0–13.2]; attempted suicide: 6.4% [95% CI 5.6–7.3]; and

TABLE 2 Unadjusted Prevalence Ratios of Suicide Risk Behaviors Among High School Students, by POM (YRBS, United States, 2019)

POM Status	Unweighted No.	Seriously Considered Attempt ^a (<i>n</i> = 1684) % (95% CI)	Unadjusted Prevalence Ratio (95% CI)	Made a Plan ^b (<i>n</i> = 1395) % (95% CI)	Unadjusted Prevalence Ratio ^c (95% CI)	Attempted ^d (<i>n</i> = 703) % (95% CI)	Unadjusted Prevalence Ratio ^e (95% CI)	Felt Sad or Hopeless ^f (<i>n</i> = 3259) % (95% CI)	Unadjusted Prevalence Ratio ^g (95% CI)
Overall	8661	—	—	—	—	—	—	—	—
Current POM ^c	661	44.4 (39.2–49.8)	2.91 (2.59–3.26)	39.4 (33.8–45.2)	3.11 (2.70–3.59)	32.5 (28.3–36.9)	5.37 (4.53–6.37)	65.4 (59.9–70.4)	1.96 (1.79–2.14)
Past POM ^f	638	37.2 (33.3–41.2)	2.43 (2.16–2.74)	32.6 (28.6–36.9)	2.57 (2.22–2.99)	18.7 (15.6–22.1)	3.09 (2.50–3.82)	57.4 (52.1–62.6)	1.72 (1.57–1.89)
Never POM ^g	7362	15.3 (14.1–16.5)	Referent	12.7 (11.6–13.8)	Referent	6.0 (5.3–6.9)	Referent	33.4 (31.7–35.1)	Referent

—, not applicable.

^a Seriously considered attempting suicide during the 12 mo before the survey.

^b Made a plan about how to attempt suicide ≥1 time during the 12 mo before the survey.

^c Taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed ≥1 time during the past 30 d.

^d Attempted suicide ≥1 time during the 12 mo before the survey.

^e Almost every day for ≥2 weeks in a row and stopped doing some usual activities during the 12 mo before the survey.

^f Taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed ≥1 time during lifetime but not during the past 30 d.

^g Never taken prescription pain medicine without a doctor's prescription or differently from how a doctor prescribed.

felt sad or hopeless: 32.8% [95% CI 31.2–34.6]) or not sure (past POM: 7.3% [95% CI 5.0–10.6]; current POM: 11.5% [95% CI 8.2–15.9]; seriously considered suicide: 30.8% [95% CI 24.8–37.4]; made a suicide plan: 24.4% [95% CI 19.8–29.6]; attempted suicide: 14.5% [95% CI 10.1–20.3]; and felt sad or hopeless: 49.1% [95% CI 31.2–34.6]). Non-Hispanic white students more commonly reported past POM (7.6%; 95% CI 6.4–9.0), seriously considering suicide (19.6%; 95% CI 17.9–21.4), and making a suicide plan (16.2%; 95% CI 14.5–18.1) than students of other races and/or ethnicities but report lower prevalence of suicide attempts (7.9%; 95% CI 6.8–9.3). Non-Hispanic Black students reported greater prevalence of attempting suicide (11.3%; 95% CI 8.8–14.5) than students of other races and/or ethnicities. Hispanic students reported greater prevalence of current POM (9.8%; 95% CI 8.2–11.6) and feeling sad or hopeless (40.5%; 95% CI 38.1–42.9) than students of other races and/or ethnicities.

An estimated 44.4% of students who reported current POM reported that during the previous 12 months they had seriously considered a suicide attempt; 39.4% had made a suicide plan; 32.5% had attempted suicide; and 65.4% had felt sad or hopeless (Table 2). Among students who reported past POM, 37.2% had seriously considered a suicide attempt; 32.6% had made a suicide plan; 18.7% had attempted suicide; and 57.4% had felt sad or hopeless during the previous 12 months. Among students with no POM, 15.3% had seriously considered a suicide attempt; 12.7% had made a suicide plan; 6.0% had attempted suicide; and 33.4% had felt sad or hopeless during the previous 12 months (Table 2).

We used logistic regression to examine the association between recency of POM and suicide risk behaviors among high school

students. Across all suicide risk behaviors, prevalence estimates were highest among students reporting current POM, followed by students reporting past POM; prevalence estimates were lowest among students who reported no POM. After controlling for sex, race and/or ethnicity, grade, sexual identity, current alcohol use, current marijuana use, and lifetime use of illicit drugs, both current POM and past POM were significantly associated with each of the suicide risk behaviors compared with no POM (Table 3). Students who reported current POM had the highest aPRs across each of the following outcomes: seriously considered attempting suicide (aPR: 2.30; 95% CI 1.97–2.69), made a suicide plan (aPR: 2.33; 95% CI 1.99–2.79), attempted suicide (aPR: 3.21; 95% CI 2.56–4.02), and felt sad or hopeless (aPR: 1.59; 95% CI 1.37–1.84). Students who reported current POM also were significantly more likely than youth who reported past POM to report that they had seriously considered attempting suicide (past POM aPR: 1.70; 95% CI 1.46–1.99), made a suicide plan (past POM aPR: 1.78; 95% CI 1.43–2.21), and attempted suicide (past POM aPR: 1.91; 95% CI 1.43–2.56).

DISCUSSION

During 2019, ~40% of high school students had felt sad or hopeless for ≥ 2 weeks, during the previous year; 19% had seriously considered suicide; 9% had attempted suicide; and 7% reported current POM. Of particular importance, ~33% of youth who reported current POM and 19% who reported past POM had attempted suicide during 2019 compared to only 6% of students who reported no POM. Moreover, the increased risk for suicide-related behaviors and experiences, especially among students reporting current POM, remained even after accounting for demographic characteristics and

alcohol, marijuana, and illicit drug use. These findings suggest that although any POM (both current and past misuse) is associated with increases in students' risk for suicide-related behaviors and experiences, current use is associated with an even greater risk.

Previous research on recency of POM and suicide-related outcomes among adult populations indicates that adults who report past POM, persistent POM (past and current POM), and recent-onset POM are all more likely to report suicidal ideation when compared with those who report no POM.⁸ Although more research on both adult and youth populations is needed, the findings of the current study suggest that associations between recency of POM and suicide risk behaviors and experiences among youth may operate differently from among adults, with current POM associated most strongly with suicide risk behaviors and experiences among youth.

These findings suggest that identifying youth who are struggling with current POM and connecting them with substance use treatment and services could be a critical approach for preventing youth suicide. The findings from this analysis also suggest that although youth who report current POM may be at highest risk for suicide risk behaviors and experiences, all youth who report POM in their lifetime are at an elevated risk. In previous research, authors have identified a number of shared risk factors for suicide-related behaviors and POM, such as previous exposure to adverse childhood experiences and underlying mental health conditions, such as depression and anxiety.^{11–14} The co-occurrence of POM and suicide-related behaviors and experiences among high school students underscores the importance of comprehensive prevention approaches that address both

challenges and their intersecting risks and protective factors. Communities can address the intersections of POM and youth suicide through upstream primary prevention approaches, such as preventing adverse childhood experiences (eg, child maltreatment or witnessing or experiencing violence), which have been linked to higher youth POM and suicide risk,^{15,16} and by strengthening strategies that promote safe, stable, nurturing relationships and environments during childhood.¹⁷

In addition, communities can support families and prevent suicide by strengthening economic supports; teaching coping and problem-solving skills to children, adolescents, and their parents; promoting connectedness between youth and their schools, teachers, peers, and families; creating protective environments in schools and at home (eg, limiting access to such lethal means among students at risk, such as medications and firearms); promoting help-seeking behaviors; reducing stigma; and training teachers and adults to recognize signs of suicide risk (eg, gatekeeper training) and to respond effectively through referrals to evidence-based substance use and mental health treatment (eg, cognitive behavior therapy).¹⁸

The Centers for Disease Control and Prevention's Preventing Suicide Technical Package¹⁸ also provides approaches that address a range of risk and protective factors linked to suicide, and in some cases substance use, as well those at the individual, relationship, community, and societal levels. These include strategies for preventing suicide risk in the first place (eg, promoting connectedness), identifying and supporting youth at increased risk, preventing attempts and reattempts, and supporting friends and loved ones affected by suicide attempts or loss. Opioid

misuse prevention approaches include primary substance use prevention programs and improving opioid prescribing (eg, prescription drug monitoring programs, implementation of and adherence to prescribing guidelines, academic detailing, and educating prescribers and patients regarding nonopioid pain management strategies) and enhancing linkage to care and provision of evidence-based treatment of youth with opioid use disorder (eg, medication-assisted treatment).¹⁹ As the findings from this analysis suggest, getting youth who report current POM into care may be critical for preventing suicide risk behaviors and experiences. Conversely, addressing underlying suicide risk factors and getting youth who report suicidal ideation and other suicide-related risk behaviors into care may prevent POM.

This report is subject to at least 4 limitations. First, the data presented apply only to youth who attend school and therefore are not representative of all persons in this age group. During 2017, an estimated 4.7% of youth in grades 10 to 12 had left school between the beginning of 1 school year and the beginning of the next without earning a high school diploma or alternative credential²⁰; therefore, youth who experience a disproportionate level of school attrition (eg, racial and/or ethnic and sexual minority youth) might be particularly underrepresented.²⁰ Second, although survey questions used in this study have revealed good test-retest reliability,²¹ findings are subject to the typical limitations of self-reported data (eg, potential underreporting or overreporting of health-related behaviors and experiences). Third, these findings are based on cross-sectional data and therefore cannot establish causal relationships; rather, they represent

associations at a point in time. Also, the differing time frames of some of the variables reported in these analyses (eg, current POM is measured as POM within the past 30 days, whereas suicide risk behaviors and experiences are all measured for the last 12 months) provide further reason why it is not possible to determine the directionality of associations. Fourth, although the YRBS POM items are intended to capture POM, it is possible that youth also reported on misuse of nonopioid prescription pain medication. Also, although the POM items capture misuse, they do not capture distinctions between levels of misuse (eg, occasional misuse versus frequent use or having an opioid use disorder).

CONCLUSIONS

Although POM, particularly current POM, is associated with increases in the risk for suicide-related behaviors and experiences of youth within the past 12 months, comprehensive prevention approaches that address the intersections between suicide, POM, and such shared upstream risks as adverse childhood experiences provide a promising path forward for addressing these public health challenges among youth.

ACKNOWLEDGMENTS

We acknowledge the contributions of the local education agencies that participated in the Centers for Disease Control and Prevention's YRBS.

ABBREVIATIONS

aPR: adjusted prevalence ratio
CI: confidence interval
POM: prescription opioid misuse
YRBS: Youth Risk Behavior Survey

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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DOI: 10.1542/peds.2020-030601 originally published online March 1, 2021;

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