

Addressing Suicidal Thoughts And Behaviors in Substance Abuse Treatment

A Treatment
Improvement
Protocol

TIP
50



Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

Treatment Improvement Protocol (TIP) Series

50

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Contents

Consensus Panel	v
What Is a TIP?	vii
Foreword	ix
How This TIP Is Organized	xi

Part 1

Overview of Part 1	1
--------------------------	---

Chapter 1

Introduction	3
Getting Ready to Address Suicidality	4
Background Information	9
GATE: Procedures for Substance Abuse Counselors	14
Competencies	25
Next Steps	31

Chapter 2

Introduction	33
Vignette 1—Clayton	34
Vignette 2—Angela	46
Vignette 3—Leon	55
Vignette 4—Rob	63
Vignette 5—Vince	67
Vignette 6—Rena	77

Part 2

Chapter 1: The Administrative Response to Suicidality in Substance Abuse

Treatment Settings

Introduction	91
Consensus Panel Recommendations for Administrators	92
The Benefits of Addressing Suicidality in Substance Abuse Treatment Programs	92
Why Should Administrators Be Involved in a Clinical Issue?	93
Levels of Program Involvement and Core Program Components	94
The Role of Administrators in Implementing and Supporting Programming for Clients With Suicidal Thoughts and Behaviors	97
The Role of Mid-Level Staff in Implementing and Supporting Programming for Clients With Suicidal Thoughts and Behaviors	98
Legal and Ethical Issues in Addressing Suicidality in Substance Abuse Programs	98

Chapter 2: Building a Suicide Prevention- and Intervention-Capable Agency 107

- Introduction 107
- Organizational Assessment..... 108
- Organizational Planning for Becoming a Level 2 Program 110
- Program Implementation 111
- Helping Your Program Develop and Improve Capabilities in Working With
Clients Who Are Suicidal 113
- Helping Your Agency Develop and Improve Its Response to Suicidal Crises 115
- Building Administrative Support for All Levels of GATE 117

Appendix A—Bibliography..... 123

Appendix B—Advisory Meeting Panel..... 133

Appendix C—Stakeholders Meeting Participants 135

Appendix D—Field Reviewers..... 139

Appendix E—Acknowledgments 141

Index 143

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at <http://store.samhsa.gov>.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided. When no citation is provided, the information is based on the collective clinical knowledge and experience of the consensus panel.

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities by providing evidence-based and best practice guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. Field reviewers then review and critique this panel's work.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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How This TIP Is Organized

This TIP is divided into three parts:

- *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, Part 1.*
- *Addressing Suicidal Thoughts and Behaviors: An Implementation Guide for Administrators, Part 2.*
- *Addressing Suicidal Thoughts and Behaviors: A Review of the Literature, Part 3.*

Parts 1 and 2 are presented in this publication; Part 3 is available only online at <http://www.kap.samhsa.gov>. Each part is described below.

Part 1 of the TIP is for substance abuse counselors and consists of two chapters. Chapter 1 presents the “what” and “why” of working with clients with substance use disorders who have suicidal thoughts and/or behaviors. It covers:

- Basic suggestions for addressing suicidal thoughts and behaviors, along with points to keep you on track and positive attitudes and behaviors that will help you provide services to clients who are suicidal.
- Background information about suicide and substance use disorders, including risk factors and warning signs for suicide.
- A four-step process for addressing suicidal thoughts and behaviors in substance abuse treatment, summarized by the acronym GATE (Gather information, Access supervision, Take responsible action, and Extend the action).
- A set of competencies counselors should incorporate to work effectively with clients who are suicidal.

Chapter 2 presents the “how to” of working with clients with suicidal thoughts and/or behaviors. Chapter 2 contains:

- Representative vignettes of counseling sessions with clients who have suicidal thoughts and behaviors.
- Master clinician notes and comments that help you understand the client, his or her issues related to suicide, and approaches you can take in your counseling work with clients with suicidal thoughts and behaviors.
- “How-to” descriptions of specific counseling techniques.

It is strongly recommended that you read Chapter 1 before reading Chapter 2.

Part 2 is an implementation guide for program administrators and consists of two chapters. Chapter 1 lays out the rationale for the approach taken in Chapter 2 and will help you understand how administrators can provide support for programs and counselors as they address clients’ suicidal thoughts and behaviors. It is hoped that this knowledge will enable treatment programs to become suicide capable: that is, to treat substance abuse while concurrently addressing the specific needs of those who have warning signs for suicide. Chapter 2 provides detailed information on how to achieve high-quality implementation of the recommendations in *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, Part 1.*

The following topics are addressed in Part 2:

- The benefits of addressing suicidality in substance abuse treatment programs.
- The role of administrators and mid-level staff in providing care for clients with suicidal thoughts and behaviors.
- Different levels of program involvement in addressing the needs of substance abuse clients with suicidal thoughts and behaviors.
- Legal and ethical issues for consideration in managing and providing treatment to clients with suicidal thoughts and behaviors.

Part 3 of this TIP is a literature review on the topic of depressive symptoms and is available for use by clinical supervisors, interested counselors, and administrators. *Part 3* consists of three sections: an analysis of the available literature, an annotated bibliography of the literature most central to the topic, and a bibliography of other available literature. It includes literature that addresses both clinical and administrative concerns. To facilitate ongoing updates (which will be performed every 6 months for up to 5 years from first publication), the literature review will be available only online at <http://www.kap.samhsa.gov>.

Part 1

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

Overview of Part 1

Chapter 1: Information You Need to Know

Introduction (pp. 3–4)

Getting Ready To Address Suicidality provides basic principles about your role in working with clients who are suicidal (pp. 4–9)

Background Information concerning substance abuse and suicidality (pp. 9–14)

GATE, a four-step process (**G**ather information, **A**ccess supervision, **T**ake responsible action, **E**xtend the action) for addressing suicidal thoughts and behaviors in substance abuse treatment (pp. 14–25)

Competencies for working with clients with suicidal thoughts and behaviors (pp. 25–31)

Chapter 2: Clinical Vignettes Demonstrating How to Apply the Information

To illustrate and reinforce the material presented in chapter 1, six realistic scenarios involving suicidal behaviors that might arise during the course of substance abuse treatment are provided. The vignettes emphasize the GATE process and the responsible actions modeled by a counselor and his or her supervisor. *Master Clinician Notes* are provided to explain the thinking behind these actions. *How-To Notes* provide instructions for specific methods and interventions.

Chapter 1

Introduction

Did You Know?

- Suicide is a leading cause of death among people who abuse alcohol and drugs (Wilcox, Conner, & Caine, 2004).
- Compared to the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk to eventually die by suicide compared with the general population, and people who inject drugs are at about 14 times greater risk for eventual suicide (Wilcox et al., 2004).
- Individuals with substance use disorders are also at elevated risk for suicidal ideation and suicide attempts (Kessler, Borges, & Walters, 1999).
- People with substance use disorders who are in treatment are at especially high risk of suicidal behavior for many reasons, including:
 - They enter treatment at a point when their substance abuse is out of control, increasing a variety of risk factors for suicide (Ross, Teesson, Darke, Lynskey, Ali, Ritter, et al., 2005).
 - They enter treatment when a number of co-occurring life crises may be occurring (e.g., marital, legal, job) (Ross et al., 2005).
 - They enter treatment at peaks in depressive symptoms (Ross et al., 2005).
 - Mental health problems (e.g., depression, post-traumatic stress disorder [PTSD], anxiety disorders, some personality disorders) associated with suicidality often co-occur among people who have been treated for substance use disorders.
 - Crises that are known to increase suicide risk sometimes occur during treatment (e.g., relapse and treatment transitions).

Who Should Read This Chapter?

Suicide risk is a problem that every frontline substance abuse counselor must be able to address. This chapter is written for you if you are a frontline counselor in a substance abuse treatment program and/or if you work with individuals who have both a sub-

stance abuse and mental health disorder and/or if you provide supervision or consultation to frontline counselors. While the information in this TIP is specific to clients with a substance use disorder diagnosis who exhibit suicidal thoughts and behaviors, the content can be generalized for counselors addressing all people with suicidal ideation or behavior.

Why a TIP on Suicide for Substance Abuse Counselors and Supervisors?

Research consistently shows a high prevalence of suicidal thoughts and suicide attempts among persons with substance abuse problems who are in treatment (Ilgen, Harris, Moos, & Tiet, 2007) and a significant prevalence of death-by-suicide among those who have at one time been in substance abuse treatment when compared with those who do not have a diagnosis of substance use disorder (Wilcox et al., 2004). As a result, substance abuse treatment providers must be prepared to gather information routinely from, refer, and participate in the treatment of clients at risk for suicidal behavior. Suicidal thoughts and behaviors are also a significant indicator of other co-occurring disorders (such as major depression, bipolar disorder, PTSD, schizophrenia, and some personality disorders) that will need to be explored, diagnosed, and addressed to improve outcomes of substance abuse treatment.

You Can Do This!

Your clinical training in substance abuse counseling puts you in a solid position to perform the tasks outlined in this TIP. As you will learn, the first step in addressing suicidality is to “gather information,” or to perform exactly the same kind of information-gathering tasks you do every day. For example, if a client were having trouble with craving, you would first want to know more about it. Think about the types of questions you would ask. They might include “Tell me about your craving. How often do you have it? How strong is it? What makes it worse?” These questions are precisely the type you would ask about suicidal thoughts: “Tell me about your suicidal thoughts. How often do you have them? How strong are they? What makes them worse?” In other words,

even though some content areas may be less familiar to you, your training and experience in substance abuse counseling provides you with the foundation you need to address suicidal behaviors with your clients.

Consensus Panel Recommendations

You are a trained substance abuse treatment professional or an integrated treatment specialist who works with persons with co-occurring substance use and mental disorders, but most likely, your background does not include detailed training in addressing your clients' suicidal thoughts and behaviors. This TIP is designed to fill that gap and increase your understanding of relevant mental disorders.

In particular, the consensus panel recommends the following:

- Clients in substance abuse treatment should be screened for suicidal thoughts and behaviors routinely at intake and at specific points in the course of treatment (see pp. 15–18). Screening for clients with high risk factors should occur regularly throughout treatment.
- Counselors should be prepared to develop and implement a treatment plan to address suicidality and coordinate the plan with other providers.
- If a referral is made, counselors should check that referral appointments are kept and continue to monitor clients after crises have passed, through ongoing coordination with mental health providers and other practitioners, family members, and community resources, as appropriate.
- Counselors should acquire basic knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.
- Counselors should be empathic and nonjudgmental with people who experience suicidal thoughts and behaviors.
- Counselors should understand the impact of their own attitudes and experiences with suicidality on their counseling work with clients.
- Substance abuse counselors should understand the ethical and legal principles and potential areas of conflict that exist in working with clients who have suicidal thoughts and behaviors.

Getting Ready To Address Suicidality

It is important for you to be comfortable and competent when asking your clients questions about suicidal ideation and behavior. It may be challenging to balance your own comfort level with your need to obtain accurate and clear information in order to best help the client. Suggestions made by the consensus panel to ease the process follow.

Be Direct

Talking with clients about their thoughts of suicide and death is uncomfortable. However, you must overcome this discomfort, as it may lead a counselor to ask a guaranteed conversation-ending question, such as “You don’t have thoughts about killing yourself, do you?” Discomfort can also lead counselors to avoid asking directly about suicidality, which may convey uneasiness to the patient, imply that the topic is taboo, or result in confusion or lack of clarity. Instead, counselors can learn to ask, “Are you thinking about killing yourself?” Of course, death and suicide are just two examples of taboo topics for many people. The same observations can be made in addressing issues of sexuality and sexual orientation, money and finances, and relationship fantasies and behaviors. The difference is that asking about suicidal thoughts can actually save a life, as it allows a client to feel safe and understood enough to raise concerns and beliefs with you, the counselor. It is important to note that there is no empirical evidence to suggest that talking to a person about suicide will make them suicidal.

Increase Your Knowledge About Suicidality

One of the best ways to become more comfortable with any topic is to learn more about it. Suicide is no exception. Knowing some of the circumstances in which people become suicidal, how suicidality manifests, what warning signs might indicate possible suicidal behavior, what questions to ask to identify suicidality, and, perhaps most important, what the effective interventions are, can increase your competence, and as a result, your comfort in addressing this issue with clients.

Do What You Already Do Well

Good counselors are empathic, warm, and supportive, and trust their experience and intuition. However, on encountering suicidal thoughts and behaviors, counselors sometimes unwittingly employ countertherapeutic practices, such as aggressively questioning the client about his or her thoughts and feelings, demanding assurance of safety when a client cannot provide such assurance, becoming autocratic and failing to collaborate with the client, and/or avoiding sensitive topics so as not to engender sadness. These countertherapeutic practices can be the consequence of anxiety and unfamiliarity with the issue, along with fear of litigation if the client does make a suicidal act. Given these fears and issues, it is easy to see how otherwise highly skilled counselors can fall into the trap of becoming “the suicide interrogator.” Your option? Deliberately choose another path. Stay grounded and make use of your therapeutic skills when dealing with suicidal behaviors, as that is the most important time to fall back on (and not veer away from) your therapeutic abilities, experience, and training. Collect objective data, just as you would collect objective data about a client’s substance use, but don’t lose your empathy or concern in the process.

Practice, Practice, Practice

Remember the first substance abuse client you interviewed? Do you remember your internal reaction to that interview? Now, you’re a lot more comfortable talking with clients about their drug history, their current symptoms, and their plans for recovery. Nothing reduces anxiety more than practice. The same holds true about talking with your clients about suicidal thoughts and behaviors. If you need to reduce your initial discomfort on the topic, practice with another counselor or your clinical supervisor. Get feedback about how you are coming across. Start asking every one of your clients about suicidality. The more experience you have, the more comfortable you will become. You may also consider attending a workshop or getting additional training specific to the topic of suicidality.

Get Good Clinical Supervision and Consultation

Getting clinical supervision is a great way to learn and practice new skills. Contract with your clinical

supervisor to integrate skill development about suicidality into your Individual Development Plan for clinical supervision. Get feedback from your supervisor about your attitudes toward clients who are suicidal and your skills in interviewing clients. Working with a treatment team almost always increases the quality of information gathering, decisionmaking, and taking action.

Work Collaboratively With Suicidal Clients

Just as you involve clients in developing a treatment plan for recovery, so too should you involve them in suicide prevention planning. You will be most effective if you ask them about suicide with concern (but not alarm), just as you would with any other area of concern. Explain the reason(s) for your concern and any action(s) that you take, elicit their input as to what may help them be safe, and (with your supervisor), consider their input as much as possible in determining the actions that you take. Most often, the client will be willing to work collaboratively with you, particularly if you take the time to listen and to explain your actions. Informed consent should be part of collaboration with your client. Inform the client about the steps that might be taken to reduce suicide risk, steps for referral if needed, and confidentiality issues that might arise. Of course, there may be times when you and your supervisor will need to take an action over a client’s objections (e.g., arrange for an immediate evaluation at a hospital), but even in these relatively rare circumstances, you can still seek your client’s input, and make efforts to work collaboratively.

Realize Limitations of Confidentiality and Be Open With Your Clients About Such Limits

You should understand existing ethical and legal principles and potential areas of conflict (including the possible limits of confidentiality) because safety and protection of the client trumps confidentiality in certain crisis situations. When you first meet clients and as appropriate during the course of treatment, explain that, in the event of suicide risk, you may take steps to promote the client’s safety (including the potential for breaking confidentiality, arranging for an emergency evaluation over the client’s objec-

tions, and involving emergency personnel). Clients should not be given the false impression that everything is confidential or that all types of treatment are always voluntary.

Ten Points To Keep You on Track

Point 1: Almost all of your clients who are suicidal are ambivalent about living or not living.

Explanation: Wishing both to die and to live is typical of most individuals who are suicidal, even those who are seriously suicidal (see, e.g., Brown, Steer, Henniques, & Beck, 2005). For example, hesitation wounds are commonly seen on individuals who have died by suicide (e.g., hesitation scratches before a lethal cut, bruises on a temple indicating that a gun had been placed there several times before pulling the trigger). It has even been argued that the struggle between wanting to die and wanting to live is at the core of a suicidal crisis (Shneidman, 1985). Take suicidal thinking seriously and think about ways to reinforce realistic hope. Do everything you can to support the side of the client that wants to live, but do not trivialize or ignore signs of wanting to die.

Point 2: Suicidal crises can be overcome.

Explanation: Fortunately, acute suicidality is a transient state (Shneidman, 1985). Even individuals at high, long-term risk spend more time being nonsuicidal than being suicidal. Moreover, the majority of individuals who have made serious suicide attempts are relieved that they did not die after receiving acute medical and/or psychiatric care. The challenge is to help clients survive the acute, suicidal crisis period until such time as they want to live again. Moreover, treatments for suicidal clients, many with substance use disorders, including cognitive-behavioral treatment (CBT; Brown, et al., 2005) and dialectical behavioral therapy (DBT; Linehan, Schmidt, Dimeff, Craft, Kanter, & Comtois, 1999) have shown positive results in reducing repeated suicide attempts. Interventions that successfully address major risk factors such as severe substance use, depression, and marital strife also have the potential to reduce suicidal behavior. Although data are limited, other specific interventions have been shown to prevent suicide deaths (Mann, Apter, Bertolote, Beautrais, Currier, Haas, et al., 2005).

Point 3: Although suicide cannot be predicted with certainty, suicide risk assessment is a valuable clinical tool.

Explanation: Substance abuse counselors work with many high-risk clients. Determining with accuracy who will die by suicide using tests or clinical judgment is extremely difficult, if not impossible (Pokorny, 1983). Although precisely who may die by suicide cannot be known, suicide risk assessment is a valuable clinical tool because it can ensure that those requiring more services get the help that they need. In other words, it is not necessary to have a crystal ball if the assessment information shows that a client fits the profile of an individual at significant risk. In such instances, appropriate actions should be taken.

Point 4: Suicide prevention actions should extend beyond the immediate crisis.

Explanation: Clients in substance abuse treatment who have long-term risk factors for suicide (e.g., depression, child sexual abuse history, marital problems, repeated substance abuse relapse) require treatment of these issues, whether or not they show any indication of current risk for suicide. Individuals with a history of serious suicidal thoughts or suicide attempts, but with no recent suicidal thoughts or behaviors, may be monitored to identify any recurrence of suicidality.

Point 5: Suicide contracts are not recommended and are never sufficient.

Explanation: Contracts for safety are often used as a stand-alone intervention, but they are never sufficient to ensure the client's safety. Contracts for safety are widely used to reduce legal liability, but the consensus panel is aware of no significant evidence that such contracts offer any protection from litigation. They may, in fact, make litigation more likely if suicide prevention efforts appear to be hinged on the contract or if they provide the counselor with a false sense of security. It is misguided to predicate decisions on whether the client "can" or "can't" or "will" or "won't" contract for safety. Use this TIP and choose from among the many other strategies to promote safety. Use contracts sparingly, if at all.

Point 6: Some clients will be at risk of suicide, even after getting clean and sober.

Explanation: Abstinence should be a primary goal of any client with a substance use disorder and suicidal thoughts and/or behaviors (Weiss & Hufford, 1999). Indeed, risk will diminish for most clients when they achieve abstinence. Nonetheless, some individuals remain at risk even after achieving abstinence

(Conner, Duberstein, Conwell, Herrmann, Jr., Cox, Barrington, et al., 2000). For example, clients with an independent depression (one that does not resolve with abstinence or is not substance induced), those who have unresolved difficulties that promote suicidal thoughts (e.g., a deteriorating partner relationship, ongoing domestic violence, victimization, impending legal sentencing), those who have a marked personality disturbance (e.g., borderline personality disorder), those with trauma histories (e.g., sexual abuse history), and/or individuals with a major psychiatric illness may continue to show signs of risk.

Point 7: Suicide attempts always must be taken seriously.

Explanation: There is often a mismatch between the intent of the suicidal act and the lethality of the method chosen (Brown, Henriques, Sosdjan, & Beck, 2004). Therefore, clients who genuinely want to die (and expect to die) may nonetheless survive because their method was not foolproof and/or because they were interrupted or rescued. Indeed, a prior suicide attempt is a highly potent risk factor for eventually dying by suicide (Kapur, Cooper, King-Hele, Webb, Lawlor, Rodway, et al., 2006). Any suicide attempt must be taken seriously, including those that involve little risk of death, and any suicidal thoughts must be carefully considered in relation to the client's history and current presentation.

Point 8: Suicidal individuals generally show warning signs.

Explanation: Fortunately, suicidal individuals usually give warning signs. Such warning signs come in many forms (e.g., expressions of hopelessness, suicidal communication) and are often repeated. The difficulty is in recognizing them for what they are. See the section on warning signs (pp. 11–12).

Point 9: It is best to ask clients about suicide, and ask directly.

Explanation: Available data do not support the idea that asking about suicide will put this idea in an individual's mind (Gould et al., 2005). A counselor's power is limited and does not include the ability to place the idea of suicide in a client's head or to magically remove such an idea. You may never know about a client's suicidality unless you ask. You are encouraged to ask directly about suicide (see the Gathering Information section, pp. 14–18).

Point 10: The outcome does not tell the whole story.

Explanation: Suicide deaths have a much lower base rate than many other deleterious outcomes that counselors encounter (e.g., relapse, treatment dropout). A client at significant risk may survive despite never being screened, assessed, or offered intervention for suicide simply because of the relatively low base rate of suicide. Therefore, a good outcome (survival) does not, by itself, equate to proper treatment of suicidal thoughts and behaviors. On the other hand, a clinical team may do a solid job of screening, assessing, and intervening with a high-risk client. Despite these efforts, a high-risk client may eventually die by suicide. Therefore, a tragic outcome (death) does not, by itself, equate to improper treatment of suicidality.

Maintain Positive Attitudes

Attitudes toward suicide vary widely. Some people hold religious or spiritual views that have strong sanctions against suicidal behavior. Others see suicide as a viable option for ending unmanageable pain or suffering or as an acceptable option in other circumstances. Some hold the view that it is all right to think about suicide but not to act on those thoughts. Our attitudes are influenced by our culture, childhood experiences, and especially, by our professional and personal experiences with suicidal thinking and behavior.

Before working with clients who are suicidal, counselors are advised to conduct their own suicidal attitude inventory. The goal of the inventory is not to change your views but rather to help you understand what your views are and how those views can positively or negatively affect your interactions with clients. Some of the items you might consider in an inventory include:

- What is my personal and family history with suicidal thoughts and behaviors?
- What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with suicidal clients?
- What is my emotional reaction to clients who are suicidal?
- How do I feel when talking to clients about their suicidal thoughts and behaviors?
- What did I learn about suicide in my formative years?

- How does what I learned then affect how I relate today to people who are suicidal, and how do I feel about clients who are suicidal?
- What beliefs and attitudes do I hold today that might limit me in working with people who are suicidal?

These views may also need to be further clarified by consultation with your clinical supervisor or with your peers.

As noted, your attitudes about suicide are strongly influenced by your life experiences with suicide and similar events. Needless to say, your responses to suicide and to people who are suicidal are highly susceptible to attitudinal influence, and these attitudes play a critical role in work with people who are suicidal. An empathic attitude can assist you in engaging and understanding people in a suicidal crisis. A negative attitude can cause you to miss opportunities to offer hope and help or to overreact to people in a suicidal crisis. Below are some attitudinal issues to consider in working with people who are suicidal.

Positive Attitude and Behavior 1: People in substance abuse treatment settings often need additional services to ensure their safety.

Explanation: Merely receiving substance abuse treatment may lessen the risk of suicide. A good working relationship with a substance abuse treatment professional is, in fact, a powerful protective factor against suicide. However, individuals who are acutely suicidal may need more services (e.g., mental health evaluation, short-term emergency hospitalization) to ensure their safety. In addition, certain clients, including those who are poorly connected to other clients and to treatment providers, clients who are making little progress in treatment, and clients at major transition points in care (e.g., moving from inpatient to outpatient care or being administratively discharged) may be at increased risk. An empathic attitude can help you recognize these challenging circumstances and proactively assess and intervene.

Positive Attitude and Behavior 2: All clients should be screened for suicidal thoughts and behaviors as a matter of routine.

Explanation: “Don’t ask, don’t tell” is not an effective agency suicide policy. Take the following actions to prevent clients from being exposed to life-threatening situations and to prevent exposing yourself and your agency to legal risk of malpractice:

- Screen for suicide and ask followup questions.
- Follow up with a client when risk has been previously documented.
- Take appropriate action when risk is detected.
- Document suicide-related screening and interventions.
- Communicate suicide risk to another professional or agency.

Positive Attitude and Behavior 3: All expressions of suicidality indicate significant distress and heightened vulnerability that require further questioning and action.

Explanation: Even in rare circumstances where clients appear to be purposefully using reports of suicidal thoughts or plans to manipulate their treatment regimen, expressions of suicidality must be taken seriously. Thus, when clients appear to “use” suicidality, it should be recognized as a very limited approach to coping. Indeed, there is often more than one reason for an act of suicide (e.g., one may simultaneously want to die *and* elicit attention). You must address clients “where they are” and not impose your own agenda. If suicidal thoughts or behaviors occur, addressing suicidality must be a priority. Even if a client really does not want to die, if his or her reports of suicidal ideation are not taken seriously, the client may act on them to “save face.”

Positive Attitude and Behavior 4: Warning signs for suicide can be indirect; you need to develop a heightened sensitivity to these cues.

Explanation: Fortunately, clients often give warning signs before making a suicide attempt, and often these warning signs include expressions of suicidal thoughts or plans. More indirect signals include expressions of hopelessness, feeling trapped, or having no purpose in life, and observable signs such as withdrawal from others, mood changes, or reckless behavior. Such signs require followup. Beyond screening for current risk, counselors should be aware of clients’ histories of suicidal thoughts and behaviors and should be on watch for indications of recurrence of suicidal thoughts or behavior and/or the emergence of warning signs, particularly when acute stressful life events (such as relapse, relationship breakup, or psychological trauma) occur.

Positive Attitude and Behavior 5: Talking about a client’s past suicidal behavior can provide information about triggers for suicidal behavior.

Explanation: Discussing past suicidal thoughts or behaviors is an important part of gathering information for suicide screening. The circumstances of past suicidal ideation and attempts can provide important insights into the scenario(s) that may promote future risk. Some clients may also wish to discuss past suicidal behavior in more depth for a variety of reasons (e.g., they never talked about it before, it represented their “hitting bottom,” the spiritual implications) that should be honored.

Positive Attitude and Behavior 6: You should give clients who are at risk of suicide the telephone number of a suicide hotline; it does no harm and could actually save a life.

Explanation: It is true that some clients will never use a hotline number. However, others will use a hotline resource. It is best to give all clients who may be at risk of suicide a hotline number because you cannot predict which clients will take advantage of it. In addition, always give “at risk” clients other options, including how to contact emergency resources after hours, mental health emergency services in the community, and instructions to go to the nearest hospital emergency room. The national suicide hotline, 1-800-273-TALK, and 911 can be accessed from anywhere in the United States. How to use a safety card with emergency contact information is discussed later in this chapter.

Summary

Positive, empathic attitudes toward clients experiencing suicidal thoughts and behaviors do not, by themselves, mean that clients will initiate or receive appropriate services. However, they do form the platform on which proactive, effective services can be built. It is important to remember that the thoughts, emotions, and behaviors accompanying negative attitudes toward suicidality can be a major impediment to quality care. Understanding that clients with suicidal thoughts and behaviors can benefit from intervention and treatment, that people who make verbal expressions of suicidality have needs that aren't being addressed, and that there is a relationship between a client's suicidality and his or her substance abuse can make a huge difference in a client's overcoming a suicidal crisis and staying in recovery.

Background Information

The Link Between Substance Abuse and Suicidality

There is a strong link between substance use disorders and risk for suicidal behavior.

- Suicide is a leading cause of death among people who abuse alcohol and drugs (Wilcox et al., 2004).
- Compared with the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk for suicide; people who inject drugs are at about 14 times greater risk for suicide (Wilcox, et al., 2004).
- Individuals with substance use disorders are also at increased risk for suicidal ideation and suicide attempts (Kessler et al., 1999).
- Depression is a common co-occurring diagnosis among people who abuse substances that confers risk for suicidal behavior (Conner et al., 2007; Murphy, Wetzel, Robins, & McEvoy, 1992; Roy, 2001, 2002). Other mental disorders are also implicated.
- People with substance use disorders often seek treatment at times when their substance use difficulties are at their peak—a vulnerable period that may be accompanied by suicidal thoughts and behaviors.

There is a strong link between acute substance use and risk for suicidal behavior.

- Alcohol's acute effects include disinhibition, intense focus on the current situation with little appreciation for consequences, and promoting depressed mood, all of which may increase risk for suicidal behavior (Hufford, 2001). Other central nervous system depressants may act similarly.
- Acute alcohol intoxication is present in about 30–40 percent of suicide attempts and suicides (Cherpitel, Borges, & Wilcox, 2004).
- Intense, short-lived depression is prevalent among treatment-seeking people who abuse cocaine, methamphetamines, and alcohol, among other groups (Brown et al., 1995; Cornelius, Salloum, Day, Thase, & Mann, 1996; Husband et al., 1996). Even transient depression is a potent risk factor for suicidal behavior among people with substance use disorders.

Overdose suicides often involve multiple drugs like alcohol, benzodiazepines, opioids, and other psychiatric medications (Darke & Ross, 2002).

The risk for suicidal behavior may increase at any point in treatment.

- Suicide risk may increase at transition points in care (inpatient to outpatient, intensive treatment to continuing care, discharge), especially when a planned transition breaks down. Anticipating risk at such transition points should be regarded as an issue in treatment planning.
- Suicide risk may increase when a client is terminated administratively (e.g., because of poor attendance, chronic substance use) or is refused care. It is unethical to discharge a client and/or refuse care to someone who is suicidal without making appropriate alternative arrangements for treatment to address suicide risk.
- Suicide risk may increase in clients with a history of suicidal thoughts or attempts who relapse. Treatment plans for such clients should provide for this possibility.
- Suicide risk may increase in clients with a history of suicidal thoughts or attempts who imply that the worst might happen if they relapse (e.g., “I can’t go through this again,” “if I relapse, that’s it”)—especially for those who make a direct threat (e.g., “This is my last chance; if I relapse, I’m going to kill myself”). Treatment plans for such clients should provide for this possibility.
- Suicide risk may increase in clients with a history of suicidal thoughts or attempts when they are experiencing acute stressful life events. Treatment plans for such clients should provide for this possibility, for example, by adding more intensive treatment, closer observation, or additional services to manage the life crises.

Types of Suicidal Thoughts and Behaviors

Precise definitions of four types of suicide-related concepts will help clarify important nuances in the subject matter of this TIP.

Suicidal thoughts

Suicidal ideation: Suicidal ideation is much more common than suicidal behavior (Conner et al., 2007; Kessler et al., 1999). Suicidal ideation lies on a continuum of severity from fleeting and vague thoughts

of death to those that are persistent and highly specific. Serious suicidal ideation is frequent, intense, and perceived as uncontrollable.

Suicide plans: Suicide plans are important because they signal more serious risk to carry out suicidal behavior than suicidal ideation that does not involve planning (Conner et al., 2007; Kessler et al., 1999). Suicide planning lies on a continuum from vague and unrealistic plans to those that are highly specific and feasible. Serious suicide planning may also involve rehearsal or preparation for a suicide attempt.

Suicidal behaviors

Suicide attempt: A suicide attempt is a deliberate act of self-harm that does not result in death and that has at least some intent to die (Silverman, Berman, Sanddal, O’Carroll, & Joiner, 2007). Attempts have two major elements: (a) the subjective level of intent to die (from the client’s subjective perspective, how intensely did he or she want to die and to what extent did he or she expect to die?); and (b) the objective lethality of the act (from a medical perspective, how likely was it that the behavior would have led to death?) (Beck, Schuyler, & Herman, 1974; Harriss, Hawton, & Zahl, 2005). Although all suicide attempts are serious, those with high intent (client clearly wanted to die and expected to die) and high lethality (behavior could have easily led to death) are the most serious.

Suicide: Suicide is an acute, deliberate act of self-harm with at least some intention to die resulting in death (Silverman et al., 2007).

Other suicide-related concepts

Suicidal intention: Suicidal intention (also called “intent”) signals high, acute risk for suicidal behavior. Having suicidal intent is always serious because it signals that the client “intends” to make a suicide attempt. Some indicators of “high intent” include drafting a suicide note or taking precautions against discovery at the time of an attempt.

Suicide preparation: Behaviors that suggest preparation signal high, acute risk for suicidal behavior. Preparation may come in many forms, such as writing a suicide note or diary entry, giving away possessions, writing a will, acquiring a method of suicide (e.g., hoarding pills, buying a weapon), making a

method more available (e.g., moving a gun from the attic to beside the bed), visiting a site where suicide may be carried out (e.g., driving to a bridge), rehearsing suicide (e.g., loading and unloading a weapon), and saying goodbye to loved ones directly or symbolically.

Other harmful behaviors

Non-suicidal self-injury (NSSI): NSSI is also commonly referred to in the literature as “deliberate self-harm” and “suicidal gesture.” NSSI (for example, self-mutilation or self-injury by cutting for the purpose of self-soothing with no wish to die and no expectation of dying) is distinguished from a suicide attempt or suicide because NSSI does not include suicidal intent. This TIP does not focus on NSSI. Suicidal behaviors and NSSI can co-exist in the same person and both can lead to serious bodily injury.

Self-destructive behaviors: Behaviors that are repeated and may eventually lead to death (e.g., drug abuse, smoking, anorexia, pattern of reckless driving, getting into fights) are distinguished from suicidal behavior because an act of suicide is an acute action intended to bring on death in the short term. This TIP does not focus on self-destructive behaviors.

Warning Signs for Suicide

Warning signs are defined as acute indications of elevated risk. In other words, they signal potential risk for suicidal behavior in the near future. Warning signs may be evident at intake or may arise during the course of treatment. Warning signs always require asking followup questions (discussed in the Gathering Information section, pp. 14–18). As identified by a panel of experts on suicidal behavior (Rudd et al., 2006), warning signs can be direct or indirect. **Direct** indications of acute suicidality are given the highest priority. They are:

- **Suicidal communication:** Someone threatening to hurt or kill him- or herself or talking of wanting to hurt or kill him- or herself.
- **Seeking access to a method:** Someone looking for ways to kill him- or herself by seeking access to firearms, available pills, or other means.
- **Making preparations:** Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

You may also observe **indirect** warning signs in substance abuse clients who are not suicidal. Nonetheless, these warning signs are critical to follow up on to determine the extent to which they may signal acute risk for suicidal behavior. You can remember them by the mnemonic IS PATH WARM:

- I = Ideation
- S = Substance Abuse
- P = Purposelessness
- A = Anxiety
- T = Trapped
- H = Hopelessness
- W = Withdrawal
- A = Anger
- R = Recklessness
- M = Mood Changes

Some of the IS PATH WARM warning signs are self-evident (e.g., substance abuse); others require brief explanation. “Purposelessness” refers to a lack of a sense of purpose in life or reason for living. “Trapped” refers to perceiving a terrible situation from which there is no escape. “Withdrawal” refers to increasing social isolation. “Anger” refers to rage, uncontrolled anger, or revenge-seeking. “Anxiety” is a broad term that refers to severe anxiety, agitation, and/or sleep disturbance. “Mood changes” refers to dramatic shifts in emotions.

Warning signs are often in evidence following acute stressful life events. Among people who abuse substances, break-up of a partner relationship is most common. It is also important to look for warning signs in your clients when relapse occurs and during acute intoxication.

Stressful life events include:

- Break-up of a partner relationship.
- Experience of trauma.
- Legal event.
- Job loss or other major employment setback.
- Financial crisis.
- Family conflict or disruption.
- Relapse.
- Intoxication.

Each of the **direct** warning signs indicates potential for suicidal behavior in its own right, and, if present, requires rigorous followup. The **indirect** warning signs may or may not signal risk for acute suicidal behavior (for example, “substance abuse” is the norm

among your clients). In all cases, they require further followup questions to determine if they may indeed indicate acute suicidality.

Risk Factors

Risk factors are defined as indicators of long-term (or ongoing) risk. They are different from warning signs, which signal immediate risk. Risk factors for suicidal thoughts and behaviors among individuals with substance use disorders have been well researched (Conner, Beautrais, & Conwell, 2003; Conner et al., 2007; Darke & Ross, 2002; Ilgen et al., 2007; Murphy et al., 1992; Preuss et al., 2002; Roy, 2001; Schneider et al., 2006). The list below, although not exhaustive, is informed by these studies.

Risk factors for suicidal thoughts and behaviors

These risk factors include:

- Prior history of suicide attempts (most potent risk factor, although it should be remembered that about half of all deaths by suicide are first-time attempts).
- Family history of suicide.
- Severe substance use (e.g., dependence on multiple substances, early onset of dependence).
- Co-occurring mental disorder:
 - Depression (including substance-induced depression).
 - Anxiety disorders (especially PTSD).
 - Severe mental illness (schizophrenia, bipolar disorder).
 - Personality disorder (best researched are borderline and antisocial personality disorders).
 - Anorexia nervosa.
- History of childhood abuse (especially sexual abuse).
- Stressful life circumstances:
 - Unemployment and low level of education, job loss, especially when nearing retirement.
 - Divorce or separation.
 - Legal difficulties.
 - Major and sudden financial losses.
 - Social isolation, low social support.
 - Conflicted relationships.
- Personality traits:
 - Proneness to negative affect (sadness, anxiety, anger).
 - Aggression and/or impulsive traits.

- Firearm ownership or access to a firearm.
- Probable risk factors (although greater certainty requires more research in people with substance use disorders):
 - Inflexible/rigid personality characteristics.
 - Sexual orientation (lesbian, gay, or bisexual).
 - Chronic pain.

Protective Factors

Protective factors are defined as buffers that lower long-term risk. Unlike risk factors, factors that are protective against suicidal behavior are not well researched (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Fewer protective factors than risk factors have been identified among people who abuse substances and other populations. Reasons for living are perhaps the best researched protective factors in the literature (Linehan Goodstein, Nielsen, & Chiles, 1983; Oquendo Dragasti et al., 2005).

The following are known and likely protective factors:

- Reasons for living.
- Being clean and sober.
- Attendance at 12-Step support groups.
- Religious attendance and/or internalized spiritual teachings against suicide.
- Presence of a child in the home and/or childrearing responsibilities.
- Intact marriage.
- Trusting relationship with a counselor, physician, or other service provider.
- Employment.
- Trait optimism (a tendency to look at the positive side of life).

A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are in evidence, the presence of protective factors does not change the bottom-line assessment that preventive actions are necessary, and should not give you a false sense of security. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do **not** immunize clients from suicidal behavior and may afford no protection in acute crises.

Protective factors vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor. Others include a strong affiliation with a clan, tribe, or ethnic community; faith in and reliance on traditional healing methods; strong spiritual values

shared among community members; and absence of cultural trauma such as that of families of Holocaust survivors and American Indians who were sent unwillingly to boarding schools to be acculturated.

Suicide Versus Suicide Attempt

Prevalence: Suicide attempts are much more common than suicides. In the United States, there are approximately 32,000 suicides annually (National Center for Injury Prevention and Control [NCIPC], 2007). More than 10 times that number of self-inflicted injuries were reported in 2006, although the proportion of these injuries in which there was intent to die is unknown (NCIPC, 2007).

Suicide Methods: The most common method of attempted suicide is an attempt to overdose. Cutting (for instance, wrists) with a knife is also common.

Lethality: Use of a firearm and hanging are the most lethal methods of suicide. The most common method of death by suicide is firearms, followed by hanging (NCIPC, 2007). Attempts by overdose and self-cutting are much more likely to be survived (Shenassa, Catlin, & Buka, 2003).

Risk of Suicide and Suicide Attempts: Age, Gender, and Race or Ethnicity

Age

Adolescents and young adults are more likely to make nonfatal suicide attempts than older individuals (NCIPC, 2007). However, older individuals are more likely to die by suicide. Older adults' elevated risk for suicide deaths is attributable to their tendency to show high suicide intent, to use more deadly methods, and to their bodies' greater fragility to the effects of acts of self-harm (Conwell, Duberstein, & Caine, 2002). Because many older adults live alone, they are less likely to be rescued (Szanto et al., 2002). The extent to which these general population patterns pertain to people treated for substance use disorders is not clear.

Gender

Women are more likely to attempt suicide than men, although the difference in prevalence of suicide

attempts between men and women is not as high as once believed (Nock & Kessler, 2006). Men are more likely to die by suicide than women (NCIPC, 2007). Overall, men carry out fewer suicidal acts, but they tend to show higher intent to die (Nock & Kessler, 2006), and use more deadly methods (Goldsmith et al., 2002). The extent to which these general population patterns pertain to people treated for substance use disorders is not clear.

Race and ethnicity

According to national statistics on suicide (NCIPC, 2007), Whites and Native Americans have higher rates of suicide than African Americans; males are at highest risk in all of these racial groups. The highest rate of suicide among White males is during older adulthood (age 70 and older), while the highest rates of suicide among Native American and African American males occur much younger—during late adolescence and young adulthood. It should be noted that suicide rates among Native Americans vary significantly depending on tribe and region of the country. Some data also suggest that risk factors differ across racial groups. For example, the presence of an anxiety disorder may be an especially important risk factor for suicide attempts among Blacks (Joe, Baser, Breeden, Neighbors, & Jackson, 2006). The extent to which these general population patterns pertain to people treated for substance use disorders is not clear. There is a particularly low prevalence of deaths by suicide among African American females, although it is unknown if this data holds true for African American females with a substance use disorder (NCIPC, 2007).

Hispanics/Latinos have fairly similar rates of suicidal thoughts and behavior compared with White, non-Hispanic individuals (NCIPC, 2007). Among youth and young adults, the prevalence of suicidal thoughts and behavior increases among Hispanics/Latinos who are more acculturated to mainstream American culture, particularly among females (Zayas, Lester, Cabassa, & Fortuna, 2007). The extent to which these general population patterns pertain to people treated for substance use disorders is not clear. Additional information on race and ethnicity and substance abuse treatment can be obtained in the planned TIP, *Improving Cultural Competence in Substance Abuse Treatment* (CSAT, in development d)

Reasons for Suicidal Behavior

There is often more than one reason for a suicide attempt. For example, a client may want to get back at his or her estranged partner (induce guilt), demonstrate distress (cry for help), *and* want to die.

Therefore, it is important not to trivialize suicide attempts that may involve motivations other than to die. In other words, if at least some wish to die was present at the time of the attempt, regardless of whether there were other reasons for the act, then the behavior should be considered a suicide attempt. Some, but not all, potential reasons for a suicide attempt include:

- Desire to die.
- Hopelessness.
- Extreme or prolonged sadness.
- Perceived failure or self-hate following relapse.
- Loneliness.
- Feeling like a burden to others.
- Disinhibition while intoxicated.
- Escape from a painful emotional state.
- Escape from an entrapping situation.
- Get attention.
- Impulsive reaction to an acute stressful life event (e.g., break-up).
- Hurt another individual (e.g., make another individual feel guilty).
- Paranoia or other psychosis (e.g., command hallucination to take one's life).
- Escape a progressively deteriorating health situation (e.g., terminal disease).

GATE: Procedures for Substance Abuse Counselors

Gather information

Access supervision

Take responsible action

Extend the action

The Consensus Panel agreed on a formulation of the role of substance abuse treatment counselors in addressing suicidal thoughts and behaviors identified by the acronym **GATE**. The elements in GATE reflect behaviors that are within your scope of competence as

a substance abuse counselor regarding helping clients who are at risk for suicide. You are familiar with gathering information from clients with substance use disorders; this skill can be translated into gathering information about suicidal thoughts and behaviors. Supervision may be a regular part of your agency's program; with a client who is suicidal, it is a necessity. You know how to plan for the treatment of a client with a substance use disorder; this skill can be applied to planning for a client to address his or her suicidal thoughts and behaviors. You typically follow up with clients to coordinate care, check on referral appointments, monitor progress, and enlist support from family and community resources. These counselor activities are essential when working with clients who are suicidal.

If you have advanced training in a mental health discipline (such as social work, psychology, or professional counseling) along with specialized training in suicidality, you might also be prepared to take on other treatment tasks with clients with suicidal thoughts and behaviors, such as assessment, specialized suicide interventions, or treatment of co-occurring mental disorders such as depression and psychological trauma. These advanced skills, while very important, are not a primary focus of this TIP, although some advanced skills are illustrated in the clinical vignettes of Vince and Rena in chapter 2.

The quick overview below is supplemented by a flow chart (see p. 16) and the more detailed sections that follow.

Quick Overview of GATE

G: Gather information

There are two steps to gathering information: (1) screening and spotting warning signs, and (2) asking followup questions. Screening consists of asking very brief, uniform questions at intake to determine if further questions about suicide risk are necessary. Spotting warning signs consists of identifying telltale signs of potential risk. Ask followup questions when clients respond "yes" to one or more screening questions or any time you notice a warning sign(s). The purpose of asking followup questions is to have as much information as possible so that you and your supervisor and/or treatment team can develop a good plan of action. You will want to provide as much information as possible to another provider should

you make a referral. Examples of screening questions, warning signs, and followup questions are provided below.

A: Access supervision and/or consultation

You should never attempt to manage suicide risk alone even if you have substantial specialized training and education. With suicidal clients, two or three heads are almost always better than one. Therefore, speak with a supervisor, an experienced consultant who has been vetted by your agency, and/or your multidisciplinary treatment team when working with a client who you suspect may be dealing with suicidal concerns. It is a collective responsibility, not yours alone, to formulate a preliminary impression of the seriousness of risk and to determine the action(s) that will be taken. Accessing supervision or consultation can provide invaluable input to promote the client's safety, give you needed support, and reduce your personal liability. Some guidelines for making effective use of supervision and consultation are provided below.

T: Take responsible action(s)

The guiding principle here is that your action(s) should make good sense in light of the seriousness of suicide risk. The phrase "make good sense" indicates that your action(s) is "responsible," given the seriousness of risk. The next section expands on this principle and provides a list of potential actions covering a wide range of intensity and immediacy that you and your supervisor or team may take.

E: Extend the action(s)

Too often, suicide risk is dealt with acutely, on a one-time basis, and then forgotten. As with substance abuse, vulnerable clients may relapse into suicidal thoughts or behaviors. This means that you will need to continue to observe and check in with the client to identify a possible return of risk. Another common problem is referring a suicidal client but failing to coordinate or even follow up with the provider. Suicide risk management requires a team approach, and as your client's addiction counselor, you are an essential part of this team. A range of extended actions is provided below.

Documenting all the actions you have taken is impor-

tant because it creates a medical and legal account of the client's care: what information you obtained, when and what actions were taken, and how you followed up on the client's substance abuse treatment and suicidal thoughts and behaviors. This record can be useful for your supervision or consultation, to your team, and to other providers.

On the next page is a graphic depiction of the elements of **GATE** (Figure 1.1). It is designed to help you see how the completion of one element leads to decisions and specific actions in the next.

Detailed Explanation of GATE

G: Gather information

This stage proceeds in two steps: (1) screening and/or spotting warning sign(s) and (2) asking followup questions. Substance abuse counselors should be expected to gather information about suicidal thoughts and behaviors. Gathering information is different from formal assessment because an assessment is a process by which a professional synthesizes and interprets information. Substantial training, supervision, and experience is required to have sufficient clinical judgment to make the fine distinctions necessary for assessment.

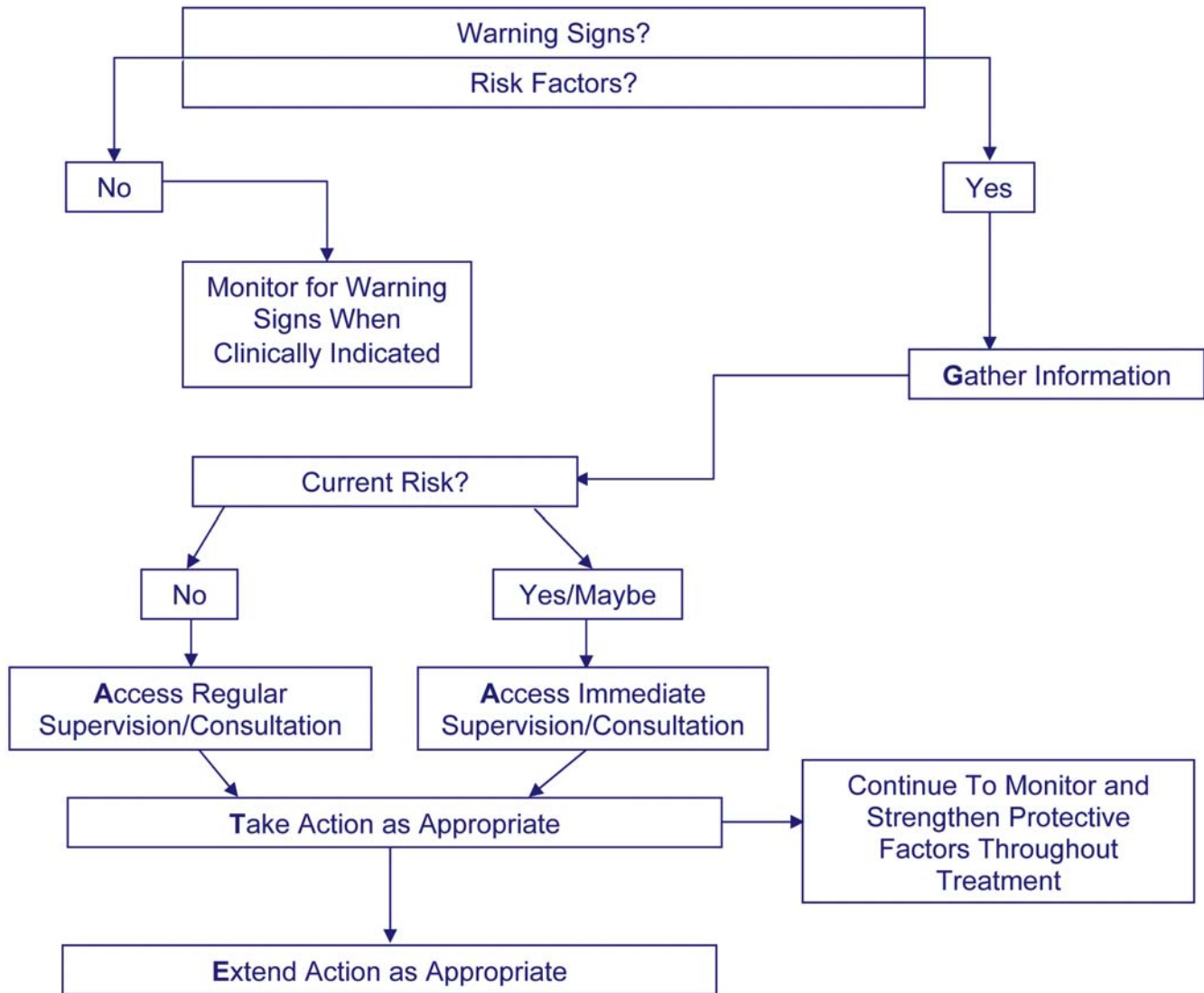
As much as possible, you should avoid "stacking" questions (peppering clients with one closed-end question after the other), which will tend to generate defensiveness and/or false reassurances of safety. If you are unclear about the answer from the client or if you sense a degree of defensiveness, you might consider asking the same question in a different way somewhat later in the interview. Ambiguous or vague answers are always important to pursue further because they may be a sign of discomfort with the topic, anxiety about disclosure, evasiveness, and/or uncertainty (e.g., "I don't know", "I'm not sure"), with the understanding that clients will not always be able or willing to provide greater clarity.

Screening

Sample screening questions: If your agency does not provide you with standard screening question(s) on suicidal thoughts and behaviors, use the questions provided below. They introduce the topic of suicide and screen for suicidal thoughts and attempts. The timing of the questions is important; they should be asked in the context of a larger discussion of, for



Figure 1.1
Decision Tree
How to Address Suicidal Thoughts and Behaviors
in Substance Abuse Treatment



instance, mood or quality of life. Ask the same screening questions verbatim for every new client.

Introducing the topic (use either statement):

1. Now I am going to ask you a few questions about suicide.
2. I have a few questions to ask you about suicidal thoughts and behaviors.

Screening for suicidal thoughts (ask either question):

3. Have you thought about killing yourself?
4. Have you thought about carrying out suicide?

Screening for suicide attempts (ask either question):

5. Have you ever tried to take your own life?
6. Have you ever attempted suicide?

Note that the introductory items are brief and straightforward. With slight word changes, items 3 and 5 are taken from a research interview for the study of alcoholism (Bucholz et al., 1994) that have been used in research on suicidal thoughts and behavior (Conner et al., 2007), and items 4 and 6 are taken from a national survey that has provided information on suicidal thoughts and behavior in the general population (Kessler et al., 1999).

The National Suicide Prevention Lifeline has produced a wallet-sized card for counselors entitled: “Assessing Suicide Risk: Initial Tips for Counselors” that lists five questions counselors can ask about suicide. The card additionally provides the warning signs contained in “IS PATH WARM” (described on p. 11 of this TIP) and offers brief advice on actions to take with people who are at risk. The card is available online at http://stepupprogram.org/docs/handouts/suicide_warning_signs.pdf. Bulk copies (item SVP06-0153) can be ordered at <http://nmhich-store.samhsa.gov/publications/ordering.aspx>.

Additional options for screening

Multi-item measures that contain an item about suicidal thoughts and behaviors may also be used for screening. Items that screen for suicidal thoughts can be found on several other well-validated depression measures including the

What To Do If You Think a Person Is Having Suicidal Thoughts

You cannot predict death by suicide, but you can identify people who are at increased risk for suicidal behavior, take precautions, and refer them for effective treatment.

- **Ask** the person directly if he or she (1) is having suicidal thoughts/ideas, (2) has a plan to do so, and (3) has access to lethal means:

- “Are you thinking about killing yourself?”
- “Have you ever tried to hurt yourself before?”
- “Do you think you might try to hurt yourself today?”
- “Have you thought of ways that you might hurt yourself?”
- “Do you have pills/weapons in the house?”

- ▶ This *won't* increase the person's suicidal thoughts. It *will* give you information that indicates how strongly the person has thought about killing him- or herself.

- ▶ Take seriously all suicide threats and all suicide attempts. A past history of suicide attempts is one of the strongest risk factors for death by suicide.
- ▶ There is no evidence that “no-suicide contracts” prevent suicide. In fact, they may give counselors a false sense of reassurance.

- **Listen and look** for red flags for suicidal behavior, indicated by the mnemonic:

IS PATH WARM?

Ideation—Threatened or communicated
Substance abuse—Excessive or increased

Purposeless—No reasons for living
Anxiety—Agitation/Insomnia
Trapped—Feeling there is no way out
Hopelessness

Withdrawing—From friends, family, society
Anger (uncontrolled)—Rage, seeking revenge
Recklessness—Risky acts, unthinking
Mood changes (dramatic)

• Act.

- If you think the person might harm him- or herself, do not leave the person alone.
- Say, “I’m going to get you some help.”
- Call the National Suicide Prevention Lifeline, 1-800-273-TALK. You will be connected to the nearest available crisis center. Or...
- Go to SAMHSA’s Mental Health Services Locator (www.mentalhealth.samhsa.gov/databases/) or Substance Abuse Treatment Facility Locator (<http://dasis3.samhsa.gov>).

Assessing Suicide Risk: Initial Tips for Counselors

NATIONAL
**SUICIDE
 PREVENTION**
 LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 Substance Abuse and Mental Health Services Administration
www.samhsa.gov

CMHS-SVP-0153

original and revised versions of the Beck Depression Inventory (BDI or BDI-II; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961; Beck, Steer, & Brown, 1996) and Hamilton Depression Rating Scale (Hamilton, 1960) as well as on instruments that are administered verbally, including versions of the Addiction Severity Index (ASI; McLellan et al., 1992). The BDI-II may be purchased, whereas the ASI may be downloaded at no cost from the Internet (<http://www.tresearch.org/tools/download-asi-instruments-manuals/>)

If a client endorses any level of suicidality on the relevant items from these measures, you will want to ask followup questions. TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005d), also contains useful suicide screening options for persons with co-occurring disorders.

Asking followup questions

It is important to ask followup questions when a client answers “yes” to a screening question at intake, when you note a warning sign(s), or at any time during the course of treatment when you suspect the client is suicidal, even if you can’t pinpoint why. Followup questions and their answers enable you to have as much information as possible when you discuss the situation with your supervisor or team and allow you to convey solid information if you make a referral to another provider.

Sample followup questions about suicidal thoughts:

1. Can you tell me about the suicidal thoughts?
2. If the client requires more direction:

For example, *What brings them on?*

How strong are they?

How long do they last?

3. If you do not already know:

*Have you made a **plan**? (If yes) What is your plan?*

*Do you have access to a **method** of suicide? A gun? An overdose?*

*Do you **intend** to attempt suicide?*

Always ask an open-ended question first (see sample question 1). Clients may tell you spontaneously all of the information you need to know. Open-ended questions can help you avoid “grilling” the client.

Information not provided by clients may be elicited with followup questions to determine characteristics such as the precipitants, strength, and duration of the suicidal thoughts (see sample question 2). Finally, if information related to **planning**, **method**, and **intent** does not come to light spontaneously, always gather these critical pieces of information (see sample question 3). A client’s inability or unwillingness to provide the necessary information may be an indicator of increased risk and that should be noted in discussion with your treatment team or your supervisor.

Gathering additional information about suicide attempts is straightforward. You will want to ask the client to explain the attempt through an open-ended question such as “Please tell me about the attempt” and ask followup questions to find out more about it. If there was more than one suicide attempt, ask these questions about the *most recent* attempt and the *most severe* attempt (if it differs from the most recent act). The answers to these questions will be very helpful in characterizing the seriousness of suicidal behavior.

Sample followup questions about suicide attempts:

1. *Please tell me about the attempt.*
2. If the client requires more direction:

For example, *What brought it on? Where were you? Were you drinking or high?*

3. If you do not already know:

To gather information about **lethality**:

What method did you use to try to kill yourself?

Did you receive emergency medical treatment?

To gather information about **intent**:

Did you want to die? How much?

Afterward, were you relieved you survived, or would you rather have died?

The lessons that apply to asking about suicidal thoughts also apply here: ask an open-ended question first, ask followup questions to determine the circumstances of the attempt such as the precipitating event, setting, and the role of acute alcohol or drug use, and finally, if information related to **lethality** and **intent** does not come to light spontaneously, always continue to gather these critical pieces of information (see sample question 3).

Summary of G: Gather information

The gathering information task consists of collecting relevant facts. Screening questions should be asked of all new clients when you note warning sign(s) and any time you have a concern about suicide, whether or not you can pinpoint the reason. Inquiries about suicidal thoughts and attempts always start with an open-ended question that invites the client to provide more information. Followup questions are then asked to gather additional, critical information. Routine monitoring of suicide risk throughout treatment should be a basic standard in all substance abuse treatment programs.

A: Access supervision or consultation

You should not make a judgment about the seriousness of suicide risk or try to manage suicide risk on your own unless you have an advanced mental health degree and specialized training in suicide risk management and it is understood by your agency that you are qualified to manage such risk independently. For this step, obtaining consultation does not refer to merely getting input from a peer. Although such input may be helpful, consultation is a more formal process whereby information and advice are obtained from (a) a professional with clear supervisory responsibilities, (b) a multidisciplinary team that includes such person(s), and/or (c) a consultant experienced in managing suicidal clients who has been vetted by your agency for this purpose. When obtaining supervision or consultation, assemble all the information you have gathered on your client’s suicidal thoughts and/or suicide attempts through the screening and followup questions, as well as data from other sources of information (e.g., other providers, family members, treatment records).

In some circumstances, you will need to obtain *immediate* consultation (see the vignettes in chapter 2 on

Clayton and Leon). In other circumstances, obtaining consultation at regularly scheduled supervision or team meetings may be sufficient (*regular* consultation). The examples listed below are for illustrative purposes only; other circumstances requiring immediate consultation may exist.

Circumstances at intake requiring access to immediate supervision or consultation include:

- Direct warning signs are evident (suicidal communication, seeking access to method, making preparations).
- Followup questions to suicide screening questions suggest that there is current risk.
- Followup questions to indirect warning signs suggest that there is current risk.
- Additional information (e.g., from the referral source, family member, medical record) suggests that there is current risk.

Circumstances during treatment that require access to immediate supervision or consultation include:

- Emergence (or re-emergence) of direct warning signs.
- Emergence (or re-emergence) of indirect warning signs that, on followup questioning, suggest current risk.
- Your client's answers to suicide screening questions asked during the course of treatment suggest current risk.
- Additional information (e.g., from another provider or family member) suggests current risk.

Circumstances at intake requiring access to regularly scheduled supervision or consultation include:

- One or more indirect warning signs are present, but followup questions indicate that there is no reason to suspect current risk for suicidal behavior per se (e.g., a client is socially isolated and abusing substances, but otherwise shows no indications of suicidality).
- One or more risk factors are present, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- During screening, your client discloses a history of suicidal thoughts or suicide attempt(s), but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- Additional information (e.g., from the referral source or family member) suggests your client has

a history of suicidal thoughts or attempts, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.

Circumstances during treatment that require access to regularly scheduled supervision or consultation include:

- Your client reports (or alludes to) a history of suicidal thoughts that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- Your client reports (or alludes to) prior suicide attempt(s) that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- Additional information (e.g., from another provider or family member) suggests a history of suicidal thoughts or attempts that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.
- Client with a history of suicidal thoughts or behavior experiences an acute stressful life event or a setback in treatment (e.g., substance abuse relapse), but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.

You will find it useful to know who your consultant (supervisor, team, outside consultant) is for issues of suicidality in your program, what your agency policy is regarding acutely suicidal clients, and where such patients could be referred. Having this information in advance can free you to focus on the immediate situation when a crisis arises. If you suspect that information on acute suicidality might arise in a session, it is wise to alert your supervisor in advance that you might contact him or her for information, support or consultation while the client is still in your office.

Summary of A: Access supervision or consultation

Risk for suicidal behavior may be evident at intake or at any time during the course of treatment. Supervision or consultation to address risk may be obtained immediately or at a regularly scheduled time, depending on the urgency of the situation.

Having a plan in place ahead of time for obtaining immediate supervision or consultation will help ensure a therapeutic response and will avoid unnecessary distress and scrambling.

Immediate supervision or consultation should be obtained when clients exhibit direct suicide warning signs (see p. 11 for direct warning signs) or when they report at intake having made a recent suicide attempt. Substance abuse relapse during treatment is also an indication for supervisory involvement for clients who have a history of suicidal behavior or attempts.

T: Take responsible action

A useful guiding principle in taking responsible action is that your actions should make good sense in light of the seriousness of suicide risk. This section explains this principle, applies it to taking responsible action(s), and provides a list of potential actions. In the legal system, the standard used to assess responsibility and liability is to compare a given practitioner's judgment and behavior with what another equally trained and experienced treatment practitioner would have done in the same circumstances.

The key factor—although not the only factor—in considering the action(s) to take is a judgment about the seriousness of risk. Seriousness is defined as the likelihood that a suicide attempt will occur and the potential consequences of an attempt. Briefly, if a client is judged to be likely to carry out a suicide attempt (for example, has persistent suicidal thoughts and a clear plan) and if the client expects the suicide attempt to be lethal (for example, a plan to use a gun that the client keeps at home), there is high seriousness. In contrast, if a client is judged to be unlikely to carry out an attempt (for example, has fleeting ideation, no clear plan, and no intention to act) and any attempt may be expected to be nonlethal (for example, thoughts of swallowing some aspirin if there is any in the medicine cabinet), there is lower seriousness. In chapter 2, you will meet counselors who address issues of seriousness of a threat or attempt to make judgments about how to proceed with the session. **Judgments about the degree of seriousness of risk should be made in consultation with a supervisor and/or a treatment team, not by a counselor acting alone.**

The actions taken should be sensible in light of the information that has been gathered about suicidal

thoughts and/or previous suicide attempts. Although the potential actions are many, they can generally be described along a continuum of intensiveness. In instances of greater seriousness, you will generally take more intensive actions. For less serious circumstances, you will be more likely to take less intensive actions. Note that “less intensive” does not equate to inaction; it merely indicates that there may be more time to formulate a response, the actions may be of lower intensity, and/or fewer individuals and resources may be involved.

In some instances, an immediate response is required (see the vignettes in chapter 2 about Clayton, Vince, and Rena). In general, responses that require immediate action may be considered more intensive.

Examples of immediate actions include arranging transportation to a hospital emergency department for evaluation, contacting a spouse to have him or her arrange for removal of a gun from the home and arrange safe storage, and arranging on the spot to have a mental health specialist in your program further evaluate a client. Examples of non-immediate, but important, actions include making a referral for a client to an outpatient mental health facility for evaluation, scheduling the client to see a psychiatrist for possible medication management, and ordering past mental health records from another provider.

Some interventions can be considered more intensive than others. These include interventions that reduce freedom of movement (e.g., arranging an ambulance to transport a client to a hospital emergency department), are expensive (e.g., inpatient hospitalization), compromise privacy (e.g., contacting the police to check on a high-risk client), and/or restrict autonomy (e.g., asking a spouse to arrange for safe storage of a weapon). Other interventions in managing suicide risk, although less intensive, may also go beyond the usual care of a substance abuse client and may be experienced by a client as unnecessary or intrusive. Arranging further assessment with an outpatient mental health provider or through a home visit by a mental health mobile crisis team, for instance, may be seen as burdensome to the client. Less intensive interventions do not reduce freedom of movement, do not sacrifice privacy, are comparatively inexpensive, and/or do not restrict autonomy.

Another aspect of intensiveness concerns the number of individuals involved (e.g., client, case manager, counselor, mental health professional, concerned spouse) and the number of actions taken (e.g., psychi-

atric medications, substance abuse counseling, family sessions, case management coordination). In other words, in general, the greater the number of interventions, and the more individuals involved, the more intensive the action(s).

What actions can you take?

The list of actions below is not exhaustive but includes the most common actions. At times, one action will suffice, whereas at other times, more than one (and perhaps many) will be required. You and your supervisor or team will strive to do things that make good sense in terms of their intensity. Your actions should match the seriousness of risk. Often your response will involve arranging a referral (if the necessary resources are not available within your agency). The list below is in no particular order.

- Gather additional information from the client to assist in a more accurate clinical picture and treatment plan.
- Gather additional information from other sources (e.g., spouse, other providers).
- Arrange a referral:
 - To a clinician for further assessment of suicide risk.
 - To a provider for mental health counseling.
 - To a provider for medication management.
- To an emergency provider (e.g., hospital emergency department) for acute risk assessment (see the vignette on Vince for a discussion of relevant issues).
- To a mental health mobile crisis team that can provide outreach to a physically inaccessible client at his or her home (or shelter) and make a timely assessment.
- To a more intensive substance abuse treatment setting.
- Restrict access to means of suicide.
- Temporarily increase the frequency of care, including more frequent telephone check-ins.
- Temporarily increase the level of care (e.g., refer to day treatment).
- Involve a case manager (e.g., to coordinate care, to check on the client occasionally).
- Involve the primary care provider.
- Encourage the client to attend (or increase attendance) at 12-Step meetings such as Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous.
- Enlist family members or significant others (selectively, depending on their health, closeness to the client, and motivation) in observing indications of a return of suicide risk.
- Observe the client for signs of a return of risk
- Create a safety card (see below) with the client in the event of a return of acute suicidality.

Safety Cards and Safety Plans

With all clients with suicidal risk, consider developing with the client a written **safety card** that includes at a minimum:

- A 24-hour crisis number (e.g., 1-800-273-TALK).
- The phone number and address of the nearest hospital emergency department.
- The counselor's contact information.
- Contact information for additional supportive individuals that the client may turn to when needed (e.g., sponsor, supportive family member).

To maximize the likelihood that the client will make use of the card, it should be personalized and created with the client (not merely handed to him or her). Discuss with the client the type(s) of signs and situations that would warrant using one or more of the resources on the card. It is ideal to create a wallet-size card with this information so clients can easily keep it with them. Have backup copies of the card available in the event that the client loses the card (which frequently happens) so that it can be quickly replaced. Consistent with this TIP's emphasis on **Extending the action**, you should check in with the client from time to time to confirm that he or she still has the card (ask the client to show it to you) and remains willing to use it if the need arises.

Counselors with advanced mental health training and experience in work with clients who are suicidal may be in a position to formulate a more detailed **safety plan**. Such a safety plan and an example of its use with a client are described in chapter 2 in the vignette with Rena.

- Create a detailed safety plan (see below) with the client in the event of relapse to alcohol or drugs.
- Give the client an emergency hotline number, for instance, the national hotline 1-800-273-TALK.
- Invite the client to contact you (or an emergency hotline) in the event of acute suicidality.

As mentioned earlier, there is little or no empirical evidence to support “suicide contracts” (an agreement from a client to contact the counselor or someone else before making a suicide attempt) as a “stand alone” intervention. However, the consensus panel strongly recommends that counselors help clients at risk of suicidal thoughts and behaviors develop a safety card, sometimes referred to as an emergency card. Such a plan ideally identifies who a client in crisis can turn to for immediate help, where they can go for help, other proactive behaviors the client can take (such as maintaining sobriety), and what kind of information they should give to providers so that the crisis is recognized and addressed. A related technique is a Commitment to Treatment agreement, which focuses the client’s attention on the specific behaviors (such as attending treatment sessions, setting recovery goals, completing homework assignments, and taking medications as prescribed) that support recovery and potentially reduce suicidal thoughts and behaviors. The difference in the two techniques is that safety cards and plans focus on preventing or intervening in crises, while the Commitment to Treatment agreement focuses on behaviors that positively support treatment outcome.

For counselors with more experience and training in work with clients who are suicidal, an advanced skills safety plan can be used. An example of an advanced skills plan is described in the vignette with Rena. An advanced plan might emphasize helping the client recognize when direct and indirect warning signs are becoming more apparent, develop coping responses, and focus on the client’s emotional regulation.

Referring a client who is ambivalent about treatment or is resisting treatment: It is common to make a referral either for further evaluation, treatment of suicide risk, treatment of a mental health condition (for example, depression), or for a combination of services. Sometimes, however, there will be times when you make a referral that a client does not agree is necessary or simply does not wish to accept. By taking the time to discuss the reasons for your actions and by listening and acknowledging their concerns, clients who are suicidal will usually soften their stance and become more willing. Eliciting a

client’s input as to what he or she believes would be most helpful and using these suggestions, as appropriate, can also go a long way to eliciting cooperation. Anything appropriate that you can do to give a client a sense of choice or control will be helpful.

Although a referral for emergency evaluation is usually not necessary and less intensive action(s) will typically suffice, there will be times when such an action is needed. In these instances, a resistant client may become more willing if provided some sense of control, for example, through a question such as “Would you prefer to call your family before you go to the emergency department or would you rather I call them after you get there?”

In the end, if a client refuses to cooperate in additional evaluation, you (in close coordination with your supervisor or team) will need to take the necessary steps to arrange for the evaluation (e.g., by arranging an ambulance or police escort) as described in your agency policy. The client should not be left unaccompanied while such arrangements are being made. Supervisors can facilitate their counselors’ current knowledge of the company’s policy on emergency referrals by reviewing it with them on a regular basis, as appropriate.

A note on inpatient treatment for suicidality: It is important that counselors, clients, and their family members know what to expect from inpatient psychiatric hospitalization. Generally, the treatments are short term (5–7 days), and if the clinical team concludes that suicidality is substance-induced, the stay may be shorter (Ries, Yuodelis-Flores, Comtois, Roy-Byrne, & Russo, 2008). During hospitalization, the focus is typically on medication management and disposition planning, with a minimal focus on addressing ongoing stressors therapeutically. As a result, most or all of the psychosocial difficulties that prompted admission will still need to be addressed when the client returns to treatment. A study of psychiatric inpatient admissions to one large, university-based hospital showed that “substance-induced suicidality,” as rated by clinicians, represented 40 percent of all admissions, indicating the extent to which substance-related problems promote such admissions (Ries et al., 2008).

Summary of T: Take responsible action

The intensiveness of the actions that you take in coordination with your supervisor or team should make good sense in light of the information that you have

gathered, with more serious risk requiring more intensive action(s). The action(s) may include referring the client for a formal assessment or for additional treatment. Taking the time to prepare clients for a referral and providing them some sense of control will be helpful in eliciting their cooperation.

E: Extend the action

A common misconception is that suicide risk is an acute problem that, once dealt with, ends.

Unfortunately, individuals who are suicidal commonly experience a return of suicide risk following any number of setbacks, including relapse to substance use, a distressing life event (e.g., break-up with a partner), increased depression, or any number of other situations. Sometimes suicidal behavior even occurs in the context of substantial improvement in mood and energy. Therefore, monitoring for signs of a return of suicidal thoughts or behavior is essential. There is also a tendency to refer a client experiencing suicidal thoughts and behaviors to another provider and then assume that the issue has been taken care of. This is a mistake. It is essential to follow up with the provider to determine that the client kept the appointment. It is also critical to coordinate care on an ongoing basis, for example, to alert a provider that a client has relapsed and may be vulnerable to suicidal thoughts. Extending the action emphasizes the importance of watching for a return of suicidal thoughts and behaviors, following up with referrals, and coordinating on an ongoing basis with providers who are addressing the client's suicidal thoughts and behaviors.

What extended actions can you take?

The list below mentions many common extended actions but is not exhaustive. It is in no particular order.

- Confirm that a client has kept the referral appointment with a mental health provider (or other professional).
- Follow up with the hospital emergency department when a client has been referred for acute assessment.
- Coordinate with a mental health provider (or other professional) on an ongoing basis.
- Coordinate with a case manager on an ongoing basis.
- Check in with the client about any recurrence of or change in suicidal thoughts or attempts.
- Check in with family members (with the client's knowledge) about any recurrence of or change in suicidal thoughts or attempts.
- Reach out to family members to keep them engaged in the treatment process after a suicide crisis passes.
- Observe the client for signs of a return of risk.
- Confirm that the client still has a safety plan in the event of a return of suicidality.
- Confirm that the client and, where appropriate, the family, still have an emergency phone number to call in the event of a return of suicidality.
- Confirm that the client still does not have access to a major method of suicide (e.g., gun, stash of pills).
- Follow up with the client about suicidal thoughts or behaviors if a relapse (or other stressful life event) occurs.
- Monitor and update the treatment plan as it concerns suicide.
- Document all relevant information about the client's condition and your responses, including referrals made and the outcomes of the referrals.
- Complete a formal treatment termination summary when and under whatever circumstances this stage of care is reached.

Summary of E: Extend the action

Suicide prevention efforts are not one-time actions. They should be ongoing because suicidal clients are vulnerable to a recurrence of risk. A team approach is also essential, as it requires you to follow up on referrals and coordinate with other providers in an ongoing manner. The actions listed above represent many, but not all, of the extended actions you may use to promote safety throughout treatment. Work closely with your supervisor or team in developing a plan of extended actions. Finally, document the client's eventual progress and status at the point of your treatment termination.

Documenting GATE

Documentation of suicidality is critical to promoting client safety, coordinating care among treatment professionals, and establishing a solid medical and legal record. Documentation entails providing a written summary of any steps taken pertaining to GATE, along with a statement of conclusions that shows the rationale for the resultant plan. The plan should make good sense in light of the seriousness of risk.

Examples of Roberta, Mark, and Fernando, below, illustrate documentation across a continuum of seriousness of suicidality. Counselors, supervisors, or consultants may provide such documentation. Many programs or State regulatory bodies recommend or mandate a particular format in which this documentation can occur. Generally, such formats can accommodate all of the information contained in our GATE protocol.

In the notes below, the italicized text is the actual note. These examples are “ideals.” Notes in routine clinical practice may fall short of this level of detail and organization. Nonetheless, the notes serve as models for documentation. Agencies may implement checklists as well (e.g., warning signs, risk factors, protective factors) to assist you with documentation. Even with the use of a checklist, a conclusion statement and the articulation of the plan are always needed.

Documentation example 1

The following is from an intake evaluation of Roberta, a 40-year-old African-American woman seeking treatment for cocaine dependence. The situation was not acute, so regular supervision was used and no immediate actions were taken.

Gather information: The client made a suicide attempt at age 31 by overdosing on over-the-counter sleeping pills following a sexual assault for which she received overnight treatment in a hospital emergency department. She was ambivalent about the suicide attempt and immediately afterward was relieved that she survived. Since that time, she has not reattempted; she reported no current or recent ideation, plan, or intent. She reported that she no longer uses sleeping pills and has none in her possession. She stated that her strong faith in God prevents her from making another attempt. No warning signs for suicidal behavior were evident.

Conclusion: There is a history of suicidal behavior but no indication of a need for action.

Access supervision: Her suicide-related history will be discussed at the next team meeting on January 14.

Documentation example 2

The following is from an intake evaluation of Mark, a 29-year-old White male who is separated from his wife and entering treatment for alcohol dependence.

The situation required immediate supervision and an intervention of intermediate intensity.

Gather information: Mark reports that he has thoughts of suicide when intoxicated (about once a week), during which he becomes preoccupied with the separation from his wife. The thoughts last a few hours, until he falls asleep. They occur while he is home alone. He has not acted on them, reports no plan or intent to attempt suicide, and reports that he does not own a firearm. He reports no history of suicide attempts.

Access supervision: This writer took a break in the intake to review this information with supervisor, John Davidson, LCSW.

Conclusion: It was concluded that emergency intervention is not required because Mark has not acted on his suicidal thoughts and has no plan or intent. However, further assessment is indicated given suicidal ideation, marital estrangement, and active alcohol dependence.

Take action: I reviewed these considerations with Mark and he agreed to a referral for an outpatient mental health evaluation. Mark has an appointment scheduled for June 18 at 1:00 p.m. with Martha Jones, MSW, of the Mental Health Clinic.

Extend the action: On Tuesday, June 17, this writer called Mark to remind him of his appointment. He said he remembered his appointment and planned to attend. I called the Mental Health Clinic late in the afternoon on June 18. Mark had kept his appointment and scheduled a second appointment for the following week.

Documentation example 3

The following is from a progress note for Fernando, a 22-year-old Hispanic male. He is an Iraq war veteran who had been doing well in treatment for dependence on alcohol and opiates, but had missed group therapy sessions and not returned phone calls for the past 10 days. This situation occurred in a substance abuse clinic within a hospital and required accessing immediate supervision and interventions of high intensity.

Gather information: Fernando came in, unannounced, at 10:30 a.m. today and reported that he relapsed on alcohol and opiates 10 days ago and has been using daily and heavily since. Breathalyzer was .08, and he reported using two bags of heroin earlier this morn-

ing. He reported that he held his loaded rifle in his lap last night while high and drunk, contemplating suicide.

Access supervision: This writer's supervisor, Janice Davis, CDC, was called to join the session.

Conclusion: It was determined that emergency intervention is necessary because of intense substance use, suicidal thoughts with a lethal plan, and access to a weapon.

Take action: At 11:00 a.m., a hospital security guard and this writer escorted Fernando to the emergency department where he was checked in. He was cooperative throughout the process.

Extend the action: Dr. McIntyre, the Emergency Department physician, determined that Fernando requires hospitalization. He is currently awaiting admission. This writer will follow up with the hospital unit after he is admitted and will raise the issue of his access to a gun.

Competencies

You now have some basic information about suicide and the effects of suicidal thoughts and behaviors on substance abuse treatment. Through the steps summarized as GATE in this TIP, you are becoming familiar with your role in addressing suicidal

thoughts and behaviors. These capabilities result in a short list of the knowledge, skills, and attitudes you need to be able to effectively work with people in substance abuse treatment who are suicidal or have a history of suicidal thoughts and behaviors.

The consensus panel agreed on eight competencies for working with clients who are suicidal in substance abuse treatment settings. These competencies are derived from a variety of resources, including *Practice Guideline and Resources for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Association, 2003), *Assessing and Managing Suicidal Risk: Core Competencies for Mental Health Professionals* (American Association of Suicidology, Suicide Prevention Resource Center, and Education Development Center, 2006), and *The Assessment and Management of Suicidality* (Rudd, 2006). They reflect the core knowledge, skills, and attitudes that you as a substance abuse counselor should incorporate to work effectively with clients who evidence suicidal thoughts and behaviors and form the basis for the skills presented in the vignettes in chapter 2 of this TIP. Few counselors will be proficient in all of these competencies. However, it will be helpful to evaluate your strengths and weaknesses in light of these competencies, so you can increase your skills in working with these individuals.

**COMPETENCIES FOR ADDRESSING SUICIDAL THOUGHTS AND BEHAVIORS WITH
CLIENTS IN SUBSTANCE ABUSE TREATMENT¹**

Core Competencies	Knowledge	Skills	Attitudes
<p>1. GATE: Gather information by consistently asking uniform screening questions of all new clients, recognizing warning signs, and asking followup questions about suicidal thoughts, behaviors and warning signs.</p>	<ul style="list-style-type: none"> • The importance of routinely addressing suicide because it is a leading cause of death among people with substance use disorders • The importance of routine screening and what to do if a screen is positive • The warning signs that indicate the need to ask questions • Followup questions to ask in order to characterize suicidal thoughts • Followup questions to ask in order to characterize suicide attempts 	<ul style="list-style-type: none"> • Consistently ask screening questions • Consistently spot warning signs • Consistently ask followup questions when screening questions or warning signs indicate the need • Ask questions about suicide in a nonjudgmental and nonconfrontational manner • Supportively gather information on suicidal thoughts including frequency, intensity, and factors that make the thoughts more painful or less painful • Supportively gather information on suicide attempts including the degree of desire to die, the method used, and any treatment received • Gather information in a culturally sensitive manner 	<ul style="list-style-type: none"> • View suicide screening, watching for warning signs, and asking followup questions as a routine part of the job of substance abuse counselor, in light of the elevated risk for suicidal behavior among substance abuse clients • Desire to understand suicidal thoughts and behaviors as well as possible, without assuming a formal role as expert or making independent judgments about risk • Do not dismiss clients' reasons for being suicidal or trivialize their suicidal thoughts or behaviors • Desire to understand the client's distress and point of view • Manage the anxiety that arises when empathically listening to clients

1. Based on American Psychiatric Association, 2003; Rudd, 2006; and American Association of Suicidology, Suicide Prevention Resource Center, & Education Development Center, Inc. (2006).

Core Competencies	Knowledge	Skills	Attitudes
<p>2. GATE: Access supervision and/or consultation to ensure quality care and planning next steps for client services and referral to additional resources. There is a need to obtain input from supervisors and/or consultants in interpreting information gathered about suicidal thoughts and behaviors.</p>	<ul style="list-style-type: none"> • The need to obtain such input for treatment planning • How to organize material on suicidal thoughts and behaviors, including information presented by clients and other sources, to make best use of supervision and consultation • Your agency's crisis response plan in an emergency 	<ul style="list-style-type: none"> • Present the information to supervisors or consultants in an efficient, organized fashion • Present all of the potentially relevant information (avoid presenting data selectively, for example, to make one course of action more likely than another) • Integrate information from a variety of sources (supervision and consultation) into an action plan • Prepare an action plan based on information gained in clinical supervision and/or consultation 	<ul style="list-style-type: none"> • Be willing to seek input and/or assistance when suicide-related information indicates the need • Err on the side of getting input when there is doubt about whether such input is required • Maintain a positive attitude toward eliciting supervision and consultation and a willingness to make use of such input
<p>3. GATE: Take responsible action by developing and implementing a treatment plan to address suicidality and coordinating the plan with other providers.</p>	<ul style="list-style-type: none"> • The need to make referrals for assessment and treatment of suicidal thoughts or behaviors or related mental health conditions • The roles of a variety of community agencies and resources to address suicide and other mental health-related needs • How to make referrals to such agencies and resources in a timely manner (e.g., numbers to call, where to send the client, what he or she should expect) • Elements of collaborative treatment planning steps • The principle that the level of the response to suicidality by providers should match the level of acuity of risk (i.e., the plan should make sense in light of the assessed need) 	<ul style="list-style-type: none"> • Respond to positive suicide screens and to warning signs (at intake, during treatment, at transitions in care) • Participate in the development and implementation of a written assessment and treatment plan that addresses the client's risk for suicide along with the client's substance abuse problems • Collaborate with supervisor and/or treatment team to develop an emergency plan for high-risk clients to ensure safety • Make referrals to appropriate resources, including helping resistant clients accept and follow through on referrals • Apply principles of crisis management with actively suicidal clients • Restrict suicide methods for clients who are suicidal (e.g. remove weapons, restrict medication availability) 	<ul style="list-style-type: none"> • Maintain objectivity in talking to clients about suicidal thoughts • Maintain a therapeutic stance with clients who are resistant to a crisis response plan or commitment-to-treatment agreement • Maintain objectivity in weighing the value of hospitalization for individual clients in close coordination and cooperation with other treatment team members and professionals • Respond therapeutically to clients who express strong emotions of hopelessness, sadness, anxiety, or anger in treatment • Maintain a positive, non-punitive attitude toward clients who are noncompliant with treatment plans • Be aware of attitudes of self and others toward inappropriately using coercive measures with suicidal clients

Core Competencies	Knowledge	Skills	Attitudes
<p>4. GATE: Extend the responsible action(s) by ensuring that referral appointments have been kept, sharing information, and continuing to monitor clients after crises have passed (through ongoing coordinating with mental health providers, and enlisting the support of family and community resources as appropriate).</p>	<ul style="list-style-type: none"> • Warning signs and changes in such signs that may indicate deterioration or emergent risk • Strategies to collaborate with other disciplines and agencies in a manner that meets the needs of the client and is mutually beneficial • Strategies to collaborate with family and other community supports in a manner that meets the needs of the client and is mutually beneficial 	<ul style="list-style-type: none"> • Monitor and respond to re-emergence of warning signs • Work collaboratively with other treatment providers including mental health providers • Follow up and track clients to monitor quality of care • Help clients accept and follow through on community referrals • Work collaboratively with family members to improve treatment compliance and safety • Explore family attitudes and values that could facilitate or impede treatment • Maintain ongoing documentation of client services 	<ul style="list-style-type: none"> • Maintain an objective, nonjudgmental attitude toward a variety of helping organizations and their staff • Advocate for suicidal clients to receive treatment and use community and family resources, while not assuming responsibility for their behavior • Foster a sense that a variety of community resources working together may be more helpful than one person or agency working alone • Acknowledge the value of family and other support systems

Core Competencies	Knowledge	Skills	Attitudes
<p>5. Basic knowledge about the role of warning signs, risk factors, and protective factors in suicide risk among people with substance use disorders.</p>	<p>Warning Signs:</p> <ul style="list-style-type: none"> • Direct: <ul style="list-style-type: none"> Suicidal communication Seeking access to method Making preparations • Indirect: <ul style="list-style-type: none"> I Ideation S Substance Abuse P Purposelessness A Anxiety T Trapped H Hopelessness W Withdrawal A Anger R Recklessness M Mood Changes <p>Risk Factors:</p> <ul style="list-style-type: none"> • History of prior suicide attempt • Family history of suicide • Severe substance abuse • Co-occurring mental disorder • Personality disorder or maladaptive traits • Child abuse (especially sexual) • Stressful life circumstances • Firearm ownership or access <p>Protective Factors:</p> <ul style="list-style-type: none"> • Clean and sober • Religious attendance/ holds faith beliefs against suicide • Childrearing responsibilities • Intact marriage • Trusting relationship with a helping provider 	<ul style="list-style-type: none"> • Understand difference in perspective/goals (e.g., counselor's goal to prevent suicide and client's goal to eliminate psychological pain) and the need for the counselor and client to collaborate to articulate common goals • Make a realistic judgment of one's competence, training, and time to evaluate and care for a suicidal client with a substance use disorder • Note warning signs, risk factors, and protective factors but does not independently conduct a formal risk assessment (without specialized training and education) 	<ul style="list-style-type: none"> • Manage one's own reactions to suicidal behavior • Maintain a collaborative, nonadversarial therapeutic stance • Be empathic and non-judgmental with people who experience suicidal thoughts and behaviors

Core Competencies	Knowledge	Skills	Attitudes
<p>6. Empathy for suicidal clients. Have empathy for individuals who are suicidal, particularly those who are chronically suicidal, by appreciating the complex reasons for suicidal behavior and distinguishing myths from facts about suicide.</p>	<ul style="list-style-type: none"> • There is usually more than one reason for a suicidal act • Ambivalence about suicide is the norm and showing hesitancy (or ambivalence) about an act of suicide in no way guarantees future safety • Clients who are chronically suicidal (e.g., those with past acts of self-injury that were for manipulation or to get attention) are not protected from suicide • Clients with borderline personality disorder have high rates of suicidal behaviors 	<ul style="list-style-type: none"> • Understand and appreciate the client's perspective • Provide support to potentially suicidal clients at setbacks and transition points in treatment and at the time of stressful life events • Refer the client to speak with his or her mental health provider about issues related to chronic suicidal thoughts and behaviors • Collaborate closely with such providers to reduce the potential for risk 	<ul style="list-style-type: none"> • Recognize that clients' perceptions of the reasons for suicidal behavior, although not necessarily logical to others, are congruent with the client's own perceptions • Identify one's own attitudes that are counter-productive in managing suicide risk • Approach client suicidality from the perspective of a complex problem with many options for response
<p>7. Cultural competence. Honor and respect the beliefs, language, interpersonal styles, and behaviors of the cultures of individuals and families receiving services.</p>	<ul style="list-style-type: none"> • The culture's beliefs, norms, and values influence ideas about the nature of relationships, the way people live, and the way people organize their world • No culture is fully protected against suicide • Suicide may be regarded differently in different cultures 	<ul style="list-style-type: none"> • Work effectively in cross-cultural situations • Identify and adapt to cultural norms of clients • Ask questions in a culturally sensitive manner • Make referrals in a culturally sensitive manner 	<ul style="list-style-type: none"> • Value the differences among cultural groups • Recognize that clients need to present their dilemma in the context of their cultural norms • Appreciate that different cultures use and represent suicide differently

Core Competencies	Knowledge	Skills	Attitudes
<p>8. Legal and ethical issues. Understand legal and ethical issues (for the counselor) related to suicide risk assessment, management, and documentation.</p>	<ul style="list-style-type: none"> • Steps necessary to obtain informed consent • Elements related to risk screening and treatment planning • How and when to obtain clinical supervision or consult with a senior colleague concerning a client who is suicidal • State laws pertaining to suicide • Regulatory statutes and agency risk-management policy • Legal issues related to clients who are suicidal • Exceptions to confidentiality 	<ul style="list-style-type: none"> • Document informed consent, screening information, warning signs, risk considerations, treatment plan, care management, interaction with colleagues, progress, and outcomes • Protect client records and rights to privacy and confidentiality following Health Insurance Portability and Accountability Act (HIPAA) • Implement, with clinical supervision, usual and customary care for these clients • Protect clients' rights in the event of suicidal behavior or a client's death from suicide 	<ul style="list-style-type: none"> • Understand that a “don't ask, don't tell” policy toward suicide generally increases (not decreases) vulnerability to a lawsuit • Understand that documenting suicide risk promotes client safety and communication among providers and is important for the sake of the medical/legal record • Understand that refusing care to individuals who are suicidal and referring them out, but failing to see that such individuals follow through with a referral, generally increases (not decreases) vulnerability to a lawsuit • Determine objectively whether consultation with another professional would be helpful in an individual case • Understand the need to respond to the legal and regulatory issues related to work with clients who are suicidal • Do not allow fear of blame or lawsuits to interrupt quality client care

Next Steps

You have probably started thinking about how you might assist a suicidal client in your own substance abuse treatment program. Now you have basic information, fundamental clinical principles and positive attitudes, basic facts about suicide and its relationship to substance use disorders, a set of competencies that will help you address suicidality, and guidelines about what your role as a substance abuse counselor can be in working with clients who are suicidal.

In the next chapter, you will meet a number of clients who are experiencing or have experienced suicidal thoughts and behaviors of varying degrees of intensity. The dialog among clients, counselors, and supervisors illustrates a number of ways substance abuse treatment and suicidality intervention can interact, and how GATE can be implemented in several treatment settings, and with different types of complicating factors.

Chapter 2

Introduction

In this chapter you will meet six people with substance use disorders who are experiencing suicidal thoughts and behaviors to varying degrees. Through their dialog with counselors, supervisors, and family members, you will see how suicidal thoughts and behaviors may manifest. You will also see that these thoughts and behaviors are typically accompanied by co-occurring mental disorders, such as depression, psychological trauma, and other anxiety disorders.

The elements of GATE (**G**ather Information, **A**ccess supervision, **T**ake responsible action, **E**xtend the action—see chapter 1) are portrayed in different settings and situations. You will read about counselors working with clients who are resistant to treatment for their suicidal thoughts and behaviors, about the effects of suicidal thoughts and behaviors on family members and others, and about managing suicidal crises. While the vignettes demonstrate treatment methods and techniques that are within the scope of practice and range of substance abuse counselors, vignettes 5 and 6 also include several advanced techniques that are more appropriate for use by experienced counselors. The consensus panel has made a significant effort to present realistic encounters with clients using counseling approaches that include motivational interviewing (MI), cognitive-behavioral therapy (CBT), supportive psychotherapy, and crisis intervention methods. In all of these therapeutic approaches, basic counseling dynamics (such as relationship building; managing rapport in stressful situations; giving feedback; assessing, understanding and responding to the needs expressed by the client; and seeking consultation and supervision as needed) are demonstrated. Please note that the panel does not intend to imply that the approach used by the counselor in the vignette is the “gold standard,” although the approach shown does represent competent practice that can be performed in real-life settings.

The vignettes begin with an overview, a substance abuse history, a suicide-related history, and a list of the learning objectives for the vignette. Each of the following additional features is also embedded in the counselor and client dialog:

- **Master clinician notes** are comments from an experienced counselor or a supervisor about the strategies used, possible alternative techniques, thoughts of the clinician, and other information counselors should have.
- **“How-to” notes** contain information on how to implement a specific intervention.

Master clinician notes represent the combined experience and wisdom of the contributors to this TIP. The notes provide insights into the cases and suggest possible approaches. Some of the techniques described in the notes may or may not be appropriate for you to use, depending on your training, certifications, and licenses. It is your responsibility to determine what services are legally and ethically appropriate for you to provide within the scope of your practice. If you are unsure, ask a supervisor.

This format was chosen to assist counselors at all levels of mastery, including beginning counselors, those who have some experience but need more diversity and depth, and those with years of experience and training who are true master clinicians. Client scenarios are presented in vignettes in the following pages. Each client is in treatment for a substance use disorder, and is experiencing some suicidal thoughts. By way of introduction:

Vignette 1, Clayton, illustrates how to obtain and secure a firearm safely from a high-risk client by enlisting the help of a family member.

Vignette 2, Angela, shows how to work collaboratively with family in discharge planning for a high-risk client from an inpatient unit.

Vignette 3, Leon, depicts how to link a high-risk client safely with an outpatient mental health program that is better able to meet his needs.

Vignette 4, Rob, shows a therapeutic response to a client who provocatively and inaccurately alludes to suicide in group, causing distress in the group and distracting from his true concerns.

Vignette 5, Vince, illustrates a rapid referral to the emergency department for a client at acute risk for homicide-suicide.

Vignette 6, Rena, depicts a crisis response for a client who calls her counselor when drinking and acutely suicidal, and introduces two advanced techniques (detailed safety plan, hope box).

Vignette 1—Clayton

Overview

This case illustrates the GATE process for working with substance abuse clients with suicidal thoughts and behaviors. The vignette begins with a meeting between Clayton and his counselor (Darren) and illustrates how clinical supervision plays an important role in addressing client suicide risk. It specifically addresses working with a client who is not in an immediate suicidal crisis but has warning signs for suicide. It also examines issues of removing a potential suicide weapon and illustrates the importance of working with family.

Participants: Clayton (client), Darren (counselor), Jill (supervisor), and Barbara (daughter).

Substance Abuse History

Clayton is a 61-year-old Caucasian man who used injection drugs as a young adult and contracted hepatitis C. He quit using injection drugs without treatment and about 10 or 15 years later developed alcohol dependence. He entered treatment 5 years ago and has been sober for 18 months. He has a cirrhotic liver but does not want to consider getting on a transplant list. He attends at least four Alcoholics Anonymous (AA) meetings a week, participates in an ongoing recovery group, and sees a substance abuse counselor individually on an as-needed basis. He lives alone, has two grown children with whom he has occasional contact, and lives on his retirement pension. He retired 3 years ago from a supervisory position at a local small manufacturing plant where he worked for 30 years.

Suicide-Related History

Clayton tried to kill himself in his twenties by overdosing on heroin. He was taken to an emergency room and released about 12 hours later. He did not follow up on treatment recommendations. He began having suicidal thoughts again following his last relapse 18 months ago. While drinking, he decided he might shoot himself but did not actually make a suicide attempt. Since stopping drinking and returning to treatment, he has had occasional thoughts of killing himself, particularly when the pain from his liver disease becomes burdensome and when he feels like he has no future. Clayton maintains that he is not acutely suicidal now but says he might act if the pain becomes worse or if he is unable to take care of himself. The suicidal thoughts arise when he feels hopeless and when he becomes afraid that he might reach a point of being physically unable to take care of himself. He took out his gun and examined it last week, an action that concerned his AA sponsor enough to urge Clayton to call his substance abuse counselor for an appointment.

Learning Objectives

1. To illustrate GATE and how this model can be applied in substance abuse treatment settings.
2. To demonstrate screening for suicide risk.
3. To highlight the role of clinical supervision in addressing the needs of the client.

4. To recognize when there are indications of continuing risk even when the client is currently denying suicidal thoughts.
5. To demonstrate three types of action:
 - Remove a potential suicide weapon.
 - Involve family in treatment.
 - Make a referral to a specialized community resource for further assessment.
6. To illustrate a followup process to ensure that the client has removed the weapon from his home and has followed through on the referral to a specialized community resource.
7. To illustrate how case management is important in helping Clayton manage a variety of life problems including substance abuse recovery, pain management, suicidality, mental health care, and physical health care.

[Clayton has requested an appointment with his counselor.]

COUNSELOR: Clayton, you said on the phone you are having some trouble and would like to see me.

CLAYTON: Well I haven't been feeling so good. I've been having a fair amount of pain for the past couple of months or so. I'm not sleeping all that great. I don't feel very well. My sponsor in the program told me to give you a call.

COUNSELOR: We'll I'm glad you did call.

CLAYTON: I've been going to the pain management clinic like you told me to. That helps—the meds and the pain management program, but sometimes the pain still gets pretty bad and I start sinking.

COUNSELOR: How much pain have you been having?

CLAYTON: I'm in pain all the time, but it flares up real bad about every other day. What happens is that the bad pain comes for several hours, sometimes four hours or so, and it makes it really hard for me to do anything. It just beats me down.

COUNSELOR: In the past we've used a scale of 1 to 10 to rate your pain. Where would you put yourself on that scale now?

CLAYTON: When it flares up, I'd say about 8 or 9. Then, after a few hours it goes down some—maybe down to a 3 or 4 or 5. It never goes away all the way. And you know, I can't take narcotic pain pills. The pain clinic gives me some meds—the non-addictive kind, but they don't help all the time.

COUNSELOR: When the pain has gotten up in that 8 to 10 level, those are the times when you feel like you're "sinking" and "feeling down?" Clayton, tell me some more about what those terms mean to you.

CLAYTON: Well, I mean it's the whole thing. You know I'm not going to go through with the liver transplant thing, even if I could get a new one. I don't want to be a burden on anybody, and I don't want to slip again. I tried working a little bit last year just to see if I could. A friend in the program let me work a few hours a day at his store. But I couldn't work all the times he wanted me to because of the pain attacks.

COUNSELOR: Sometimes in the past when those feelings of hopelessness have come up and you've had that kind of pain, I know you've had thoughts about suicide. Have those thoughts come back?



Master Clinician Note: Observe that the counselor does not wait for Clayton to bring up issues of suicide, but rather initiates the conversation in a way that normalizes the discussion and invites Clayton to provide more information.

Some specific points to consider when discussing suicide with a client include:

- Use clear, direct terms, not euphemisms for suicide (for instance, say “have you thought of killing yourself?” or “Have you thought of taking your life?” rather than “have you thought of doing anything foolish?”)
 - Ask direct questions, but do so with care and compassion.
 - Ask open-ended questions that require more than a “yes” or “no” answer.
 - Acknowledge that talking about suicidal thoughts and behaviors is difficult but that having the discussion is important.
-

CLAYTON: Well, I think it’s, like I said, not knowing what lies ahead. If I’m ever gonna get beyond this and not bother my family about the whole thing and not feel like I can’t do as many things as I was able to do. All those kinds of things add up at once and I’d say those thoughts are there especially when everything collapses, when I’m not sleeping and the pain is worse, I don’t know . . . it all just gets to be too much.

COUNSELOR: Yeah, it sounds pretty overwhelming and seems like you feel help would be hard to find.

CLAYTON: Well you know, I don’t want to bother my family, and I really don’t want to be a burden on anybody. Sometimes I don’t even know if I want to continue the liver treatment.



Master Clinician Note: Clayton avoids addressing the question of suicidal thoughts, except in an indirect way. Instead of grilling Clayton for the information, the counselor files away the issue temporarily and talks about pain for a few minutes, a comfortable topic for Clayton. The counselor then returns to his concerns about Clayton’s suicidal thoughts. The expectation is that Clayton will feel more comfortable in talking about them if the counselor slows down a bit and goes at his pace.

COUNSELOR: Does it help to talk to anyone about your pain, like people in your AA program, or in the group here or your family when things get real bad?

CLAYTON: I don’t know. I really don’t want to cry on other peoples’ shoulders. I don’t want to tell my kids, there’s nothing they can do. It helps that some people—friends in the program—know and give me some support. And I’ve talked to you about it some.

COUNSELOR: It’s not easy to share what you’re going through with others, and I really respect how you’ve shared with some peers, and that you’ve given me your trust. What gets in the way of talking with your kids about it?

CLAYTON: Well, I see my daughter and her family some. She lives about 10 miles out of town. My son and I talk every now and then, but he lives about five hours from here. We just talk about his kids, and I ask him about his job and that’s about it. We really haven’t been close since he was a teenager. I was drinking the whole time he was growing up, and we never have got beyond what happened back then, what I did and what he did too.

COUNSELOR: We talked a little bit about that: the family relationship has been difficult for you. You said you’ve been feeling like a burden.

CLAYTON: Yeah. I haven't really told them about the liver, how bad it is. I don't really want them to get all upset. They've got their own lives now.



How To Screen for Suicide

Just a few questions about suicidal thoughts and behaviors can provide substance abuse counselors with the information they need to decide if further exploration of suicide is necessary. The five questions used in this vignette are drawn from the longer discussion of gathering information in chapter 1. The five questions used in this vignette are:

1. Are you thinking about killing yourself?
2. Have you ever tried to kill yourself before?
3. Do you think you might try to hurt yourself today?
4. Have you thought of ways you might kill yourself? or Do you have a plan for how you might kill yourself?
5. Do you have pills or weapons to kill yourself in your possession or in your home? or Do you have ready access to pills or a weapon that you might use to kill yourself?

When a reply indicates the presence of suicidal thoughts or behaviors, the counselor should follow up with open-ended questions that seek to obtain additional information. For instance, if a client acknowledges a prior suicide attempt, the counselor would want to know more about when the attempt occurred, what method was used, what else was happening in the person's life when the attempt occurred, and why the attempt was unsuccessful. (See the detailed discussion on this important topic in Part 1, chapter 1.)

COUNSELOR: So you've had a sort of mixture of difficulties over the course of the last couple of weeks including thoughts about feeling hopeless and perhaps even thoughts of taking your own life. I know it's a difficult subject, but do you mind if we talk a little bit more about this?

CLAYTON: That's okay.

COUNSELOR: Thanks. I appreciate your willingness. One concern I have is about your hopeless feelings and where they might lead, for instance, whether they lead to thoughts about killing yourself.

CLAYTON: Yeah. I've thought about it. I've had a gun for a long time.

COUNSELOR: I wonder if you could say a little bit more about the thoughts, and what you've thought of in terms of the gun.

CLAYTON: I don't do much with the gun now. I used to use it for target practice and stuff. My son and I used to take it out years ago.

COUNSELOR: Do you remember the last time you got the gun out?

CLAYTON: Yes, last week. Funny, I guess I haven't had it out of the closet in years, but I took it out the other night and just checked it out.

COUNSELOR: Were you thinking about killing yourself when you took the gun out?

CLAYTON: You know, not really. I don't know why I took it out. But later, I was feeling pretty bad, and I wondered if that was what I was doing. It bothered me enough that I told my sponsor about it, and he told me to give you a call.

COUNSELOR: I'm glad you did.

CLAYTON: Me too.

COUNSELOR: Could I ask how often the thoughts of suicide occur?

CLAYTON: I'd say about every week or so.



Master Clinician Note: Observe that the counselor occasionally asks the client's permission to continue probing, showing respect for the client and providing him with a sense of control. Also notice how the counselor picked up on hopelessness and followed it up with a more specific mention of "thoughts about killing yourself." Using this direct phrase showed Clayton that this is not a taboo subject, and indeed the counselor can handle this topic, opening the door to a revealing discussion about Clayton's suicidal thoughts and plan to use his gun. As you will see, the counselor continues to gather information, which will be necessary for deciding what actions to take. There are many similarities between obtaining information about suicidality and the information you, as a substance abuse counselor, routinely get about substance use history and current use. The information you want to obtain is the information that is directly relevant to treatment planning. Other information that might be useful in later treatment can be gathered at a later time. As with obtaining information about drug history, it is important to be specific and persistent, without "grilling" the client. The counselor will now obtain more specific information about suicidal thoughts.

COUNSELOR: Clayton, when the thoughts about killing yourself come up, how long do they last? How much time do you spend thinking about it? For example, does it come and go quickly or is it something that you stop and really think about?

CLAYTON: Sometimes it will stick around for a while, a couple of hours. I guess it's gotten a little worse over the past 4 or 5 months and lasting longer.

COUNSELOR: Do you mind sharing with me a little bit about what you are thinking about during that period?

CLAYTON: Just not being around and, like I said, not causing my family more grief than I've already caused them, getting out of the pain and things like that. It's not like I spend the whole time then thinking about how I'm going to shoot myself. It's more like I just think I'd be better off dead, I wouldn't feel all this pain. . . It just seems pretty reasonable when I'm in that frame of mind.

COUNSELOR: Clayton, have you thought about killing yourself today?

CLAYTON: You mean like this morning? No, it's not like it is right in front of me. It just more hangs around in the background.

COUNSELOR: Thank you for that clarification. I also wonder if you've done anything in preparation for taking your life.

CLAYTON: I don't know what you mean.

COUNSELOR: For example, giving away things, saying goodbyes, arranging affairs, making sure your gun works. Have you found yourself doing anything like this?

CLAYTON: Uh, I've made sure that possessions—things that I own and stuff—would be given out the way they should be in terms of taking care of that kind of thing but not really much beyond that.

COUNSELOR: Anything else?

CLAYTON: Well I just talked to an attorney about where whatever possessions I have will go, and I made a will. But with my physical condition, I need to do that anyway. It's not like I'm getting all the ducks in a row.

COUNSELOR: It kinda sounds like you've redone your will.

CLAYTON: Yeah.



Master Clinician Note: There is a pause in the conversation at this point. The counselor is considering that he might consult with Jill, his supervisor, about how to proceed. He is concerned particularly about letting Clayton leave the office, knowing that he has recurrent suicidal thoughts, has considered shooting himself, and has access to a gun. He decides to address the issue of getting some advice from Jill directly with Clayton.

COUNSELOR: Clayton, at this point I am going to take the opportunity to touch base with my supervisor for a few minutes. The reason I need to do that is because some of the areas we have discussed, including your chronic pain, the hopelessness, the suicidal feelings, and your gun have me concerned about your health and safety. If Jill, my supervisor, is available, would you mind if she joins us?

CLAYTON: I knew I shouldn't have said anything. What are you going to do, lock me up?

COUNSELOR: I can appreciate that you feel nervous, but try not to jump to conclusions. I just want to get some input to make sure we're doing everything possible to help you with your struggle and keep you safe. In this instance I think she can be helpful to both of us. What I want to do is give her a call and see if she can step in.

CLAYTON: Okay, I suppose you're just trying to do the right thing.

COUNSELOR: Yes, I want as much expertise available to us as possible. Thanks for understanding.



Master Clinician Note: Darren raised the issue of involving his supervisor skillfully. First, he consulted with Clayton about it. Second, he validated Clayton's feelings. Third, he gave Clayton a rationale for the supervisor consultation. And, fourth, he kept the focus on Clayton's well-being.

[Darren telephones Jill, his clinical supervisor.]

COUNSELOR: Jill, this is Darren. Clayton, who I think you know, is in my office right now, and we're talking about his pain related to his liver disease and how he is coping with that. He's had thoughts about suicide, and I'm wondering if you could join us for a few minutes as we make some decisions about how to handle this.

SUPERVISOR: Yes, I'm glad you called, I'll be right in

[*Jill, Darren's supervisor, was in a meeting with another counselor that she broke away from in order to intervene in this more urgent situation.*]



How To Prepare for Suicidal Crises

Agencies should have a policy for addressing immediate crises that arise during counseling sessions. The policy should specifically state that if a counselor feels he or she needs direction in a life-threatening crisis, a supervisor or other senior staff member should be contacted for input. More information is included in Part 2 of this TIP.

[In the interim until Jill enters the office, Clayton and Darren resume their conversation, focusing primarily on Clayton's depressive symptoms.]

[Jill enters room after knocking.]

COUNSELOR: Clayton, have you met Jill?

CLAYTON: Yes. Jill, I remember you from when you were a counselor here and did the evening aftercare group.

COUNSELOR: Yes, Clayton, I remember you from the group, it's good to see you again.

[Clayton, Jill, and Darren spend a few minutes developing rapport. Darren briefly describes Clayton's reports of suicidal thoughts, the weapon in his house, his thoughts about redoing his will, and Darren's concerns that Clayton might be depressed. Jill is unaware of Clayton's suicide attempt many years ago.]

SUPERVISOR: Clayton, one other thing that I would like to ask about. Have you ever tried to kill yourself?

CLAYTON: Not really. Well, maybe, when I was doing hard drugs, in my twenties, years ago. I tried to overdose one time. I used enough heroin that it should've killed me, plus I was drinking, but I just passed out, and that was it.

SUPERVISOR: Can you tell me some more about what happened?

CLAYTON: Well, I shot up. I knew the stuff was good, pure. I tried to end it, and I just went out.

SUPERVISOR: Did someone find you?

CLAYTON: I think someone called an ambulance, and they took me to the hospital. They kept me maybe a day.

SUPERVISOR: Was there any followup?

CLAYTON: Nah.

SUPERVISOR: Okay, and you haven't made any other suicide attempts?

CLAYTON: Nah.

SUPERVISOR: Thanks, Clayton, for sharing that with me. I just needed to check that out. The issues that stand out to me are that your pain comes on pretty reliably every other day now, that you can get pretty down when this happens, and sometimes have thoughts of suicide, that you have a gun that you've thought of using, and, for the first time in a long time, you got the gun out. Would you say that's a fair summary?

CLAYTON: Yeah, that says it, I guess.

COUNSELOR: I agree, that captures the situation pretty well.

SUPERVISOR: The place I'd like to start is the gun. The reason I say that is because it's just like getting sober, it's important to get the booze out of the house, so that when the craving hits, or there is a crisis of some sort, a bottle is not right there tempting you. It's the same thing with having a gun, most of the time it's not a prob-

lem, but when the worst of the pain hits, and when the suicidal thoughts come, there is that added chance of taking action, and having the gun right there makes it more likely. What do you think of doing something about the gun, in order to make the situation safer?



Master Clinician Note: Bear in mind that Jill knows Clayton from when she did the aftercare group. She has a background in mental health counseling and has had additional training in addressing suicidality. As a result she is clear about what to do and feels confident making this intervention on the spot, rather than discussing it first with Darren, or obtaining additional input from the program director or a consulting expert.

CLAYTON: Well, I must admit when I got sober that I thought it was a little overkill to remove all the alcohol from the house, even the stuff in the liquor cabinet that I never paid any attention to, but it turned out you were right, it would've been tougher to get through those moments when the craving hit if the alcohol was right there.

SUPERVISOR: Agreed. Having a gun in the house is kind of like having alcohol in the house.

CLAYTON: I've thought about it now and then, but I haven't really had it out in a while, except that one time last week, so I'm not exactly sure, what are you suggesting I do?

SUPERVISOR: Well, what I'd like to do is have you make an agreement with me and Darren to go ahead and get rid of the weapon, not necessarily forever, but right now, given your pain and all, giving it to someone you know and trust would seem a lot safer than having it in your home. Whose help might you get in safeguarding the gun?

CLAYTON: My daughter Barbara maybe? I don't really want to get my sponsor involved in this, he's great, but he gets nervous. Truthfully, I don't really like the idea of bothering Barbara. I also don't want to burden her with my liver disease and being sick and not being able to take care of myself. But I can't think of anyone but Barbara who could take care of the gun, and I know she'd do it in a minute for me.

COUNSELOR: I can see that you're not totally comfortable asking Barbara, but if it has to be done, it sounds as if she is the best choice. Is that correct? Am I hearing you right?

CLAYTON: Yeah, that nails it pretty well.

COUNSELOR: Then Barbara it is. Thanks for working with us on that difficult decision.

SUPERVISOR: Agreed. We appreciate your working with us like this. This is difficult stuff to be sure. One more thing I'd like to ask. How would you feel about it if Darren or I confirmed with Barbara that you gave her the gun?

CLAYTON: If you gave me some time to do it.

SUPERVISOR: How much time do you think that you need?

CLAYTON: I could get it to her in the next couple days or so, and she'll have it. I'll talk to her.

SUPERVISOR: Your suggestion is very reasonable and I appreciate it a great deal. However, I think Darren and I would feel even better about it if we took care of it today. I know you might see this as pushy, but I wonder if you would mind if we gave her a call now?

CLAYTON: This feels like it is really rushing it. I mean, I'm not going to shoot myself tonight. I'm pretty sure of that.

SUPERVISOR: Yes, I thought you might feel like you were being rushed. Please let me slow down and explain. Although there is a parallel between having alcohol in the house in recovery and having a gun in the house in

this situation, they are not exactly the same. What I mean by that is, with relapse, there is the opportunity to learn from the mistake and remove the alcohol, but, unfortunately, with a gun it's essential to get it right the first time. There may not come a second chance. For that reason, Darren and I tend to be a little more “pushy” and insistent with your situation than, say, if we were talking about preventing a relapse; the stakes are much higher. From our perspective, then, it makes more sense to take care of it now.

CLAYTON (reluctantly): I understand although it still feels pushy. Well . . . OK. I'm not sure we can get her, and if we do, I don't want to get her all upset. But we can try her cell phone.

COUNSELOR: Thanks for hanging in there. Before we make the call, I suggest that we make a plan for what we're going to say.



Master Clinician Note: Observe that Darren, the counselor, can clearly see where Jill is going at this point and so he steps back into the conversation and assumes the task of working with Clayton and his daughter around safeguarding the gun. Accordingly, Jill recognizes that it is ideal to empower Darren to manage the situation to the extent possible, and so she steps back and allows Darren to work with Clayton around the gun directly, while continuing to observe the interaction to ensure that the plans to remove it are made and that any other important safety issues are addressed. Darren already has a release to speak with Clayton's daughter and has spoken with her briefly on occasion about his progress.

CLAYTON: Well, I guess, I'm thinking y'all are overreacting a bit to all of this. But I understand where you're coming from.

COUNSELOR: I really appreciate you trying to see our point of view. Let's talk for just a minute before we call your daughter, about what you want to say, how you think she might react, how you want us to be involved.

CLAYTON: Yeah, probably, yeah, she doesn't know much. I mean, she knows I've been doing good in the program, and it's working. And she knows that I haven't been feeling well lately but she really doesn't know much about—she knows my liver's not in great shape; but she doesn't know about the pain being so bad.

COUNSELOR: It's a fairly major thing to kind of drop on her and then to talk with you a little bit about the fact that you need to have her take the gun as well. Do you have a sense for how you're going to bring that up with her? Do we need to talk about that for a minute before we make the phone call? It would seem to make some sense for us to discuss it.

CLAYTON: Um, well, like I said, she knows I've had some liver problems but she doesn't know how bad it is. I could just tell her, you know, I don't have to get into that too much, I don't think right now, do I?

COUNSELOR: Well, I think it's up to you. I would imagine she's going to have some questions about why you're calling. You're going to tell her that you need to give her a gun, and you would like her to take it this afternoon if possible, that you've been having some difficulty. So it's really up to you how much you tell her, but I want to make sure we have thought about any kinds of questions or concerns ahead of time.

CLAYTON: Right.

COUNSELOR: So we can kind of anticipate them before you make the phone call.

CLAYTON: Yeah, I don't see any problem, I mean, as long as she can come over, which I think she can; I mean, she lives maybe 20 minutes from my apartment. I think she's visiting her mother this afternoon. I think she would do it.

COUNSELOR: Okay, all right. One thing: does Barbara have any experience handling and safely storing guns?

CLAYTON: Not much experience, but she's got an area in her attic that she keeps locked. I know that's where she'd lock up the gun.

COUNSELOR: That's really good to know. If you're okay with it, I think we're ready to make the call.

CLAYTON: Are you going to be listening in to the call?

COUNSELOR: We'd be willing to, glad to in fact, if that's okay. It might come in handy if Barbara has any questions she wants to ask us. Would it be alright if we put the call on speakerphone?

CLAYTON: Yeah, that's fine, sure. I mean, if you want to. You could explain this stuff better than me, I'm sure.

COUNSELOR: Well, we'd be happy to. There may be different points where Jill or I can offer some support or say something if you're a little bit at a loss for words, and when she has a question, if you could kind of give me the nod, I'll certainly chime in and offer some help if you need it.

SUPERVISOR: Yes, that sounds excellent, I'll be happy to enter into the conversation as well if necessary, although for the most part I'll allow you and Darren to speak with Barbara.

CLAYTON: Okay.

[Clayton dials his daughter Barbara's cell phone number.]

BARBARA: Hello?

CLAYTON: Barbara, hi, it's Dad.

BARBARA: Hi, Dad, how are you?

CLAYTON: I'm, you know, I could be better. I'm sitting here with my counselor and his supervisor and they thought I should give you a call; they are actually on the speakerphone here.

BARBARA: Okay.

CLAYTON: Sorry I bothered you; I hope I'm not catching you at a bad time. I know you are probably visiting with your mom right now.

BARBARA: Oh, no, you don't bother me at all when you call, Dad, I'm glad to hear from you. I just wonder why you're calling with your counselor.

CLAYTON: Well, he thinks I should talk to you about maybe coming over and getting my gun, you know, it's . . . , he thinks that maybe it would be better if you picked it up, or whatever. What do you think?

BARBARA: I think that's pretty scary.

CLAYTON: I'm not sure we need to do it, but he thinks we need to do it, so, but, you know. Could you just keep it for awhile? And in fact, if you want to talk to him, he's here.

BARBARA: I would like to talk to him.

COUNSELOR: Barbara, this is your father's counselor, Darren. I'm imagining you may have some questions.

BARBARA: Hi, Darren. This is pretty scary. I mean, I'll be happy to come over and pick up Dad's gun, but what's going on?

COUNSELOR: Well, your dad's been doing great with sobriety, but unfortunately he's been having a lot of pain, and he feels hopeless on and off, and sometimes has thoughts of killing himself. So, we've advised your dad to get the weapon out of the house, just to be on the safe side.

BARBARA: And I certainly will be happy to come over and get the gun. Dad, do you really think that you could kill yourself? That would be really awful.

CLAYTON: No, I think I'm gonna be all right, my counselor's just being extra cautious, don't worry about me. We can talk more about it, it's a lot to talk about on the phone, but it's okay if you get the gun. It's what they want me to do, and I'm going to go along with them.

BARBARA: Okay, I'll be right over. Are you going to be home Dad?

CLAYTON: Well, I can be there in maybe a half hour.

COUNSELOR: Barbara, I understand it's a scary thing, but it seems like a really good precaution to take.

BARBARA: And I appreciate that you're doing that. And I'll certainly do anything I can to help, but, Dad, why is this happening? What's going on? I mean you've been sober for—it's just like we're getting to know each other, and now all of a sudden, I find out you're depressed. I didn't know any of this was going on.

CLAYTON: Well, it's a lot, you know, we can talk about maybe—I don't know . . . we can, well, you know, my liver's not been doing great and—

BARBARA: What do you mean your liver's not good? I knew you had some problems with your drinking, what do you mean your liver hasn't been doing great? What's that mean?

CLAYTON: Well, the doctors say my liver is pretty bad, and I've sometimes had a lot of pain with it.

BARBARA: What? We need to talk, Dad. I need to know what's going on. This is all pretty scary—you're scaring me, Dad. But I—I'll be right over.

COUNSELOR: And, Barbara, I appreciate you doing that. One of the things your dad and I can talk about is maybe it would be helpful for the three of us to sit down. This is a lot to take in, particularly over the phone. Do you think that might be a good idea?

CLAYTON: Sure.

BARBARA: I think that would be really helpful for me. I have a lot of questions, and I think I'll probably have a lot more, but the first thing is, I will be right over to get the gun.

COUNSELOR: Just two more quick things. One, do you have a safe way to store the gun? Second, after you've obtained and secured the gun, I wonder if you can call me to confirm that you've picked it up.

BARBARA: Yes, I have an area in my attic where I lock up things and I'm good about keeping the key hidden.

COUNSELOR: That's great, please confirm with me after you've locked away the gun.

BARBARA: Yes, absolutely I'll give you a call.

[Darren proceeds to give Barbara the office telephone number.]

COUNSELOR: And Barbara, the other thing I would encourage you to do is just to make a list of the questions that you have. I know this is overwhelming to have all of this dropped on you in one afternoon. So if you just make a list of the questions, you can bring those in and the three of us can sit down and go through those, and try to get you the information and the answers that you need and that your dad is comfortable with. It's likely that your dad could benefit from more treatment for his hopelessness and depression than he is getting right now, and so I think that's something we should talk about when we meet.

[Darren makes a mental note to give Barbara the 1-800-273-TALK number when she calls back.]

BARBARA: That sounds like a really good idea. I-I-I am so rattled right now, I can't even think, but I can do that and bring those in, and I think that would be helpful.

COUNSELOR: Clayton, anything else that comes to mind?

CLAYTON: No. Thanks, Barbara.

BARBARA: Okay, Dad, I'll be—

CLAYTON: Don't worry about me.

BARBARA: I can't not worry about you, Dad, but I'll be right over to get the gun.

CLAYTON: All right. Thank you. Bye.

BARBARA: Bye.



How To Work With the Family of a Client Who is Suicidal

As in treatment of substance abuse illnesses, family and significant others can be an important recovery resource. Some of the steps you, as a counselor, can take with family members include:

1. Providing information about suicide, particularly dispelling misconceptions and providing accurate information.
2. Increasing awareness of signs and symptoms that a loved one might be experiencing suicidal thoughts and/or behaviors, especially recognizing warning signs or a significant change in risk factors.
3. Making suggestions about how to talk to a loved one who is experiencing suicidal thoughts: what to say, and equally important, what not to say.
4. Making suggestions for how to recognize the need for and provide emotional support to a person who might be feeling overwhelmed and hopeless.
5. Providing emergency resources (such as 1-800-273-TALK or local suicide hotlines and crisis centers in a suicidal crises).
6. Planning for how to access and possibly remove suicide methods, such as guns or pills, to reduce the likelihood of high-risk behaviors.

In working with family members, be sure to honor ethical and legal constraints on confidentiality and obtain appropriate consents for release of information from your client.

Sometimes family members are not a positive force for suicide prevention and intervention, so care must be taken to assess how responsive the family members are to helping the client and if they possess the capacity to be a positive force in the client's life at this time.

COUNSELOR: Clayton, thanks for making the call. How do you feel about the phone call?

CLAYTON: I think it's, you know, a little too much to do all that, but I'm willing to go along with it.

COUNSELOR: Thanks for being flexible. Let's talk tomorrow by phone just to see where we are and where we need to go from here.

SUPERVISOR: I can see that you both have things under control. Thanks for allowing me to join your meeting. You did some excellent work here just now.

[Jill leaves the meeting.]

Followup

Darren received a call from Barbara acknowledging that she had stored the gun in her locked attic. Ideally, firearms should be stored unloaded, but in this case, there was probably a greater risk of unintentional injury to Barbara if she attempted to unload the gun. Therefore, she simply stored it, given that she has a locked space for it and is the only person with the key. If Darren had not heard from Barbara, he would have been sure to contact her to determine if anything went wrong with the plan and, if necessary, to develop an alternative plan. A positive outgrowth of the counselor's intervention was that Barbara expressed an interest in meeting with the counselor and her dad to learn more about how she could be involved in his treatment and recovery. With Clayton's permission, a joint visit was arranged for the following week. Clayton also agreed to a mental health consultation, and one was scheduled for later in the week to evaluate his depression and further assess suicide risk. Plans were also made for him to continue to visit a local pain clinic to help with pain relief. He was given the 1-800-273-TALK hotline number to call in an emergency.

Clayton was cooperative throughout, agreeing to remove the weapon that created high potential for taking a lethal action. If his daughter hadn't been available, Darren and Jill would have had a decision to make about whether or not any other immediate intervention steps were necessary. They may have wanted to get additional input concerning this question. A detailed discussion of removing weapons from the possession of suicidal patients is provided by Simon (2007). Although the article is not written specifically for substance abuse treatment settings, it offers sound guidance. Treatment programs may be willing to have clients bring in substances that they might use to kill themselves, with a procedure for handling such substances (e.g., by flushing them with a witness and documenting that this occurred). However, accepting a weapon from a suicidal client is highly problematic, because bringing a weapon into a facility may create risk to staff and clients (and typically violates agency policies) and because the provider may ultimately be required to return the weapon to the client, an untenable situation. As shown in this vignette, family members are often willing to help in such instances and are open to coaching about the need to store guns securely and separately from ammunition. In addition, family members may decide not to return the weapon or to get rid of it. A worthy option to explore for your program is your local police department, as some police departments have special policies for receiving suicide weapons.

Darren took the time, with Jill's help, to debrief and document his actions with Clayton related to his suicidal thoughts and to gain additional guidance for the followup sessions. Some of the points they considered include:

- The information he gathered.
- How he accessed consultation with Jill and invited her into the session.
- The actions he took to contact Barbara and elicit her support in removing the gun.
- His referral of Clayton for an evaluation of his depression and Darren's support for Clayton continuing treatment at the pain clinic.
- The followup sessions he scheduled with Clayton and Barbara.

Discussion of the necessity for documentation and the style of documentation are provided in chapter 1. It is important to note in the documentation that Clayton and his daughter were both given the hotline number and were advised to call the number at any time if needed.

Vignette 2—Angela

Overview

Angela is a 44-year-old African-American woman with a history of chronic bipolar disorder and substance dependence. These illnesses have created numerous problems, including relationship conflicts with her family, unstable employment and housing, and poor adherence to healthcare treatment. She is currently in an inpatient psychiatric unit that specializes in the treatment of co-occurring disorders following a relapse to crack

cocaine use. She made a suicide attempt by drug overdose just prior to this admission. Since being in the hospital, her psychiatric symptoms appear to be stabilized. Her counselor and the treatment staff are concerned that her stability is tenuous, and that if she relapses again following discharge, she may rapidly become suicidal. In light of her suicide attempt and her chronic history of relapse and serious mental illness, her doctor intends to keep her in the hospital for several more days of observation.

Participants: Angela (client), Lupe (counselor), Walter (brother), and Carla (sister-in-law).

Substance Abuse History

Angela has a long history of cocaine dependence with relatively brief periods of abstinence. She was hospitalized for cocaine dependence twice in the past 4 years. Her drug use is intertwined with bipolar symptoms so it is difficult for her to remain clean when hypomanic or depressive symptoms occur, and at the same time, her drug use exacerbates these symptoms. She has done well since being hospitalized and has cooperated with treatment. The primary challenge now concerns discharge planning. Angela believes that she requires minimal aftercare treatment and intends to move back in with her brother and sister-in-law and their two children.

Suicide-Related History

Angela has made two suicide attempts, the first one as a teenager. Her most recent attempt, which precipitated her admission to the co-occurring disorders unit, was made while coming off cocaine. She had been deeply depressed for several weeks and overdosed on a variety of drugs that had been prescribed for her over the last few years. She was unconscious when discovered and taken to the emergency department. Once stabilized medically, she was admitted to the co-occurring disorders program. Although Angela denies any suicidal thoughts at this time, staff remain concerned about her potential for suicidal behavior upon initiation of cocaine use, a likelihood in light of her chronic substance dependence history. She shows poor insight into the severity of her mental illness, drug abuse, and suicide potential.

Learning Objectives

1. To illustrate treatment planning with a client at elevated risk of suicide.
2. To demonstrate family involvement in treatment planning.
3. To demonstrate case management skills in suicide prevention efforts.
4. To offer an understanding of the interaction of substance abuse, mental disorders, and suicidal behaviors.

Meeting Between Angela's Counselor and Her Clinical Supervisor

Angela's counselor, Lupe, asked that part of her weekly clinical supervision session be set aside to discuss her concerns about treatment planning for Angela. Angela's family has just notified her that they are not willing to have her return to their home and be with their children if there is a risk of drug relapse. Lupe and her supervisor discuss the complex interplay of Angela's drug use, her psychiatric illness, and the environmental stressors she faces (lack of employment, social isolation, and poverty). They conclude that this combination of forces indicates a high potential for relapse and resultant crises, and though less certain, a potential return of suicidal thoughts. They decide to recommend ongoing treatment efforts, perhaps a day hospital or a long-term mental health/substance abuse residential care program, once she leaves the intensive co-occurring disorders unit. They also agree that it would be unethical to give a false sense of optimism about her prognosis to the family to persuade them to take her back. Assuming that she cannot return to her brother's home to live in the immediate future, other supportive housing resources need to be identified. They know that Angela will need to accept and participate in any discharge plan or she will only undermine it after discharge. They also realize that they cannot force her to accept long-term residential or day treatment after discharge, no matter how clear it is to them that such treatment is warranted.

The decisions reached in the supervision about the next steps include:

Lupe will contact Angela's brother Walter (after Angela has signed a release for Lupe to do so) and ask him to participate in Angela's discharge planning.

The staff will need to work with Angela and her family to find an alternative and more structured setting where she can be monitored for relapse of her substance abuse and psychiatric symptoms, and for a return of suicidal thoughts and behaviors. Since Walter is apparently emphatic that she cannot return to his home, this presents an opportunity to identify a more intensive treatment alternative, for example, supportive living plus day hospital treatment, options that she would never had agreed to if her brother had not forced the issue.

Lupe's objectives are to help Angela and her family with case management services to reach agreement for these arrangements. Some of the treatment goals she will try to implement include seeking to ease Angela's transition back into the community; help her develop peer support; and continue to monitor her psychiatric and substance abuse treatment needs, warning signs for suicide, and medication compliance.

Counselor and Angela's Brother

[When Lupe and Walter meet, they have an initial brief interchange focused on developing rapport. Walter seems defensive, and Lupe would like him to be more a part of the solution than an adversary.]

WALTER: Let me get straight to the point: she's gonna relapse. I mean she's come in places like this and then she uses and she shows up at our door. We take care of her and I loan her money. She takes money if I don't lend her any. We're worn out. My wife is giving me a lot of grief about how I keep taking care of my little sister. I mean she's not 18 anymore. She took pills and passed out when she was supposed to be watching our kids. I found her passed out on our sofa and had to call 911 when I couldn't wake her up. I wasn't even sure if she was alive. Just to be straight with you, Angela's not coming back to our house now. I know our kids will miss her. When she's clean, she's better to them than she was to her own kids. But when she's using, she's a real burden on me and my family. We just can't do it anymore. And then when she doesn't take her medication and gets out of treatment she gets crazy. It just keeps going on and on.

COUNSELOR: Thank you for being up front with me about this.

WALTER: Yeah, well, it's the only way we'll get anywhere. Thanks for meeting with me, by the way. It's a welcome change. Last time she was in the hospital, nobody talked to me.

COUNSELOR: Yes, it's good we're communicating. Like you, we want to be sure Angela can be in a supportive environment when she leaves, an environment that will support her abstinence and help her keep her psychiatric illness in check. It sounds like you and your wife have been fantastic in terms of supporting your sister. And I know her children are not involved, so it has fallen on you and your wife.

WALTER: I'm glad you see where I'm coming from. This is not the first time with Angela. We've been through this many times with her.

COUNSELOR: Once I learned that you wouldn't be taking Angela back to your house, I had a chance to discuss alternatives with my supervisor and our treatment team, and also discussed possibilities briefly with Angela, although we didn't come to any firm agreement. The alternative that seems to make the most sense is for Angela to first enter a halfway house program for people with co-occurring substance use and mental disorders and then, later, move toward a supportive residential housing program, which could last up to 120 days or more. Additionally, while she's in the halfway house, she would continue to participate in intensive outpatient services here at the clinic. For starters, that outpatient treatment could be as frequent as 5 days a week, what we call "day hospital," until she achieves some success in recovery.



Master Clinician Note: It is important for counselors to be aware of ongoing residential treatment and housing options for clients who have a history of homelessness, a history of instability in obtaining and maintaining housing, and those in need of long-term supervised care. Some treatment possibilities in your community may include:

- Oxford Houses—a residential housing option found throughout the United States for people recovering from substance use disorders.
- Halfway houses for people leaving inpatient care.
- Sobriety houses, focusing on long-term supervised residential care.
- State and Federally funded long-term treatment programs.
- Supervised living.
- Group homes or other community resources.

In addition, housing options are numerous: housing funded through the HUD Homeless Assistance grants, such as Single Room Occupancy buildings, Shelter Plus Care, and Supportive Housing Programs, which are available to individuals who are homeless and have disabilities; programs that provide rental subsidies for sober housing and supportive services; modified therapeutic communities; day treatment with abstinence-contingent housing and employment services; and emergency and transitional shelters with onsite substance abuse treatment and relapse prevention programs. For more information about substance abuse treatment and homelessness see the planned TIP *Substance Abuse Treatment for People Who Are Homeless* (CSAT, in development j).

WALTER: Hold on a second, I'm all for Angela doing something besides living with us, but aren't halfway houses places for people who have been to jail?

COUNSELOR: Well, not everyone in halfway houses is coming from jail. The program we would like to use is specific to the needs of people who have both substance use disorders and a co-occurring mental disorder. And we hope that in a few months Angela could transition to having her own small apartment, in a supervised residential environment where there would be someone to make sure that she takes her meds and continues to participate in treatment here. When she is able, they can also help her with employment. And in the meantime, she would be responsible for helping maintain the residential housing facility, in addition to keeping her own unit maintained. And, of course, we really want to monitor her psychiatric symptoms and her potential for suicidal thoughts and behaviors.

I know that Angela feels very connected to you, your wife, and your kids, and that relationship is very important to her. But I hope she can understand your position that going back to your home just isn't an option right now.

WALTER: If you can find a healthy place for her, my wife would kiss you. Angela's been a drug addict since she was in her teens, and she always has big plans. She gets an apartment or she gets a boyfriend or she goes into a program and she always ends up back on our doorstep. What am I gonna do? She's strung out. She's gonna end up on the street. We take her in, we clean her up, she makes promises and then you know what happens. If you can get her in a place where they'll be nice to her and they'll give her medications and be good to her that's great, but I got enough to take care of.

COUNSELOR: I understand, and that's why we hope this kind of step-by-step collaborative plan, between Angela, your family, and us will work. And we do hope you will remain a big part of her life. Help her to be part of the family—have her be a part of family ceremonies and special occasions because we know that is important

for her. But as you say, she also needs to live apart from your family, find her own life, and build her own support system. Help her to be independent.

WALTER: About this suicide thing. You know my sister's a drama queen. Do you really think she's gonna kill herself? I mean, she's been using drugs since she was a teenager. Maybe she just went overboard when I found her.

COUNSELOR: We'll never know what would've happened if you hadn't found her, but based on my discussions with her and the report from the emergency department, we do believe that she tried to kill herself. She has a mental illness, bipolar disorder, and that has a high suicide risk. Also, as you might be aware, she tried to kill herself once as a teenager as well, also with pills. Fortunately, people like Angela who are vulnerable to becoming suicidal aren't that way all the time. I'm just getting to know Angela, and I don't have a crystal ball, but she may be vulnerable again if she relapses, and her relapses tend to happen when her mental illness is poorly controlled, especially when she's depressed. So her addiction and mental illness feed off of one another, creating a vicious cycle. Suicide potential isn't the only issue that Angela's facing, but it is an added concern that we have—one that says to us that we should keep her in the hospital a bit longer, for more observation to be sure she's safe, as well as to do everything that we can to put together a sound discharge plan. The success of that plan will ultimately depend on Angela, but we'd like to do our part to make it as realistic and supportive as possible.

WALTER: Well, to be honest, I see it your way. She always says things that are off the wall, but a few weeks ago she made a couple of remarks that were downright scary, something like "you'll be sorry when I'm gone" and "nobody cares about me so what's the difference what happens to me?" I didn't give it much thought at the time, but now it seems she was telling me something.

COUNSELOR: Yes, those statements are what we call warning signs for suicidal behavior. If she does make statements like that in the future, you should interpret it as an indication of danger for suicide, and we can work together to prevent another suicide attempt. Let's discuss this further when we meet with Angela.



Master Clinician Note: Counselors should be aware of warning signs that indicate suicidal thinking and/or acute risk for suicidal behavior. Warning signs include suicidal communications (“It’s not worth it anymore,” “You’d be better off without me,” “Nobody cares anyway,” “I might as well kill myself,” “I’d be better off dead,” “I might as well be dead”), seeking access to methods of suicide (for example, hoarding pills, moving a gun that has been in storage), and any actions that suggest getting prepared for suicide (for example, giving away possessions, making arrangements in case of death). Warning signs also include changes that suggest a turn for the worse, for example indications that an individual is feeling trapped or hopeless, behaving recklessly, becoming withdrawn, or experiencing dramatic swings of mood. See pp. 11–12 for a fuller discussion of warning signs. Acute stressful life events may trigger risk for suicidal behavior, like relapsing, breaking up with a partner, losing a job, or being the victim of trauma. Additionally, as discussed below, it is important to help family members be cognizant of warning signs and help them plan how to take action if they notice warning signs.

WALTER: I can't tell you how relieved I am that she's here right now. I sleep good at night knowing she's in this place. Worries me sick what will happen after she leaves. You were saying, there is someplace she can go?

COUNSELOR: We would like her to get into supportive residential housing, but we think first she might do better in a more structured halfway house environment until she is well stabilized with her abstinence and her

mental illness. At the moment it's not a guarantee, although the sooner Angela is referred, the better, in terms of any wait.

WALTER: She's got a bed in this place?

COUNSELOR: Not at the moment, no. Getting that process started immediately is important, and for that we'll need Angela to agree to it. We want to be sure that Angela gets enough care. With too little support, her odds of maintaining the gains she started here drop.

Maybe we can call Angela in now and the three of us can meet.

WALTER: Sounds good to me.

[Angela joins Lupe and Walter.]

COUNSELOR: Hi, Angela. Thanks for giving permission for Walter to talk with me today and to join us now.

ANGELA: Hi, Lupe. Hey, hi Walt!

COUNSELOR: How are you doing?

ANGELA: I'm doing fine.

WALTER: Yeah, well you best get yourself fine. I mean how many times have we done this? You get so-called fine, you get cleaned up and then you use drugs, then you show up at our door. We take care of you, and now this lady is telling me you're suicidal.

ANGELA: This is different. I'm really fine this time. I'm gonna be okay.

WALTER: Angela, you know that Carla and I love you. Our kids love you. We wouldn't have you in our lives if we didn't care about you, and we don't want to see anything happen to you. But this suicide thing is scary. I know you're an addict. You've been an addict forever. But, suicide? Angie, when I found you I thought you were dead. Your breathing was so shallow I thought you stopped breathing altogether, I thought you were gone. I was really scared.

ANGELA: This is different. I'm fine this time. I'm gonna be fine.

WALTER: Yeah. Tell it to Carla.



Master Clinician Note: Lupe recognizes that there is family anger as well as little understanding of Angela and her illnesses. She also recognizes that this may be the first chance Walter has had to express this frustration. Rather than focus on his anger, which would likely just make him more defensive, Lupe decides to focus on his concerns and caring for Angela. She also recognizes, however, that if Walter's anger becomes an impediment to his being involved in treatment, it will need to be addressed. Encouraging family involvement in Angela's treatment may be very beneficial for both Angela and her family and will likely enhance treatment efficacy as well.

COUNSELOR: Walter, suicide is an important risk for Angela—and something we need to stay focused on, along with her abstinence and her mental illness. I know that you love your sister and she loves you. I think Angela has been working on helping herself and she's willing to continue working toward that goal. And I know you have some realistic concerns about her relapsing that need to be addressed.

ANGELA: I'm not gonna relapse.

COUNSELOR: Angela, I don't think anybody plans on relapsing. But it happens when people in early recovery aren't paying attention to the things that help them stay clean and sober. One of your goals here is to develop a personal recovery plan that identifies your triggers and looks at the opportunities and resources you have to address those triggers.



How to Incorporate Suicide Prevention in Relapse Planning

Clients who relapse with alcohol or drugs and active mental illness are at significant risk for suicidal thoughts and behaviors. As a result, planning for coping with suicidal thoughts and behaviors needs to be part of a relapse plan (see the planned TIP, *Relapse Prevention and Recovery Promotion* [CSAT, in development f]). Some possible elements of the plan are:

1. Develop a plan for safety in the event of relapse in individuals who you have reason to believe will be at risk for suicide upon relapse (e.g., call your counselor, come to the clinic to see your counselor, call the National Suicide Prevention Lifeline at 1-800-273-TALK, go to the emergency department of your nearest hospital).
 2. Be aware of and address client speech that projects a suicidal result from relapse (e.g., challenge statements such as “if I use, I’ll kill myself,” “if I relapse, I’ll use ’til I die,” or “if I relapse, that will be the end for me”).
 3. Use mental health interventions to aid in relapse prevention (e.g., psychopharmacology, individual psychotherapy).
 4. Encourage the client to be actively involved (including a sponsor) in a 12-Step or other supportive program.
-

ANGELA: But I can come home later, right Walter? 'Cause I'm fine.

WALTER: I think we should do what Lupe says. I mean no treatment program has ever talked with us like this. She's taken the time to talk with us, to work with us. It sounds like they went through a lot of trouble to make a plan for you and you have a really bad addiction. I mean you've had problems and been an addict since you were 17. You need more than just coming into this hospital. You gotta go to this program like she's talking about, live there, stay sober. We can talk about you coming home later, but you have to keep going to your program. You gotta start listening to these people.

ANGELA: But I'm fine, I'm fine.

WALTER: Yeah. Okay.

COUNSELOR: I know you believe you're fine right now Angela. Our goal, all three of us, you, me, and Walter, is to help you stay fine.

[Lupe outlines for Angela the housing plan that she and Walter discussed.]

LUPE: I just want to see if there were any questions that either of you might have at this point.

WALTER: I want to say I love Angela. We wouldn't have her in our lives if we didn't care about her, and we don't want to see anything happen to her. She's been an addict forever. I'm used to that, but the suicide thing frightens me.



Master Clinician Note: A concern for providers and families is that suicide risk is high after discharge for clients with a history of a previous suicide attempt and/or other significant risk factors. Families can do a number of things. They should remain watchful for warning signs. Before the patient leaves the hospital, family members should have a specific plan for whom to call and/or what to do in the event of acute warning signs (e.g., call the National Suicide Prevention Lifeline at 1-800-273-TALK, bring the individual to the psychiatric emergency department, call the clinic where the patient is being referred). Family members should not presume that, simply because a family member was just in the hospital, they are protected from suicidal behavior.

Other helpful actions are restricting access to firearms and exercising some control over the supply of medications (e.g., giving a week's supply at a time to the client and holding onto the rest, to prevent overdose). Families are also advised to be involved in inpatient and outpatient treatment of their relatives. Some common responses of family members when someone has thought about or attempted suicide include:

- Feeling angry toward the suicidal person.
- Feeling guilty.
- Wanting to punish the suicidal person.
- Hovering over the person to ensure that they don't attempt again.
- Frequently interrogating the suicidal person about their thinking.
- Emotionally withdrawing from the suicidal person.

All of these reactions can be counterproductive. Family counseling for family members and significant others can be of benefit to both the family and the client.

COUNSELOR: Well, Angela is aware that she has a number of risk factors for suicide, including her bipolar illness. She acknowledges that just a few weeks ago she took a bunch of pills in an effort to kill herself. So, it is definitely something we need to be concerned about. And Walter, let's talk for a minute about what you might notice that could mean Angela is having suicidal thoughts.

WALTER: Well, like I said, I feel bad now that Carla and I didn't pick up on her talk about maybe not being around much longer and us "being sorry when she's gone."

COUNSELOR: Well, listening for those kinds of messages is important. I think another thing is just being aware that there are times when Angela is more likely to be at high risk than other times. For instance, when she is using or when her mood is not well regulated, when she is not taking her medication, when she is avoiding treatment, and when she is depressed.

WALTER: Well, you're right. When Angie isn't too high or low and when she is clean she is okay to be around. She's good with our kids and takes care of herself.

COUNSELOR: Angela, I'm interested to hear what you have to say about this.

ANGELA: Well, I've said, I ain't gonna use, and I ain't gonna try to kill myself. Those days are over.

WALTER: Yes, yes, that's what you always say Angela.

[Pause while Angela looks away, frustrated.]



Master Clinician Note: It is common for tension to exist between clients and family or significant others over the risk of relapse and recurrence of suicidal thoughts and behaviors. While clients may deny or minimize risk, those close to them often experience distrust and anxiety (especially with a past pattern of relapse and recurrence). The counselor can address and normalize this experience and then reorient both parties back to the need for developing plans to support recovery and safety.

COUNSELOR: It's understandable that there is some tension between you about the future. This commonly occurs where the recovering person—Angela—tries to convince her family that she will be fine. What's important is to have plans in place to support recovery and safety. It is not only helpful to you, Angela, but also helpful to your family. So let's review the plan, Walter.

WALTER: So, we should watch for when we think she's depressed or sad or hopeless or if she says she wants to kill herself. And if it sounds like she's gonna be strung out, withdrawn, or out of touch with treatment. Those kinds of things, Right?

COUNSELOR: Right. And one other thing, Walter. What will you do if you see those signs?

WALTER: Well, I'll call her on it, and I'll telephone you.

COUNSELOR: I'd be happy to hear from you in those circumstances, although my primary job is treating patients like Angela when they are here on the floor and so, after discharge, there will be other counselors working more closely with Angela on an ongoing basis. So it will be important to have their contact information and to get in touch with them.

ANGELA: How long are you expecting me to stay in this residential place?

Resources for Family Members and Friends

The National Suicide Prevention Lifeline has published a booklet, *After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department*, with a Spanish version, *Después de un Intento de Suicidio*. These can be downloaded from <https://store.samhsa.gov/shin/content/SMA08-4357/SMA08-4357.pdf> and <http://store.samhsa.gov/product/Despu-s-de-un-intento-de-suicidio-Gu-a-para-cuidar-a-su-familiar-despu-s-del-tratamiento-en-la-sala-de-emergencias/SMA08-4358>, respectively. Additionally the American Association of Suicidology publishes a newsletter, *Surviving Suicide*, written by survivors for survivors. Click on the Survivors page at <http://www.suicidology.org>.

Several excellent sources of information are available for those whose family member or friend has died by suicide:

- Suicide Prevention Resource Center (<http://www.sprc.org>). In the customized information menu, select "survivors."
- The National Organization for People of Color Against Suicide (<http://www.nopcas.com/>) has valuable information that can be accessed via it's website.
- American Foundation for Suicide Prevention (<http://www.afsp.org>). Click on the menu option "Surviving Suicide Loss."
- The American Association of Suicidology (<http://www.suicidology.org>) has a variety of print resources, including information about support groups.

COUNSELOR: Well, Angela, let's focus on getting in before we start planning on getting out. I'd like you to sign this release so I can start the process for you to go to a halfway house when you leave our program. Then, when you've had a chance to continue day treatment here on an outpatient basis and you are doing well, we can work on arranging a transition to a place where you can have your own apartment.

ANGELA: Okay, go ahead. I'll sign one more of those papers you're always having me sign.

COUNSELOR: Great, that sounds like a plan. I'll go get a consent form. One other thing we can do is schedule the next meeting with the three of us. Would that be okay with you Walter?

WALTER: Yes, I'm agreeable. Like I said before, nobody asked me to be part of Angie's treatment before. This is the first time I ever felt like I knew what was going on and had information about what I can do to help.

COUNSELOR: Okay, let's set something up. How would the end of the week be for you?

[The session ends with Angela signing a release and a followup session being scheduled.]

Followup at 6 Months

Angela completed the inpatient treatment program and was referred to a local halfway house. After 2 months, she was accepted to a supervised living facility. She attended an additional month of day hospital treatment following her discharge and has remained clean and sober for a longer period than any time in her adult life (7 months counting her month-long hospitalization). While in the halfway house, she continued attending a Double Trouble support group for people with co-occurring substance use and mental disorders. She has continued in weekly outpatient counseling, where the focus remains on strengthening her commitment to abstinence, monitoring her psychiatric symptoms, and strengthening her relationships with others. She and other people in the Double Trouble group often eat at a local restaurant after meetings, and Angela expressed much satisfaction at having girlfriends in her life for the first time since she was a teenager. She had one hypomanic episode lasting about 2 weeks shortly after completing her day hospital program. This coincided with her admission to the supervised residential living facility. Her counselor worked with her residential supervisor and with Walter to continue their observation of her behavior, and her medication was readjusted. The hypomanic episode gave staff and Angela a chance to practice the relapse prevention strategies that had been developed during her inpatient stay. The staff concur with Angela's report that she has not experienced suicidal thoughts or behaviors. Angela, Walter, and her outpatient counselor have met on a monthly basis to be sure that communication has been maintained between Angela and her family, and Angela occasionally visits Walter and his family on weekends and some holidays. She feels accepted in the residential setting and has begun to see that as her home.

Vignette 3—Leon

Overview

Leon, age 24, is an African American veteran of the Iraq War who is currently a college sophomore. He delivers pizza in the evenings. He has exhibited symptoms of posttraumatic stress disorder (PTSD) such as flashbacks, startle reactions, general apprehension, and intrusive images. He also shows symptoms of depression (sadness, sleep disturbance) since he returned from Iraq. He was discharged from the military when his 4 years were up, but the symptoms persisted. About a year ago he went to a Veterans Affairs (VA) clinic and received prescriptions for depression and sleep disturbance along with instructions to follow through with mental health counseling. He was in counseling with a psychologist and took the prescribed medication for about 6 months, at which point he discontinued treatment because he was feeling better.

Substance Abuse History

Leon's drinking rapidly escalated after he started college last year, and his alcohol abuse continues. He drinks a fifth, sometimes two fifths, of vodka a week. Mostly he drinks after he gets off work around 11 p.m. and finds that "a couple" of drinks help him get to sleep around 2 a.m. Then he sleeps until around 7 a.m. When he doesn't sleep he gets restless, irritable, and startles easily.

Last night he had his usual two or three drinks of straight vodka in his dorm room after he got off work. He was found in a stuporous state the next morning around 9 a.m. and was rushed by ambulance to the local hospital. They kept him for several hours at the emergency department (ED), determined that he had not been drinking enough to warrant a detoxification admission, and eventually released him after he provided assurances that he would participate in alcohol counseling at the college alcohol and drug program. The ED staff made an appointment for him at the college alcohol and drug program this afternoon.

Suicide-Related History

Leon denied any suicidal thoughts or behaviors when questioned in the ED. The ED personnel ordered a urine toxicology to assess for any drugs that may have contributed to his stuporous state prior to arrival, but when he quickly became alert and responsive, they released him before obtaining the results of his urine tests. They also mentioned ruling out suicidal ideation in their referral to the college counseling center. The emergency room personnel were not aware that Leon had been treated for depression at a VA facility last year.

Learning Goals

1. To highlight the correlation between high alcohol and other drug consumption and suicidal behavior.
2. To explore how psychological trauma, depression, and substance abuse create a high-risk psychological environment for suicidal thoughts and behaviors.
3. To illustrate how an individual might minimize or disguise suicidality in an initial interview.
4. To illustrate how suicidal thoughts and behaviors can manifest among members of ethnic and racial minorities that historically have been thought to be at low risk for suicide.
5. To demonstrate how to obtain a consult with a supervisor for a client in the office who has a recent suicide attempt.
6. To emphasize the role of followup after referral of a client with suicidal thoughts and behaviors

[Leon arrives on time for his appointment at the college counseling center and is met by his counselor, James. Leon presents for the session looking somewhat bedraggled and hung over. He is withdrawn, not very communicative, and does not make much eye contact. The counselor is aware of his referral from the ED and the nature of his treatment in the ED, although he is not clear about the circumstances that led to his evaluation.]

With this in mind, James decides to take some time to build a connection with Leon. They talk in rather general terms about what brought Leon to the clinic, and Leon begins, without much prompting, to describe his drinking patterns and life at college. Leon also mentions that he is an Iraq War veteran, having served 4 years in the Army after leaving high school. James does not pursue information about Leon's military experience, but rather lets Leon provide the information he is willing to give voluntarily.

Leon then describes what he remembers of the last 24 hours. Apparently he was blacked out part of the time but remembers being in his room last night and being in the ambulance on the way to the hospital.]

COUNSELOR: Leon, let me see if I can summarize some of what you've been telling me. You think you've been drinking too much recently, mostly vodka, and you've had some blackouts. And these have been a concern to you. From your description, it seems your drinking has increased lately.

LEON: Yeah. In fact, I didn't drink the whole year I was in Iraq, 14 months actually.

COUNSELOR: Anything you can think of that caused this increase in drinking?

LEON: Not really. I feel a lot of pressure, feel bad, worried. Then I drink. Actually, I drink pretty much every night. I sometimes drink more than I really want to. It helps me sleep.

COUNSELOR: And it sounds like you mostly drink alone.

LEON: Yeah.

[Long pause while the counselor waits to see if Leon wants to say more.]

COUNSELOR: Lots of pressure.

LEON: Yeah.

COUNSELOR: Can you tell me some more about the pressure?

LEON: Well, I don't have much time for anything but work and school. Work is #*%! I drive around in the dark looking for addresses to deliver pizza. It's cold. One #*%! last week gave me a 50 cent tip. That didn't even pay for the gas. Also, I only get to study a little bit at work.

COUNSELOR: Other pressures?

[Long pause.]

LEON: When I'm alone, I get to thinking

[Pause, counselor doesn't want to interrupt.]

LEON: About stuff in Iraq. I've had #*%!ing incoming mortar land on the building next to where I was sleeping. Two guys were killed. Then the return fire starts. And you wonder where the next incoming is going to land. Plus some other stuff. Sometimes when I finally get home from work and lay down to go to sleep, I think about that stuff.

[The counselor proceeds to inquire about trauma-related symptoms, and Leon reveals a series of symptoms that suggest PTSD. He also tells the counselor about going to the VA Mental Hygiene clinic, the prescription he was given, and his participation in treatment with Dr. Rogers, a VA psychologist, for about 6 months after entering the VA program. Leon also mentions that he attended Alcoholics Anonymous (AA) on and off while in the VA program and had a sponsor at one time.]



Master Clinician Note: Some of Leon's risk factors for suicide include a history of substance abuse, PTSD-related symptoms, depression, and isolation. These symptoms, together with his ED admission, cause the counselor to wonder about suicidal thoughts or behaviors. Because of the combination of the client's age and race, he is also at increased risk of suicide.

COUNSELOR: Leon, I'm wondering if Iraq and the symptoms you just shared with me have anything to do with the increase in your drinking in the last year.

LEON: I drink to go to sleep and not remember that stuff.

[Another long pause.]

COUNSELOR: Leon, I imagine that sometimes you just wish there were a way to escape all of this stuff . . . the pressure of school and work, the memories, the drinking. . . .

LEON: Yeah.

[Another long pause.]

LEON: I think I may have had four or five pills last night too. I don't remember taking them, but the bottle was empty when I went back to my room after leaving the emergency room and before coming over here today.

COUNSELOR: Pills?

LEON: Sleeping pills. I don't know how many were there, but there were only a few left, maybe four or five at the most. I got them from VA when I went there last year. I don't remember taking them last night, but the bottle was empty this afternoon.

[Another long pause.]

LEON: I think I just wanted to go to sleep. I guess. Maybe that's why I couldn't wake up this morning and why they took me to the emergency room. I didn't tell anybody about the pills.

COUNSELOR: Thanks for telling me.

LEON: I don't remember taking them.

COUNSELOR: Your guess is that you were taking them to fall asleep. Are there any other possibilities?

LEON: Like what do you mean?

COUNSELOR: Well, you've been having a rough time, so I guess I was wondering if it is possible that you were trying to hurt yourself or even kill yourself when you took the pills since you emptied the bottle.

LEON: Sorry, but I can't really go there.

[Long pause.]

COUNSELOR: Leon, I may be way off, but I get the sense that you want to confide in me, but you are having trouble making the decision to do that.

[Long pause.]

COUNSELOR: Please take your time. This is important.

[Another pause.]

LEON: Screw it, I told myself I wasn't going to say anything, but screw it, I'll talk about it. I tried to off myself last night. I figured pills were the way to go. If it worked, it would be chalked up as an accident. I just can't live like this anymore, you don't know how I feel everyday. Death would be a relief from this. It would have to be.

COUNSELOR: You're in a lot of pain.

LEON: Tell me about it. Yeah, I know, believe me, I've thought about how to do it. I've thought about pills mostly. I've had too much with guns. Sometimes I've thought about what it would have been like to be shot in Iraq. All the blood and stuff. I don't want that. Sometimes I look out a window and think I could jump. But I might just get crippled up. Same thing with stepping out in front of a bus on College Avenue. But, who knows, these are just random ideas. It's not like I think about it all the time. I don't have any clear ideas about how I'd take myself out, if it ever came to that. Anyway, I don't think I'm ever gonna kill myself, what with the effect on my mom and all.

COUNSELOR: Are you concerned you might act on those thoughts? Be unable to control them?

LEON: I'm not too concerned. I'm not going to kill myself. No offense man, but that's what white people do. Last night I was drunk and just made a mistake, I guess.



Master Clinician Note: High rates of suicide and nonfatal suicidal behavior among Black males, particularly among youth, are cause for grave concern. Depending on the age, the suicide rate among Black males ranges from two to seven times higher than among Black females (who are generally at low risk). Suicide is a form of self-destructive behavior that differs from other risk-taking behaviors (e.g., getting killed through drug use and street violence) that some young Black men, particularly those living in urban areas of concentrated poverty, are prone to. In the latter cases, the individual accepts the possibility that physical harm could result from his actions, rather than intending or expecting such an outcome as with suicide (Joe, 2003). Widespread disbelief that Black Americans would engage in suicidal behavior continues despite research documenting a rise in suicide among young Black males (Centers for Disease Control [CDC] 1998; Joe & Marcus, 2003) such that their rate is closer to the rate in young White males than in previous decades, although White males continue to have a somewhat higher rate (National Center for Injury Prevention and Control, 2007).

COUNSELOR: Unfortunately the reality is that Black people as well as White people die by suicide.

LEON: Well, it's probably better that the pills are gone.

COUNSELOR: I hear you. On that we can both agree.



Master Clinician Note: The counselor is organizing his thinking about assessment and treatment planning for Leon. His perception is that Leon is a relatively isolated student, with few social supports, who has PTSD symptoms and depressive symptoms, abuses alcohol, is having suicidal thoughts, and made a suicide attempt last night. His possible co-occurring disorders indicate that he needs more intensive treatment than can be addressed in an outpatient college substance abuse program. James decides to pause the session for now and have Leon briefly wait in the waiting room with another clinical staff member while he consults with his clinical supervisor. James knows that a potentially acutely suicidal client should never be left alone.

COUNSELOR: Leon, the way we usually work here is that, when I meet somebody for the first time and find out about why they came to the counseling center, I check in with my supervisor. The two of us talk and work out what we think would be the best plan for what the next steps should be. Would you mind sitting in the waiting area for a few minutes? I'll be back after I've had a chance to get some input. Okay with you?

LEON: Yeah, I guess.

[James briefly describes the situation to his supervisor and asks for help specifically with treatment planning and how to ensure Leon's safety. James feels that an integrated treatment plan must address Leon's suicidal thoughts and behaviors, his drinking, his PTSD and depressive symptoms, and his disconnection or isolation from friends and family. He suspects that there is a high probability that Leon will not follow through on outpatient referrals without intensive case management. The counselor is sensitive to Leon's sitting in the waiting room and purposefully keeps the consultation session brief.]

Decisions the counselor and supervisor reach are:

- 1. Further evaluation for suicidality is important, including consultation with the emergency department where Leon was seen this morning.*
- 2. Leon's potential for suicide is directly linked to his mental health symptoms and substance abuse, and both issues need to be addressed in treatment.*
- 3. Intensive substance abuse treatment and case management are important over the next few weeks until Leon has stabilized. This can best be accomplished in the local VA treatment facility.*
- 4. They need to make some plans to support Leon until he can make contact with VA and begin treatment.*
- 5. The counselor needs to continue to maintain contact with Leon to ensure that he accepts the referral and continues to participate in treatment.*
- 6. Efforts should be made to help Leon reconnect with the AA group he attended a few times last year.*

James returns to his session with Leon.]

COUNSELOR: Leon, I've talked with my supervisor, and we have some ideas that I hope you will agree to accept. In light of last night with the drinking and the pills, we would like to have you talk to someone. We're worried about the pills, and while I believe you when you say you aren't going to kill yourself, it is also important not to just ignore what happened. It is a signal of how much pain you're feeling and it requires that we take the depth of your struggle seriously and develop a plan that can realistically help you to begin to feel better. We can't help but think that your use of alcohol as well as the experiences that you had in Iraq contributed to your drinking and taking the pills last night, so it's important to get help for your drinking and your war-time experiences.

We think the best place to address all of this would be with Dr. Rogers, whom you saw at the VA hospital. They have programs to confront these issues that are really beyond the scope of our treatment programs here. You've been there before, so you know the place a bit, and it sounds as if you responded pretty well to the treatment. And I'm wondering if you agree with this.

LEON: I think you're overreacting to last night. Anyway, it's true I went to VA last year for 6 months or so and then quit going when I started feeling better. I didn't exactly like taking pills but I stuck with them. It wasn't too bad. I liked Dr. Rogers, he was cool.

COUNSELOR: Tell me more about what happened there.

LEON: Well, I started feeling better, so I stopped.

COUNSELOR: Okay, well, what I would like to see us do today is make a plan that really works for you. And I'm going to follow up with you too, to give you the support we can offer and to make sure you get the treatment you need.

LEON: All right, I'm listening.

COUNSELOR: Thanks, I appreciate that. Could I get your permission to call VA and make an appointment for you now? Then I want us to talk some about what you need to do to take care of yourself between now and when you get to VA.

LEON: Okay.

[The counselor has Leon sign the appropriate release of information form and makes the call to the VA intake worker. They arrange an expedited appointment for tomorrow morning. The counselor agrees to fax pertinent materials to the VA in advance of the appointment.]

COUNSELOR: Leon, let's talk some about what you can do to take care of yourself tonight before your appointment tomorrow.

LEON: Whaddya mean?

COUNSELOR: Well, for openers, is there anyone you know who could be a support to you tonight?

LEON: Is this really necessary? I've got an appointment tomorrow, after all, isn't this overkill?

COUNSELOR: I suppose I could see how this might seem like an overreaction but on the other hand, you were in the ED this morning, and took an overdose last night, and so it seems much better to land on the side of overresponding rather than underresponding. As well, I don't think of it as overresponding so much as simply trying to do the smart thing.

LEON: All right, I can see you are not going to drop it, so let me see who I can come up with. Nobody in school, that's for sure, they all drink like me. When I used to go to AA, there was a cool guy there, he was my sponsor for a little while, he would always say "call my cell anytime," and I did call a few times and he always answered. He'd take me to meetings. I even called his cell once the day after I was drinking, and he didn't yell at me or judge me, just listened patiently and then got me to a meeting, I was pretty amazed. Anyway, I can give him a call. He's a nice guy, graduated from school here a couple of years ago and lives just off campus still.

COUNSELOR: Now that sounds like a "smart thing." I really appreciate your coming up with that. Since you bring up AA, that might be a solid way to get a little support tonight, or at least keep you from being isolated. Is there a meeting scheduled tonight?

LEON: Yeah, there's one just off campus, it meets every weeknight at 8:00, pretty popular meeting, always a bunch of people there. I used to walk there once or twice a week, that's where I met my sponsor.

COUNSELOR: That's pretty solid, the meeting will be there for you whether or not your sponsor is around, and from what you've said he'd more than likely be willing to talk with you, or perhaps even meet you at the meeting, assuming you can reach him at that number.

LEON: Yeah, he was always gung ho, I wouldn't be surprised. Anyway, I can hit the meeting. I've got nothing better to do tonight. I'm not up for studying, I'll tell you that much, and don't want to mess with any of those guys in the dorm, they act like kids.

COUNSELOR: That's great Leon. I'd like to stay with this safety planning a bit longer. Okay with you?

LEON: We're cool.

COUNSELOR: You said you took all the sleeping pills. You don't have any more. Is that right?

LEON: Yes, that's right.

COUNSELOR: No tranquilizers, no antidepressants, no sleeping pills, no booze. No other prescription drugs in your dorm room, right?

LEON: Yes, roger that. You must've won the "hero counselor award" or something.

COUNSELOR: No, I've won no such award, and hero definitely doesn't come to mind. I am just trying to be thorough. And so thanks for hanging in there while I try to dot all the i's and cross all the t's. Along those lines, I'd also like to provide you information about who you might call if you have a difficult time tonight, for example if you become depressed or start thinking about suicide again. I want you to have my number, the number of a national suicide hotline, and the number of the emergency services program here at the college.

LEON: That's not gonna happen.

COUNSELOR: I believe you, and I hope you're right. I think your plan to go to a meeting tonight, and to contact your old sponsor is fantastic. This is just one last, added safety measure. Here is my card. On the back of it I'll write the number that you can call if you have an emergency during nonbusiness hours. Also, I'll write the number of the national suicide prevention hotline and the emergency services number. These numbers were set up specifically for people who are going through a lot—people like yourself—so there is no shame if you're in a bad way and need someone to speak with to help you through it.

LEON: Okay, got it. All right, this is helpful. I never knew about these numbers.

COUNSELOR: Do you have transportation to VA tomorrow?

LEON: I have my car.

COUNSELOR: Okay, just to confirm. Tomorrow morning, you'll have your VA appointment at 9:30 a.m. with Dr. Rogers. You are going to call your sponsor and make a meeting tonight. If you find yourself getting overwhelmed, thinking about drinking or thinking about suicide, you'll call our emergency number or the 800 hotline on the card you have.

LEON: Okay.



How to Develop a Campus Suicide Prevention Team

On most campuses, mental health resources are limited, yet after recent highly publicized incidents of campus violence, anxiety about students with mental health problems is high. Campus suicide prevention teams ultimately can assist and support limited mental health professionals. To develop a campus suicide prevention team:

- Identify campus professionals who have responsibility for students at risk. Most often they are deans of students; health, counseling and substance abuse services; residence life; judicial affairs; police; and emergency medical technicians.
 - Identify a variety of situations and what the issues are: confidentiality concerns, legal issues, voluntary and involuntary situations, campus and community resources, evening and weekend professional mental health support, gaps in services, and procedures for managing alcohol intoxication and drug overdoses.
 - Develop a smaller group to meet weekly to discuss at-risk students and coordinate mental health, academic, and environmental risks.
 - Create policies and procedures to support both voluntary and involuntary medical leave processes for at-risk students. Most often, voluntary procedures are used; however, involuntary procedures are sometimes necessary and often require legal counsel to develop.
-

COUNSELOR: Just to let you know, I'm going to follow up with the VA tomorrow afternoon to make sure you made it there and to see how things went.

LEON: Yeah, I figured. Don't worry, I'll keep the appointment, I can't keep living like this, I hope they can do something for me, some meds again or counseling or something.

COUNSELOR: They have several types of treatments available, and they've tailored their services to returning vets like you. So I think they'll be able to help you out. I certainly think that you deserve to feel better than you have been lately.

Followup

Leon left the session feeling understood and supported. He had clear plans for the next steps he needs to take and was mobilized to take these steps. The counselor confirmed that Leon kept his appointment at the VA and had been enrolled in a substance abuse and co-occurring disorders program for returning vets. He was able to arrange his treatment schedule in a way that only required dropping one class and was able to continue his job. He has restarted his antidepressant medication, and treatment staff at the VA are continuing to monitor suicide warning signs and risk factors. The counselor in this vignette was careful to document his screening for

substance abuse and suicidality, the consultation with his clinical supervisor regarding referral, the referral that was made, and the followup on the referral to the VA.

Vignette 4—Rob

Overview

This case illustrates gathering information from a client who alludes to suicide. The counselor must discern how to proceed with Rob and also address the impact Rob has had on the counseling group where he made indirect references to suicide. The counselor must sift through what she knows to understand Rob's risk factors, warning signs, and protective factors for suicidal behavior. The vignette also raises issues of treatment transition in early recovery and addressing ambivalence.

Substance Abuse History

Rob is a 39-year-old Caucasian accountant. He is gay and is in a conflicted, long-term relationship. He is nearing completion of an intensive outpatient treatment (IOT) program. During his twenties he used a variety of psychoactive substances, but his drug of choice was marijuana, sometimes laced with PCP. In his thirties, he began to drink heavily and has done so for 6 years now. This is his first treatment effort, and he entered treatment as a result of a crisis in his relationship. Also, he has been missing work as a result of his alcohol use and the volatility of the relationship. He went to his Employee Assistance Program (EAP) at work, and EAP personnel identified Rob's substance abuse and referred him to an IOT.

Suicide-Related History

At the end of group last night, Rob made a reference to suicide: "I might be better off dead." Until then, no significant warning signs of suicidality had been noted with Rob. The group, however, immediately picked up on his comment and began to question him about suicidal thoughts, which he denied. His counselor, Joyce, believed it was important to follow up with Rob after group. Joyce also recognized the importance of addressing the group's anxiety and concern about Rob. Long-term risk factors for Rob include depression, a troubled partner relationship, work-related problems, and minority sexual orientation. In addition, he is at a treatment transition point that may create vulnerability. Protective factors include a generally solid work history and remaining abstinent through the treatment program thus far.

Learning Objectives

1. To illustrate how subtle signs of suicidality can manifest in an intensive treatment environment.
2. To demonstrate a therapeutic response to subtle signs of suicidality.
3. To illustrate the significance of understanding risk factors, warning signs, and protective factors during the course of treatment.
4. To illustrate the effect that a client's statements regarding suicide can have on other clients in the treatment program.

[The vignette begins with Joyce's meeting with Rob for an individual counseling session immediately after the group during which he alluded to suicide.]

COUNSELOR: Rob, the reason I asked to speak with you after group is that you made a comment right at the end that you might be better off dead. I have some concern about that. Can you talk a little more about what was going on with you?

ROB: I'm just #*%! . Nothing is going well. Sometimes I think I'd be better off dead. I think it would be better for my parents, for my boyfriend, maybe it would just be better for you. I don't feel like I belong. I don't feel

good at all. I thought recovery was supposed to make me better, supposed to fix things, and now I don't feel fixed.

COUNSELOR: You've worked really hard on your recovery, but I'm hearing you say that the struggle, especially with relationships, is so painful that you might do anything to escape it, even use again. Before we go any further though, Rob, I just want to check something out with you. Are you using at all?



Master Clinician Note: Clients who have relapsed to substance use are particularly susceptible to suicidal thinking and, potentially, to suicidal behavior.

ROB: I'm clean, Joyce. I told you that. I told the group that. I'll pee in the cup if you want.

COUNSELOR: Okay, good. I believe you, just wanted to be sure. Providing a urine sample isn't necessary today. At this point, I'd like to focus on your comment in group. I want to hear more from you about your thoughts of killing yourself.

ROB: I haven't given it much thought, really. I'm just frustrated, and things don't seem to be working out like they are supposed to. I just said that in group.

COUNSELOR: It sounds like you'd like to stop how you're feeling. As we talked about in group a few days ago, early recovery can be a real struggle, two steps forward and one step back. And sometimes things don't get better immediately. In fact, sometimes things feel worse when you begin to make changes.



Master Clinician Note: Early in her interview with Rob, Joyce needs to clarify whether Rob is minimizing his suicidality or if he really just made an impulsive statement in group to express his frustration. She wants to establish whether or not managing active suicidality will be the focus of her meeting, or if the focus will be on the provocative nature of his speech and its impact on the group. Therefore, Joyce first prioritizes gathering information about suicidality, and once she is satisfied that there is little data to indicate current risk, she switches the focus to his impact on the group.

Joyce's counseling style is more direct, perhaps even more confrontational, than other counselors depicted in these vignettes. This style illustrates the spectrum of counseling approaches in real world practice. But note that Joyce is still careful to avoid grilling or accusing Rob, which could make him defensive.

ROB: I'd like to stop feeling bad. Recovery isn't what I'd thought it'd be. I thought I'd feel better about myself. I'm not comfortable.

COUNSELOR: And I hear that. And I also know this is hard to talk about. But I want to ask again if you are thinking about killing yourself.

ROB: I don't need that. I don't need that stress. I'm not going to do anything like that today. I'm just stressed out.

COUNSELOR: Okay, not today. But that leaves tomorrow and the next day and next month open.

ROB: No, I'm not really thinking about killing myself, if that is what you want to hear.

COUNSELOR: Rob, it isn't about what I want to hear. It's about what you are contemplating doing.

ROB: Okay, okay. I'm not thinking about killing myself. I just need some relief from this pressure. And I know it would be the end of my relationship with Sammy if I drink again.

COUNSELOR: So what I'm hearing you say is that you have been feeling upset but you haven't been having thoughts of suicide. Is that an accurate summary, or do I have that wrong in some way?

ROB: That sums it up pretty well.

COUNSELOR: I'm glad I understand where you're coming from. I'd like to ask just a couple of more questions along these lines. One question is whether you've ever attempted suicide?

ROB: No, never. I'm scared of pain; that's not my thing.

COUNSELOR: What plans have you made about killing yourself?

ROB: None, I've never gotten that far, I don't know what I'd do if I ever seriously thought about it.

COUNSELOR: Okay, thank you for providing the answers to my questions about your safety. I wonder if we could shift gears now and discuss the group a bit, their concerns about what you said in group tonight and how you might approach this when you go back tomorrow night.

ROB: After they all jumped on me tonight, I'm not sure I want to go back.

COUNSELOR: Part of treatment is learning how to face this kind of situation: how to handle yourself in difficult circumstances and be sober at the same time. You've done a good job in treatment, Rob, and you are almost finished with your IOT program.

ROB: I feel like you're dumping me. I don't understand. What is this place? You bring us in. You help us. You take care of us. You just have some arbitrary deadline when we're supposed to be better. And then you just throw us to the wolves.



Master Clinician Note: Joyce recognizes that Rob is diverting attention from discussing how he will handle himself in group, but also is expressing his concern about the upcoming treatment transition. She wants to acknowledge his concerns and still keep the focus on how Rob will react in the group tomorrow.

COUNSELOR: If you could write your treatment plan right now, if you could spell out your group experience, what would you say would be most useful for you in bettering your group sessions?

ROB: I don't know. I like the one-on-one. I sorta put up with the group. Meeting with you . . . I like the one-on-ones.

COUNSELOR: Right now, how about if we look at continuing our individual sessions twice a month for the next few months. However, there's something that definitely needs to be addressed. I'm going to insist that in order to stay in the one-on-ones you're going to need some of the group experience too. Did you notice how the group reacted when you said you might kill yourself?

ROB: Did I notice!

COUNSELOR: Greg said you had a lot to live for. Allison asked "does that mean you're going to kill yourself?" Bill said something about making sure you got home okay tonight. The group members are really concerned about you. And I don't think we can just sweep that under the rug now.

ROB: I'm not sure I even heard. I was in my own head.

COUNSELOR: Listening now to what they said, what do you think of their reaction?

ROB: Are you saying I shouldn't say how I feel?

COUNSELOR: No, not at all. Actually, that is part of what I'd like you to work on, to express how you feel. My sense is that your statements about being "better off dead" and related comments weren't really statements of how you feel; you were using them more like slang expressions to indicate your general frustration and anxiety. As a result, with those provocative comments, you threw the group off track from the real issues, including fear of transitioning out of the group and frustration in your relationship. What I would like to help you do is to express more directly your issues and feelings to the group. In that way they won't be going down the wrong path, focusing on your safety, when they could be helping you sort through these difficulties.

ROB: I didn't mean to make people nervous. I was just upset and said something impulsively. Are you saying I did the wrong thing in group?

COUNSELOR: No, I'm not. People were naturally distressed. Because you are part of the group, it has to be talked about that way. It's not about your doing something bad or wrong. It occurs to me that your statement tonight about being better off dead may indicate that we need to think through your transition plan a bit more carefully. Maybe part of this is that you do need to be in primary treatment a bit longer and that we need to look carefully at how the transition occurs.

ROB: One thing's for sure, I'm not looking forward to going back into the group. Are you going to support me?

COUNSELOR: Sure, I'll support you. If it's all right with you, at some point in the group I'll let them know that you want to talk a little bit about what happened in the last group, and straighten them out about what's really going on. However, I won't do that right away, I want to give you the chance to raise the issue on your own first.

ROB Yeah, I can do that.

COUNSELOR: Well that's our plan. Tomorrow, you'll come into group and give the group an opportunity to discuss some of their issues. Also, let me talk with the team about your transition plan to make sure that we are covering all of the bases and going at the right pace.

ROB: Okay, cool.

Followup

Rob returned to the next group meeting and, with Joyce's support, addressed his suicide reference in the earlier session. He was able to hear the concerns of the other group members, and a good discussion among group members ensued with several other members briefly sharing prior experiences with suicidal thoughts.

Joyce met with her supervisor and together they decided to adapt Rob's treatment plan to include an extension of treatment with twice-monthly individual sessions for an additional 2 months. Joyce will continue to monitor Rob for warning signs. She will also work to strengthen protective factors such as maintaining abstinence, treatment attendance, and maintaining his employment. She will discuss the possibility that he attend a support group or get involved with another community resource as a kind of safety net that will always be there for him. In a later discussion with Rob, it was decided that couples' counseling might be useful after he has 3 months of stable sobriety. Joyce ensured that both Rob and his partner had information on contact resources if suicidal ideation should recur in the future.

Joyce documented the session with Rob including the information gathered, the distinction between frustration and suicidal ideation as he expressed it, and the re-evaluation of transition plans.

Vignette 5—Vince

Overview

Vince is a 52-year-old Caucasian mill worker with a history of substance abuse, aggression, and relational difficulties. This is his third effort at substance abuse treatment. He volunteered for intensive outpatient treatment three evenings per week after an altercation with his wife that culminated in his physically assaulting her. During his second week of treatment, while at work at the mill, he was served an order of protection, mandating that he not have contact with his wife and that he not enter their home.

He came to the treatment program this evening agitated, angry, and believing he had been victimized. His counselor, Kara, attempted to help Vince work to resolve the crisis, but he deflected the issue and became more agitated. Vince mentioned that he might as well be dead, so Kara began to question him about suicide risk. Vince defiantly described how he would kill himself with his handgun. Kara was unsure whether Vince was making a plea for attention or was actively suicidal and realized she was not in a position to make that decision. The counselor must explain to Vince the need for a psychiatric evaluation for suicidality in the emergency room of the local hospital.

A Note on Homicide/Suicide

Break-up by a partner or a threat to a partner relationship is a common precipitant of suicide among vulnerable males with substance use disorders (Duberstein Conwell, & Caine, 1993; Heikkinen et al., 1994; Murphy, Armstrong, Hermele, Fischer, & Clendenin, 1979). Often, this scenario follows a pattern of intimate partner violence (Conner, Duberstein, & Conwell, 2000). Men who abuse alcohol and/or drugs and are confronted with a break-up or threat to their relationship, particularly those showing a pattern of jealousy, domestic violence, legal difficulties, or prior suicidal behavior, may also be prone to committing homicide followed by suicide (Bossarte, Simon, & Barker, 2006; Marzuk, Tardiff, & Hirsch, 1992). Indeed, the risk factors (male, substance dependence, violence history), precipitating event (relationship break-up), and warning signs (suicidal communication, ideation, feeling trapped, hopelessness, anger, recklessness, mood change) observed in Vince's case could set the stage for him to take his own life or, even more tragically, to murder his estranged wife before his suicide. Consequently, his case is doubly concerning.

Substance Abuse History

Vince has a history of substance abuse dating back to his teenage years. His academic performance in school indicates that he may have had an undiagnosed learning disability and relationship difficulties with other students and with authority figures. He joined the U.S. Navy and was medically discharged after 6 months for "emotional problems" and misconduct while drinking. He went to work for a local paper mill and, while occasionally in trouble for attendance problems, has worked there for 26 years. He has worked his way up to a forklift driver. He married Jolene when he was 32. They have no children together, although Jolene has two children from a previous marriage who live on their own. Vince's drinking has been a problem in the relationship since before they married, but, until now, they have not been legally separated. Vince's two other treatment efforts were precipitated by marital crises. As a result of the recent physical abuse, Jolene insisted that Vince get treatment again and move out of the house. He moved into a garage apartment belonging to his brother-in-law.

Vince has never sustained abstinence. After both treatment episodes, he was drinking beer again within a month. He has occasionally attended AA as an extension of treatment, but has shown little interest in continuing attendance when active treatment ends. His typical drinking pattern is to drink three to four beers each weekday after work and two six packs or more a day on the weekends. He rarely appears intoxicated but almost always, except when working, is under the influence of alcohol. He makes sure he doesn't have alcohol in his system while at work because forklift drivers at the plant are randomly screened for alcohol and illegal

drugs, and a positive screen is grounds for immediate dismissal. The most significant of his alcohol-related problems come when he “breaks out,” drinking bourbon or vodka until he passes out. During these episodes, he becomes verbally and physically abusive. On several occasions, he has ended up in jail on drunk and disorderly or assault charges. These occasions have extended as long as a week. He takes sick leave from work, and Jolene stays at her brother’s house until he gets too sick to continue drinking.

Suicide-Related History

Vince’s warning signs were triggered by receipt of the protective order. They include his spontaneous suicide communication “I might as well be dead,” a lethal plan (handgun), anger and agitation, and feeling trapped by and hopeless about his marital situation. Vince’s long-standing risk factors include a history of chronic alcoholism from an early age, poor response to past treatments, emotional volatility (particularly anger), social isolation, firearm ownership, and history of aggression and violence toward others. Protective factors are stable employment, current sobriety, good attendance in his current treatment program, and a working connection with his counselor.

Learning Objectives

1. To demonstrate gathering information about suicidality with a client in an emotional crisis.
2. To demonstrate the role of compassion and concern in developing a therapeutic relationship with a client who may elicit anger or disgust from the counselor.
3. To demonstrate crisis intervention and referral with a client who is not initially cooperative with treatment planning.
4. To illustrate specific strategies for working with resistant clients.

[The dialog begins with Kara and Vince in an individual counseling session that evening. Because Vince is agitated, Kara arranges the seating so they both have a clear path to the door, with no obstructing furniture, and discreetly alerts colleagues near her office to listen for anything (e.g., shouting, unusual or loud noise) that might suggest that she is at risk.]

COUNSELOR: Well, Vince, I appreciate that you came in and sat down to talk with me. I heard from other treatment staff this evening that you’ve been upset.

VINCE: Damn it, she told me she wasn’t gonna do that. She told me if I get treatment, if I’d go again, you know, she wouldn’t leave me. And I’m at the mill today, and damn it, there comes this letter from this judge and this damn lawyer that I’m paying for. I’m payin’ for him, and he sends me this letter that says I can’t go to my own house. Now, that’s just not right. I pay for that house.

COUNSELOR: You got the letter today?

VINCE: Yeah.

COUNSELOR: Yeah. That is upsetting.

VINCE: I can’t believe it—that she’d do that. You know, the thing is, I mean, I know I get angry at her. She spends money like you can’t believe. And I know I get angry, and I know I shouldn’t drink. I know that too. But, you know, without her, without her, there’s just nothing for me!

COUNSELOR: Well, you know, that’s a big leap from getting this letter from a lawyer to saying that you’re going to be without her forever. Can you fill in some of the blanks for me, and help me understand what’s been happening over the last couple of weeks? We haven’t talked in a lot of detail about this.

VINCE: Well, the deal was, we had that bad little episode.

COUNSELOR: Now, that’s the one where you got violent, is that correct?

VINCE: Yeah, I did get physical.

COUNSELOR: You hurt her pretty badly, if I recall correctly.

VINCE: Sometimes I think she exaggerates a little bit too.

[Long pause during which Vince stares at the floor, shaking his head.]

VINCE: But I did hit her, I did hit her. I just get so mad, and I did hit her. But that was, you know, we had this deal: I'd come to treatment, and I like treatment, I like the fellows here. I like you, you know, and I could keep working, and I'm living apart from her. I'm living in my brother-in-law's garage. It's her brother, but we kinda get along and I'm living in his garage apartment, and so I've been coming to treatment. And I've been doin' fine until this happened, and it just, like, it knocked the legs out from under me, and I was—

COUNSELOR: You've been working hard. You've made a commitment, and you've been here for every session, I think.

VINCE: Damn right, I've been working hard.

COUNSELOR: You sound extremely upset today. This protective order hit you pretty hard.

VINCE: I just love that woman; I just love her. And I don't know how I can live without her. I just—*[sighs]*.

COUNSELOR: You know, when I hear you say that, it troubles me: that you don't know how you would live without her. What do you mean when you say that you're not sure that you can live without her?



Master Clinician Note: Kara attempts to focus on Vince's allusion to suicide, but Vince deflects. The counselor decides to let the subject go for now and return to it later. For clients who have difficulty talking about suicide, acknowledging this fact and introducing the topic carefully can make a difference. Some examples of introductory comments are:

- “Now I have a few questions to ask you about suicide if that's okay.” Then, after the client nods permission, “Have you been having thoughts of suicide?” Proceed with questions.
- “I would like to speak with you about suicidal thoughts and behavior. Is that all right?”
- “These seem like difficult questions for you. Is it all right if we proceed?”
- “The topic of suicide can be uncomfortable, so I really appreciate your discussing it with me openly.”
- “I'd like to ask you some more questions about your suicidal thoughts so that I can understand them. Is that okay with you?”
- “I'd like to ask you some more questions about your suicide attempt so I can understand what happened. Is that okay with you?”

It is also important to express empathy before seeking permission to explore more sensitive and private questions, especially at the outset of an interview. You might say, for instance, “You're going through a very painful time in your life right now, so painful it could seem that life is unbearable.” You might continue, “The topic of suicide is uncomfortable, so I really appreciate your discussing it with me openly. May I have your permission to hear more and understand that better?”

VINCE: I just can't imagine living without that woman. I just—there would be nothing left for me. We don't have any kids, never did. And she has some kids by her first marriage, but they don't spend that much time with me. And there's just nobody else in my life, and I might as well be dead, if I don't have her. And damn it, you know, it's the lawyer who did all this. There's just no reason for this. There's just *[sighs]* . . . One little event, it just goes to hell in a hand basket; it's just too much. It's just—

COUNSELOR: Do you mind—let’s talk a little bit about that letter, because when you get upset and angry, I know that it’s difficult to keep focused on what’s happening now—what really is the problem. So, let’s go back to that letter. Do you mind sharing a little bit about that with me? Just help me understand exactly what it said.

VINCE: The lawyer wrote me a letter and said I can’t go to my own house and I can’t talk to my own wife, and that doesn’t leave me much to do except sit in a damn garage. I really don’t want to drink ‘cause if I drink, man, I know, you know, I’m just gonna get flat out of control if I drink. I’ve met the cops in this town a few times, and I know that I don’t wanna meet them again when I’m drinking. And I just don’t wanna drink.

COUNSELOR: Your decision not to drink is a wise one; I really support you on that. It takes a lot to stay sober after getting this kind of news.

[Pause. Vince’s eyes tear up briefly but he fights them back. He is looking down, sullenly.]

COUNSELOR: Vince, I want to explore a couple of things with you if I have your permission.

VINCE: Sure, I guess. I’m not going anywhere.

COUNSELOR: You said a minute ago that you aren’t sure you could live without Jolene. Does that mean you are having suicidal thoughts or plans?

VINCE: Well, I mean, this woman is my whole life. She’s all I have. We’re married, damn it! It’s that damned lawyer causing all of this.

[Kara senses Vince’s agitation and defensiveness and, while not satisfied that the issue of suicidal intent has been adequately addressed, decides to not push the topic now, but to cycle back to it.]

COUNSELOR: Have you been feeling a pretty strong urge to drink?

VINCE: No, not really; I’m just mad as hell, but I know how I am. I’ve been through treatment a couple of other times here, and one of the things I learned was that when I get mad is when I’m likely to get drunk. It’s what AA calls HALT, hungry, angry, lonely, and tired. I drink a little beer at other times, but it’s when I get mad and I get drunk that I get in trouble. And, really, I don’t wanna do that, you know? But I’m mad as hell right now, I’ll tell you that!

COUNSELOR: I’m getting that.

VINCE: It just feels like the whole #*%!ing world’s against me!

COUNSELOR: Well, it can seem that way, sometimes.

VINCE: I’m glad somebody understands that, I mean, she sure doesn’t, apparently. I haven’t talked to her. I can’t talk to her, that’s that. I can’t talk to her; I can’t go home.



Master Clinician Note: Kara sees a chance to again address Vince’s allusion to suicide and decides this time to seek Vince’s permission to discuss “a painful and difficult topic.” By eliciting his cooperation she hopes to avoid his resistance to discussing suicide.

COUNSELOR: Can we, for just a moment, go back and explore your comment that you can’t live without Jolene? I want to make sure I understand what you are saying. Are you agreeable?

VINCE: I guess so; I got no place else to go. And actually, I kind of gotta thank you for talking to me. I do. I know I get kind of upset, and I can’t be a lot of fun to talk to when I get this way.

COUNSELOR: Well, I appreciate your willingness to talk with me about this difficult topic. Frankly, I'd rather have you sitting here with me being upset, talking about some options and maybe some things we could do about it, than have you outside being upset and deciding to go out and get in trouble.

VINCE: Yeah, I might go out and get in trouble.

COUNSELOR: Well, how about if we go back to that comment that you made a minute ago. I want to make sure that I understand this. You tell me that you're angry, and I know in the past when you've gotten this angry, and particularly when you've started drinking again, that you lose control. And you made a comment about not wanting to live without Jolene. Can you help me understand, what did you mean by that? Did you mean that you're thinking about killing yourself or killing Jolene?

VINCE: I just can't imagine—I can't imagine living without that woman. You know. Kind of serve them right if I went out and just blew my brains out, you know? Just spattered blood and brains all over the place. Maybe she'd feel better. Yeah, yeah. To tell you the truth, I say I don't wanna go out and drink—I'm really kinda scared to; if I went out and got drunk right now, I really don't wanna mess with her, and ain't nobody else to mess with but me. And if I didn't mess with her, I'd probably mess with me. If the truth is known, that's probably the truth. Yeah.



Master Clinician Note: At this point the counselor has made a decision that Vince needs an emergency room evaluation today, given his warning signs (suicidal ideation, suicidal communication, access to a gun, anger/agitation) triggered by an acute stressful event, risk factors (poor impulse control, aggression and violence, inability to establish abstinence, unstable marriage), and his minimal protective factors (with the exception of stable employment). Solidifying this decision, Vince has a recent history of significant violence towards his wife and is alluding to relapsing and “messing with her,” indicating not only that he is at risk, but that she is as well. From this point forward, the counselor’s focus is on eliciting as much cooperation from Vince as possible to obtain emergency evaluation, with the understanding that the need for such an evaluation is non-negotiable. The counselor will also bring her supervisor into this process to confirm her decision and to assist her as needed with Vince.

COUNSELOR: When you talked about that, you sounded like, have you had thoughts of shooting yourself? Is that the idea that's been going through your head?

VINCE: Well, you know, like, I'm sittin' here with you right now, I'm not gonna act on it right now.

COUNSELOR: Okay.

VINCE: But I couldn't say I wouldn't act on it if I left here right now, you know, I mean, there's just no #*%! place to go! 'Cept to a garage with a bed in it.

COUNSELOR: I'm glad we're together right now so you're not alone. Really bad feelings and urges to drink or to hurt yourself or someone else are not something we choose; the feelings are just there sometimes. But we can make good choices or less good choices about how to deal with bad feelings. Could we explore your choices in this situation?

VINCE: I guess so, yeah, I mean, I don't have nothing better to do. I don't wanna, I really, I came in tonight, I don't, I don't wanna go to group tonight. I don't wanna deal with this stuff, talk to people about it, I don't want them—whining about it. Analyzing it. I don't wanna do that. So, I'm okay just sitting here talking to you about it. I don't know where it's gonna take me, but, it beats going out and getting drunk.

COUNSELOR: Well, I agree. It definitely beats going out and getting drunk. Why don't we sit here and talk a little while, and then we can come to some decision about what's going to be best for you. I do know that in the past, group has been an option for you to talk about what is going on.

VINCE: Yeah, I just don't wanna go in there tonight and have all these people saying, oh that's terrible, and, I don't know what they're gonna say, really. But, I just know if I start talking about it, every time I start talking about it, I just start getting upset about it again; I open that letter and look at it, and there I go again.

COUNSELOR: Well, when we look back over time and we think about how you've been in treatment a couple of times. I'm sure you've learned some things that have been helpful for you.

VINCE: Yeah.

COUNSELOR: When you get upset, when you get angry, when it triggers that craving and you feel the need to use and you feel like your anger is escalating, what kinds of things have been helpful for you? What sorts of things have you done that have really helped diffuse some of that anger and helped you move forward?

VINCE: Well, one thing is get away from her because when I'm likely to get out of control, I take it out on her. Now, there's two kinds of drinking I do. One kind is I just drink a little beer. And the other kind is where we get in these arguments, and when we get in these arguments, I just say, the hell with the whole thing. And I wanna get as drunk as I can get. And that's how I feel now. But what I've learned in treatment, the other two times, is not to get into those arguments. And that's what happened 2 weeks ago. I thought everything was fine, and she started picking, picking, picking, you know. And it doesn't seem to matter what I do, it ain't gonna be good enough for her. And then I get #**%led off, and I drink, and then I hit her a couple of times.

COUNSELOR: It sounds like it's really important for you to keep your distance right now—not to have contact with Jolene.

VINCE: I don't have any choice, I don't think. I mean, if I don't keep my distance, I'm gonna go to jail, and I don't wanna do that.

COUNSELOR: So, we can work on your keeping your distance, but how can you keep your distance in a healthy way? How do you keep your distance in a productive way without drinking and without escalating this anger and, like you said, going back and sitting in that garage apartment?

VINCE: I don't know where I'm goin' tonight. I mean, that just . . . I can't go home because I don't have a home anymore. I'm paying for most of it, but I can't go to my own home. I don't wanna call people about this and whine about, "oh, my wife gave me a letter, I can't go home," you know? I don't wanna do that. So I just know if I leave here, it's gonna be real hard not to drink.

COUNSELOR: Well, I know that in the short time that I've known you and that we've worked together, that when you've felt this way and you've been hurt and wounded in this way in the past, that—

VINCE: Well, that wounded is the right word there, I tell ya.

COUNSELOR: How do you feel like you've been wounded? It sounds like that was an accurate word.

VINCE: Jeez, look at what she did to me, you know, I love that woman.

COUNSELOR: Well, in the past you've described her as the most important person in your life, I think.

VINCE: She is, Kara, she is. I can't imagine living without her.

COUNSELOR: It's painful to think about missing somebody that you love, somebody that you care about.

VINCE: I don't plan on losing her. If I lose her, that's it for me. I don't plan on losing her. I don't know how I'm gonna—I really think the lawyer put her up to this. They'll make a big deal and get a whole lot of my money out of it.

COUNSELOR: You know, Vince, when I hear you say that, and I hear you talk in this way, and you feel this amount of anger, I know in those past incidents when you felt this way how out of control things can get. With how angry and upset and hurt you are right now, and how vulnerable you are to drinking, and how bad your judgment might get if you start to drink, well it all adds up to a really volatile and unsafe situation, for both you and Jolene. I'm way too concerned about you to think about what might happen if you go home tonight. Gosh, I'd be worried to death that I'd be reading about you in tomorrow's papers, and that would be a terrible ending to all of the hard work you've put into your recovery. I mean you've been really trying. Gee, you haven't missed a single group, and you've been sober from the get-go, and you've shot straight with me from day one, and I really appreciate that. Therefore, I feel like I've got to be just as straight with you. Tonight Vince, given where you're at, what we really need to start discussing very seriously is you getting an evaluation at our emergency room, and very likely coming into the hospital for a little while until you can right yourself again.

VINCE: Oh, I ain't gonna sit in no emergency room all night. I don't know where I'll go. I really don't wanna drink. I wanna drink, but I know what would happen if I do drink.

COUNSELOR: Well, I don't want you to drink, and I don't want you to be in a position where you're at risk to hurt yourself or to make a bad decision.

VINCE: I don't want a bunch of shrinks looking at me; I don't want people—I know people from the mill go to the emergency room every day and, damned if I want them to see me in the emergency room, waiting to see a shrink!



Master Clinician Note: Vince clearly does not want to go the emergency room and Kara is a critical strategic juncture. MI provides a framework that can be used to address Vince's reluctance to go to the emergency room (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999b]). From an MI perspective, the counselor can attempt to "roll" with Vince's resistance by trying to understand his concerns about going to the emergency room and helping him explore both reasons against and reasons for going to the emergency room. By taking this approach, the counselor avoids creating resistance by treating Vince's potentially legitimate concerns as unreasonable. Instead, the counselor acknowledges Vince's concerns and tries to help him explore some of the pros of the decision. Given the severity of the situation, the counselor believes that an evaluation in the emergency department is needed. Although she will show as much respect for Vince's autonomy as she can, she will explain to him that the evaluation is important because it will prevent him from hurting the people he loves or doing something he will regret.

COUNSELOR: But at the same time, you've said that you want to make sure you're safe: that you take the right steps and that you want to honor this commitment that you made to recovery. You've done a nice job working on that. But tonight you've raised enough concern for me that we really need to go down to the emergency department and look at having you evaluated and determine whether or not it's the best place to be. I mean, you've received some incredibly tough news today, and you're reeling from it, and still trying to make sense of it. You're angry and hurt and really just beside yourself. If alcohol gets added in, well, it could just really all blow up, with terrible consequences for you. I'm frankly worried that you could shoot yourself. I also have to be honest with you Vince. I'm afraid for Jolene's safety if you leave here tonight and go drink. This is one of those times, when things have gotten really tough, that it's important to allow me and other professionals like me to do some of your thinking for you, because your judgment is not the best right now. Believe it or not, you can get through even this time, as impossible as that might seem right now, but you have to allow us to help you.

VINCE: Oh, #&*@; I shouldn't have even told you this stuff in the first place, you know?

COUNSELOR: Does it scare you a little bit to think about it?

VINCE: It scares me that, whoa, I don't know what's worse, getting put in the city jail or getting locked in the hospital, you know?

COUNSELOR: What's the worry that you have about the hospital? Can you help me understand that?

VINCE: Yeah, I don't want people calling me crazy. I mean, I'm a drunk, but I'm not crazy! You know? And I don't want people saying, "oh, did you hear about Vince, gonna kill himself, yuk, yuk, yuk," you know? I don't need that #*%! I got enough problems already!

COUNSELOR: Is that what you hear me doing? Do you hear me calling you crazy?

VINCE: No, no, no. I really think you want the best for me, Kara. I really do. I really do, but I don't wanna get locked up with a bunch of nuts. And I don't want people talking behind my back, I want . . . tell you what, we'll just call this off and I'll promise you I won't kill myself.

COUNSELOR: Well, I'm not sure, Vince. Just a few minutes ago, you told me clearly that you felt out of control.

VINCE: Oh, I am. I am mad.

COUNSELOR: Well, what we're talking about is not having you stay in the hospital and be labeled as crazy but recognizing that when you're at risk and feeling out of control we need to do some things to help you regain control. We need to help you maintain your recovery and do some things that are healthy for you. We're talking about your taking that step.

VINCE: Where are you talking about sending me?

COUNSELOR: We'll just walk downstairs to the emergency department and I'll go with you, and as a part of our policy, we have to have a security guard go with us and sit with us, but—

VINCE: Oh, jeez! That's—

COUNSELOR: It sounds like a lot.

VINCE: Yeah.



Master Clinician Note: Vince feels threatened by the referral to the emergency department. Kara, in keeping with agency policy, makes two decisions. The first is that she will not leave Vince alone. The second is she will involve security to help her escort Vince to the emergency department. While the ideal would be to have a collaborative stance with Vince, helping him make the decision to go to the emergency room voluntarily, Kara recognizes that, one way or another, Vince must be assessed by skilled mental health staff for his potential for suicide and interpersonal violence. The more ownership Vince can take of his decision to seek evaluation and treatment, the better.

COUNSELOR: But that's just a part of the policy; it doesn't mean you're being arrested, or anything. What it means is that I would go with you and sit with you and we'll talk with the staff there and get their opinion about what might be best and what is the best way to help you right now. If they think being in the hospital is the best option, you would be in an environment where we can help you regain some control and maintain all the progress that you've made.

VINCE: Yeah, I think what I want you to do is call Jolene and tell her what she's done to me—that I'm gonna end up on a nut ward because of her and her lawyer.

COUNSELOR: You know, it can certainly feel that way, but from where I'm sitting, I see you taking a step to be responsible for your own recovery. I see it as a willingness on your part to do what's necessary to maintain the progress you've made.

VINCE: The way I see it is I'm between a rock and a hard place. I don't have anyplace else to go, but damn, I don't wanna go to the nut ward but I do want her to know how bad she hurt me, too.

COUNSELOR: It sounds like it's pretty important for you to have her understand that you've been hurt.

VINCE: Can she come see me?

COUNSELOR: Vince, I don't see how it could possibly be in your best interests to have Jolene see you the way you are feeling and thinking right now.

VINCE: That's true enough. If I talked to her I'd just get #*%!ed off again, and that wouldn't help. First of all, how long am I gonna be there? How long are you talking about? I mean, are you talking weeks?

COUNSELOR: I can't predict for you what will happen, Vince. Sometimes when clients go to the emergency department, all that happens is an evaluation. Then people stay a day or two or three with a plan to follow up with me. Then there are times where people are admitted to the hospital for a longer period of time. It is highly unusual for people to be admitted to the hospital for weeks, especially with all of the current insurance restrictions. I suppose that's possible but it's highly unlikely. I don't want to guess what will happen in your case, although it is certainly possible that you will be admitted to the hospital until you are under better control of your thinking and your emotions, and that a hospitalization may last a few days or more. It all depends on whether the doctors judge the situation to be safe enough to allow you to be discharged, or if they think more assessment and treatment are necessary in the ED or on one of the hospital floors in order to make things safe. Jolene's safety is also at stake here, and that's a consideration too. Just like me, the staff in the emergency department won't want anything to happen to her, just like they don't want anything to happen to you.

VINCE: So what's gonna happen in the ED?

COUNSELOR: I've had a lot of experience working with the ED. I can tell you that you'll be there at least a few hours and that you'll be evaluated by a counselor first, most likely a nurse or social worker. Then you'll see a doctor who will talk to you and also rely on the information that the nurse or social worker provides him or her. I'll call them to make sure that they also have my opinion. When I speak to them I'm going to advocate that they admit you to the hospital because I know you pretty well, and I really think that you're not in a good position to go back to the garage where you're living at this time, and that you could benefit tremendously from a cooling off period. They'll talk with you about a plan that could range anywhere from being discharged to being admitted to the hospital until things calm down, which I'd prefer. Although they will want your input, it's possible that they will arrange temporary hospitalization for you even if you object strongly to it for the sake of safety. They may also want to touch base with Jolene to make sure that she's safe.

VINCE: Do I have any choice?

COUNSELOR: I've gotten to know you pretty well, and this is really what needs to happen at this point. It's one of those things in recovery that just needs to be done, I'd appreciate it if you could trust me on that.

VINCE: Yeah, I knew you'd say something like that. I'm not sure why I bothered asking.

COUNSELOR: Yeah, well you've gotten to know me pretty well, too. I need to touch base with my supervisor real quick and let him know what we're doing. I just want to quickly let him know our plan, plus I need to let him know where I'll be in case someone wants to get hold of me in the next little while. I also need to touch base with security so that they can escort you and me down there.

[Pause. Vince shows no sign of leaving his chair.]

[Kara calls her supervisor with Vince present, tells him that there is an emergency situation with Vince that requires that he be escorted to the ED as a precaution to prevent suicide and violence. She had discussed Vince with her supervisor, and they had anticipated that he might become homicidal if Jolene initiated separation and discussed that suicidality was also a possibility. Therefore, her supervisor quickly confirms the acuity of the situation. Convinced that emergency evaluation is needed, he endorses the plan without delay and makes arrangements for security to come to assist in escorting Vince to the ED. As the supervisor calls security, it frees up Kara to continue to speak with Vince to keep him calm. Given Vince's history of violence, the supervisor requested more than one security officer to assist. Two security officers arrive, and they allow the counselor to initiate all of the direct interactions with Vince and, although in his presence throughout, allow Vince enough space that he does not feel threatened or "handled." They are also prepared to call for more back-up and the local police if Vince runs or becomes aggressive, neither of which occur.]

After Vince is checked in, the counselor provides all the relevant information to the ED staff and stresses the potential risk to Jolene that will require contacting her as a precaution. She also emphasizes to the ED staff in clear and unambiguous terms that in her opinion, and that of her supervisor, Vince is an acute danger to himself and his wife and requires hospitalization until his affect stabilizes and his judgment improves. She also makes a concrete plan with the ED staff that they will be in communication about Vince's status the following morning. Although the counselor made the decision early about of the need for emergency evaluation, she took the time to discuss this with Vince in a firm but caring manner, facilitating his cooperation. As she has had previous experience in escorting acutely suicidal patients to the ED, has worked collaboratively with her supervisor in these instances, and has specifically discussed in supervision the possibility that Vince might require an emergency evaluation if Jolene initiated separation, all that was required from the supervisor in this situation was a quick confirmation of Vince's acuity and the appropriateness of the plan. Moreover, he was of great assistance in getting security, allowing the counselor to engage Vince uninterrupted.]

Followup

Kara stayed with Vince through the ED evaluation process, suspecting that if she left, he would find a reason to impulsively leave. The ED social worker did a brief evaluation, and the psychiatrist who saw Vince following the evaluation decided to admit him to the psychiatric service for observation. With Vince's permission, Kara notified his employer that he was hospitalized. He was hospitalized for 4 days and released with a followup treatment plan that included returning to substance abuse treatment in the intensive outpatient treatment program and regularly scheduled appointments with the attending psychiatrist, who coordinated continuing re-assessment of Vince's suicidality among all his caregivers in partnership with Kara, who served as case manager. Kara provided case management services to ensure that Vince kept his appointments and continued to participate in substance abuse and mental health treatment. As Vince neared completion of intensive substance abuse treatment, Kara arranged for Vince and Jolene to begin couples therapy to decide whether they would dissolve their marriage or work on it. The order of protection filed by Jolene was amended to allow them to meet together in the counselor's office.

Kara's documentation of the case included Vince's expressions of suicidal thoughts, his allusions to potential risk of violence to others, his risk factors for suicide, the warning signs she observed, and his limited protective factors. She noted his high potential for substance use relapse. She also documented Vince's resistance to voluntarily seeking help for his suicidality, her consultation with her supervisor, and the fact that security personnel accompanied her and Vince to the ED. She also described the information she gave to the emergency department personnel and that she remained in the emergency department until the determination to hospitalize Vince was made. She also noted recommendations that were made for post-hospitalization care.

Vignette 6—Rena

Overview

Rena is a Native-American woman living in a rural area of a state in the Western United States. She has been sober for 6 months and has a history of child sexual abuse. She began having obsessive thoughts of killing herself yesterday, and she cannot stop the thoughts. She called her counselor, Martin, and the dialog below is from the telephone call.

The case demonstrates some of the interplay of shame, trauma, substance abuse, and suicidality, and illustrates specific advanced counseling techniques that can be used to interrupt obsessive thoughts, build strengths, and help a client mobilize to take action.

Substance Abuse History

Rena is a 34-year-old Native-American woman with a history of sexual abuse by an uncle. The sexual abuse began when Rena was 8 years old and continued through her teenage years. She has been in recovery from alcohol dependence for about 6 months. She began drinking as a teenager and came into treatment almost a year ago at the insistence of her husband. A significant issue in her recovery has been managing trauma symptoms, including obsessive thoughts. Since she lives almost 40 miles from her treatment center, her primary aftercare services have been provided by telephone with occasional visits to her counselor when she comes to town. She has limited contact with other people recovering from substance abuse, but maintains ongoing supportive relationships with her family. She has three children, ages 15, 12, and 8.

Suicide-Related History

Rena's suicidality is related to her psychological trauma symptoms. Since the age of 15 she has had thoughts of suicide as an escape from her emotional pain. On two occasions as a teenager she made suicide attempts by cutting her wrists. Neither attempt was medically serious and no treatment or followup was undertaken at the time. During her days of active alcohol abuse she would occasionally, while drinking, be overcome with painful feelings of shame, sadness, and fear and would begin having obsessive suicidal thoughts. Until yesterday, she had not had these thoughts since she quit drinking 6 months ago. The thoughts don't include a specific suicide method but are more about the relief she would feel from being dead.

Suicide and American Indian/Alaska Native Populations

While rates vary widely among tribes, American Indian and Alaska Native people, as a whole, have significantly higher rates of suicidal behavior than people of other races and ethnicities. Some of the variables that seem to affect this elevated suicide rate include high rates of substance abuse and major psychiatric illness and cultural alienation that can increase risk factors and lower protective factors for suicide. Those who live on geographically isolated reservations may have limited educational and employment opportunities, as well as no easy access to mental health or substance abuse services. Particularly high rates of suicide are found among American Indian males, ages 15–24. A higher percentage of American Indian suicides are alcohol related, compared with the general population (Olson & Wahab, 2008). The effects of culture can be seen in each stage of help-seeking behavior (Goldston et al., 2008). Suicide prevention and intervention efforts need to be tribe specific, emphasizing the cultural beliefs and practices unique to the tribe and recognizing the specific helping resources that are available and acceptable to that particular group. The involvement of the community in suicide prevention efforts is critical.

In recent years, the Indian Health Service (IHS) and SAMHSA have made suicide prevention among Native Americans a high priority and have funded a variety of programs to address their needs. Descriptions of these demonstration programs can be found at the Web site of the IHS Community Suicide Prevention initiative

(<http://www.ihs.gov/suicideprevention/>). Also relevant to suicide prevention is SAMHSA's Gathering of Native Americans curriculum (<http://www.samhsa.gov/tribal-ttac>), a substance abuse prevention program that emphasizes skill transfer and community empowerment and presents a prevention framework based on values inherent in traditional Native cultures. Additional information can also be obtained from the planned TIP, *Substance Abuse Treatment With American Indians and Alaska Natives* (CSAT, in development h).

Learning Objectives

1. To demonstrate a crisis suicide intervention over the telephone.
2. To illustrate how a detailed safety plan can be developed and used.
3. To illustrate a specific technique to intervene with obsessive suicide thoughts (the hope box).
4. To illustrate how an experienced counselor can build strengths for a client to mobilize to take action in the face of powerful emotions of shame, fear, and sadness.

[*Martin, Rena's counselor, receives a telephone call around 2 p.m. one afternoon.*]

COUNSELOR: Hello?

RENA: Uh, Martin, this is Rena.

COUNSELOR: Rena, how are you doing?

RENA: Uh, Martin, uh, remember helping me develop a safety plan for when I start having thoughts of hurting myself? I tried the first couple of steps, but they didn't help at all.

COUNSELOR: Sure, Rena. Are you having those thoughts now?



How to Help a Client Develop a Detailed Safety Plan

A variety of strategies can be used to help clients anticipate, identify, prepare for, and intervene in suicidal crises. All clients with suicide risk factors can benefit from a Commitment to Treatment agreement (described in Part 2, chapter 2). All clients at risk for a suicide crisis should have a safety card (described in Part 1, chapter 1) that lists people and organizations that can be contacted in a suicidal crisis or when the client anticipates a suicidal crisis. These contacts include emergency contact information for their counselor, local treatment resources, local and national suicide hotlines, and contact information for significant others who can assist in a crisis. The safety card should be individualized for each client.

A more detailed safety plan is a more advanced treatment intervention that consists of a hierarchically arranged description of coping strategies that the client agrees to use during a suicidal crisis. It is developed collaboratively by the client and counselor and written down so that both the client and counselor can keep a copy. The safety plan consists of four main sections, with the understanding that clients can move to a subsequent section if their crisis is not resolved by following the instructions in an earlier section. (See Berk, Henriques, Warman, Brown, & Beck, 2004; Henriques, Beck, & Brown, 2003; Wenzel, Brown, & Beck, in press).

The first section is a list of the warning signs that indicate that a crisis may be developing. Warning signs can include thoughts (e.g., “I can’t take it anymore”), thinking styles (e.g., racing thoughts), emotions (e.g., intense depression), behaviors (e.g., isolating oneself), and/or physiological sensations (e.g., racing heart).

Clients who recognize that they are heading for a suicidal crisis move on to the second section, which consists of coping strategies that clients can use without the help of another person. Examples of these kinds of coping strategies include diverting activities appropriate for the individual, such as walking the dog or reading the Bible.

The third section consists of friends or family members that the client can call in the event that the individual coping strategies are not successful in resolving the crisis. It is important to list the telephone numbers of these individuals so they can be contacted immediately.

The fourth section includes the telephone numbers of professionals who can be contacted in times of crisis, including the client’s substance abuse counselor, the on-call counselor who can be reached outside of business hours, a 24-hour emergency treatment facility, and other local support services that handle emergency calls. When the safety plan has been completed, the counselor works with the client to ensure that it will be used successfully, such as by discussing the precise location where the safety plan will be kept. Over the course of treatment, new coping strategies that are developed can be added to the safety plan.

RENA: I’m scared, Martin, I’m scared. I-I-I can’t stop the thoughts that I’m gonna hurt myself.

COUNSELOR: Well, I’m glad you called. And I’m really glad you could put your safety plan to use. You sound pretty frightened.

RENA: I’m scared. I can’t, I can’t, I can’t stop myself from thinking I’m gonna hurt myself.

COUNSELOR: Can you tell me what the thoughts are that you’re having? What are the thoughts that are going through your head?

RENA: I wanna die. I wanna die.

COUNSELOR: When did this start?

RENA: I don’t know. Last night, maybe. Maybe yesterday sometime.

COUNSELOR: So, this has been going on for a couple of days, going on for a little while?

RENA: It just gets worse. It gets worse and worse. All I think about is how I wanna kill myself. I think about what to take—pills—I’ve got pills here in the house. And I wanna take ‘em and I just wanna go to sleep but I’m afraid I’ll take ‘em and then get sick and throw ‘em up and not die.

COUNSELOR: So, you do have pills there in the house.

RENA: Yeah. Yeah. I don’t even know what they are. I don’t know. Some of them are for the kids, some of ‘em are for Frank; I don’t know what they are. I have my pills for depression but I haven’t taken them in a long time. They’re just a bunch of pills. I don’t—I just—I want—I’m scared, I just wanna die.

COUNSELOR: Well, I wonder if we could talk for a little bit and you could help me get a better idea about how you’re doing. Would that be all right?

RENA: Yeah, okay.

COUNSELOR: Well, I understand what you’re saying more or less. I hear that you’re scared. Are you there by yourself?

RENA: Huh, what?

COUNSELOR: Are you by yourself? Are you alone?

RENA: Frank got angry at me and he left. He just—he went somewhere. He'll be back.

COUNSELOR: Is anyone else in the house?

RENA: The kids aren't here. The kids are gone. The kids, I don't know where they are. I—I haven't slept in, I don't know, several days, and so this morning, I just couldn't get out of bed, and they all left, and it's just getting worse and worse, and I can't stop the thoughts.

COUNSELOR: Have you been drinking at all?

RENA: A little.

COUNSELOR: Can you help me understand how much when you say, a little bit?

RENA: I just, I want to stop the thoughts and I had, we didn't have much in the house, Frank took most of the alcohol out of the house. But we had some beer and I drank a couple of beers. And some Kahlua. That stuff tastes awful!

COUNSELOR: Do you have any alcohol left at this point?

RENA: No, and that's part of the problem. I'm so scared and I don't have—I've gotta stop the thoughts. I can't stop the thoughts, and I don't have any way to stop 'em except the pills. And so I called you.

COUNSELOR: Well, I'm glad that you called me and I know that that was our agreement, and so I'm glad to hear from you. I know it's hard for you to tell me that you've been drinking again as well, but it's good that you did.

RENA: I feel so ashamed.

COUNSELOR: Well, I appreciate you taking this step. It really is an incredible step, and this is one of the things we talked about, that when you start feeling this way, and it starts to get at a level where you don't feel like you can manage it or control it, that you and I need to talk in order to move things forward and help you try to get some control. Now, as a part of how we've done this in the past, we had talked about using your hope box. Have you done that? Is that something that you did today?



How To Set Up a Hope Box With Clients

The hope box is a cognitive-behavioral intervention developed by researchers at the University of Pennsylvania (Berk, Henriques, Warman, Brown, & Beck, 2004; Henriques, Beck, & Brown, 2003; Wenzel, Brown, & Beck, in press). When people are having suicidal thoughts and feeling hopeless, they tend to think in all-or-nothing terms: their life is truly hopeless. They need to be reminded to examine how they are thinking and use the coping skills they have developed to manage other times when they have felt hopeless. They need to be challenged to think of actions they can take other than suicide. There is no single way to establish a hope box (sometimes referred to as a "hope kit") with a client, but the guidelines below may be helpful.

Get clients thinking about things in the past that have given them hope or that have prevented them from attempting suicide:

- Pick a time when a family member helped you in the past.
- Go back in your life and recall when a particular friend was helpful.
- Tell me about a time when someone you didn't know well did something special (a doctor, an employer).
- Pick a situation when you did something that made you feel more hopeful (walking in your neighborhood, working in the garden).

- Describe a time in your life when you felt proud of yourself or something you did (when you got a good report card, when you got a raise or a compliment).
- If you were to give me a photograph of hope, what would it look like?

Ask them to put something that reminds them of each person, event, activity, or time into a container.

When they have a new item for the hope box, they should explain to you what it is, its significance, and in what way it makes them feel hopeful.

Elicit a commitment from the client to practice thinking about two items in the hope box every day at home. They should describe to themselves how they feel when they recall the person, event, or time.

Encourage the client to add one new item to the hope box each week (or appropriate length of time).

After the hope box has been established, remind clients that they can go to their hope box when they are feeling hopeless or sad, pick an item, and try to regain the feelings they have experienced in the past.

The hope box is a concrete marker of hope and serves multiple purposes. If a client has gone through the steps of developing and implementing a hope box, they have made a tangible commitment to living: one that, by its very nature, is personalized. The hope box helps stop the escalation of obsessive ruminations about reasons for dying, along with associated emotional upset and dysphoria. The hope box is a practical exercise designed to activate reasons for living and disrupt the cycle of despair. It helps reorient the client toward constructive problemsolving and effective regulation of emotions. Most important, though, the hope box is an intervention that facilitates self-management; that is, it provides an opportunity for the client to learn to manage crises and emotional upset individually, without external intervention. Real and lasting hope is founded in the client's knowing that he or she can effectively and independently manage the problems of daily living.

RENA: No, I haven't thought about it.

COUNSELOR: Okay.

RENA: It's here.

COUNSELOR: Would you mind getting it out, and let's just walk through it. Let's talk a little bit about it.

RENA: Give me a minute. I've got it, but I don't see how that's gonna help me.

COUNSELOR: Well, let's go through it. I know in the past that it has helped, and I know that at different times we've gone through it and it's been effective at helping stop some of the obsessive thinking, particularly when you're thinking about suicide. Do you want to take one of the items out and tell me a little bit about it?



Master Clinician Note: The counselor wants to help Rena anchor herself in the present and maintain contact with the counselor, rather than focusing on past trauma or her perceived hopelessness in the future. Focusing on the hope box is in the here-and-now and helps Rena ground herself.

RENA: The thoughts are terrible right now. They're just terrible.

COUNSELOR: Well, let's focus on the hope box. So let's redirect your attention to that. And why don't you just take one of the items out and tell me a little bit about what it is.

RENA: It's a picture, a picture of me with my children.

COUNSELOR: Can you tell me a little bit about the picture? When was it taken, where was it taken?

RENA: I don't know. Maybe a couple of years ago, Marilyn looks like she's about 13. It looks like we were at a pow-wow.

COUNSELOR: Rena, what's happening in the picture?

RENA: We're all just standing there. I think Frank must have taken it. It's me and my girls.

COUNSELOR: Can you talk a little bit about what was happening then?

RENA: I don't know. All I can think about is who will take care of my girls if I'm gone. I'm so sad and so scared.

COUNSELOR: Can you tell me some more about feeling sad, what that is about?



Master Clinician Note: Trauma, particularly during childhood, is common among people who attempt suicide, particularly those who have made multiple suicide attempts. Traumatic memories can be activated in a number of ways, including both internal and external events. External precipitants include day-to-day stressors. This can include a host of possibilities, but most revolve around interpersonal relationships, particularly if they are abusive in nature. It is more common, though, for internal events to activate the suicidal crisis. These include thoughts, feelings, images, and sensations, some that even the client is not fully aware of at the time. When memories of previous trauma are activated, the net result is often overwhelming shame, subordination, impotence, guilt, helplessness, and feelings of being a burden—all facilitating hopelessness and thoughts of suicide.

RENA: I look at my girls and I think about me when I was their age and I just get sad. That's what I'm feelin' now. I feel like I just wanna kill myself. Just quit.

COUNSELOR: There were some difficult times during that period in your life; there were also some times during that period when you felt better, when things were different. Do you recall any of those times?

RENA: I guess I felt better at school.

COUNSELOR: What was it that you liked about school?

RENA: I could be somebody else. I didn't feel dirty at school. They didn't know.

COUNSELOR: How did you feel at school?

RENA: I don't remember, maybe happy. Maybe okay.

COUNSELOR: Do you recall some of the friends, some of the people you spent time with, that you felt close to?

RENA: Yeah, I had girlfriends.

COUNSELOR: Can you tell me a little bit about them?

RENA: They liked me, and we did things together. And I was a good student. Always obeyed the teachers.

COUNSELOR: What did they like about you? What was it that you recall that they liked about you?

RENA: I can't think of why anybody would like me right now. But back then I guess they liked me because I was a good friend. I was loyal.

COUNSELOR: You know, I remember hearing you describe that in the past that you were loyal, dependable; you were somebody that they could count on and look to for support. Do you remember some of those times?

RENA: Yeah. I took care of my brothers and sisters. And I was loyal to my friends.

COUNSELOR: How do you feel, as you talk about it?

RENA: A little better, I guess.

COUNSELOR: Because your voice sounds sad. You sound a bit tearful.

RENA: I'm more sad than scared right now. I'm so sad. I'm so sad for my children.

COUNSELOR: What is it that you feel sad for, about your children?

RENA: That I might leave them.

COUNSELOR: Do you recall when we talked about the difference between sadness and shame?

RENA: Yeah.

COUNSELOR: What do you remember about those conversations?

RENA: That I've felt so much shame in my life, and that when I feel shame I get really sad.

COUNSELOR: And do you remember some of the differences when we talked about your shame about the abuse? We talked about feeling responsible.

RENA: Yeah, that really helped me.

COUNSELOR: What about that was helpful?

RENA: That when I feel shame, I feel like it's my fault. And when I feel sad, it's just that I feel sad about what happened. That was helpful to me.

COUNSELOR: And do you recall when we talked about feeling responsible for the abuse and blaming yourself? Then we connected this to your feeling that maybe you should die: that killing yourself was attached to feeling responsible for something that I think we both agreed you weren't responsible for.

RENA: Yeah. When I feel shame, I want to hurt myself.

COUNSELOR: Yes, and it sounds to me that this really is sadness. That this is sadness over something that happened many years ago.

RENA: I feel really sad right now. I feel sad that I drank.

COUNSELOR: How sad? Say that again.

RENA: I feel sad that I drink. I feel sad for my children.

COUNSELOR: I think it's important that you've recognized that, that you understand that this sadness is about many different things, and it can feel a little bit overwhelming. Does it feel overwhelming to you?

RENA: The sadness doesn't feel overwhelming; the sadness has been with me so long, it just feels natural, and the scary thoughts feel overwhelming.

COUNSELOR: So, maybe, taking your hope box out and starting this process, kind of disrupts those thoughts a bit and stops those thoughts. Would you agree?



Master Clinician Note: As mentioned above, the hope box provides the client with the opportunity to manage the suicidal crisis both independently and effectively. This is important because it facilitates self-efficacy and empowers the client. For many clients, this is the crux of recovery, moving toward independence and empowerment over their life, to have choices and options and not be limited by past traumatic events. The hope box also provides a tangible process to overcome feelings of shame and helplessness so often associated with suicidality. The personal nature of the hope box is most likely responsible for its potency.

The hope box is one of many more advanced techniques that counselors can use to intervene with clients with suicidal thoughts and behaviors. Another advanced technique described in Rena's vignette is the detailed safety plan. These techniques are somewhat more advanced than the other strategies described in this TIP, and extend somewhat beyond GATE, but are illustrated here for substance abuse counselors with advanced mental health training who wish to incorporate suicide-related treatment into their counseling portfolio. Describing additional intervention techniques is beyond the scope of this TIP. There are many excellent resources for clinicians (see Jobes, 2006; Rudd, 2006; Wenzel, Brown, & Beck, in press).

RENA: Yeah.

COUNSELOR: Rena, could we go back to the hope box and your photograph of you and the girls for just a minute? Can you look at the photograph again and tell me your reaction?

RENA: My girls are so sweet. They look happy.

COUNSELOR: And can you tell me about you right now, what's happening with you?

RENA: I feel calmer. Not so sad. I love my girls. I don't think I could kill myself and leave my girls alone.



Master Clinician Note: In many ways, children are a tangible marker of hope for clients. Children are the client's life legacy. It is important for clients to recognize and understand the impact of suicidal behavior on their children, the vulnerability and risk it can create. Similarly, it is critical to emphasize that in their role as parent, they are protector and nurturer. This is true despite their own history of abuse and neglect. They can stop the cycle of abuse and provide for their children that which they wanted most: safety, protection, and love.

COUNSELOR: Let's talk for a minute, now that those thoughts have calmed down a little bit. Do you feel like you're able to talk about some other things? Because I think maybe we need to take some steps to make sure that you're safe.

RENA: Yeah.



Master Clinician Note: The counselor has worked to establish connection and rapport with Rena and to assess the situation. His perception is that Rena is more grounded now than when she called, but he also is aware that she has been drinking and could rapidly lose her grounding when the telephone connection is ended. He therefore decides it would be best if Rena came to town to the emergency room for an evaluation and possible hospitalization. The counselor now begins to move from gathering information to taking action.

COUNSELOR: I'm a little concerned, and I'll tell you, to be real blunt with you, Rena, I'm very concerned that you're alone, that you feel very sad and depressed, and you've been drinking a bit, and you have your pills available. And you've been having these thoughts about killing yourself, and I'm a little concerned about that, and I think we need to take some steps to make sure that you're okay.

RENA: It scares me to think I might do that.

COUNSELOR: It scares me to think that you might do that, too. What do you think would be the best thing for us to do at this point? Is there anyone around who could help?

RENA: No, Frank's not here. I don't know where the kids are. I think they're just with their friends down the road.

COUNSELOR: I think you told me earlier, and we had identified that your mother, in addition to Frank, was someone that we could count on and talk to in case of emergency, in cases of a crisis. Is that still the case? Do you still feel that your mother is somebody we can count on?

RENA: I haven't talked to her today; I guess she's at home.

COUNSELOR: Now, remind me, how close does your mother live to your house?

RENA: Just over the hill, maybe a quarter of a mile.

COUNSELOR: So, just a short distance away? How would you feel about my talking with your mother and having your mother come down and bring you in so that we can make sure that you're safe?

RENA: I hate her knowing—I don't think that I need to come in. I think I can do this by myself.

COUNSELOR: Can you help me understand your thinking about your ability to do this yourself? What is it that makes you come to the conclusion that you can manage this one on your own?

RENA: I just don't want to upset her.



Master Clinician Note: The counselor doesn't want to pressure Rena unnecessarily; feeling this will just increase her resistance and perhaps invite Rena to become more anxious. Rather, he decides to explore the situation more until he feels Rena may be more open to coming into town.

COUNSELOR: Sounds like a more—

RENA: I've upset her enough. And I've been so proud of not drinkin'. And I don't want to upset her.

COUNSELOR: It sounds like you're worried about you using your mom, somehow, and getting her upset. Do you remember when we looked at this issue about shame and sadness, and we said that when you are feeling shame, you have a tendency not to reach out, not to ask for help. Do you remember those conversations?

Resources on Suicide Among American Indians

Several Web sites provide information on suicide specifically for American Indian populations:

- One Sky Center (<http://www.oneskycenter.org>) has the draft of a 100-page Guide to Suicide Prevention on its Web site. The Guide includes a Community Assessment Tool and lists additional resources.
- The Suicide and Mental Health Association International (https://www.iasp.info/resources/Groups_at_Risk/First_Nations/) Web site has readings and facts about suicide.
- Healing of Nations (<http://www.healingofnations.org>) devotes several pages of its Web site to suicide prevention and crisis intervention.
- The American Indian Health Council (http://www.indianhealth.com/human_services.htm) has a page on suicide prevention.
- The Indian Health Service Web site has descriptions of programs, curricula, and other resources on suicide of particular relevance to American Indians (<http://www.ihs.gov/suicideprevention/>).

RENA: It's never been easy for me to ask for help.



Master Clinician Note: “Shame-based” people often feel they don’t deserve help. Arguing or debating with people about their self-worth and value is most often futile. Rather, the counselor just chooses to address Rena as if she feels worthy, even if she can’t experience that within herself.

COUNSELOR: And that’s why I’m so pleased that you called me, and that you actually used our plan. A part of that plan was to have your mother available as well, and I think that this is one of those times when we need your mother. Let’s not let the shame that’s there for many reasons, and isn’t accurate, block that and stop us from reaching out when we need to reach out. Because I know in the past, your mother’s been willing to help, and I really think that she’ll be willing to help now and won’t think of it as an inconvenience.

RENA: Would you not tell her why, would you not tell her I’ve been drinking?

COUNSELOR: Well, I think I’m going to have to tell her that you’ve been having some trouble. I’m not sure we can get around that. It’s going to be apparent to your mom, and I know that in the past when we talked with your mother about having her involved during crises, she was more than happy to help, and wanted to do things that would help you recover.

RENA: I don’t think I could drive myself.

COUNSELOR: Well, I don’t think you could, either; I think we’re in agreement on that, and that’s why I think I need to go ahead and give your mother a call. So, let me give her a call and have her drive you in.

RENA: Okay, try not to tell her that I’m drinking or that I’m thinking about killing myself.



Master Clinician Note: The most critical thing to remember about crisis phone calls is to remain calm and patient throughout. A calm, patient, and persistent orientation facilitates hope. You should always be oriented toward productive solutions, with the most frequent solution simply being time. In all likelihood, the longer the call continues, the more effectively the crisis will be diffused. The crisis call is about effective regulation of emotions and problem solving. The call provides the client with an opportunity to vent.

It is important not to argue with the client. If the client has not used the hope box, the crisis call is a chance to walk the client through the hope box. It is also critical to make sure that the client's method for suicide has been removed. If the crisis continues unabated, having the client come in for an emergency session or go to the emergency room is advised. Contacting family members during an acute suicidal crisis is also important if initial efforts fail. In most States, it is permissible to violate confidentiality during a suicidal crisis. It is important to also consider having the patient sign crisis management consent forms early in the treatment process, allowing the clinician to contact specific family members if and when a suicidal crisis emerges. This proactive step is particularly important for those who have made multiple suicide attempts. In order to contact family members during a crisis, you need to have access to the appropriate phone numbers, and know which family members offer healthy, supportive relationships. This requires careful planning early in the treatment process.

COUNSELOR: How about if I agree to tell her only what's necessary to make sure that she knows how important it is to get you in so we can make sure you're safe. Would that be agreeable?

RENA: Tell her something like I'm having bad thoughts and I called you.

COUNSELOR: I think we can manage telling her that you're in a position where we're worried about your safety and that she needs to come with you, accompany you and not leave you alone during this time. She was aware that that was a problem for you before. How does that sound to you?

RENA: Okay.

COUNSELOR: Okay. Well, let me walk through with you what I'm going to do, and make sure this is okay with you. I'd like to call your mother and ask her to bring you in. I'm going to give her a time limit: a deadline by which she needs to have you in town. I also will tell her I want her to give me a call when she gets to your house, before the two of you leave for town. Then, if you're not here within an hour and a half, I'm going to have to go ahead and notify the police to come out and make sure that you're safe.

RENA: Oh, please don't call the police. Frank would kill me.

COUNSELOR: Well, at this point, I think that we just need to make sure that you're okay. I don't have any doubt that your mother's going to go ahead and come on down and bring you in, but I just wanted to let you know that we need to have that happen within a certain time limit, just to make sure that everything's okay and that you're safe.

RENA: I don't mean that Frank would really kill me, just that he would be so angry with me.

COUNSELOR: Well, my guess is, he'd want you to be safe as well. And this is one of those times. Do you think you can agree with that?

RENA: I don't want anybody mad at me.

COUNSELOR: Well, let me tell you very clearly, Rena, not only am I not mad at you, I'm actually proud of you for the step that you've taken. This is one of those critical steps in your recovery about overcoming that feeling of shame and reaching out when you need help in order to maintain your recovery and sobriety. This is a step in that direction, and so that was one of our goals. So I'm really proud that you've reached the goal.

RENA: What's going to happen to me when I get to town with you?

COUNSELOR: Well, we're going to sit down and talk with someone else about where you are right now and maybe what the best response is. That may mean that you'll be spending a little bit of time in the hospital to

help you get to a place where you're safer and you can return to outpatient care. Do you have some thoughts or questions about that?

RENA: It scares me that I'm gonna have to go to the hospital.

COUNSELOR: It can be a scary thought. But it also can be a good step for you.

RENA: Okay.

COUNSELOR: So, do we have an agreement?

RENA: Mmm-hmm, yeah.

COUNSELOR: Okay, well, I'm going to put you on hold on the phone for now and call your mother. I'll let you know when I've talked to her and that she is on her way to your house. Are you willing to hold on the phone for now? It will be a few minutes.

RENA: Okay.

Followup

Martin had Rena's mother's telephone number in her case record. He called her and she agreed to go immediately to Rena's home to take her to the hospital emergency department. Rena's mother telephoned when she arrived at Rena's house. About an hour later, she telephoned Martin to confirm that they had reached the hospital. In the interim, Martin had called the hospital emergency admissions department to notify them that Rena would be arriving. He talked with the social worker to explain the situation and to arrange for the social worker to coordinate services with him. Had Martin not been able to contact Rena's mother, he was prepared to telephone the county sheriff's office to bring her to the hospital.

Martin was careful to document all of the activity in Rena's case record, including:

- Providing suicide intervention by telephone.
- Soliciting current risk factors (i.e., emotional pain, pills, drinking, being alone).
- Reviewing previous learning and validating that the process is painful but also underscoring Rena's progress.
- Using the hope box technique to help Rena get grounded and reconnected to positive aspects of her life.
- Eliciting agreement to involve her mother in taking her to the emergency room and providing support.
- Following up with Rena's mother and emergency room staff.

Part 2

Addressing Suicidal Thoughts and Behaviors:

An Implementation Guide for Administrators

An Overview of Part 2

This guide for administrators has two chapters:

Chapter 1 surveys pertinent issues for administrators regarding how suicidal thoughts and behaviors can and should be addressed in substance abuse treatment, including:

- The role of administrators and mid-level staff in providing care for clients with suicidal thoughts and behaviors.
- Different levels of program involvement in addressing the needs of substance abuse clients with suicidal thoughts and behaviors.
- Legal and ethical issues for consideration in managing and providing treatment to clients with suicidal thoughts and behaviors.

Chapter 2 presents specific protocols, policies, and procedures useful in:

- Helping an agency become capable of handling suicide prevention and intervention.
- Helping a program develop and improve staff capabilities in working with clients who are suicidal.
- Helping an agency develop and improve its response to suicidal crises.
- Building administrative support for all components of GATE.

Chapter 1

The Administrative Response to Suicidality in Substance Abuse Treatment Settings

Introduction

This Treatment Improvement Protocol (TIP) is designed not only to help substance abuse counselors meet the needs of clients with suicidal thoughts and behaviors, but also to provide information and direction to program administrators, clinical supervisors, and other senior staff who are charged with developing and implementing policies and administering programs for substance abuse and co-occurring disorder treatment. This part of the TIP is addressed to you in your role as an administrator. Suicidal thoughts and behaviors are a significant issue for many clients in substance abuse treatment, and, as we will demonstrate in this chapter, affect not only the individual, but also other clients, staff, and program functioning. It is essential that programs provide the structure and resources to address suicidality as it emerges with clients considering treatment or while in treatment.

Suicide is among the leading causes of death for people who abuse alcohol and drugs (Wilcox, Conner, & Caine, 2004). Individuals with substance use disorders are also at increased risk for suicidal ideation and suicide attempts (Kessler, Borges, & Walters, 1999). People with substance use disorders who are in treatment are at especially elevated risk for a number of reasons (Wilcox et al., 2004). They enter treatment at a time when their substance abuse is out of control and when stress from marital, legal, job, health, or interpersonal problems is exceptionally high. Many may have other issues that increase their risk for suicide, including co-occurring mental health problems (e.g., depression, posttraumatic stress disorder, and some personality disorders) and substance-induced effects (e.g., symptoms in the context of drug use, intoxication, or withdrawal), such as substance-induced depression, anxiety, or psychosis.

It is particularly important for you to understand two pivotal areas regarding services for substance abuse clients exhibiting suicidal thoughts and behaviors. First, the role of the substance abuse treatment program is to provide safety for its clients. Recognizing suicidality when it appears, having policies and procedures for addressing suicidal thoughts and behaviors, and ensuring that treatment for the substance use disorder is not lost in the suicidal crisis saves lives and improves treatment continuity for all clients in the treatment setting. As discussed below, few substance abuse treatment programs are capable of meeting all of the treatment needs of clients who are suicidal. Treating suicidal thoughts and behaviors is often beyond the scope of services in substance abuse programs, much as treating substance abuse is beyond the scope of many treatment programs for other life problems. Nevertheless, substance abuse programs have an obligation to recognize suicidal ideation and behaviors, to address those symptoms, and to assist clients in getting the help they need.

Second, it is imperative that counselors have a consistent clinical protocol, supported by strong and effective agency policies and clinical supervision, that allows them to act effectively when clients who are suicidal are identified. To this end, the consensus panel for this TIP developed a protocol with the acronym GATE, which calls for the following steps:

- **G**ather information.
- **A**ccess supervision or consultation.
- **T**ake action to ensure appropriate care and safety for the client.
- **E**xtend the action beyond the immediate situation to promote ongoing treatment and safety.

The role of administrators, senior staff, and clinical supervisors in each step of the GATE process is discussed in Part 2, chapter 2.

Part 1 of this TIP addresses the needs of substance abuse counselors working with clients with suicidal thoughts and behaviors. But without the substantial and knowledgeable support of program administrators like you, the application of skills and information presented in Part 1 is likely to be limited. Helpful choices and strategies may be underused and inconsistently applied. Program administrators have to create, implement, and monitor policies and procedures for addressing the needs of suicidal clients and for supporting counselors in order for an agency to be successful in the prevention of and intervention in suicidal thoughts and behaviors.

Consensus Panel Recommendations for Administrators

The consensus panel that convened to address administrative issues for this TIP made specific recommendations for you. It is obvious that administrators, senior staff, and clinical supervisors play a role in the development, implementation, and ongoing support of each of these recommendations, and that without your support, these recommendations would not be implemented.

- The administrator should be able to articulate the goals and objectives of the program as they relate to suicidality, client safety, and crisis intervention, and must be actively involved in crisis resolution.
- Personnel should be trained to a level of competence within their range of expertise and licensure or certification to manage intervention with clients who are suicidal (see the section on competencies, pp. 25–31).
- Substance abuse programs should have a risk management plan that addresses the needs of clients who are suicidal. This includes, but is not limited to, the following:
 - All clients in substance abuse treatment should be screened for suicidality.
 - The facility should meet all public health and safety codes.
 - Personal safety for clients and staff should be addressed in policies and procedures.
 - Suicidal behaviors that become critical events (i.e., circumstances in which clients or staff are at risk of significant psychological or physical trauma or death) should be investigated by a

- review panel to identify how the program can be strengthened in the context of these events.
- Staff should be debriefed after critical events, as this provides an opportunity for positive changes and improvements in client care throughout the organization.
- Substance abuse treatment programs need to have protocols, accessible to all staff, that offer guidelines for addressing the needs of clients who exhibit suicidal thoughts and behaviors. These protocols may include a flowchart highlighting the chain of command in seeking supervision and administrative guidance.
- Personnel should be knowledgeable of the social and medical resources available to persons in suicidal crisis and the procedures or protocols to be followed for their use.
- Community relationships should be developed and maintained that will support interventions with clients who are suicidal within the program or the referral system.
- Substance abuse treatment programs need to have standardized methods of documentation for how suicidal ideation or behavior was identified, supervision or consultation that was sought as a result, actions that were taken, and followup that occurred.
- Crisis services, either as a component in the treatment program or through arrangement with other agencies, should be available 24 hours a day. This includes referral, coordination, and followup, as required by law enforcement; hospital emergency rooms; and any other referral source.

The Benefits of Addressing Suicidality in Substance Abuse Treatment Programs

Historically, misconceptions within agencies (either explicit or implicit) may have hindered effectively addressing suicidal thoughts and behaviors.

Examples of these misconceptions and myths include:

- Talking about suicide will put it in the minds of clients.
- Raising the issue of suicidality during early treatment will detract from the business at hand.
- Screening for suicidality is not the job of a substance abuse counselor.

- Once someone enters treatment, they are significantly less likely to have suicidal thoughts or behavior.
- If you don't ask about suicidal thoughts or behaviors, the program and the counselor won't be legally at risk if the patient attempts suicide or dies from suicide.

Mistaken ideas such as these serve to perpetuate ineffective responses to clients with suicidal thoughts and behaviors. Other misconceptions about suicide common among substance abuse treatment providers and the general public are discussed in Part 1, chapter 1 (pp. 6–7). Today, however, it is more widely accepted that proactively addressing suicidality in substance abuse treatment programs is advantageous from a number of perspectives.

First, addressing clients' suicidal thoughts and behaviors in substance abuse treatment *does save lives*. The early action of clinical staff can prevent suicide attempts and suicide deaths.

Second, addressing suicidal thoughts and behaviors of clients in substance abuse treatment *keeps clients from dropping out of treatment*. More often than not, unacknowledged and unaddressed suicidal thoughts and behaviors represent a crisis in the client's life. The client's response to this crisis may be to lose focus on gaining sobriety and to return to familiar but unhealthy coping mechanisms, which may include substance use. Addressing suicidal thoughts and behaviors gives a clear message to clients that these types of problems are not overwhelming to the counselor and that immediate assistance is available. This reassures clients that they and the counselor are working together to get the help they need and that most problems they encounter can be resolved with the help of appropriate treatment.

Third, active suicidality on the part of a client *disrupts treatment* for other clients in the treatment setting. A client's suicidal thoughts and behavior can be deeply upsetting to others in treatment. Many, and perhaps most, substance abuse clients in early recovery can identify with a person with suicidal thoughts. The difficulty with identifying and processing powerful emotions related to suicide and with being able to self-affirm in the face of these emotions, along with the difficulty resulting from overidentification with other clients, all serve to disrupt treatment progress.

Finally, for treatment programs, addressing issues of suicidality leads to positive programmatic efforts through:

- Increasing the competence of staff to address crises.
- Reducing risk management issues related to legal liability.
- Improving program consistency and coordination.
- Increasing staff retention through reducing counselor burnout, lowering staff stress, and promoting a greater sense of counselor and frontline support from administrators.

Why Should Administrators Be Involved in a Clinical Issue?

Suicide Is an Important Programmatic Issue

As previously stated, clients in substance abuse treatment are at elevated risk for suicidal thoughts, suicide attempts, and deaths by suicide. Additionally, research and the experience of clinicians and administrators among the TIP consensus panelists confirms that the suicidal behavior of a client in treatment for substance abuse disrupts treatment for *all* clients. It increases the anxiety of others who may also be having suicidal thoughts, and invites clients and staff to focus on an issue not necessarily related to their primary treatment and recovery goals. In this sense, it occupies valuable client and staff time that could be spent on recovery goals.

Substance abuse programs need to have policies and procedures to address treatment issues raised by suicidality, such as responding promptly and consistently to suicidal crises, gathering additional information, seeking advice and support of other clinical staff and supervisors, making referrals, following up, and documenting activities.

Suicidal behavior creates unique stressors for staff in terms of time, emotional reactions, clinical uncertainty, and the need for additional supervisory consultation. Research supports significant clinician distress when a client dies by suicide (Hendin, Haas, Maltzberger, Szanto, & Rabinowicz, 2004; Hendin,

Lipschitz, Maltsberger, Haas, & Wynecoop, 2000). As with addressing the other needs of clients, administrators need to establish policies and procedures for guiding staff in addressing and resolving suicidal crises. Clear guidelines for accessing supervision and support need to be established, including offering clinical staff opportunities to “debrief” and learn from the experience of the crisis. Suicidal crises in the agency also offer the opportunity to evaluate how current policies and procedures could be strengthened and adapted to better suit current needs.

Issues around suicidality sometimes push the agency toward a crisis state that can potentially disrupt normal patterns of communication, continuity, and governance. You will need to be actively involved in the organization’s crisis response to ensure that the agency is strengthened as a result of the experience and that gaps in effective response are identified and addressed. Issues related to suicide often manifest after regular hours or away from primary treatment sites, necessitating new and innovative approaches to addressing the crisis. For instance, the potential for suicidal thoughts and behaviors of clients in intensive outpatient programs may necessitate an on-call system for senior staff and clinical supervisors. For an inpatient setting, a clinical supervisor trained in suicide interventions might need to be on call in the evenings to respond to a suicidal crisis.

Finally, suicidal behavior of clients in treatment poses unique legal and ethical issues for programs. These issues are discussed in some detail later in this chapter.

Levels of Program Involvement and Core Program Components

This TIP identifies three levels of program involvement in suicide prevention and intervention. This chapter describes the programmatic elements that are considered essential to each level. Each level increases the capability of the program to identify clients at risk for suicidal thoughts and behavior, the resources the program possesses to intervene with the client, the programmatic elements in place to provide safety and treatment to people who are suicidal, and the resources the program possesses to intervene in suicidal crisis events.

Level 1 Programs

The TIP consensus panel recommends that, at a minimum, **all programs providing substance abuse treatment to clients** should be **Level 1**. Level 1 programs have the basic capacity to identify clients who are at risk and identify warning signs for suicide as they emerge. Clinical staff have the skills to talk comfortably with clients about their suicidal thoughts and behaviors, are knowledgeable about warning signs and risk factors for suicide among clients in treatment for substance abuse, and, with appropriate supervisory support, can make referrals for formal suicide risk assessment. The program has clear policies and procedures for referral in place, and procedures and protocols for managing suicidal crises in the agency are available to all staff. Some of the characteristics of Level 1 programs include:

- All clinical staff recognize that clients in substance abuse treatment are at increased risk for suicidal thoughts and behaviors.
- All clinical staff have had basic classroom education in risk factors, warning signs, and protective factors for suicide. The educational effort (as with the following two characteristics) focuses on the knowledge, skills, and attitudes described in the professional competencies in Part 1, chapter 1.
- All clinical staff have had basic classroom education in recognizing misconceptions about suicide, have had an opportunity to replace them with accurate and contemporary information, and have explored their own attitudes toward suicide and suicidal behavior.
- All clinical staff have had basic classroom education and clinical supervision in recognizing clients’ direct and indirect expressions of suicidal thoughts.
- All clinical staff have the skills to talk with clients about suicidal thoughts and behaviors and collect basic screening information (see the information on screening in Part 1, chapter 1).
- The substance abuse treatment program has basic protocols for responding to clients with suicidal thoughts and behaviors. These protocols reflect established policies and procedures of the agency, including when counselors should obtain consultation from other staff, clinical supervisors, or outside mental health consultants; documentation procedures for recording information in client records; referral procedures; and the steps to be

undertaken to ensure appropriate followup of referrals and other actions.

- The substance abuse treatment program has formalized referral relationships with programs capable of addressing the needs of clients with suicidal thoughts and behaviors and specific protocols for how a referral is made. These formalized referral relationships are documented in writing, specify the conditions under which a referral is made, identify a contact person, specify potential costs and who is responsible for costs of care, and contain any other information relevant to the referral process. These relationships are updated and confirmed on a quarterly basis.
- The program has protocols for managing suicidal crises that are available for all staff. These protocols identify the types of situations that might constitute a crisis, indicate how counselors are to receive clinical supervision or consultation, specify what actions can be taken by the counselor and what actions need to be taken by program administrators, and state what documentation should be made regarding crisis interventions.

The TIP consensus panel recognizes that many substance abuse treatment programs (particularly small, free-standing outpatient clinics; programs in rural and remote locations; and specialized treatment resources) may not possess the resources to provide the more advanced care that a Level 2 program (see below) might offer. At the same time, because the risk factors for suicidal thoughts and behaviors are so high among people in substance abuse treatment, and even higher among specific treatment populations (described in Part 1, chapter 1), the characteristics noted above are essential for high-quality care. All programs should at least meet the above standards. These standards meet the basic criteria of client safety, appropriate documentation, and program responsiveness to issues concerning suicide as they emerge and to suicidal crises.

Level 2 Programs

Some substance abuse treatment programs, particularly those with more staff, more diversified services, and possibly those with administrative links to other programs (for instance, mental health) have the capacity to offer more care for clients with suicidal thoughts and behaviors. Specifically, these programs may be able to maintain continuity of substance abuse treatment on an outpatient or residential basis

while concurrently addressing the treatment needs of clients with active warning signs for suicidality. These efforts extend beyond Level 1 services and are termed in this TIP as **Level 2** programs.

Some of the attributes that might be found in Level 2 programs, in addition to those services and resources of Level 1 programs, include:

- The program has at least one staff member with an advanced mental health degree (for instance, licensed Ph.D. psychologist, or licensed clinical social worker) who is specifically skilled in providing suicide prevention and intervention services and in providing clinical supervision to other program staff working with clients with suicidal thoughts and behaviors.
- The program has the capability to continue substance abuse treatment services for clients with suicidal thoughts and behaviors while monitoring those clients for suicidal symptoms and an exacerbation of psychiatric symptoms of depression, anxiety, or other co-occurring disorders.
- The program has formalized ongoing relationships (within the agency or in the community) with mental health professionals trained in suicide intervention to address emergency needs.
- The program can offer consultation services to Level 1 programs on an as-needed basis.

Level 3 Programs

Some substance abuse treatment programs have the capacity to provide services to acutely suicidal clients that allow the client to continue receiving substance abuse treatment while in the midst of a suicidal crisis. The TIP consensus panel has identified these programs as **Level 3**. Most often, the programs that can offer these services are administratively linked to hospitals and inpatient psychiatric services.

In addition to the standards for Level 1 and Level 2 programs, Level 3 programs can offer:

- Programs linked to a mental health or hospital setting that provides security for people who are actively suicidal and have high risk factors.
- Frequent, regular periods of contact with the client (known as suicide watch), or beds (or an area) designated as observation beds (previously known as suicide-watch beds).
- Clinical staff can perform comprehensive suicide assessments in-house that determine level of risk,

treatment needs, and necessity for legal constraint on the client.

- The treatment agency has the appropriate certifications to legally detain clients who are actively dangerous to themselves or others. Such certifications are more commonly held by mental health rather than substance abuse treatment facilities.

Fortunately, the need for Level 3 services is limited and the vast majority of clients with suicidal thoughts and behaviors can be effectively managed and treated for their substance abuse and suicidal thoughts and behaviors in Level 1 and 2 programs. Nevertheless, appropriate resources for people who are acutely suicidal and for whom substance abuse is a closely related disorder are a valuable addition to the treatment continuum of care.

Implementing a Level 1 or Level 2 Program

A variety of decisions and implementation strategies must go into preparing your program to be Level 1 or 2. These issues can be divided into four broad categories:

1. Developing an overall policy regarding the program's approach to addressing suicidality
2. Implementing and revising policies and procedures to reflect the organization's goal to provide quality services to clients who exhibit suicidal thoughts and/or behaviors
3. Establishing a system to monitor and evaluate policies and procedures regarding suicidality and to adapt these as needed.
4. Providing staff development and educational opportunities related to suicide for current and newly hired staff.

The following checklist reflects some of how these issues need to be considered.

1. Do you have a program policy statement about: Acknowledgment of suicide as a significant risk in your client population?
 - If no, establish a committee to write one.
 - If yes, is it fully understood by all staff?

Risk management for suicide and other high-risk behaviors (see sample policies in Part 2, chapter 2)?

If no, establish a work group to study the issue and write one.

If yes, is it fully implemented with all staff?

Screening for suicide as part of the program's routine protocol?

If **no**, develop or adapt screening questions in this TIP or other knowledgeable sources, then arrange training for all staff (support, counseling, substance abuse, and clinical supervisory).

If **yes**, do you have specific questions to explore with clients with suicidal thoughts and behaviors? Has training been completed for all staff? Is the training specific to each staff member's role? Is there a provision for clinical supervision or consultation?

Provision for services to be provided to suicidal clients?

If **no**, read this TIP carefully, consult with other community substance abuse and mental health resources about their services, and attend training or hire a trainer for your agency.

If **yes** and services are provided by referral, does your agency have formal agreements with other agencies or individuals?

If **yes** and services are provided in-house, what services are available? Who is responsible for overseeing these services? Who is qualified to provide them? Who monitors their use and effectiveness? How do clients access them? Do the policies include involvement of family members or significant others? Do the policies include transportation to other care providers?

Staff development for services to suicidal clients?

Does the program have a system in place to orient new employees to the policies and procedures regarding suicidal thoughts and behaviors?

Are there opportunities for all clinical staff to have refresher or advanced courses emphasizing skills in working with clients with suicidal thoughts and behaviors?

Provision for agency review of critical events?

Does the program have a procedure for review of critical events (such as suicidal behavior of clients) to adapt and update policy and procedures? Is a specified individual or position responsible for convening and conducting critical event reviews?

What documentation is necessary?

2. Are these policies implemented as written, reviewed regularly, and revised as necessary?
 - If **no**, create a workgroup to explore the gaps in implementation and review. Charge the group with creating a plan to complete the implementation process and systematically review the policies with an eye to making revisions as needed.
 - If **yes**, are the policies regarding the likelihood of suicidal thoughts and behaviors, screening, services, followup, and documentation fully integrated into the program? Are they congruent with current staffing? Do they match the current client population?
3. Are these policies and procedures monitored and evaluated?
 - If **no**, establish a workgroup (or assign an individual) to devise a method for monitoring and evaluation. Get buy-in from staff members to make needed program improvements.
 - If **yes**, is there an individual or work group assigned to monitor and evaluate them? Monitoring should include the outcomes for all positive screens for suicidal thoughts and behaviors. How is the feedback from monitoring and evaluation communicated to program staff so that program improvements can be made?
4. Is there a critical incident review process?
 - If **no**, design and develop a process to review events and recommend changes to existing policies and procedures.
 - If **yes**, is a critical event committee established to collect data, evaluate them in light of existing policies and procedures, and recommend changes to existing policies and procedures as needed?

The Role of Administrators in Implementing and Supporting Programming for Clients With Suicidal Thoughts and Behaviors

Administrative staff, especially executive directors and program directors, play a particularly important leadership role in creating an environment that fosters rapid identification of and quality services to clients with suicidal thoughts and behaviors. Without the commitment of the program's administrative staff, it is difficult for mid-level staff (clinical supervisors and senior counselors) to implement policy and to support effective clinical practices. Commitment is demonstrated by advocacy of the need for services for suicidal clients, by follow-through on suggestions and plans for programming, and by delivery of a consistent message that fosters support for change and program improvement. Program planning should additionally include input from direct services staff in planning and implementation. Not only does this help mid-level and direct-service staff take ownership of the new initiative; it also prevents a sense that they are being told to add responsibilities to their already heavy workload.

Administrative leadership means communicating a vision of how the program can benefit by providing services to clients who are suicidal. This vision is communicated through explicit goals and a clear statement of how all will benefit from improved services. In this light, it is important that program leaders can communicate in a knowledgeable and articulate manner about suicidality. Treating the issue of suicidality with the importance, priority, and seriousness it deserves communicates your commitment to implementation and ongoing improvement of care.

Finally, leadership needs to inspire others in the organization to become aware of and committed to reducing the incidence of clients' suicidal thoughts and behaviors in the program. Inspiration is communicated through enthusiasm for current and new programmatic elements, optimism about the change process, and an unwillingness to accept anything but

success in the effort. This enthusiasm can be demonstrated by emphasis on suicide prevention in staff meetings, active participation in the planning process, attendance at and participation in training events, and recurring reminders to staff at all levels of the importance of suicide prevention. Such inspiration becomes contagious to other staff and is particularly effective when resistance to change is expressed by frontline staff. Inspiration supports the significance of the effort.

The Role of Mid-Level Staff in Implementing and Supporting Programming for Clients With Suicidal Thoughts and Behaviors

Clinical supervisors and senior counselors play a critical role in responding to clients' suicidal thoughts and behaviors in substance abuse treatment settings. They are typically the "go-to" staff when a counselor suspects that a client is suicidal. More often than not, their responsibility is to make the clinical decisions that affect client care and the overall functioning of the clinical services component of a substance abuse treatment agency. You can ensure that mid-level staff are aware of these responsibilities and adequately trained to carry them out.

Clinical supervisors have the primary responsibility for gathering necessary information from counselors when a client acknowledges suicidal thoughts and/or behaviors. They must be able to make decisions about what and how much additional information to gather from the client, determine what consultation with appropriate mental health professionals is warranted, decide how the substance abuse counselor can prepare a client for a potential referral, evaluate what assistance the counselor needs in making appropriate referrals, and ensure that the treatment plan has been effectively implemented and/or updated. Additionally, it is often the clinical supervisor who has to make important decisions related to legal and ethical issues when a client has suicidal thoughts and behaviors.

Having the responsibility to address all of these issues means that clinical supervisors need to be particularly knowledgeable and skilled in all elements of GATE, the framework for addressing suicidality used

in this TIP. They must also have the clinical skills necessary to manage crisis situations and the clinical and personal attitudes to foster effective use of these skills.

In this sense, clinical supervisors and other mid-level clinical staff are liaisons between frontline substance abuse counselors and administrators. Clinical supervisors and senior clinical staff have the responsibility of informing administrators of the effectiveness of established policies and procedures and, because of their unique perspectives, need to be involved in shaping and formulating policies and procedures. Because of their ability to integrate their clinical experience with an understanding of the program's mission, goals, and services, they should have a primary role in planning and adapting policies related to suicide. It is primarily their responsibility to implement policies and procedures developed as a result. Finally, it is their responsibility to keep the awareness of issues related to suicide risk in the agency in the forefront for administrators, frontline staff, and support staff.

Obviously, mid-level staff play a critical role in addressing suicidal thoughts and behaviors in substance abuse programs. But they can only be effective if administrators recognize the responsibility they shoulder and respond with appropriate support and guidance. Such support includes hearing the concerns and needs of clinical supervisors in regularly scheduled staff meetings, supporting training related to suicidality, participating in developing interagency relationships for the consultation and referral of clients who are suicidal, encouraging the development of relationships with professionals outside the agency, supporting clinical supervisors in improving their skills through supervision of supervisors, and encouraging active involvement of supervisors in developing and adapting policies and procedures.

Legal and Ethical Issues in Addressing Suicidality in Substance Abuse Programs

Clients with suicidal thoughts and behaviors raise unique ethical and legal issues for substance abuse treatment programs. While it is the responsibility of counselors to address these concerns, as administra-

tors, you have the responsibility of setting policies and procedures to ensure that the agency is in compliance with applicable legal and ethical standards. At the broadest level, legal and ethical practice issues are measured in the context of a program offering a reasonable standard of care to clients to ensure their safety and appropriate treatment. Maris, Berman, and Silverman (2000b) define standard of care as “the degree of care which a reasonably prudent person or professional should exercise in the same or similar circumstances” (p. 487). The authors elaborate by including “the duty to exercise that degree of skill and care ordinarily employed in similar circumstances by the average clinical practitioner” (p. 488) and “the duty to make reasonable and appropriate decisions using sound clinical judgment” (p. 490).

Carrying out this standard of care inevitably involves both legal and ethical considerations. In this TIP, legal issues are defined as those issues that are subject to laws and legal regulations. Generally, these issues are fairly clear-cut, with examples or illustrations defining what is legal and what is illegal.

Ethical concerns relate to professional standards of care and concern the moral issues that arise in the conduct of professional services. Each profession concerned with substance abuse treatment (e.g., substance abuse counselors, social workers, professional counselors, psychologists, physicians) has a different set of professional standards. Additionally, each professional association, such as the Association for Addiction Professionals, the National Association of Social Workers, the American Counseling Association, the American Psychiatric Association, and the American Psychological Association, has a set of ethical standards to which their membership agrees to adhere. Finally, in States where these professional groups are licensed, the State licensing board may have an additional set of ethical standards to which persons licensed by that group must adhere. (A more detailed discussion of ethical issues begins on p. 103.)

Legal Issues

The legal issues regarding suicidality for substance abuse programs are primarily related to standards of care, maintaining appropriate confidentiality, and obtaining informed consent. Both the Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) provide standards of care for clients at risk of suicide that programs must consider for accreditation (e.g., MacNeil, 2007). Additionally, the American Psychiatric Association (2003) and other professional organizations offer practice guidelines for the clinician that set appropriate and reasonable standards of care. While many of these guidelines are for professional activities beyond the scope of substance abuse counselors, they offer a resource for such issues as confidentiality, informed consent, referral procedures, and treatment planning that have relevance to counselors working in substance abuse treatment agencies.

Maris et al. (2000b) points out three common malpractice “failures” for work with suicidal clients.

1. *Failure in assessment.* For substance abuse treatment programs, this means failure to (1) gather information (such as the standard screening questions noted in Part 1, chapter 1), (2) consider that information in treatment planning, (3) recognize warning signs or risk factors as they emerge in treatment, or (4) obtain records from other sources (e.g., previous substance abuse or psychiatric treatment) that would have indicated a significant risk of suicidality.
2. *Failures in treatment.* For substance abuse treatment programs, this might mean failure to (1) consider the impact of an intense substance abuse treatment environment on a client’s suicidality, (2) prepare a client for treatment transitions, including administrative discharges, (3) make appropriate referrals for clients with suicidal thoughts and behaviors, and (4) follow up on referrals.
3. *Failure to safeguard.* Substance abuse treatment programs have an obligation to clients to create a physically and psychologically safe environment. Creating this safe environment means observation procedures for clients in inpatient or residential settings who are potentially suicidal, efforts toward weapon removal for both inpatient and outpatient clients, and an awareness of medication use by clients who are potentially suicidal. Informed consent documentation should include an explanation of the limits of confidentiality (i.e., the duty to warn in specific situations). In addition, you should implement a policy and procedure for obtaining a release from clients who are at sig-

nificant risk or have warning signs of suicide to contact a family member or significant other if the counselor, with appropriate clinical supervision, feels the client may be at significant risk of attempting suicide. While the client must have an opportunity to revoke the release, it gives the agency some option with a client who is actively suicidal.

In all situations, failure to document actions makes it more difficult to legally defend one's professional behavior. It is essential to properly document warning signs, risk factors, and protective factors; steps taken to address these signs; the consultation or supervision that was obtained; the referrals that were considered and/or made; the client's response to the referral; and the followup that was conducted. Examples of appropriate documentation are presented in Part 1, chapter 1.

Still another variable for consideration of legal issues is liability, both for the agency and for the practitioner. Both may be held responsible when standards of care are not met. Rudd (2006) distinguishes between malpractice liability as a concern of the institution and professional liability (failure to meet the ethics or standards of practice of one's profession), which is a concern of the individual practitioner.

Part of your job is to protect the program and the practitioner from both types of liability. Programs may be held responsible for meeting standards of care (e.g., identifying clients who are at risk for suicide and taking steps to ensure the safety of those clients), but programs can also be responsible for the actions of counselors employed by the program when those counselors or other professional staff do not adhere to professional standards of practice, commit a violation of law (e.g., confidentiality), or when the program does not provide adequate support (e.g., clinical supervision) to counselors or other professional staff.

Foreseeability

Foreseeability concerns the expectation that a practitioner (substance abuse counselor or mental health professional) should have been able to foresee the potential suicidal risk that a client might experience. Without conducting basic screening for an individual with suicide risk factors, a counselor might be perceived as not taking appropriate steps to foresee suicidality.

In Part 1, chapter 1, the consensus panel recommends that five basic questions be included in initial client interviews and at appropriate followup points to gather information about a client's suicidal thoughts and behaviors. These questions are taken from "Assessing Suicide Risk: Initial Tips for Counselors," reproduced on page 17. Any affirmative answers require followup questioning, a consultation with a clinical supervisor or consultant, and possible further evaluation by staff trained in suicide assessment. Administrators can implement an intake protocol that includes these five questions, which are:

- Are you thinking about killing yourself?
- Have you ever tried to kill yourself before?
- Do you think you might try to kill yourself today?
- Have you thought of ways you might kill yourself?
- Do you have pills or a weapon to kill yourself in your possession or in your home?

It is important to note that most substance abuse counselors do not have the skills to conduct an assessment for suicide risk. Assessments need to be conducted by mental health professionals skilled in suicide assessment because they involve making judgments about risk, treatment options, referral needs, and emergency responses. These judgments are beyond the scope of practice for substance abuse counselors. Most substance abuse counselors are, however, capable of screening for suicidality. Screening involves being sensitive to risk factors and warning signs for suicidality (see the descriptions of risk factors and warning signs in Part 1, chapter 1), and asking appropriate questions (such as those listed in Part 1, chapter 1) in interviews and counseling sessions with clients in treatment for substance abuse. If the screening indicates evidence of suicidal thoughts and/or behaviors, the client can and should be referred for a more structured and detailed suicide risk assessment.

Implementing treatment and referrals to reduce the potential for suicide

Most substance abuse clients with suicidal thoughts and behaviors need specialized care beyond the scope of practice for most substance abuse counselors. In this context, the primary tasks of the substance abuse counselor are to ensure safety of the clients, gather information about suicidal thoughts and

behaviors, obtain supervision or consultation to determine a treatment plan, help clients get to the resources they need for successful treatment of their suicidal thoughts and/or behaviors, and follow up to ensure that proper care has been received and that clients accepted the care. This process is analogous to staff in a social service or health program identifying a client with a substance use disorder, concurrent with other problems that brought them to the social service or health care resource. It is the responsibility of staff in such a program to be aware of warning signs and symptoms of substance abuse, to be able to talk to the client about substance use, to make referrals for appropriate treatment, and to follow up to ensure that treatment was accepted and used. But it is beyond the scope of practice of a social service counselor or nurse in a health clinic, for instance, to actually *provide* the substance abuse treatment.

You have a role in seeing that this chain of events rolls forward in a timely and uninterrupted manner. First, you can ensure that counselors are well trained in gathering information regarding suicidal thoughts and behaviors. This includes developing sensitivity to risk factors and warning signs, becoming comfortable in discussing suicide with clients, and being aware of how one's own attitudes toward suicide affects his or her relationship with people who are suicidal. Second, you need a means of support for counselors working with clients who are suicidal. If the organization does not have a clinical supervision program or staff members with special training and expertise in suicide, the counselor will need assistance from an external consultant. Third, you need to know about and have relationships with community organizations to which clients who are suicidal could be referred or transferred. Developing relationships with other health care facilities, such as mental health clinics and hospitals (preferably formalized through memoranda of understanding) can give a substance abuse treatment team a variety of options for referring clients with suicidal thoughts and behaviors.

The substance abuse counselor's role is pivotal in ensuring that clients receive proper care. But it is equally important that substance abuse counselors, with oversight from their administrators, practice within the scope of their professional competencies and skills. To transcend the limits of acceptable practice creates malpractice liability for counselors and for their agency.

Maintaining safety for clients at risk of suicide

Maintaining safety for clients with suicidal thoughts and behaviors means making reasonable efforts to promote their immediate and long-term well-being. Historically, suicide contracts (sometimes referred to as "no-suicide" contracts) with clients have been used by some clinicians to ensure safety. No-suicide contracts generally specify that clients will not do something that would put them at risk of harm or self-injury. There is often an accompanying agreement that the client will contact the counselor or other professional if they begin having suicidal thoughts or behaviors. There is, however, no credible evidence that these contracts are effective in preventing suicide attempts and deaths (Rudd, Mandrusiak, & Joiner, 2006), and this TIP specifically recommends that agencies refrain from using them.

A more contemporary approach to client contracting is a Commitment to Treatment agreement (see the sample in Part 2, chapter 2). Such treatment agreements can support and enhance engagement with the client, possibly lowering risk, by conveying a message of collaboration.

Another issue of client safety is weapon removal. Every agency should have a written policy and procedure for handling weapons that might be used to cause bodily harm or death. Generally, this policy should promote the client's giving the weapon to a family member or significant other in lieu of giving it to the counselor or other program staff. Significant legal liability can arise if a staff member accepts a gun or other weapon from a client and then refuses to return it, if the weapon is illegal, or if a weapon is kept on the premises of the program with potential availability to other clients.

Efforts to promote client safety are, in part, dependent on the intensity and restrictiveness of the treatment environment. On one end of this continuum of care is outpatient counseling, generally conducted on a once-a-week basis. At the other end of the continuum is a secure, locked, and staff-monitored psychiatric unit. In between are intensive outpatient care, day (or evening) hospitalization, a half-way house environment, and traditional substance abuse inpatient rehabilitation care.

Administrators can establish policies and procedures to match the level on this continuum with the appli-

cable safety needs and concerns for clients with suicidal thoughts and behaviors. For instance, Bongar (1991) cites the following ways to reduce liability of suicide behaviors in an outpatient treatment setting:

- Increase the frequency of visits.
- Increase the frequency of contacts (for instance, telephone calls).
- Obtain consultation with a professional with expertise in suicide.
- Give a maximum of a week's supply of antidepressant medication (or a month's supply of other medication).
- Make sure weapons are placed in the hands of a third party.
- Involve other resources in support (for instance, family members if they can be supportive).
- Give the patient telephone numbers of suicide prevention and crisis centers.
- Know the resources that are available for emergencies and outpatient crises.
- Be reachable (or have another contact) outside of office hours (evenings, weekends, and vacation time).

In an inpatient rehabilitation setting, a different set of safety steps might be taken, including:

- Active visual monitoring of the client.
- Consideration for referral to a more secure psychiatric unit.
- Consultation with a staff or a consultant mental health professional for a suicide risk assessment.
- Monitor dispensing of antidepressant and other potentially fatal medications.
- Searches at intake and during treatment as indicated to ensure that the client does not possess weapons, drugs, or other prohibited items.
- A physical environment free of opportunity for suicidal behaviors (e.g., no sharp objects or bath and shower fixtures from which rope-like material could be suspended).

Release of information and confidentiality issues

Two recurring issues of concern to substance abuse program administrators in working with clients with suicidal thoughts and behaviors are (1) the circumstances under which information pertaining to treatment can be released and (2) confidentiality, particularly in contacting family and significant others when a client acknowledges suicidal thoughts and behav-

iors. The consensus panel recommends having clients who are deemed to be at risk for suicidal thoughts and behaviors sign an emergency release of information at the beginning of treatment that allows the program to contact family members in case of an emergency. Clients, in most cases, must still have the right to revoke the consent if they so desire.

Program policies and procedures should be clear that simply acknowledging suicidal thoughts or behaviors is not sufficient cause for violating a client's rights to confidentiality by contacting family members, friends, or another treatment agency without first obtaining a consent for release of information. As in other situations, the release of information must be specific to the situation, the nature of the material released, who can have access to the information, and a time-frame in which the release is valid.

The informed consent documentation signed by the client on admission should include an explanation of the limits of confidentiality (e.g., the duty to warn in specific situations). If a client is at imminent risk of harming herself or himself, first responders (such as police), can be contacted, but the circumstances necessitating the contact need to be fully justified and documented. It should generally be program policy that such contact is only made with the approval of a clinical supervisor or administrator. Some examples of imminent risk include a telephone call from a client saying he has just made a suicide attempt and is in danger, or a client who leaves the agency threatening to kill himself, has identified a method, and seems likely to carry out a suicidal threat.

When working with a client with suicidal thoughts or behaviors, it is good program policy to actively encourage family involvement in treatment and to encourage the client to be open with her or his family about suicidal thoughts and behaviors. As when treating substance abuse, the family members need education and information about suicide, warning signs, and particularly, about what to do when suicidal thoughts or behaviors are present in the client.

As in any other treatment situation, no information regarding a client's condition, treatment plan, or other data should be released without the client's written permission. The only exception is if the client is in imminent danger of harming himself or herself or others in a life-threatening manner. If this happens, refer to State and Federal regulations that address this issue. Administrative staff or senior clin-

ical supervisors should make the decision if a client's right to confidentiality is to be compromised.

A related question concerns the duty to warn when a client is at risk for harming another person. Generally, there is no duty to warn family members if a client is suicidal, unless that behavior threatens to harm another person.

Ethical Issues

A wide variety of ethical issues arises when working with substance abuse clients with suicidal thoughts and behaviors. Additionally, the professional groups that work with this population have differing ethical codes. In fact, even within a profession, counselors working in different States can have different ethical codes depending on where they are licensed or certified. As opposed to legal issues, where there is often a clear guideline for legal versus illegal behavior, ethical issues are often grey areas without defined prescriptions for counselor behavior. Finally, ethical issues often overlap with legal issues. For instance, there are legal concerns about confidentiality of client information and records, but ethical standards also govern counselor behavior in this area. The same is true for responsibility for client safety, how a referral is made and followed up, and in client termination from treatment.

You need to make efforts to ensure agency policy is consistent with the ethical guidelines of professional groups that guide clinical staff practice in the agency. These ethical standards may be promulgated by treatment program associations or organizations for clinical supervisors, counselors, and other treatment personnel. They may be established by regulatory organizations that affect the program. As an example, a program's policy about how counseling services are provided to clients with suicidal thoughts and behaviors needs to be consistent with ethical guidelines about scope of practice for substance abuse counselors who are not specifically trained to treat suicidality. The policy should state that treatment for suicidal clients will be provided by staff with degrees in mental health disciplines who have been trained to treat clients who are suicidal.

Ethical practice has to transcend all levels of organizational behavior. Ethics is often thought of as an issue for frontline staff: counselors, physicians and nurses, psychologists, and social workers. But clinical

supervisors also have ethical guidelines (see, e.g., ethical standards of the Michigan Certification Board for Addictions Professionals [<http://www.mcbap.com/>]), and, at least implicitly, program functioning needs to be guided by ethical practice as well. All these levels need to be consistent in the application of ethical boundaries, for instance, how information about a client who is suicidal is released in a crisis situation, or how decisions are made to transfer a client to another program better able to address acute suicidal thoughts and behaviors.

Malpractice

Malpractice is the intentional or unintentional improper or negligent treatment of a client by a counselor, resulting in injury, damage, or significant loss. It is a growing concern for substance abuse treatment programs. Malpractice is a legal proceeding even though the claim of improper or negligent treatment might have been generated by alleged unethical behavior. (For more detailed information on malpractice, see Falvey, 2002 or Gutheil & Brodsky, 2008.)

Informed consent

A special area of ethical practice with clients with suicidal thoughts and behaviors relates to informed consent for treatment (Rudd, Williamson, & Trotter, in press). Informed consent for substance abuse treatment is an ongoing process in which the client is an active participant in defining what treatment methods and approaches will be undertaken, the expected outcomes of that intervention, the risks and expected efficacy inherent in the care, and alternative treatments that might be used. Clients who evidence suicidal thoughts and behaviors have some special needs for informed consent in addition to those normally given to other clients. You should develop and implement protocols for informed consent applicable specifically to clients who are suicidal. For instance, the client should be clear that if his or her suicidality becomes more overt or debilitating, specialized treatment resources may be required. It is important that the issue of informed consent be raised when treatment is initiated.

Additionally, the program might institute special precautions to protect the safety of the client. It might, in some circumstances, be appropriate to inform the client that the intensity of substance abuse treatment

might cause suicidal thoughts to become more frequent or more intense. This might be the case, for example, when counselors are working with clients with co-occurring substance abuse, suicidal thoughts, and psychological trauma. The protocols might specify what actions can be taken if suicidal thoughts increase, at what point special protective care measures must be taken, and at what point special treatment (such as medication) is indicated.

Admission, transfer, and treatment termination

Ethical issues for substance abuse treatment programs working with clients with suicidal thoughts and behaviors arise around their admission, transfer, and administrative termination. Historically, many substance abuse treatment programs have simply had a policy not to accept clients who exhibit suicidal thoughts or behaviors. The effect of this policy has been that clients who were suicidal continued to be admitted to these programs but could not openly discuss their suicidal thoughts, or they were denied treatment for their substance abuse. Likewise, many of the same clients would be denied treatment by mental health service providers who saw the clients' problem as originating in a substance use disorder.

Fortunately, these practices have been largely discontinued. In fact, many people in the field would find it unethical for a program to deny care to someone who is suicidal unless the program can clearly define how the client's condition is inappropriate for care in the specific program. In that case, the program has an ethical responsibility to help clients find the best care for their needs available in the community.

A related issue of treating substance abuse clients with suicidal ideation or behavior is when they need to be transferred to another treatment facility that can offer safer or more intense care, often for co-occurring disorders (such as depression) that accompany the substance use disorder and suicidality. Substance abuse treatment programs need to have clear policies and guidelines stipulating that a referral for more intensive care does not necessarily mean the end of a client's involvement with the program. The client may need to return to the program when less intensive care is warranted. In effect, transfer does not mean discharge.

Likewise, clients cannot be discharged if they are discovered to have suicidal thoughts and behaviors. It is unethical and may be illegal to discharge a client in clear distress without guaranteed and subsequently confirmed followup with an appropriate provider. Programs have an obligation to provide services to that client either directly through the resources of the program or by referral or transfer to another program better able to treat the client. From an ethical standpoint, this should be made an organizational policy.

If clients complete substance abuse treatment and are discharged from their intensive substance abuse treatment program but still have some detectable level of suicidal thoughts and behaviors, specific efforts should be made to ensure that treatment for that client continues, either in a specialized program for clients who are suicidal or in a continuing care extension of the substance abuse program.

Additional training

An ethical issue for substance abuse programs is in providing training for counselors in suicidality. Counselors should not be expected to address suicidal thoughts and behaviors without additional training. The consensus panel strongly recommends that administrators help counselors get additional training to address the competencies listed in Part 1, chapter 1, including these knowledge, skills, and attitudinal domains:

- Gathering information.
- Accessing supervision and consultation.
- Taking responsible action.
- Extending the responsible action with follow-up and documentation.
- Basic knowledge about the role of warning signs, risk factors, and protective factors.
- Empathy for clients who are suicidal.
- Cultural competence issues in recognizing and addressing the needs of clients who are suicidal.
- Legal and ethical issues in addressing suicidality in the agency.

It is insufficient to simply train counselors to recognize suicidality or in facts about suicide and substance abuse. The above competencies need to be considered in preparing counselors to work with people who are suicidal in the context of substance abuse treatment. A variety of training materials can be

used in addition to the material in this TIP. The Suicide Prevention Resource Center (SPRC) produces a variety of workshops and training materials for counselors (<http://www.sprc.org>) through its Training Institute. The Addiction Technology Transfer Centers (ATTCs), funded by SAMHSA (<http://www.healthknowledge.org/>), offer a variety of training opportunities. Courses in Counseling Suicidal Clients and Crisis Intervention are currently being offered by email correspondence and on the Internet. Finally, a variety of State training pro-

grams, including summer institutes on alcohol and drug problems, present workshops for substance abuse counselors working with suicidal clients.

In summary, substance abuse treatment programs face a variety of ethical issues in treating substance abuse clients who evidence suicidal thoughts and/or behaviors. Program administrators need to address these ethical concerns in agency policies and to translate those policies into specific procedures for mid-level supervisory staff, for substance abuse counselors, and for other staff members.

Chapter 2

Building a Suicide Prevention- and Intervention-Capable Agency

Introduction

The previous chapter presented an orientation for administrators about how suicide affects a substance abuse treatment program. It focused on several conceptual issues, including why a program administrator should be concerned with suicide, levels of agency preparedness to address suicide, and the legal and ethical considerations of working with clients in substance abuse treatment who have suicidal thoughts and behaviors.

This chapter presents four programming and implementation issues of primary concern to administrators and provides the tools you will need to:

- Help an agency become suicide prevention and intervention capable.
- Help a program develop and improve staff capabilities in working with suicidal clients.
- Help an agency develop and enhance its response system to suicide crises.
- Build administrative support for all components of GATE (Gathering information, Accessing supervision, Taking action, and Extending the action).

Community-based substance abuse treatment programs come in a wide variety of sizes and orientations, with major differences in staff and other features. Given their size, staffing, orientation, and other features, not all substance abuse treatment programs will be able to provide all of the necessary services to all clients with suicidal thoughts and behaviors. In addition, some high-risk clients may be inappropriate for a given agency.

To further complicate matters, clients come into substance abuse treatment with a variety of needs and levels of risk. In the past, many agencies simply declined to treat anyone who might be a suicidal risk. However, such an option no longer exists, and such a general declaration now seems irresponsible and possibly programmatically unethical. With this in mind,

substance abuse treatment programs now have to decide:

- Which clients who are suicidal they can adequately serve.
- Which clients will need to be linked with an agency that can better meet their needs.

Substance abuse treatment programs also need to strive to improve their services to a point where clients with elevated risk may be accommodated and treated (Level 2). Such an orientation is within the realm of most programs today. Such a shift does, however, require your knowledgeable commitment along with a plan for design, implementation, and evaluation of services and training of clinical supervisors, substance abuse counselors, and other treatment staff.

As noted before, the accrued benefits of becoming a Level 2 substance abuse treatment program are:

- Clients can remain in substance abuse treatment even though co-occurring problems like suicidality are present. Staying in treatment for substance use disorders may be critical for the client's recovery and rehabilitation.
- The Level 2 substance abuse program can be responsive to a variety of crisis states related to suicide that might otherwise disrupt functioning for the client who is suicidal, other clients, and program staff.
- The responsiveness of the program to issues of suicidality may increase the capacity of the program to respond to other client crises that present in the treatment program.
- Being a Level 2 substance abuse treatment program means staff have additional skills and diversity that can benefit the overall treatment program.
- Being Level 2 allows the program to treat clients who have specific co-occurring mental disorders who would otherwise have to be referred, thereby

potentially increasing program effectiveness and building financial benefits to the program.

- Most important, being a Level 2 program helps identify clients with suicidal thoughts and behaviors who would otherwise be undetected. Being a Level 2 program, in fact, has the potential to save lives.

This TIP recognizes that not all programs can treat clients with elevated risk of suicide. A Level 2 program has specially trained staff, being able to address and monitor suicidality onsite for many clients rather than through referral, and being prepared to coordinate treatment for a variety of co-occurring disorders often implicated in suicide risk (e.g., depression, borderline personality disorder, PTSD, anxiety disorders). Some programs are too small to have this capacity, others too specialized (such as many halfway houses). For these programs, being Level 1, and having working relationships with other agencies in the community for consultation, supervision, and referral may be sufficient.

Being a Level 2 program begins with your recognition of the need and value of addressing suicidal thoughts and behaviors in the program in a comprehensive way. This process requires three basic steps.

1. Organizational assessment
2. Organizational planning
 - Organizing a team or workgroup to address planning
 - Deciding on specific targets for change
 - Determining how and when to begin implementation
3. Program implementation
 - Adapting existing policies and programs
 - Implementing and integrating new programmatic elements

A valuable resource for administrators working in substance abuse treatment settings is *The Change Book* (Addiction Technology Transfer Center, 2004), which describes the organizational change process used in this TIP. In addition, you may want to review *Implementation Research: A Synthesis of the Literature* (Fixsen, Naom, Friedman, Blase, & Wallace, 2005) for more information on the scientific basis for various implementation practices.

Organizational Assessment

Historically, organizational change in substance abuse treatment settings has tended to occur as a result of pressure from the outside: mandates from funding resources, rules and regulations from State agencies, or standards from accrediting bodies. But more and more, as programs and management become increasingly skilled and sophisticated, the perception of organizational assessment and change as an ongoing, internal, data-based, quality improvement-focused process has evolved. Research (e.g., Ogbonna & Harris, 1998; Schneider, 2002) supports that successful interventions and positive evolution of organizations depend not only on the quality of the intervention, but also on the organizational culture.

Gathering Data on the Effects of Suicidality on the Program

To get a snapshot of your organization's current ability to address suicidal thoughts and behaviors, you will need to consider your responses to the questions below.

Clients with suicidal thoughts and behaviors:

- How are clients with suicidal thoughts and behaviors currently identified in the treatment population? Does the program only identify clients who are in an obvious, self-disclosed suicidal crisis? Are screening questions for suicide routinely asked in clinical interviews? If not, a study of current clients might be considered in which the five screening questions recommended in this TIP (see Part 1, chapter 1, p. 17) are asked of all clients.
- What might you do to identify those clients whose suicidality is “under the program radar”? Are counselors aware of risk factors and warning signs of suicidality that might encourage them to explore suicidality in more detail with high-risk clients?
- How do suicidal thoughts and behaviors among clients in your program affect treatment in your program? Do clients with suicidal thoughts and behaviors have their treatment interrupted by referral to other programs? Do staff routinely dismiss suicidality as merely representing a defense against doing the work of recovery? Do clients experience their suicidality as a disruption to their

substance abuse treatment? Do clients experience their disclosure of suicidal thoughts and behaviors and subsequent referral to another program for treatment as “punishment” for their disclosure?

- What is the impact of client suicidality on the performance of treatment staff? Do staff feel prepared to screen and respond to clients with suicidal thoughts and behaviors? Are staff prepared to manage individuals who are suicidal not only for the clients’ own safety, but also in ways that minimize any impact on other clients? Do staff feel prepared to address this issue in their day-to-day practice?

The current organizational response to clients with suicidal thoughts and behaviors:

- What is the current organizational response to clients who are suicidal? Are there clear policy and procedure statements for managing clients with identified suicidal thoughts and behaviors?
- Do staff consistently document current and past suicidal thoughts and behaviors of clients?
- Do treatment records indicate that most clients with suicidal thoughts and behaviors are referred for specialized consultations when needed for services or treatment planning?
- Are the client’s suicidal thoughts and behaviors and the organization’s response (including consultations) integrated as a clinical issue into the treatment plan?
- What is the typical treatment response to clients who are experiencing a suicidal crisis? Are they able to maintain their substance abuse treatment while their suicidality needs are addressed?
- How would clinical staff (including clinical supervisors) define the optimal response to the variety of treatment issues raised by clients who are suicidal?

The impact of suicidal clients on program staffing:

- If the program is to become Level 2, how will that change affect staffing patterns, clinical practices, and staff morale?
- Are staff fearful of working with clients who are suicidal because of legal and malpractice consequences?
- Do staff believe that they have sufficient skills and knowledge to screen for suicidality and talk comfortably about suicidality with clients? Do they know about treatment resources for suicidality?

Can training and clinical support in the form of supervision and consultation be developed and/or enhanced to help clinical staff feel more positive about the change?

- Is there a mechanism within the program to offer debriefing and professional support to counselors after serious adverse events (e.g., suicide attempt at the facility, suicide attempt by a client that led to significant injury regardless of where the attempt occurred, suicide death)?
- Is the staff resistant to this organizational change? If so, will it be helpful to have this information up front so that staff needs can be addressed and accommodated?

The organizational culture, including attitudes about suicide:

- Is suicide treated as a serious problem in the agency?
- Do staff at any level of the organization have negative attitudes toward suicide? If so, can administrators expect resistance to the effort to become a Level 2 program?
- Will attitudes such as “people who are suicidal do not belong in substance abuse treatment” or “working with people who are suicidal is dangerous and a real source of legal liability” or “clients who are suicidal will disrupt treatment for everyone else in the program” be barriers to effective change? Does the organizational change process need to be prepared to confront these attitudes?
- Does the organization have good relationships with mental health agencies, hospitals, and other places where clients with suicidal thoughts and behaviors can be referred?
- Is it feasible to include staff from all levels of the organization in the change process to promote ownership of the changes by all staff?

A good source of information on addressing suicidal thoughts and behaviors is to consider what other programs in your area are already doing and the efforts they made to arrive at their current level of competence in meeting the needs of clients who are suicidal. The goal of organizational change is not to duplicate services or to create overlapping, competitive environments. At the same time, each program should be able to offer services to its client population without automatically referring clients out who present with complicating difficulties (passing the buck).

Additionally, the experience of other programs in your area in organizational change regarding suicidality may provide valuable information in planning your own change process.

Other good resources for strengthening the capacity of a substance abuse treatment program to be Level 2 include Shea (2002) and Jobes (2006). The Suicide Prevention Resource Center (<http://www.sprc.org>) can provide helpful guidelines to assist substance abuse programs in becoming Level 2.

As these kinds of data are being gathered, the information has to be organized, placed in the context of the organizational goals to address suicidality, and integrated into steps in the planning process.

Generally, data will come in various forms: some solid numbers, some impressions, some as summaries of the reactions of a variety of staff. It must be noted that data-gathering is not a static, one-time process but an evolving effort that needs to be part of the total, ongoing change effort. A method for documenting the implementation of policies toward becoming Level 2 and of assessing adherence to policies should be implemented.

Organizational Planning for Becoming a Level 2 Program

Once data have been collected and the problem has been defined and described, the next step is to *organize a team or work group* to address the issue of planning the change. TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008), describes the process of team development that can be applied to organizational planning for addressing suicidality:

1. Identify one person to lead the effort. This person must have the backing of senior administration and the respect of clinical staff.
2. Obtain the commitment of the chief executive officer of the agency to articulate the vision for implementation throughout the agency, with all stakeholders, and to the public.
3. Convene an implementation work group consisting of key leaders from different stakeholder groups: consumer leaders, family leaders, team leaders, clinical leaders, and program and administrative leaders. Some stakeholders will serve as ongoing

members of the work group while information from others may be solicited through focus groups.

4. Identify the program oversight committee to which the work group will report. For example, if your agency has a quality improvement committee, the work group may report its findings, recommendations, strategic plans, and modifications to that committee. This is one way to initiate and sustain implementation of program changes.

Some issues specific to suicide should be included in the planning process. For instance, depending on your program's current level of competence in suicidality, local mental health providers who have specialized knowledge and skills in addressing suicidal thoughts and behaviors should be invited into the planning process. Their knowledge of the needs of individuals with suicidal thoughts and behaviors and their awareness of community resources might prove helpful. If you anticipate that the management of clients' suicidal thoughts and behaviors will involve referral to other agencies, those agencies might need to be involved in the program planning stages.

The organizational work group should be able to *arrive at specific targets for change*. Some examples of targets for clients with suicidal thoughts and behaviors might include:

- Screening all new clients for suicidal thoughts and behaviors.
- Increasing the number of clients who are able to stay active in substance abuse treatment while their suicidal thoughts and/or behaviors are monitored and addressed entirely within the program or conjointly by another agency that is taking the lead in addressing suicidality.
- Increasing the skills of frontline substance abuse counselors in working with GATE: their comfort and skill levels in screening for suicidality and talking with clients about their suicidal thoughts and behaviors, their willingness to seek supervision or consultation on suicide-related issues, their ability to effectively make appropriate referrals to other resources for suicidal clients and to follow up with clients who have been referred.
- Increasing the capacity of clinical supervisors in the program to address the supervision needs of frontline counselors regarding suicide.
- Improving the connection between policies and procedures in the program and the actual needs of frontline counselors and clients.

The third step in organizational planning is *deciding how and when to start the implementation process*. Most programs find it more productive to make organizational changes in incremental steps, observing and evaluating the changes as they occur, rather than in one large leap. Larger changes tend to be more difficult to integrate into the existing system, and it is harder to correct the missteps that inevitably occur in the process. The timing of implementation is also important. Basically, should initiate change when the organizational system is most likely to be able to integrate the changes without distracting from the program’s mission. Making too many changes too quickly can disrupt normal functioning and hinder the integration of new efforts. Ill-timed change can create more resistance than would have otherwise occurred. The implementation should have a system to monitor milestones so as to ensure sustainability.

Program Implementation

Adapting Existing Policies and Programs

It is quite possible that your program already has a variety of policy statements and programmatic elements that relate to client suicidality. For instance, your program probably has a policy about how to handle weapons that are brought onsite, what actions are to be taken when weapons are discovered, and who is to be notified. You also probably have policy statements that indicate what actions are to be taken

when a client acknowledges active suicidal thoughts, intent, or behavior. You have policies concerning who can be contacted in client emergencies and when police or other first responders can be notified.

You already have program policy and programmatic elements that, while not being specific to suicidal clients, may be directly translatable to suicidal crises and to care for clients who acknowledge suicidal thoughts and behaviors. For instance, you probably have policies related to the care of clients with co-occurring disorders, such as a “no wrong door” policy, or programmatic elements such as one or more clinicians who are specially trained in working with clients with co-occurring disorders.

Implementing new policies and programmatic elements, therefore, is more often a case of adapting existing policies and procedures to meet the needs of clients with suicidal thoughts and behaviors. The organizational planning group mentioned earlier could review current program policies and procedures to see how they need to be adapted and revised. The work group might also be charged with examining how issues of client suicidality can be integrated into current policies for co-occurring disorders, crisis management in the program, contact with family and significant others in emergencies, and making referrals to other, specialized resources.

Implementing and Integrating New Programmatic Elements

It may be the case, however, that new policies and programmatic elements need to be incorporated into

Sample Policy 1
Topic: Clinical staff training and competence
Policy Statement: All clinical staff will receive training in suicidality and its impact on substance abuse treatment and can demonstrate basic competence in screening clients with substance use disorders for suicidal thoughts and behaviors.
Procedures:
<ol style="list-style-type: none"> 1. All clinical and support staff will participate in a 1-day training session covering suicidality and its impact on substance abuse treatment retention and outcomes, attitudes toward clients with suicidal thoughts and behaviors, and intervention resources for clients who are suicidal. 2. The clinical supervisor of new employees will provide site-specific information on the procedures for screening and referring individuals who are experiencing suicidal thoughts and behaviors. 3. Clinical competence checklists completed at hire and annually thereafter will ensure that all clinical staff members have a basic knowledge of the benefits of addressing suicidal symptoms, understanding protocols for detecting client suicidality, and awareness of appropriate referral procedures.

Sample Policy 2**Topic:** Screening and referral of clients with substance use disorders and suicidal thoughts and behaviors**Policy Statement:** All clients will be screened for suicidality and will be monitored and/or referred as needed.**Procedures:**

1. During the intake process, all clients will be screened for suicidal thoughts and behaviors using a standard protocol in which all counselors are trained.
2. Individuals demonstrating suicidal thoughts and behaviors will, after appropriate clinical supervision or consultation, be referred for assessment by a qualified mental health professional (QMHP) as needed.
3. All screening results, consultation sessions with the clinical supervisor, and referrals (and ongoing communications) to a QMHP will be documented in the client's record.
4. The counselor providing services to clients with suicidal thoughts and behaviors will provide the client with an emergency contact list that includes agency personnel, emergency mental health providers, and a suicide hotline. The client can refer to this list if his or her symptoms worsen outside business hours or when substance abuse counselors are not available.

Sample Policy 3**Topic:** Individual client observation in a residential facility**Policy Statement:** Special procedures will be instituted for clients in crisis who require hourly monitoring.

Provisions will be made for observation and/or a treatment area for clients who are displaying a level of emotional or psychological crisis and may need to be separated from their treatment unit for a period of time up to 48 hours. Each transfer or observation must result in a psychological or psychiatric consult. An observation checklist will be completed every hour during a client's stay in observation. This is not designed to assess for suicidality, but to identify symptoms that may require additional professional re-assessment.

Intent:

This policy is *not* designed to replace the policy for suicidal patients. This facility is not dually licensed as a psychiatric or mental health facility; therefore patients who have been assessed as being capable of carrying out suicidal or homicidal ideation or intent will be transferred to an acute stabilization unit.

It is the intent of this policy to address the needs of crisis stabilization that do not meet the criteria for hospitalization or involuntary admission to an acute care hospital. Clients will receive the appropriate level of ongoing observation and treatment for their individual needs, such as the patient who is evaluated as not being a threat to himself or others yet manifests a level of emotional or psychological crisis. This process will allow clients to have a quiet space to focus on their immediate stabilization and ensure that the treatment unit is not harmed by these crisis situations.

Procedure:

1. The client's counselor, unit Clinical Coordinator, and/or the Executive Director are responsible for the initial assessment and ongoing decision for observation of all clients, whether this occurs on the treatment unit or in the Medical Unit.
2. During client crisis, a psychologist, psychiatrist, Masters-level counselor or a nurse will perform assessment and re-assessment.
3. The Medical Unit, staffed with nurses and support staff is the first choice for crisis stabilization up to 48 hours. Clients in the Medical Unit or observation area will remain on the census of their treatment unit.
 - The Coordinator or Director of the treatment unit will call the charge nurse of the Medical Unit to make the initial request for observation.
 - The charge nurse will make every attempt to accommodate the request to observe the patient if there is a bed available and the acuity of the rest of the clients allows staff to observe. (Other staff members may be used if staffing is an issue.) The admissions schedule for the unit will be evaluated to assess bed availability.

- On approval, the client treatment unit staff will transport the client to the Medical Unit and provide a staff member to remain on the unit for the duration of the observation and assist either the Medical Unit staff or observe the client, depending on the needs of the Medical Unit and the client. The staff member may be requested by the nurse to be present on the Medical Unit a number of hours or for the entire shift.
 - It is preferred that the staff member accompanying the client has rapport with the client or clinical credentials to assist the client in stabilization.
4. If the Medical Unit is unable to accept the client for observation, the following options exist. The Director or on-call coordinator will make the determination as to the next best option based on the individual case.
- The coordinator may use other units or programs in the agency. It is recommended that the client be moved from his or her treatment unit to a safe and available dormitory area. The door alarms on either side of the area should be set in order to monitor the client's whereabouts during observation.
 - Other available areas should be safe, with priorities for units with lower census, first floor rooms, gender-separate areas, quiet and comfortable, and those that do not interfere with the programs.
 - To best use available staff in monitoring the client on an individual basis, staff should preferably be of the same sex and have some existing rapport with the patient.
 - Staff should be equipped with a communication device and have surrounding staff aware of the location of the observation as well as the need to relieve or assist the observer if needed. Hourly communication is required.
 - Staff observing the patient are to be trained in both de-escalation of clients as well as the purpose and process of observing. This training includes the use of an hourly checklist and protocol for contacting professional staff if needed.

the treatment program. New policies may need to be specific to suicide or may address larger issues in the program, such as clinical supervision, how emergencies are handled, or screening for a variety of co-occurring disorders. Every substance abuse treatment program should, at the least, have a policy statement that acknowledges that suicide is a significant issue for clients in substance abuse treatment and that the program has a role in identifying suicidality among its clients by screening all clients for suicidality and a responsibility to help those clients get the services they need, either through program staff or referral. The policy should then elaborate on procedures for addressing those issues.

New programmatic elements that might need to be instituted include training for all clinical supervisors regarding when services for clients with suicidal thoughts and behaviors can be provided in-house, how referrals are made, and managing suicidal crises in the agency.

Helping Your Program Develop and Improve Capabilities in Working With Clients Who Are Suicidal

Well-written policies and implementation plans to address suicidal thoughts and behaviors will be ineffective without clinical and support staff who have the training, skills, and motivation to carry them out. It is your responsibility to ensure that staff are prepared to address these needs.

Part 1, chapter 1 lists eight core competencies for substance abuse counselors working with clients who are suicidal. These competencies offer a good baseline for defining the knowledge, skills, and attitudes required of frontline counselors. In addition, senior counseling staff and clinical supervisors should be skilled in recognizing and managing suicidal crises, using consultations with external experts, and working with clients who are suicidal and resistant to counseling interventions. (See vignettes 5 and 6 in Part 1, chapter 2. Vince and Rena are clients who require more advanced skills.) The checklist below reflects some of the skills applicable to senior clinical staff and clinical supervisors that extend beyond the eight competencies mentioned above.

Checklist: Characteristics and Competencies of Clinical Supervisors

Attitudes

- Clinical supervisors have the basic characteristics needed to provide services to treat clients with suicidal thoughts and behaviors and to supervise others to manage such clients
- Clinical supervision extends beyond talking about treatment to directly observing and coaching counselors
- Awareness of compassion fatigue or vicarious trauma in counselors and when to facilitate help for counselors experiencing these symptoms

Knowledge

- Clinical supervisors need to have all of the training of frontline counselors. In addition, they need the following knowledge specific to supervision:
- The role of clinical supervision in substance abuse treatment
 - How to train frontline substance abuse counselors in screening of suicidal clients
 - When a client with suicidal thoughts and behaviors needs additional services beyond the qualifications of substance abuse counselors
 - The role of transference and countertransference in the counseling and supervisory relationship
 - How to recognize resistance to change among clinical staff and strategies to address it
 - Change processes, process steps, and strategies for supporting them

Supervisory Skills

- Articulates his or her approach and philosophy to clinical supervision as it relates to approaches described in the literature
- Identifies and responds to variations in learning styles among counselors
- Is comfortable with and able to resolve conflict among team members
- Models advanced counseling skills, including development of therapeutic alliance, termination, and managing client resistance
- Uses direct observation or taping to conduct supervisory sessions
- Can teach and model skills in a variety of approaches to counseling that are applicable to substance abuse clients with suicidal thoughts and behaviors
- Can determine when referral to a QMHP for a suicide assessment is required
- Facilitates referrals to QMHPs both within and outside the treating agency
- Provides incentives through encouragement and support for counselors to enhance skills in treating clients who are suicidal
- Can assess counselor competence and develop professional learning plans and supervisory interventions

It is important that training reflect the skills needed by substance abuse counselors. This TIP emphasizes that the role of the substance abuse counselor in working with clients with suicidal thoughts and behaviors is to screen, obtain supervision or consultation, take appropriate action (including potentially making a referral), monitor (under clinical supervision), and follow up with clients who are suicidal. Treating suicidality is beyond the scope of practice for most substance abuse counselors, as it requires advanced training in mental health disciplines and, preferably, advanced training in assessment, treatment, and intervention. Trainers should understand the needs and limits of practice of substance abuse counselors and not offer skills that most counselors are not prepared to use.

Rather than a one-time training, the training plan for developing skills in working with clients who are suicidal in substance abuse treatment needs to be ongoing. Shorter training sessions extending over several weeks are preferable to a single full-day session. Regardless of the format for initial training, followup refresher programs lasting 2 hours and emphasizing actual experiences of the participants in working with clients who are suicidal are essential. Training should emphasize building on existing skills and applying existing skills (for instance, in making referrals) to clients who are suicidal, rather than introducing new skills sets. For instance, if counselors in Program A have already received extensive training in motivational interviewing (MI), then the skills training for addressing suicidal thoughts and behaviors should

emphasize MI methods (e.g., Gathering information from clients who may be at risk in a manner that does not create defensiveness).

In addition to didactic training sessions, other ways to stimulate dialog and the development of clinical skills for use with clients who are suicidal are:

- Have the topic be a regular agenda item in treatment team meetings and include all high-risk clients in the discussion.
- Have a brown-bag lunch with a senior staff member as trainer.
- Designate one senior counselor or clinical supervisor in a treatment unit to be the “go-to person” on suicide and give that person time (on the job) to take an online or continuing education course.
- Peer review accompanying group supervision.
- Make it a topic of the month for clinical supervision for all counselors.
- Have a training session on treatment planning for suicidal clients.
- Have pairs of counselors role play various parts of GATE.
- Keep GATE active as a clinical tool by having annual 1-hour refreshers on suicide and the use of GATE.

Helping Your Agency Develop and Improve Its Response to Suicidal Crises

Suicide risk management too often is reactionary and reserved for clients in acute, suicidal crisis. However, most clients experiencing suicidal thoughts and behaviors are not in an acute crisis and do not warrant crisis management. Indeed, most situations can be managed adequately in a matter-of-fact, methodical manner that is not crisis driven. This TIP encourages programs to screen, educate, and intervene early when clients experience suicidal thoughts and/or behaviors, and to take action across the continuum of risk. By doing so, you are likely to prevent many situations from erupting into full blown crises, and be more effective in managing suicide risk within your agency.

That said, there will inevitably be situations that arise suddenly and unpredictably where a crisis response is required. Programs should have specific

policies that address those crisis situations. Three examples of suicidal crises are the vignettes of Clayton, Vince, and Rena in Part 1, chapter 2. Clayton reveals suicide ideation and acknowledges that he has taken a gun in his house out of safekeeping and examined it while thinking of suicide. Vince receives news that his wife has filed an order of protection against him, and he rapidly spirals into a preoccupation with suicide. He also alludes to potential violence towards his wife and her lawyer. Rena begins drinking, re-experiences childhood trauma, finds herself losing her psychological supports, and begins to have intense thoughts of suicide. These are just a few of the myriad circumstances that can occur even in the face of the best treatment and organizational planning and for which specific agency policies and procedures need to be in place.

Policy and procedure for suicidal crises are often best considered in the context of larger issues of crisis management in the agency. CSAT is developing a tool entitled “Crisis Management: A Guide for Substance Abuse Counselors” that addresses this issue. The kinds of crises that can occur in a program include active suicidality on the part of a client, aggressiveness, violence, threats of violence toward others, death of a client, severe injuries or health crises with clients, and special protective issues for children and adolescents at risk for endangerment or abuse. In addition to providing a rationale for crisis management, the tool offers specific advice on what steps counselors should plan for, the varieties of contact information front line staff should have available in crisis situations, and the importance of documentation.

Some of the components of effective policy and procedures for suicidal crises that need to be considered include:

- Defining a situation requiring a crisis response (compared with a non-crisis event).
- Specific actions that the counselor or treatment provider should take to ensure the client’s safety (e.g., taking action to reduce availability of methods of suicide).
- Who should be notified and how quickly that notification should take place.
- What kinds of consultation or clinical supervision should occur and how it should be requested.
- The situations under which significant others or first responders should be notified and how pertinent confidentiality regulations can be upheld.

- How a client's possession of a weapon or other suicide method (such as medication) should be addressed by the counselor and/or the clinical supervisor or other senior staff.
- How clients should be monitored during the crisis (e.g., the policy might specifically state that clients should not be left alone in an office, the waiting room, or other unsecured areas without supervision). A policy of physical restraint needs to be clearly stated.
- How staff who greet clients and receive incoming telephone calls are to respond to crisis calls or events in the agency.
- How a counselor can access immediate help by telephone or other emergency notification process
- How emergency referrals should be made, who should actually make the referral, and what kind of information should be released to the referral program or institution.
- How to address a client's resistance to receiving care for suicidality or resistance to accepting referral for consultation or treatment.
- How clients should be transported to other programs or resources.
- What followup contact should be made with other programs or resources after the referral.

- What kinds of documentation should occur throughout this process.

Program policies should specifically state that it is not the counselor's role to make a final determination of whether the client is at acute or imminent risk for suicide. This judgment needs to be left to providers with the necessary training and education. It is the counselor's role to help the client get to the appropriate resources where those kinds of evaluations can be made.

Specific agency policies should spell out how clinical supervisors should address suicidal crises. Such policies might indicate when the supervisor should step in and become actively involved in the client's care (as opposed to being a resource for the counselor); when program senior administration should be notified; when first responders (such as police and emergency medical services) should be contacted; and the types of incident documentation the supervisor needs to prepare and file.

As mentioned earlier, the Commitment to Treatment Statement (see figure 1 below) is one procedure that can be adopted when suicidal thoughts and behaviors are noted. Having both the client and counselor sign

Figure 1. Sample Commitment to Treatment Statement

I, _____, agree to make a commitment to the treatment process. I understand that this means that I have agreed to be actively involved in all aspects of treatment, including:

1. Attending sessions (or letting my counselor know when I can't make it).
2. Setting goals.
3. Voicing my opinions, thoughts, and feelings honestly and openly with my counselor (whether they are negative or positive, but most importantly my negative feelings).
4. Being actively involved during sessions.
5. Completing homework assignments.
6. Taking my medications as prescribed.
7. Experimenting with new behaviors and new ways of doing things.
8. Implementing my crisis response plan when needed.

I also understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount of energy and effort I make. If I feel that treatment is not working, I agree to discuss it with my counselor and attempt to come to a common understanding as to what the problems are and identify potential solutions. In short, I agree to make a commitment to living. This agreement will apply for the next 3 months, at which time it will be reviewed and modified.

Signed _____ Date _____

Witness _____

Adapted from Rudd, 2006.

the statement helps promote engagement in treatment.

A related technique is a safety card, which gives clients resources to use in a crisis (see p. 21 in Part 1, chapter 1). Counselors might want to use both techniques.

The goal of agency policy for managing clients who are acutely suicidal is to give enough direction to clinicians and clinical supervisors to guide them in crisis situations, while at the same time not attempting to anticipate every kind of crisis situation related to suicidal thoughts and behaviors. Counselors and supervisors need to be able to use their clinical training, experience, and judgment to address specific situations. Policy needs to guide how the counselor's and supervisor's clinical skills are used.

Finally, every serious adverse event (e.g., suicide attempt at the facility, suicide attempt by a client that leads to significant injury regardless of where the attempt occurred, suicide death) should result in a debriefing and postvention that considers how the event unfolded, how the specific action steps facilitated or hindered resolution of the crisis, how policy worked (or didn't work) to address the crisis, and how policy and procedure can be improved to further enhance the capability of the agency in responding to crises.

Postvention refers to dealing with the aftermath of suicide with survivors who may be family, friends, fellow students, teachers, coworkers, supervisors, fellow patients, counselors, physicians, or any other people who knew the individual and may be affected by the suicide. Additionally, the postvention needs to address how the emotional and psychological responses of the staff involved in the situation were considered. Staff should emerge from the postvention feeling supported and capable and guided by agency policy, senior administration, and clinical supervisors. They should feel their emotional responses to the event were addressed and that they had an opportunity to resolve unfinished business that may have arisen during the crisis. Counselors who provided direct services to clients who died by suicide may also benefit from counseling to help them work through the situation, ideally by a provider experienced in postvention. Counselors who have experienced a suicide in their personal life may especially benefit. Time is often an ally in the healing process.

Building Administrative Support for All Levels of GATE

This TIP has advocated a protocol, GATE, that recognizes the skills of substance abuse counselors and how those skills can be applied in substance abuse treatment settings with clients who are experiencing suicidal thoughts and behaviors. The protocol emphasizes screening for suicidality, obtaining supervision or consultation, taking appropriate actions, and following up on the actions taken.

GATE recognizes that two components frequently addressed in training for suicide prevention and intervention are beyond the skill level of many substance abuse counselors and should be left to persons in mental health disciplines with advanced training and skills in suicidology. These two components are:

1. Suicide assessment, in which the extent of suicidal thinking and behavior is determined, an assessment of risk for self-injury or death may be undertaken, and clinical diagnoses (such as depression and trauma syndromes) may need to be made.
2. Treatment of suicidal states, which may include addressing co-occurring disorders, prescribing medication, decisions about hospitalization, challenging suicidal beliefs, and other treatment methods beyond the scope of most substance abuse counselors.

It is imperative that administrators, senior organizational policymakers, and clinical supervisors recognize the strengths and limitations of practice of substance abuse counselors and not ask staff to practice in areas beyond the scope of their skills and knowledge. That said, it is also important that substance abuse counselors be supported by administration in their efforts to address the needs of suicidal clients.

Gathering Information

Because of the elevated risk of suicidality among clients in substance abuse treatment, it is important for programs to have a clear policy statement affirming that all clients entering substance abuse treatment are screened for suicidal thoughts and behaviors. There should also be procedures for screening for suicidality when client risk factors increase, such as

Figure 2. Gathering Information Regarding Suicidality

Check all that apply		
Warning Signs	Risk Factors	Protective Factors
Direct warnings: <input type="checkbox"/> Suicidal communication <input type="checkbox"/> Seeking a method of suicide <input type="checkbox"/> Making preparations for suicide Indirect warnings: <input type="checkbox"/> I= Ideation <input type="checkbox"/> S= Substance Abuse <input type="checkbox"/> P= Purposelessness <input type="checkbox"/> A= Anxiety <input type="checkbox"/> T= Trapped <input type="checkbox"/> H= Hopelessness <input type="checkbox"/> W= Withdrawal <input type="checkbox"/> A= Anger <input type="checkbox"/> R= Recklessness <input type="checkbox"/> M= Mood Changes	<input type="checkbox"/> History of attempt <input type="checkbox"/> Family history of suicide <input type="checkbox"/> Mood disorder <input type="checkbox"/> Substance use disorder <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Select personality disorder <input type="checkbox"/> Child abuse <input type="checkbox"/> Stressful life circumstances <input type="checkbox"/> Aggressive or impulsive <input type="checkbox"/> Avoidant or isolated <input type="checkbox"/> Rigid or inflexible <input type="checkbox"/> Firearm ownership or access <input type="checkbox"/> Minority sexual orientation <input type="checkbox"/> Chronic pain	<input type="checkbox"/> Religious attendance <input type="checkbox"/> Internalized teachings against suicide <input type="checkbox"/> Child in the home <input type="checkbox"/> Childrearing responsibilities <input type="checkbox"/> Intact marriage <input type="checkbox"/> Trusting relationship with a provider <input type="checkbox"/> Treatment adherent <input type="checkbox"/> Employed <input type="checkbox"/> Trait optimism <input type="checkbox"/> Abstinent from substances
Summary: _____ _____ _____		
Plan: _____ _____ _____		
Counselor signature: _____		Date: _____
Counselor signature: _____		Date: _____

after a substance use relapse, after an emotional crisis, or during a treatment transition.

The procedure should spell out a specific screening mechanism or protocol and should specify actions to be taken if suicidality is detected. If there are positive answers to any of the screening questions, follow-up questions should be asked to gather further information (see the section on Gathering Information in Part 1, chapter 1, pp. 15–18).

An example of a checklist for gathering information regarding suicidality is presented in figure 2. Note that the information obtained is the basis for making a plan for addressing suicidal thoughts and behaviors.

Clinical supervisors should make sure that all clinical staff are aware of the policy and that the policy proce-

dures are followed. Clinical supervisors should conduct a periodic review of all staff to ensure that all clinical staff are current on suicide policy in the agency. Procedures for documentation of screening and actions taken as a result of screening should be standardized to ensure that appropriate documentation occurs. Clinical supervisors should be responsible for ensuring that documentation efforts are carried out by counselors.

Accessing Supervision and/or Consultation

Clinical supervision or consultation from persons knowledgeable and skilled in addressing suicidal behavior is essential for quality care of clients with suicidal thoughts and behaviors. Substance abuse

counselors working with clients who are suicidal need to have a clear understanding, guided by agency policy and procedure, of when and how to access supervision and consultation. They need to know when to seek immediate supervision versus supervision at some later time, what kinds of information need to be brought to the supervisor's attention, and how to access supervision or consultation in crisis situations. Even counselors with substantial experience and training in addressing suicidal thoughts and behavior need to have an opportunity to access consultation for treatment planning, and program policy should reflect this. In some settings, the treatment group may serve as an adjunct or alternative to more formal clinical supervision. Where work groups are used as a primary support system for counselors, policy should define how the group is used and how consultation is documented.

Administrators have an essential responsibility to ensure that supervision or consultation (either in the program or from outside consultants) is available and accessible and that program policy defines the role of the supervisor or consultant. The policy should be clear about the circumstances in which a counselor should obtain consultation and make provisions to ensure that consultation is immediately available in crisis situations. It should also differentiate the roles that supervisors might play in intervening with suicidal clients (in addition to roles as a consultant or teacher) and specify which actions (such as contacting first responders outside the program) can only be taken by or with approval of a senior staff person or clinical supervisor.

Supervisors can only undertake such roles with adequate training and knowledge (of suicidality, treatment, and community resources) and with a sense of competence to respond to crises and to the concerns of the counselor. In addition, clinical supervisors have to be able to respond sensitively and professionally to the emotional needs of counselors who may find their work with clients with suicidal thoughts and behaviors to be emotionally provocative and stressful.

Taking Action

All counselor actions with clients who are suicidal should be guided by and in concert with established program policies and procedures. These policies, while unique to each program, will, for the most part, have consistent points across a variety of agencies.

Some of the common points might be:

- That clients with suicidal thoughts and behaviors will not automatically be excluded from treatment for acknowledging their suicidal thoughts or behaviors.
- That all efforts will be made to help these clients stay in substance abuse treatment as long as their safety can be maintained.
- That all clients entering the program will be screened for suicidality.
- That potential warning signs that emerge during the course of treatment will be followed up.
- That all counselors will be trained in identifying and responding to suicidal thoughts and behaviors of clients in the program.
- That the program will strive to ensure that clients receive the best care available for their suicidal thoughts and behaviors, whether that care is provided in the program or by referral.

There should be a “check off” procedure so counselors are not left on their own to make care decisions for clients at acute risk. Some of the levels of care that might be considered include:

- Observation.
- Contact with the client's family and/or significant others.
- Arrangements for disposal of suicide weapons in the possession of the client.
- Referral for assessment or for more intense care
- Referral for hospitalization as required for safety.

The 24-Hour Suicide Assessment Tool (see figure 3) is an example of a tool for rating a client's current suicidal thoughts and behaviors. It rates the areas of suicidal ideation, behavior, general mood, and cognition/perception. Although this tool is more appropriate for an inpatient psychiatric setting, it can be adapted to a variety of substance abuse treatment settings—especially therapeutic communities, detoxification centers, and residential rehabilitation environments. Such a tool can be used to help guide staff to seek more intensive levels of mental health care. It should be noted that this instrument was developed by a community agency for residential treatment settings. The tool has not undergone extensive field testing.

Figure 3. 24-Hour Suicide Assessment Tool

Assessment Category	No Monitoring	Suicide Alert—Watch (Minimum 15 min.)	Level II—Observation (Minimum 15 min.)	Level I—Precaution (Constant Observation—1:1)
<ul style="list-style-type: none"> Suicidal ideation Thoughts Plans Method 	<ul style="list-style-type: none"> Verbalizes no current ideation None to occasional suicidal thoughts with no plan 	<ul style="list-style-type: none"> Verbalizes current suicidal ideation Frequent suicidal ideation Has no plan or vague plan Method unavailable or nonlethal 	<ul style="list-style-type: none"> Verbalizes current suicidal ideation Frequent suicidal ideation Has specific plan Method unavailable or available and non-lethal 	<ul style="list-style-type: none"> Verbalizes current suicidal ideation Frequent suicidal ideation Specific plan and available method Attempt within last 24 hours
Behavior cues <ul style="list-style-type: none"> Impulse control Behavioral activity Preparation for death (suicide note, giving away belongings) 	<ul style="list-style-type: none"> Adequate impulse control Consistent in behavior patterns 	<ul style="list-style-type: none"> Inconsistent impulse control Some changes in usual behavior patterns 	<ul style="list-style-type: none"> Unpredictable at times or inconsistent impulse control Distinct changes in behavior patterns 	<ul style="list-style-type: none"> Impulsive and unpredictable behavior Sudden or abrupt change in behavior Marked increase or decrease in behavior Death preparation
Mood or affect <ul style="list-style-type: none"> Predominant mood or affect Mood stability Tolerance of feelings 	<ul style="list-style-type: none"> Signs of mild depression Indicators of hopefulness Mood stable Feelings tolerable 	<ul style="list-style-type: none"> Signs of moderate depression Indicators of helplessness Some mood fluctuations Some anxiety, agitation•Feelings periodically distressing 	<ul style="list-style-type: none"> Signs of moderate depression Indicators of helplessness and hopelessness Labile mood Moderate anxiety Increased affective distress 	<ul style="list-style-type: none"> Severe depression Indicators of helplessness and hopelessness Calm resolution Severe anxiety Unbearable psychological pain
Cognition/ Perception	<ul style="list-style-type: none"> Problem solving intact Accurate perception of reality 	<ul style="list-style-type: none"> Limited problem solving Inconsistent or narrowed perception 	<ul style="list-style-type: none"> Poor problem solving Impaired reality testing 	<ul style="list-style-type: none"> Unable to problem solve Psychotic with command hallucinations Sees no alternative to suicide

- The nurse will complete the Suicide Assessment Tool (SAT) when the client is admitted.
- Results of the SAT will be communicated to the physician within 4 hours on determination of the level of suicide precaution warranted.
- The nurse will complete a new SAT at least every 24 hours for all suicide alerts.
 - Suicide Alert—Watch: The nurse will document in progress notes once per shift the condition of the client. Designated staff will do safety checks a minimum of every 15 minutes.
 - Level II—Observation: The nurse will document in progress notes the condition of the client a minimum of every 4 hours. Designated staff will do safety checks a minimum of every 15 minutes.
 - Level I—Precaution (constant observation, 1:1): The nurse will document in progress notes the client’s condition a minimum of every 2 hours. Designated staff assigned for constant observation.
- The attending physician will review the results of the SAT level of monitoring determined every 24 hours.
- The physician will order to continue or discontinue the monitoring precaution either in writing or verbally.

Nurse Signature _____ Date _____

Physician Signature Review _____ Date _____

Client Name _____ Unit _____

Treatment programs should have a policy on referrals for clients who are suicidal or those needing other specialized services. An example is provided in sample policy 4 (p. 122). The specifics of such a policy will depend on State laws and regulations.

Documenting the clinical actions taken with clients who are suicidal is critical, so counselors need to be given the time to complete this important task. Forms for use in these situations should be developed to ensure that all necessary information is obtained (additional information on documentation can be found in Part 1, chapter 1).

Counselors should also be able to look to you for guidance and support with clients who are suicidal but resist treatment. Senior clinical staff, clinical supervisors, and administrators should be prepared to work with the counselor (and the client if necessary) to resolve some of the resistance and help the client accept appropriate treatment. Several of the vignettes in Part 1, chapter 2 illustrate counselors working with resistant clients. The collaboration of senior clinical staff and clinical supervisors with counselors in these client situations enables counselors to develop their clinical skills with clients who are showing resistance and improve services to clients with a variety of needs.

As the program becomes more experienced in working with clients with suicidal thoughts and behaviors, it can be expected that a more consistent repertoire of responses to suicidality will evolve. This does not mean that responses to clients will become stereotyped, but rather that experience will create more options and greater versatility in care.

Extending the Action and Following Up

It is important for counselors and program administrators to understand that program responsibilities do not end with a client's referral to another agency. Both the counselor and administrators continue to have a responsibility to ensure that the client follows

through on the referral, that the referring agency accepts the client for treatment, and that treatment is actually implemented. You also have an ethical responsibility to ensure that the client's substance abuse treatment needs do not get lost in the process of referral. Such monitoring requires oversight by the substance abuse program with specific staff (perhaps clinical supervisors) to ensure this continuum of treatment.

Administrators can assign clinical supervisors the job of making sure that the tasks involved in extending care beyond the immediate actions are carried out.

These tasks include:

- Following up on referrals.
- Case management as required, monitoring that clients are following a treatment plan established by the counselor and the clinical supervisor or by the treatment team.
- Checking in with the client and significant others (if warranted) to ensure that care is progressing.
- Continued observation and monitoring for suicidal thoughts and behaviors that may re-emerge after the initial crisis has passed.

An organized system of followup by the supervisor, such as a checklist of clients with suicidal ideation or behavior may be required. Clinical supervision training may need to emphasize the need for such followup.

Finally, the program needs to have a standardized system of documenting followup. Often, programs are not as consistent with documentation of followup actions as they are with documentation of clinical interventions undertaken by the counseling staff. Most charting in client records is oriented to responses to specific client behaviors or problems rather than to follow up on those behaviors or problems. As a result, program policy needs to describe how the followup documentation should occur and who in the program is responsible for the documentation. Furthermore, a senior-level staff member should review the documentation for oversight and quality assurance purposes.

Sample Policy 4

Topic: Criteria for and transfer to psychiatric facility

Policy Statement: Clients meeting the criteria for transfer to a psychiatric facility will be transferred either voluntarily or involuntarily.

Criteria for Transfer

Occasionally, clients of our treatment program have co-occurring psychiatric symptoms or conditions in addition to their substance use disorder. There are occasions when clients who experience significant psychiatric symptoms may require transfer to a psychiatric facility for evaluation or treatment.

Criteria for transfer include:

1. A clear and present danger to themselves or to others in the form of suicidality, homicidality, or the intent to harm another
2. Significant psychotic behavior
3. Overt aggressive behavior endangering self or others

Process for Hospital Admission

Voluntary Admission

1. The patient is willing to sign voluntarily for admission to psychiatric facility.
2. The unit and/or on-call clinical supervisor, along with counseling staff, will determine the appropriate facility and arrange for discharge from the agency and transportation to the facility.

Involuntary Commitment

Counseling staff working with a client who is suicidal or otherwise dangerous to him- or herself or others will review the client's condition with the clinical coordinator or the Executive Director and then contact the on-call clinical supervisor who will initiate the following process. Medical staff will consult with the medical director or on-call physician prior to initiating this process.

1. Contact the County Crisis Intervention Unit at [phone number] and inform them that we would like to admit the patient as an involuntary hospital admission. A delegate will be assigned to assist with the involuntary process, to interview the client, and to authorize the warrant for transportation.
2. The staff member who witnessed the suicidal behavior or heard the suicidal statements should be present to offer that information to the delegate when they arrive.
3. After the delegate arrives and it is determined that the patient will need admission to a psychiatric facility, the delegate will contact an ambulance for transportation of the patient and when appropriate, will assist them in making those arrangements.
4. If the patient is physically unmanageable or dangerous, the police will be contacted to ensure the safety of the client and to assist in the process.

Before all admissions to a psychiatric facility, the following must be completed:

1. Have available client demographics, including insurance information, and clinical information.
2. Notify parents of an adolescent or the emergency contact for an adult that a transfer to a psychiatric facility is occurring.

Appendix A: Bibliography

- Addiction Technology Transfer Center. (2004). *The change book: A blueprint for technology transfer* (2nd ed.). Kansas City, MO: Author. Retrieved February 5, 2008, from http://www.nattc.org/pdf/The_Change_Book_2nd_Edition.pdf
- American Association of Suicidology (2006). *Assessment and management of suicide risk: Core competencies for mental health professionals. Participant manual*. Washington, DC: Education Development Center.
- American Psychiatric Association. (2003). *Practice guideline and resources for the assessment and treatment of patients with suicidal behaviors*. Arlington, VA: American Psychiatric Association. Retrieved July 2, 2008, from <http://www.psychiatryonline.com/pracGuide/pracGuideHome.aspx>.
- Beck, A. T., Resnik, H. L. P., Lettieri, D. J., Pennsylvania University Department of Psychiatry, et al. (1974). *The prediction of suicide*. Bowie, MD: Charles Press Publishers.
- Beck, A. T., Schuyler, D., & Herman, I. (1974). Development of suicidal intent scales. In A. T. Beck, H. L. P. Resnik, & D. J. Lettieri, (Eds.), *The prediction of suicide* (pp. 45–56). Bowie, MD: Charles Press Publishers.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory - II Manual*. San Antonio, TX: The Psychological Corporation.
- Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561–571.
- Berk, M. S., Henriques, G. R., Warman, D. M., Brown, G. K., & Beck, A. T. (2004). A cognitive therapy intervention for suicide attempters: An overview of the treatment and case examples. *Cognitive and Behavioral Practice*, 11, 265–277.

- Bongar, B. M. (1991). Suicide: Legal perspectives. In *The suicidal patient: Clinical and legal standards of care* (pp. 33–59). Washington, DC: American Psychological Association.
- Bossarte, R. M., Simon, T. R., & Barker, L. (2006). Characteristics of homicide followed by suicide incidents in multiple states, 2003-04. *Injury Prevention, 12*, ii33–ii38.
- Brown, G. K., Henriques, G. R., Sosdjan, D., & Beck, A. T. (2004). Suicide intent and accurate expectations of lethality: Predictors of medical lethality of suicide attempts. *Journal of Consulting and Clinical Psychology, 72*, 1170–1174.
- Brown, G. K., Steer, R. A., Henriques, G. R., & Beck, A. T. (2005). The internal struggle between the wish to die and the wish to live: a risk factor for suicide. *American Journal of Psychiatry, 162*, 1977–1979.
- Brown, G. K., Ten Have, H. T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *JAMA, 294*, 563–570.
- Brown, S. A., Inaba, R. K., Gillin, J. C., Schuckit, M. A., Stewart, M. A., & Irwin, M. R. (1995). Alcoholism and affective disorder: Clinical course of depressive symptoms. *American Journal of Psychiatry, 152*, 45–52.
- Bucholz, K. K., Cadoret, R., Cloninger, C. R., Dinwiddie, S. H., Hesselbrock, V. M., Nurnberger, J. I., Jr., et al. (1994). A new, semi-structured psychiatric interview for use in genetic linkage studies: A report on the reliability of the SSAGA. *Journal of Studies on Alcohol, 55*, 149–158.
- Center for Substance Abuse Treatment. (1993a). *Improving treatment for drug-exposed infants*. Treatment Improvement Protocol (TIP) Series 5. (DHHS Publication No. (SMA) 95-3057). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1993b). *Pregnant, substance-using women*. Treatment Improvement Protocol (TIP) Series 2. (DHHS Publication No. (SMA) 93-1998). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1993c). *Screening for infectious diseases among substance abusers*. Treatment Improvement Protocol (TIP) Series 6. (DHHS Publication No. (SMA) 95-3060). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1994). *Simple screening instruments for outreach for alcohol and other drug abuse and infectious diseases*. Treatment Improvement Protocol (TIP) Series 11. (DHHS Publication No. (SMA) 94-2094). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1995a). *Alcohol and other drug screening of hospitalized trauma patients*. Treatment Improvement Protocol (TIP) Series 16. (DHHS Publication No. (SMA) 95-3041). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1995b). *Combining alcohol and other drug treatment with diversion for juveniles in the justice system*. Treatment Improvement Protocol (TIP) Series 21. (DHHS Publication No. (SMA) 95-3051). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1995c). *Developing state outcomes monitoring systems for alcohol and other drug abuse treatment*. Treatment Improvement Protocol (TIP) Series 14. (DHHS Publication No. (SMA) 95-3031). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1995d). *The role and current status of patient placement criteria in the treatment of substance use disorders*. Treatment Improvement Protocol (TIP) Series 13. (DHHS Publication No. (SMA) 95-3021).

- Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1995e). *The tuberculosis epidemic: Legal and ethical issues for alcohol and other drug abuse treatment providers*. Treatment Improvement Protocol (TIP) Series 18. (DHHS Publication No. (SMA) 95-3047). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1996). *Treatment drug courts: Integrating substance abuse treatment with legal case processing*. Treatment Improvement Protocol (TIP) Series 23. (DHHS Publication No. (SMA) 96-3113). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1997a). *A guide to substance abuse services for primary care clinicians*. Treatment Improvement Protocol (TIP) Series 24. (DHHS Publication No. (SMA) 97-3139). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1997b). *Substance abuse treatment and domestic violence*. Treatment Improvement Protocol (TIP) Series 25. (DHHS Publication No. (SMA) 97-3163). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1998a). *Comprehensive case management for substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 27. (DHHS Publication No. (SMA) 98-3222). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1998b). *Continuity of offender treatment for substance use disorders from institution to community*. Treatment Improvement Protocol (TIP) Series 30. (DHHS Publication No. (SMA) 98-3245). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1998c). *Naltrexone and alcoholism treatment*. Treatment Improvement Protocol (TIP) Series 28. (DHHS Publication No. (SMA) 98-3206). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1998d). *Substance abuse among older adults*. Treatment Improvement Protocol (TIP) Series 26. (DHHS Publication No. (SMA) 98-3179). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1998e). *Substance use disorder treatment for people with physical and cognitive disabilities*. Treatment Improvement Protocol (TIP) Series 29. (DHHS Publication No. (SMA) 98-3249). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1999a). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series 34. (DHHS Publication No. (SMA) 99-3353). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1999b). *Enhancing motivation for change in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 35. (DHHS Publication No. (SMA) 99-3354). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1999c). *Screening and assessing adolescents for substance use disorders*. Treatment Improvement Protocol (TIP) Series 31. (DHHS Publication No. (SMA) 99-3282). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1999d). *Treatment of adolescents with substance use disorders*. Treatment Improvement Protocol (TIP) Series 32. (DHHS Publication No. (SMA) 99-3283).

- Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1999e). *Treatment for stimulant use disorders*. Treatment Improvement Protocol (TIP) Series 33. (DHHS Publication No. (SMA) 99-3296). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2000a). *Integrating substance abuse treatment and vocational services*. Treatment Improvement Protocol (TIP) Series 38. (DHHS Publication No. (SMA) 00-3470). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2000b). *Substance abuse treatment for persons with child abuse and neglect issues*. Treatment Improvement Protocol (TIP) Series 36. (DHHS Publication No. (SMA) 00-3357). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2000c). *Substance abuse treatment for persons with HIV/AIDS*. Treatment Improvement Protocol (TIP) Series 37. (DHHS Publication No. (SMA) 00-3459). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2004a). *Clinical guidelines for the use of Buprenorphine in the treatment of opioid addiction*. Treatment Improvement Protocol (TIP) Series 40. (DHHS Publication No. (SMA) 04-3939). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2004b). *Substance abuse treatment and family therapy*. Treatment Improvement Protocol (TIP) Series 39. (DHHS Publication No. (SMA) 04-3957). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2005a). *Medication-assisted treatment for opioid addiction*. Treatment Improvement Protocol (TIP) Series 43. (DHHS Publication No. SMA 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2005b). *Substance abuse treatment for adults in the criminal justice system*. Treatment Improvement Protocol (TIP) Series 44. (DHHS Publication No. (SMA) 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2005c). *Substance abuse treatment: Group therapy*. Treatment Improvement Protocol (TIP) Series 41. (DHHS Publication No. SMA 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2005d). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series 42. (DHHS Publication No. SMA 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2006a). *Detoxification and substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 45. (DHHS Publication No. SMA 06-4131). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2006b). *Substance abuse: Administrative issues in intensive outpatient treatment*. Treatment Improvement Protocol (TIP) Series 46. (DHHS Publication No. SMA 06-4151). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2006c). *Substance abuse: Clinical issues in intensive outpatient treatment*. Treatment Improvement Protocol (TIP) Series 47. (DHHS Publication No. 06-4182). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development a). *Addressing suicidal*

- thoughts and behaviors with clients in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development b). *Incorporating alcohol pharmacotherapies into medical practice.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development c). *Improving cultural competence in substance abuse treatment.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development d). *Management of chronic pain in people with substance use disorders.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development e). *Managing depressive symptoms in substance abuse clients during early recovery.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development f). *Relapse prevention and recovery promotion.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development g). *Substance abuse treatment: Addressing the specific needs of women.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development h). *Substance abuse treatment with American Indians and Alaska Natives.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development i). *Substance abuse treatment and men's issues.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (In development j). *Substance abuse treatment with people who are homeless.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration.
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- Centers for Disease Control and Prevention. (1998). Suicide among African American youths—United States, 1980–1995. *Morbidity and Mortality Weekly Report, 47,* 193–196.
- Cherpitel, C. J., Borges, G. L., & Wilcox, H. C. (2004). Acute alcohol use and suicidal behavior: A review of the literature. *Alcoholism: Clinical & Experimental Research, 28,* 18S–28S.
- Conner, K. R., Beautrais, A. L., & Conwell, Y. (2003). Risk factors for suicide and medically serious suicide attempts among alcoholics: Analyses of Canterbury Suicide Project data. *Journal of Studies on Alcohol, 64,* 551–554.

- Conner, K. R., Duberstein, P. R., & Conwell, Y. (2000). Domestic violence, separation, and suicide in young men with early onset alcoholism: Re-analyses of Murphy's data. *Suicide and Life-Threatening Behavior, 30*, 354–359.
- Conner, K. R., Duberstein, P. R., Conwell, Y., Herrmann, J. H., Jr., Cox, C., Barrington, D. S., et al. (2000). After the drinking stops: Completed suicide in individuals with remitted alcohol use disorders. *Journal of Psychoactive Drugs, 32*, 333–337.
- Conner, K. R., Hesselbrock, V. M., Meldrum, S. C., Schuckit, M. A., Bucholz, K. K., Gamble, S. A., et al. (2007). Transitions to, and correlates of, suicidal ideation, plans, and unplanned and planned suicide attempts among 3,729 men and women with alcohol dependence. *Journal of Studies on Alcohol and Drugs, 68*, 654–662.
- Conwell, Y., Duberstein, P. R., & Caine, E. D. (2002). Risk factors for suicide in later life. *Biological Psychiatry, 52*, 193–204.
- Cornelius, J. R., Salloum, I. M., Day, N. L., Thase, M. E., & Mann, J. J. (1996). Patterns of suicidality and alcohol use in alcoholics with major depression. *Alcoholism, Clinical and Experimental Research, 20*, 1451–1455.
- Darke, S., & Ross, J. (2002). Suicide among heroin users: rates, risk factors and methods. *Addiction, 97*, 1383–1394.
- Duberstein, P. R., Conwell, Y., & Caine, E. D. (1993). Interpersonal stressors, substance abuse, and suicide. *Journal of Nervous and Mental Disease, 181*, 80–85.
- Falvey, J. E. (2002). *Managing clinical supervision: Ethical practice and legal risk management*. Pacific Grove, CA: Brooks/Cole-Thomson Learning.
- Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network. Retrieved November 19, 2007, from <http://ctndisseminationlibrary.org/PDF/nirnmonograph.pdf>
- Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.) *Reducing suicide: A national imperative* (2002). Washington, DC: National Academies Press.
- Goldston, D. B., Molock, S. D., Whitbeck, L. B., Murakami, J. L., Zayas, L. H., & Hall, G. C. (2008). Cultural considerations in adolescent suicide prevention and psychosocial treatment. *American Psychologist, 63*, 14–31.
- Gould, M. S., Marrocco, F. A., Kleinman, M., Thomas, J. G., Mostkoff, K., Cote, J., et al. (2005). Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. *JAMA, 293*, 1635–1643.
- Gutheil, T. G., & Brodsky, A. (2008). *Preventing boundary violations in clinical practice*. New York: Guilford Press.
- Hamilton, M. A. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry, 23*, 56–62.
- Harriss, L., Hawton, K., & Zahl, D. (2005). Value of measuring suicidal intent in the assessment of people attending hospital following self-poisoning or self-injury. *British Journal of Psychiatry, 186*, 60–66.
- Heikkinen, M. E., Aro, H. M., Henriksson, M. M., Isometsä, E. T., Sarna, S. J., Kuoppasalmi, K. I., et al. (1994). Differences in recent life events between alcoholic and depressive nonalcoholic suicides. *Alcoholism: Clinical and Experimental Research, 18*, 1143–1149.
- Hendin, H., Haas, A. P., Maltzberger, J. T., Szanto, K., & Rabinowicz, H. (2004). Factors contributing to therapists' distress after the suicide of a patient. *American Journal of Psychiatry, 161*, 1442–1446.
- Hendin, H., Lipschitz, A., Maltzberger, J. T., Haas, A. P., & Wyncoop, S. (2000). Therapists' reactions to patients' suicides. *American Journal of Psychiatry, 157*, 2022–2027.
- Henriques, G., Beck, A. T., & Brown, G. K. (2003). Cognitive therapy for adolescent and

- young adult suicide attempters. *American Behavioral Scientist*, 46, 1258–1268.
- Hufford, M. R. (2001). Alcohol and suicidal behavior. *Clinical Psychology Review*, 21, 797–811.
- Husband, S. D., Marlowe, D. B., Lamb, R. J., Iguchi, M. Y., Bux, D. A., Kirby, K. C., et al. (1996). Decline in self-reported dysphoria after treatment entry in inner-city cocaine addicts. *Journal of Consulting and Clinical Psychology*, 64, 221–224.
- Ilgen, M. A., Harris, A. H., Moos, R. H., & Tiet, Q. Q. (2007). Predictors of a suicide attempt one year after entry into substance use disorder treatment. *Alcoholism: Clinical and Experimental Research*, 31, 635–642.
- Jobes, D. A. (2006). *Managing suicidal risk: A collaborative approach*. New York: Guilford Press.
- Joe, S. (2003). Implications of focusing on black youth selfdestructive behaviors instead of suicide when designing preventative interventions. In D. Romer (Ed.), *Reducing Adolescent Risk: Toward an Integrated Approach* (pp. 325–332). Thousand Oaks, CA: Sage Publications.
- Joe, S., Baser, R. E., Breeden, G. K., Neighbors, H. W., & Jackson, J. S. (2006). Prevalence of and risk factors for lifetime suicide attempts among blacks in the United States. *JAMA*, 296, 2112–2123.
- Joe, S., & Kaplan, M. S. (2002). Firearm-related suicide among young African-American males. *Psychiatric Services*, 53, 332–334.
- Joe, S., & Marcus, S. C. (2003). Trends by race and gender in suicide attempts among U.S. adolescents, 1991–2001. *Psychiatric Services*, 54, 454.
- Joe, S., Romer, D., & Jamieson, P. (2007). Suicide acceptability is related to suicidal behavior among U.S. adolescents. *Suicide and Life Threatening Behavior*, 37, 165–178.
- Kapur, N., Cooper, J., King-Hele, S., Webb, R., Lawlor, M., Rodway, C., et al. (2006). The repetition of suicidal behavior: A multi-center cohort study. *Journal of Clinical Psychiatry*, 67, 1599–1609.
- Kessler, R. C., Borges, G., & Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry*, 56, 617–626.
- Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology*, 51, 276–286.
- Linehan, M. M., Schmidt, H., III, Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addictions*, 8, 279–292.
- MacNeil, J. S. (2007). New JCAHO safety goal: Identify suicide risks. *Clinical Psychiatry News*, 35, 52–53.
- Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., et al. (2005). Suicide prevention strategies: A systematic review. *JAMA*, 294, 2064–2074.
- Maris, R. W., Berman, A. L., & Silverman, M. M. (2000a). *Comprehensive textbook of suicidology*. New York: The Guilford Press.
- Maris, R. W., Berman, A. L., & Silverman, M. M. (2000b). Suicide and the law. In R. W. Maris, A. L. Berman, & M. M. Silverman (Eds.), *Comprehensive textbook of suicidology* (pp. 480–506). New York: The Guilford Press.
- Marzuk, P. M., Tardiff, K., & Hirsch, C. S. (1992). The epidemiology of murder-suicide. *JAMA*, 267, 3179–3183.
- McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., et al. (1992). The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment*, 9, 199–213.
- Murphy, G. E., Armstrong, J. W., Hermele, S. L., Fischer, J. R., & Clendenin, W. W. (1979). Suicide and alcoholism: Interpersonal loss confirmed as a predictor. *Archives of General Psychiatry*, 36, 65–69.

- Murphy, G. E., Wetzel, R. D., Robins, E., & McEvoy, L. (1992). Multiple risk factors predict suicide in alcoholism. *Archives of General Psychiatry*, *49*, 459–463.
- National Center for Injury Prevention and Control (2007a). WISQARS fatal injuries: Leading causes of death reports. Atlanta, GA: Centers for Disease Control and Prevention. Retrieved May 30, 2007, from <http://www.cdc.gov/injury/wisqars/fatal.html>
- National Center for Injury Prevention and Control (2007b). WISQARS nonfatal injuries reports. Atlanta, GA: Centers for Disease Control and Prevention. Retrieved June 30, 2008, from <http://www.cdc.gov/injury/wisqars/nonfatal.html>.
- Nock, M. K., & Kessler, R. C. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: Analysis of the National Comorbidity Survey. *Journal of Abnormal Psychology*, *115*, 616–623.
- Ogbonna, E. & Harris, L. C. (1998). Organizational culture: It's not what you think. *Journal of General Management*, *23*, 35-48.
- Olson, L. M. & Wahab, S. (2006). American Indians and suicide: A neglected area of research. *Trauma, Violence, & Abuse*, *7*, 19–33.
- Oquendo, M. A., Dragasti, D., Harkavy-Friedman, J., Dervic, K., Currier, D., Burke, A. K., et al. (2005). Protective factors against suicidal behavior in Latinos. *Journal of Nervous and Mental Disease*, *193*, 438–443.
- Pokorny, A. D. (1983). Prediction of suicide in psychiatric patients: Report of a prospective study. *Archives of General Psychiatry*, *40*, 249–257.
- Preuss, U. W., Schuckit, M. A., Smith, T. L., Danko, G. P., Buckman, K., Bierut, L., et al. (2002). Comparison of 3190 alcohol-dependent individuals with and without suicide attempts. *Alcoholism: Clinical and Experimental Research*, *26*, 471–477.
- Ries, R. K., Yuodelis-Flores, C., Comtois, K. A., Roy-Byrne, P. P., & Russo, J. E. (2008). Substance-induced suicidal admissions to an acute psychiatric service: characteristics and outcomes. *Journal of Substance Abuse Treatment*, *34*, 72–79.
- Ross, J., Teesson, M., Darke, S., Lynskey, M., Ali, R., Ritter, A. et al. (2005). The characteristics of heroin users entering treatment: findings from the Australian treatment outcome study (ATOS). *Drug and Alcohol Review*, *24*, 411-418.
- Roy, A. (2001). Characteristics of cocaine-dependent patients who attempt suicide. *American Journal of Psychiatry*, *158*, 1215–1219.
- Roy, A. (2002). Characteristics of opiate dependent patients who attempt suicide. *Journal of Clinical Psychiatry*, *63*, 403–407.
- Rudd, M. D. (2006). *The assessment and management of suicidality*. Sarasota, FL: Professional Resource Press.
- Rudd, M. D., Berman, A. L., Joiner, T. E., Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., et al. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, *36*, 255–262.
- Rudd, M. D., Mandrusiak, M., & Joiner Jr, T. E. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology*, *62*, 243–251.
- Rudd, M. D., Williamson, B., & Trotter, D. (in press). The psychological and behavioral treatment of suicidal behavior: What are the common elements of treatments that work? *Oxford Textbook of Suicidology*.
- Schneider, M. (2002). A stakeholder model of organizational leadership. *Organization Science*, *13*, 209–220.
- Schneider, B., Georgi, K., Weber, B., Schnabel, A., Ackermann, H., & Wetterling, T. (2006). Risk factors for suicide in substance-related disorders. *Psychiatrische Praxis*, *33*, 81–87.

- Shea, S. C. (2002). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors*. New York: John Wiley.
- Shenassa, E. D., Catlin, S. N., & Buka, S. L. (2003). Lethality of firearms relative to other suicide methods: A population based study. *Journal of Epidemiology and Community Health, 57*, 120–124.
- Shneidman, E. S. (1985). *Definition of suicide*. New York: Wiley.
- Silverman, M. M., Berman, A. L., Sanddal, N. D., O'Carroll, P. W., & Joiner, J. (2007). Rebuilding the Tower of Babel: A revised nomenclature for the study of suicide and suicidal behaviors: Part II: Suicide-related ideations, communications and behaviors. *Suicide and Life-Threatening Behavior, 37*, 264–277.
- Simon, R. I. (2007). Gun safety management with patients at risk for suicide. *Suicide and Life-Threatening Behavior, 37*, 518–526.
- Szanto, K., Gildengers, A., Mulsant, B. H., Brown, G., Alexopoulos, G. S., & Reynolds, C. F., III (2002). Identification of suicidal ideation and prevention of suicidal behaviour in the elderly. *Drugs and Aging, 19*, 11–24.
- Weiss, R. D., & Hufford, M. R. (1999). Substance abuse and suicide. In D. G. Jacobs (Ed.), *The Harvard Medical School guide to suicide assessment and intervention* (1st ed., pp. 300–310). San Francisco: Jossey-Bass.
- Wenzel, A., Brown, G. K., & Beck, A. T. (in press). *Cognitive therapy for suicidal patients: Scientific and clinical applications*. Washington, DC: APA Books.
- Wilcox, H. C., Conner, K. R., & Caine, E. D. (2004). Association of alcohol and drug use disorders and completed suicide: an empirical review of cohort studies. *Drug and Alcohol Dependence, 76*, S11–S19.
- Zayas, L. H., Lester, R. J., Cabassa, L. J., & Fortuna, L. R. (2005). Why do so many Latina teens attempt suicide? A conceptual model for research. *American Journal of Orthopsychiatry, 75*, 275–287.

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Appendix E—Acknowledgments

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Index

A

- Accessing supervision and/or consultation element of GATE
 - administrative support for, 118–119
 - Clayton vignette, 39, 41
 - consultation process, 18
 - description, 15
 - immediate consultation, 18–19
 - Leon vignette, 59
 - overview, 15
 - regularly scheduled consultation, 19
 - Rob vignette, 66
 - summary, 19–20
 - Vince vignette, 71, 76
- Addiction Severity Index, 17
- Addiction Technology Transfer Centers training materials, 105
- Administrative response to suicidality adapting existing policies and programs, 111
 - administrative leadership attributes, 97
 - benefits of addressing suicidality, 92–93
 - building a suicide prevention- and intervention-capable agency, 107–122
 - competencies for working with clients, 25–31, 104–105
 - Consensus Panel recommendations, 92
 - criteria for and transfer to psychiatric facility
 - sample policy, 122
 - developing and improving program capabilities, 113–115
 - developing and improving the agency’s response to suicidal crises, 115–117
 - effects of suicidality on the program, 108–110
 - ethical issues, 98–99, 103–105
 - GATE procedure role, 101
 - impact of suicidal clients on program staffing, 109
 - implementing and integrating new programmatic elements, 111–113
 - importance of suicide as a programmatic issue, 93–94
 - leadership role in implementing and supporting programming for suicidal clients, 97–98
 - legal issues, 98–103
 - level 1 programs, 94–95, 96–97, 108
 - level 2 programs, 95, 96–97, 107–108, 110–111
 - level 3 programs, 95–96
 - mid-level staff role, 98
 - on-call system for senior staff, 94
 - organizational assessment, 108–111
 - organizational culture and, 109
 - organizational planning for becoming a level 2 program, 110–111
 - organizational response to clients with suicidal thoughts and behaviors, 109
 - other programs as sources of information, 109–110
 - program implementation, 111–113
 - reasons for administrators to be involved in a clinical issue, 93–94
 - sample policies, 111–113, 122
 - targets for clients with suicidal thoughts and behaviors, 110–111
 - variety of treatment programs and client needs and levels of risk and, 107
 - written policies and implementation plans, 113
- Adolescents and young people
 - suicide risk, 13
- African Americans
 - suicide risk, 13, 56, 57, 59
- After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department*, 54
- Age factors
 - suicide risk, 13, 57
- Alaska Natives. *See* Native Americans/Alaska Natives
- Alcohol use and abuse
 - suicide and, 9
- American Association of Suicidology
 - resources for families, 54
- American Counseling Association
 - ethical standards, 99
- American Foundation for Suicide Prevention
 - resources for families, 54
- American Indian Health Council
 - suicide prevention Web site, 86
- American Indians. *See* Native Americans/Alaska Natives
- American Psychiatric Association
 - ethical standards, 99
- American Psychological Association
 - ethical standards, 99

Angela vignette
co-occurring mental health problems, 46–47
counselor and Angela’s brother, 48–55
counselor/client dialogue, 47–55
followup, 55
learning objectives, 47
meeting between Angela’s counselor and her clinical supervisor, 47–48
overview, 33, 46–47
substance abuse history, 47
suicide-related history, 47

Assessing and Managing Suicidal Risk: Core Competencies for mental Health Professionals, 25
“Assessing Suicide Risk: Initial Tips for Counselors” card, 17, 100

The Assessment and Management of Suicidality, 25

Association for Addiction Professionals

ethical standards, 99

ATTCs. *See* Addiction Technology Transfer Centers

B

Background information

age factors, 13

gender factors, 13

link between substance abuse and suicidality, 9–10

protective factors, 12–13

race and ethnicity and, 13

reasons for suicidal behavior, 14

risk factors, 12

suicide compared with suicide attempt, 13

transition points in care and risk of suicide, 10

types of suicidal thoughts and behaviors, 10–11

Beck Depression Inventory, 17

C

Campus suicide prevention teams

developing, 62

CARF. *See* Commission on Accreditation of Rehabilitation Facilities

Case management

Clayton vignette and, 35

Clayton vignette

avoidance of grilling the client and, 36, 38

consultation with a supervisor, 39, 41

counselor/client dialogue, 35–46

direct questions about suicidality, 36, 38

followup, 46

learning objectives, 34–35

overview, 33, 34

substance abuse history, 34

suicidal crisis example, 115

suicide-related history, 34

Commission on Accreditation of Rehabilitation

Facilities

standards of care for clients at risk of suicide, 99

Commitment to Treatment agreements

description, 22, 101

having both the client and the counselor sign, 116–117

sample agreement, 116

Community treatment options, 49

Competencies for working with clients. *See also*

Training issues

checklist, 114

Consensus Panel recommendations, 25–31

ethical issues, 25–31, 104–105

Confidentiality

informing clients about, 5

legal issues, 102–103

limitations of, 5–6, 45, 87, 102–103

Consensus Panel recommendations for administrators, 92

asking directly about suicidality, 4, 7, 36, 38

competencies for working with clients, 25–31

confidentiality issues, 5–6, 45

emergency release of information documents, 102

GATE procedures, 14–18, 91, 117–122

general recommendations, 4

getting good clinical supervision and consultation, 5, 39, 41, 47–48, 59, 66, 71, 76

increasing your knowledge about suicidality, 4

level 1 programs, 95

level 3 programs, 95

practicing with another counselor or clinical supervisor, 5

using your therapeutic skills, 5

working collaboratively with suicidal clients, 5

“Crisis Management: A Guide for Substance Abuse Counselors,” 115

Cultural effects

help-seeking behavior, 77

as a protective factor, 12–13

D

Depression

co-occurrence with suicidality, 7, 9

screening measures, 17

Documentation

administrative support for, 121

Clayton vignette, 46

elements of, 23–24

- examples, 24–25
- importance of, 23, 121
- legal issues, 100
- Leon vignette, 62–63
- Rena vignette, 88
- Rob vignette, 66
- Vince vignette, 76

E

- Emergency evaluation referrals, 22, 71, 74, 76
- Enhancing Motivation for Change in Substance Abuse Treatment*, 73

Ethical issues

- administrators and, 98–99, 103–105
- admission, transfer, and treatment termination, 104
- compared with legal issues, 103
- competencies for working with clients, 25–31, 104–105
- description, 99
- informed consent, 103–104
- malpractice, 103
- professional groups and, 103
- training for counselors in suicidality, 104–105

- Ethnic factors. *See* Racial and ethnic factors

Extend the action(s) element of GATE

- administrative support for, 121
- list of possible actions, 23
- monitoring clients, 15
- overview, 15
- summary, 23

F

Families

- common responses to a family member's suicidal thoughts or attempts, 53, 54
- counseling for, 53
- family anger and understanding of clients' illness, 51
- helpful actions, 53
- knowledge of the warning signs of suicide, 50
- resources for family members and friends, 54
- working with the family of a client who is suicidal, 45

Followup

- administrative support for, 121
- Angela vignette, 55
- Clayton vignette, 46
- followup questions, 17–18, 100
- Leon vignette, 62–63

- Rena vignette, 88
- Rob vignette, 66
- Vince vignette, 76

G

- GATE procedures. *See also* specific elements

- administrators' role, 101, 117–122
- Angela vignette, 46–55
- Clayton vignette, 34–46
- decision tree (figure), 16
- detailed explanation, 15–18
- documenting all actions, 15, 23–25
- Leon vignette, 55–63
- overview, 14–15, 91
- Rena vignette, 77–88
- Rob vignette, 63–66
- suicide assessment component, 117
- treatment of suicidal state component, 117
- Vince vignette, 67–76

Gather information element of GATE

- administrative support for, 117–118
- checklist for, 118
- followup questions, 17–18, 100
- open-ended questions, 18, 35
- overview, 14–15
- screening measures, 17
- screening questions, 15–17, 37, 100
- “stacking” questions and, 15
- summary, 18

- Gathering of Native Americans curriculum, 78

Gender factors

- suicide risk, 13, 57, 59

H

- Hamilton Depression Rating Scale, 17

Healing of Nations

- suicide prevention Web site, 86

Hispanics/Latinos

- suicide risk, 13

Homelessness

- housing options, 49

Homicide

- risk factors, 67

Hope boxes

- setting up a hope box, 80–81
- uses for, 84

Hotlines

- national suicide hotline, 9, 22, 52, 53

- Housing options, 49

I

- IHS. *See* Indian Health Service
- Improving Cultural Competence in Substance Abuse Treatment*, 13
- Indian Health Service
 - Community Suicide Prevention initiative, 77–78
 - suicide prevention Web site, 86
- Informed consent
 - description, 5
 - ethical issues, 103–104
 - legal issues, 102
- Internet
 - training materials and courses, 105

J

- JCAHO. *See* Joint Commission on Accreditation of Healthcare Organizations
- Joint Commission on Accreditation of Healthcare Organizations
 - standards of care for clients at risk of suicide, 99

L

- Legal issues
 - administrators and, 98–103
 - compared with ethical issues, 103
 - confidentiality issues, 102–103
 - description, 99
 - documentation, 100
 - duty to warn when a client is at risk of harming another person, 103
 - foreseeability, 100
 - implementing treatment and referrals to reduce the potential for suicide, 100–101
 - informed consent, 102
 - levels of treatment and, 101–102
 - liability, 100
 - maintaining safety for clients, 101–102
 - malpractice “failures” for work with suicidal clients, 99–100
 - professional liability, 100
 - reasonable standard of care, 99
 - reducing liability in inpatient settings, 102
 - reducing liability in outpatient settings, 102
 - release of information, 102–103
- Leon vignette
 - consultation with a supervisor, 59
 - counselor/client dialogue, 56–62
 - followup, 62–63
 - learning goals, 56
 - minimization of suicidality by client, 56
 - overview, 34, 55

- substance abuse history, 56
- suicide-related history, 56

- Lethality of method
 - description, 13
- Level 1 programs
 - characteristics of, 94–95, 108
 - implementation strategies, 96–97
- Level 2 programs
 - benefits of, 107–108
 - characteristics of, 95
 - implementation strategies, 96–97
 - organizational planning for becoming, 110–111
- Level 3 programs
 - characteristics of, 95–96
 - limited need for, 96

M

- Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery*, 110
- Men. *See* Gender factors
- Mental health issues
 - co-occurrence with suicidality, 3, 7, 9, 12, 46–63, 91
- MI. *See* Motivational interviewing
- Mid-level staff. *See also* Administrative response to suicidality; Substance abuse counselors role in implementing and supporting programming, 98
- Motivational interviewing
 - skills training, 114–115
 - Vince vignette and, 73

N

- National Association of Social Workers
 - ethical standards, 99
- National Organization for People of Color Against Suicide
 - resources for families, 54
- National Suicide Prevention Lifeline
 - After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department*, 54
 - “Assessing Suicide Risk: Initial Tips for Counselors” card, 17, 100
 - suicide hotline, 9, 22, 52, 53
- Native Americans/Alaska Natives
 - Rena vignette, 77–88
 - resources on suicide among, 86
 - suicide risk, 13, 77–78
- Non-suicidal self-injury
 - description, 11
- NSSI. *See* Non-suicidal self-injury

O

- Older persons
 - suicide risk, 13
- One Sky Center
 - suicide prevention Web site, 86

P

- Positive attitudes towards clients
 - addressing suicidality as a priority issue, 8
 - giving clients a suicide hotline number, 9
 - indirect warning signs, 8
 - need for additional services for clients, 8
 - routine screening for suicidal thoughts and behaviors, 8
 - talking about a client's past suicidal behavior, 8–9
- Posttraumatic stress disorder
 - Leon vignette, 55–63
- Practice Guidelines and Resources for the Assessment and Treatment of Patients with Suicidal Behaviors*, 25
- Protective factors
 - cautions about, 12
 - cultural values and, 12–13
 - description, 12, 68
 - list of, 12
- PTSD. *See* Posttraumatic stress disorder

R

- Racial and ethnic factors
 - suicide risk, 13, 56, 57, 59
- Referrals
 - clients who are ambivalent or resistant to treatment and, 22, 68, 70
 - for emergency evaluation, 22, 71, 74, 76
 - sample policy, 112
- Relapse planning
 - incorporating suicide prevention in, 52
- Rena vignette
 - advanced skills of counselors and, 113
 - counselor/client dialogue, 78–88
 - followup, 88
 - hope box and, 81, 84
 - overview, 34, 77
 - substance abuse history, 77
 - suicidal crisis example, 115
 - suicide and American Indian/Alaska Native populations, 77–78
 - suicide-related history, 77

Resources

- for family members and friends, 54
- on suicide among Native Americans/Alaska Natives, 86

Risk factors. *See also* Warning signs of suicide; *specific factors*

- administrators' responsibilities, 101
- discharge from treatment programs and, 53
- homicide/suicide, 67
- list of, 12

Rob vignette

- counselor/client dialogue, 63–66
- counselor's consultation with a supervisor, 66
- counselor's style, 63
- followup, 66
- learning objectives, 63
- overview, 34, 63
- substance abuse history, 63
- suicide-related history, 63

S

- Safety cards and safety plans
 - copied strategies section, 79
 - description, 21, 117
 - elements of a safety plan, 78–79
 - helping a client develop a detailed safety plan, 78–79
 - Rena vignette, 84
 - telephone numbers of friends and family, 79
 - telephone numbers of professionals, 79
 - warning signs list, 79
- Safety plans. *See* Safety cards and safety plans
- Screening
 - sample policy, 112
- Screening questions
 - list, 15–17, 37, 100
- Self-destructive behaviors
 - description, 11
- SPRC. *See* Suicide Prevention Resource Center
- States
 - ethical standards, 99
 - release of information and, 102
- Substance abuse counselors. *See also* Administrative response to suicidality; Mid-level staff; *specific vignettes*
 - appropriateness of training for suicide prevention, 3–4
 - “Assessing Suicide Risk: Initial Tips for Counselors” card, 17, 100
 - awareness of community treatment and housing options, 49

- introductory comments examples, 69
- maintaining positive attitudes towards clients
 - experiencing suicidal thoughts and behaviors, 7–9
- policy for handling suicidal crises, 40
- primary responsibilities, 100–101
- supervisors' liaisons with, 98
- working with the family of a client who is suicidal, 45
- Substance Abuse Treatment for People Who Are Homeless*, 49
- Substance Abuse Treatment for Persons With Co-Occurring Disorders*, 17
- Substance Abuse Treatment With American Indians and Alaska Natives*, 78
- Suicidal ideation
 - description, 10
- Suicidal intention
 - description, 10
- Suicidal thoughts and behaviors
 - non-suicidal self-injury, 11
 - self-destructive behaviors, 11
 - suicidal behaviors, 10
 - suicidal intention, 10
 - suicidal preparation, 10–11
 - suicidal thoughts, 10
 - warning signs for suicide, 7, 8, 11–12
- Suicidality
 - achieving abstinence and, 6–7
 - administrative response to, 91–105
 - ambivalence about, 6
 - asking directly about, 4, 7, 36, 38
 - benefits of proactively addressing, 93
 - effects on children of clients, 84
 - inpatient treatment, 22
 - long-term monitoring and, 6
 - myths and misconceptions about, 92–93
 - outcomes and, 7
 - reasons for, 14
 - risk assessment and, 6
 - suicide contracts and, 6
 - taking attempts seriously, 7
 - transient nature of, 6
 - warning signs, 7, 50
- Suicide
 - as cause of death for people who abuse alcohol or drugs, 3, 9, 91
 - description, 10
 - elevated risk for persons in substance abuse treatment, 3
 - mental health problems and, 3

- Suicide and Mental Health Association International
 - suicide prevention Web site, 86
- Suicide attempts
 - compared with completed suicide, 13
 - description, 10
- Suicide contracts
 - legal liability and, 6, 101
 - usefulness of, 6, 22, 101
- Suicide crises
 - Commitment to Treatment agreements, 116–117
 - developing and improving the agency's response to, 115–117
 - policy components, 115–116
 - postvention for staff, 117
 - safety cards and, 117
 - vignette examples, 115
- Suicide plans
 - description, 10
- Suicide preparation
 - description, 10–11
- Suicide Prevention Resource Center
 - guidelines for programs, 110
 - resources for families, 54
 - training materials, 105
- Supervisors. *See also* Access supervision and/or consultation element of GATE
 - liaisons with substance abuse counselors, 98
 - responsibilities, 98
 - role in responding to clients' suicidal thoughts and behaviors, 98
 - tasks in extending care, 121

T

- Take responsible action(s) element of GATE
 - actions that “make good sense,” 15, 20
 - administrative support for, 119, 121
 - advanced skills safety plans, 22, 78–79, 113
 - Commitment to Treatment agreements, 22, 101, 116
 - continuum of intensiveness, 20–23
 - immediate actions, 20
 - inpatient treatment for suicidality, 22
 - levels of care, 119
 - list of possible actions, 21
 - non-immediate actions, 20
 - number of individuals involved and, 20–21
 - overview, 15
 - referrals for emergency evaluation, 22, 71, 74, 76
 - referring clients who are ambivalent about treatment or resistant to treatment, 22, 68, 70
 - safety cards and safety plans (exhibit), 21

- “seriousness” definition, 20
- suicide contracts, 22
- summary, 22–23
- 24-Hour Suicide Assessment Tool, 119
- Telephone interviews
 - crisis telephone calls, 86–87
 - Rena vignette, 77–88
- Telephone numbers
 - national suicide hotline, 9, 22, 52, 53
 - safety plans and, 79
- Training issues. *See also* Competencies for working with clients
 - ethical issues, 104–105
 - sample policy, 111
 - substance abuse counselors, 3–4
- Trauma symptoms
 - Leon vignette, 55–63
 - Rena vignette, 77–88
- 24-Hour Suicide Assessment Tool, 119, 120

V

Vignettes

- Angela, 33, 46–55
- Clayton, 33, 34–46
- Leon, 34, 55–63
- Rena, 34, 77–88
- Rob, 34, 63–66
- Vince, 34, 67–76

Vince vignette

- advanced skills of counselors and, 113
- counselor/client dialogue, 68–76
- counselor’s consultation with a supervisor, 71, 76
- followup, 76
- homicide/suicide and, 67
- introductory comments examples, 69
- learning objectives, 68
- overview, 34, 67
- substance abuse history, 67–68
- suicidal crisis example, 115
- suicide-related history, 68

W

Warning signs of suicide. *See also* Risk factors

- administrators’ responsibilities, 101
- direct signs, 11
- family members and, 50
- forms of, 7, 50
- indirect, 8, 11–12
- IS PATH WARM mnemonic, 11, 17
- stressful life events and, 11, 12, 50

Weapons

- Clayton vignette and, 34, 35, 42
- legal responsibility for removal of, 101
- Vince vignette and, 67

Web sites

- suicide prevention, 86

Whites

- suicide risk, 13

Women. *See* Gender factors

SAMHSA TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

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Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

This TIP is divided into three parts that are bound and produced separately.

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, Part 1, is for substance abuse counselors. It provides the “what” and “why” and “how” of working with clients in substance abuse treatment with suicidal thoughts and behaviors. It covers background information about suicide and substance use disorders, including risk factors and warning signs for suicide and a four-step process for addressing suicidal thoughts and behaviors in substance abuse treatment, summarized by the acronym GATE (Gather information, Access supervision, Take responsible action, and Extend the action). It also includes a set of competencies counselors should incorporate to work effectively with clients who are suicidal. Chapter 2 of *Part 1* represents the heart of the “how-to” for counselors. It consists of representative vignettes of counseling sessions with clients who have suicidal thoughts and behaviors. Master clinician notes help you understand the client and his or her issues related to suicide, and present approaches you can take in your counseling work with clients with suicidal thoughts and behaviors. “How-to” notes describe specific counseling techniques.

Addressing Suicidal Thoughts and Behaviors: An Implementation Guide for Administrators, Part 2, clarifies why program administrators should be concerned about this clinical issue. It will help you understand how administrators can provide support for programs and counselors as they use GATE to address clients’ suicidal thoughts and behaviors. It is hoped that this knowledge will enable treatment programs to treat substance abuse while concurrently addressing the specific needs of those who have warning signs for suicide.

Addressing Suicidal Thoughts and Behaviors: A Review of the Literature, Part 3, is for clinical supervisors, interested counselors, and administrators. It consists of three sections: an analysis of the available literature on suicidal thoughts and behaviors in clients with substance use disorders, an annotated bibliography of the literature most central to the topic, and a bibliography of other available literature. *Part 3* is available only online at <http://www.kap.samhsa.gov>.

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