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Part 1, Chapter 1, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment: Information You Need To Know

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.

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, posttraumatic 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 substance 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 objections, 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 **G**athering 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 can 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 **G**athering 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. Nonethe-less, 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 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 important 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 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 abut 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://download.ncadi.samhsa.gov/ken/pdf/SVP06-0153/SVP06-0153.pdf. Bulk copies (item SVP06-0153) can be ordered at http://nmhicstore.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 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/resources/instruments.htm). 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 sucidality 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., psychiatric 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?

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).

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.
- 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 suicidali ty: 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 morning. 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.

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.