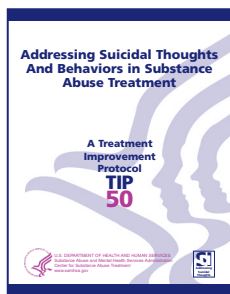


# Quick Guide

## *For Clinicians*

### **Based on TIP 50**

## **Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment**



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# **Quick Guide**

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## ***For Clinicians***

### **Based on TIP 50**

### ***Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment***

This Quick Guide is based entirely on information contained in TIP 50, published in 2009. No additional research has been conducted to update this topic since publication of TIP 50.

## WHY A QUICK GUIDE?

This Quick Guide accompanies the treatment improvement guidelines set forth in *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*, number 50 in the Treatment Improvement Protocol (TIP) series. It summarizes the how-to information in TIP 50 pertinent to substance abuse counselors and clinicians, focusing on tools, techniques, and concerns related to suicidality in behavioral health settings.

Users of this Quick Guide are invited to consult the primary source, TIP 50, for more information and a complete list of resources for addressing suicidal thoughts and behaviors. To order a copy or access the TIP online, see the inside back cover of this Guide.

**DISCLAIMER:** The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA) or the U.S. Department of Health and Human Services (HHS). No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described are intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

## WHAT IS A TIP?

The TIP series provides professionals in the behavioral health and related fields with consensus-based, field-reviewed guidelines on behavioral health topics of vital current interest. The TIP series is published by SAMHSA and has been in production since 1991.

### *TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment:*

- Provides information about suicidality.
- Focuses on the information that treatment professionals need to know and provides that information in an accessible manner.
- Synthesizes knowledge and grounds it in the practical realities of clinical cases and real situations so that the reader will come away with increased knowledge, encouragement, and resourcefulness in working with substance abuse treatment clients who have suicidal thoughts or behaviors.

### **Other TIPs of interest to readers include:**

- TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery*
- TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*

*Note: You may download TIPs and related products for free through the SAMHSA Store at <http://store.samhsa.gov>.*

## **TIP 50 IS ORGANIZED INTO THREE PARTS**

- *Part 1 for substance abuse counselors* focuses on providing the information you need to address the needs of clients with suicidal thoughts and behaviors.
- *Part 2 for program administrators* focuses on providing administrative support to implement adoption of the treatment recommendations made in Part 1.
- *Part 3 for clinical supervisors, program administrators, and interested counselors* is an online literature review that provides an indepth look at relevant published resources. Part 3 is updated periodically for up to 3 years after publication of the TIP.

Content in this Quick Guide is taken primarily from *Part 1 for substance abuse counselors*. The companion Quick Guide for Administrators draws content primarily from *Part 2 for program administrators*.

## INTRODUCTION

- The risk of suicide is significantly elevated among people who abuse alcohol and drugs. Compared with the general population, individuals treated for alcohol abuse or dependence are at about 10 times greater risk of eventually dying by suicide, and people who inject drugs are at about 14 times greater risk of eventual suicide.
- Individuals with substance use disorders are also at elevated risk for suicidal ideation and suicide attempts.
- 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.
  - They enter treatment when a number of life crises (e.g., marital, legal, vocational) may be occurring.
  - They enter treatment when their depressive symptoms are at a peak.
  - Mental health problems (e.g., mood disorders, anxiety disorders including posttraumatic stress disorder [PTSD], 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, relational problems, treatment transitions).



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## **CONSENSUS PANEL RECOMMENDATIONS**

You are a trained substance abuse treatment professional or other behavioral health professional who works with persons with substance use and/or mental disorders. However, your background may not necessarily include detailed training in addressing your clients' suicidal thoughts and behaviors. This Quick Guide and the TIP upon which it is based are designed to fill that gap and increase both your understanding of clients with suicidal thoughts and behaviors and your treatment skills for addressing the needs of these clients.

In particular, the consensus panel recommends that you:

- Screen clients in substance abuse treatment for suicidal thoughts and behaviors routinely at intake and at specific points in the course of treatment (see pp. 31–32 of this Quick Guide). Screening of clients with significant risk factors should occur regularly throughout treatment.
- Be prepared to develop and implement a treatment plan that addresses suicidality and to coordinate the plan with other providers.
- Confirm that referral appointments are kept whenever a referral is made; also continue to monitor clients after crises have passed through

ongoing coordination with mental health treatment providers and other practitioners, family members, and community resources as appropriate.

- Acquire basic knowledge about warning signs, risk factors, and protective factors as they relate to suicide risk.
- Be empathic and nonjudgmental with people who experience suicidal thoughts and behaviors.
- Be aware of the impact of your own attitudes toward and experiences with suicidality on your counseling work with clients.
- Understand the ethical and legal principles and potential areas of concern that exist in working with clients who have suicidal thoughts and behaviors.

## TYPES OF SUICIDAL THOUGHTS AND BEHAVIORS: SOME DEFINITIONS

- *Suicidal ideation*: Suicidal ideation is much more common than suicidal behavior. Suicidal ideation (or thoughts) exists on a continuum of severity from fleeting, vague thoughts of death to persistent and highly specific considerations of suicide. Thoughts may only occur periodically or may be unrelenting.
- *Suicide plans*: Suicide plans are significant because they signal a more serious risk of carrying out suicidal behavior than does suicidal ideation without planning. Suicide planning exists on a continuum from vague and unrealistic plans to highly specific and feasible plans. Serious suicide planning may also involve rehearsal or preparation for a suicide attempt.
- *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 suicide. Preparation can take 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.

- *Suicide attempt*: A suicide attempt is a deliberate act of self-harm, undertaken by an individual who has at least some intent to die, that does not result in death. Attempts have two major elements: 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 the objective lethality of the act (from a medical perspective, how likely was it that the behavior would have led to death?). Although all suicide attempts are serious, those with high intent (client clearly wanted 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, undertaken by an individual with at least some intention to die, that results in death.
- *Nonsuicidal self-injury (NSSI)*: NSSI (e.g., 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 sui-

cide attempt or suicide because NSSI does not include suicidal intent. NSSI is also commonly referred to in the literature as “deliberate self-harm” or “suicidal gesture.” This Quick Guide and the TIP upon which it is based do not focus on NSSI. However, suicidal behaviors and NSSI can coexist 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, reckless driving, getting into fights) are distinguished from suicidal behavior because an act of suicide is an acute action intended to cause death in short order. This Quick Guide and the TIP upon which it is based do not focus on self-destructive 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 to best help the client, particularly as you are learning more about suicidality.

### **Thoughts To Consider**

*Be direct.* We must often talk with clients about socially taboo topics. Become comfortable talking with clients directly about their thoughts of killing themselves. Doing so can save lives.

*Increase your knowledge about suicide.* 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—the range of effective interventions for suicidality increases your competence and comfort.

*Do what you already do well.* Faced with a suicidal client, many counselors turn into the “suicide police,” aggressively questioning and demanding assurances of safety from the client. Don’t lose

sight of what makes you a successful counselor: empathy, good therapeutic skills, and awareness of client resistance.

*Practice, practice, practice.* Nobody does something best the first time around. Get comfortable with asking all clients in substance abuse treatment about suicide. Learn to look for risk factors and warning signs (noted on pp. 19–21 of this Quick Guide). Consider attending a workshop at which you can enhance and practice your skills.

*Get good clinical supervision.* There is no substitute for working with an experienced supervisor to help you fine-tune your skills in working with suicidal clients. Good supervision should offer you opportunities to learn more about suicidality, become more aware of your own strengths and limitations in working with people who are suicidal, and practice new skills. Supervision also provides you with the oversight and input necessary to ensure that you are following the highest level of ethical and professional standards of practice.

*Work collaboratively with clients.* It is an unfounded stereotype that most people don't want to talk about their suicidality. Most, in fact, do want to talk with you; they want to collaborate and cooperate with you to reduce their pain. We almost always get better results by inviting collaboration than by acting independently.

*Recognize the limits of confidentiality when suicidality is involved.* Confidentiality rules change when clients are in imminent danger of killing themselves. However, just because a client voices a desire to die does not allow you to violate confidentiality. Know the limits of confidentiality when working with suicidal clients and always consult an experienced supervisor.



## 10 POINTS TO REMEMBER ABOUT SUICIDALITY

1. *Almost all clients who are suicidal are ambivalent about living or not living.* Wishing to both die and live is typical of most individuals who are suicidal. Take suicidal thinking seriously and consider ways to reinforce a client's sense of 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.
2. *Suicidal crises can be overcome.* Fortunately, acute suicidality is a transient state. Even individuals at high long-term risk spend more time being nonsuicidal than being suicidal. Moreover, most people who have made serious suicide attempts but then receive acute medical and/or psychiatric care are relieved that they did not die. The challenge is to help clients survive the acute suicidal crisis period until such time as they want to live again.
3. *Although suicide cannot be predicted with certainty, suicide risk assessment is valuable.* Suicide risk assessment is a valuable clinical tool because it can ensure that those requiring more services get the help that they need.
4. *Suicide prevention actions should extend beyond the immediate crisis.* Just because someone is no longer at imminent suicide risk

does not mean that he or she is “out of the woods.” 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 the clients show any indication of current risk for suicide. Individuals with histories of serious suicidal thoughts or suicide attempts but no recent suicidal thoughts or behaviors need to be monitored to identify any recurrence of suicidality.

5. *Suicide contracts are not recommended and are never sufficient.* Safety contracts or “no suicide contracts” are never sufficient as a deterrent to suicidal behavior. Use this Quick Guide and its accompanying TIP to choose from among the many other strategies that promote safety. Use contracts sparingly, if at all.
6. *Some clients will be at risk for suicide even after becoming clean and sober.* Abstinence should be a primary goal for any client with a substance use disorder and suicidal thoughts and/or behaviors. Indeed, risk will diminish for most clients when they achieve abstinence. Nonetheless, some individuals remain at risk even after achieving abstinence. Some clients in substance abuse recovery that remain at risk include those with independent depres-

sion, unresolved difficulties that promote suicidal thoughts (e.g., partner breakup, ongoing domestic violence or other traumas, impending legal difficulties), or certain personality disorders.

7. *Suicidal thoughts and behaviors must always be taken seriously.* Any indications of suicidality must be taken seriously, including those that involve little risk of death; any suicidal thoughts must be carefully considered in relation to the client's history and current presentation. Clients with histories of attempted suicide warrant particular attention.
8. *Persons who are suicidal generally show warning signs.* Fortunately, individuals who are experiencing suicidality usually give warning signs, which come in many forms (e.g., expressions of hopelessness, suicidal communication) and are often repeated. The difficulty is in recognizing these signs for what they are; often, signs are not seen until after a suicide attempt. Warning signs are discussed on pp. 19–21 of this Quick Guide.
9. *It is best to ask all clients in substance abuse treatment directly about suicide.* You may never know about a client's suicidality unless you ask the right questions. Many clients will be willing to talk about their histories and their current thoughts about suicide, but only if they

are asked. The questions you need to ask are discussed on page 32 of this Quick Guide under the heading “G: Gather Information.”

10. *The outcome does not tell the whole story.*

Most clients who are experiencing suicidal thoughts—and even those who make an attempt—don’t die. Death by suicide is, fortunately, a relatively uncommon event. You cannot assume that because someone does not die, appropriate treatment has been provided. Likewise, despite the best of assessments and precautions, sometimes an individual does die. This does not mean that the individual has received improper treatment.

## 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, which can be direct or indirect, always require asking follow-up questions.

**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 method*: Someone looking for ways to kill him- or herself by seeking access to firearms, pills, or other means.
- *Making preparations*: Someone talking or writing about death, dying, or suicide when such topics are out of the ordinary for the person to address.

Each of the **direct** warning signs indicates potential for suicidal behavior in its own right and, if present, requires rigorous follow-up. **Indirect** warning signs, on the other hand, may or may not signal risk for acute suicidal behavior (e.g., substance abuse is the norm among your clients). In all cases, warning signs require follow-up questions to determine whether they indicate acute suicidality.

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

**PATH WARM:**

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

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

## **RISK FACTORS**

Risk factors are defined as indicators of long-term (or ongoing) risk. They differ from direct warning signs, which signal immediate risk. Risk factors for suicidal thoughts and behaviors among individuals with substance use disorders have been well researched. The following list of risk factors, although not exhaustive, is informed by this research:

- Prior history of suicide attempts (most potent risk factor, although about half of all deaths by suicide are first-time attempts)
- Family history of suicide
- Severe substance use or dependence (e.g., use of multiple substances, early onset of dependence)
- Co-occurring mental disorder
  - Depression (including substance-induced depression)
  - Anxiety disorders (especially PTSD)
  - Serious mental illness (schizophrenia, bipolar disorder)
  - Personality disorder (best researched are borderline and antisocial personality disorders)
  - Anorexia nervosa
- History of child 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 impulsiveness
- Firearm ownership or access to a firearm

## **PROTECTIVE FACTORS**

Protective factors are defined as buffers that lower long-term risk. Unlike risk factors, factors that protect against suicidal behavior are not well researched. Reasons for living are perhaps the best researched protective factors in the literature. Protective factors vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor.

The following are known and likely protective factors:

- Reasons for living
- Being clean and sober
- Attendance at 12-Step support groups
- Attendance at a place of worship and/or internalized spiritual teachings against suicide
- Presence of a child in the home and/or child-rearing 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, nor should the presence of such protective factors 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.

## **GATE: A FOUR-STEP PROCESS FOR IDENTIFYING AND RESPONDING TO SUICIDALITY**

The role of substance abuse treatment counselors in addressing clients' suicidal thoughts and behaviors can be represented by the acronym **GATE**: **G**ather information, **A**ccess supervision, **T**ake action, **E**xtend the action. The elements in GATE reflect behaviors within your scope of competence as a substance abuse counselor that are relevant in helping clients at risk of suicide. You are familiar with gathering information from clients who have substance use disorders; this skill can be translated into gathering information about suicidal thoughts and behaviors. 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. Supervision may be a regular part of your agency's program; with a client who is suicidal, it is a necessity.

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 who have suicidal thoughts and behaviors, such as assessment, specialized suicide interventions, or treatment of co-occurring mental disorders (e.g., depression, trauma-related disorders). More advanced skills such as these are not, however, this TIP's primary focus. The quick overview below is supplemented by a flow chart 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 follow-up 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 follow-up questions when clients respond “yes” to one or more screening questions or any time you notice a warning sign(s). The purpose of asking follow-up 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 should convey as much information

as possible to another provider, should you make a referral or request a consultation. Examples of screening questions, warning signs, and follow-up questions are provided on pp. 34–35 of this Quick Guide.

### ***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 cases involving clients who are suicidal, 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 using supervision and consultation effectively are provided on pp. 37–41 of this Quick Guide.

### ***T: Take responsible action(s)***

The guiding principle of taking responsible action is that your action(s) should make good sense in

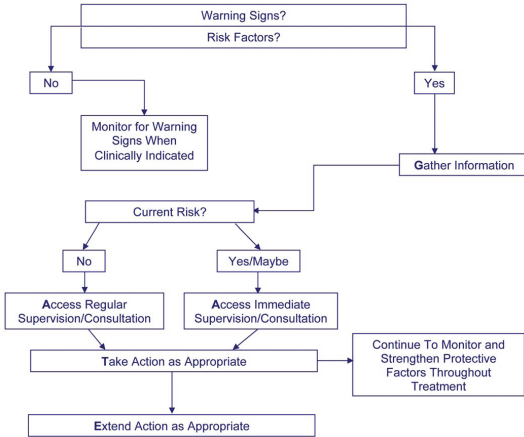
light of the seriousness of suicide risk. We expand on this principle and provide a list of potential actions covering a wide range of intensity and immediacy that you and your supervisor or team may take on pp. 37–41 of this Quick Guide.

***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 must continue to observe and check in with the client to identify a possible return of risk. Another common problem is referring a client who is suicidal 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.

Documenting all 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 to your supervisors and consultants, your team, and other providers. Examples of documentation are provided at the end of this Quick Guide.

The figure below is a graphic representation of the elements of **GATE**. It is a decision tree designed to help you see how the completion of one element leads to decisions and specific actions in the next.



## Detailed Discussion of GATE

### **G: Gather information**

Information gathering proceeds in two steps: screening and/or spotting warning sign(s) and then asking follow-up questions. 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 are required to have sufficient clinical judgment to make the fine distinctions necessary for assessment. But substance abuse counselors should be prepared to collect information from clients about suicidality and to perform basic suicide screening.

As much as possible, you should avoid “stacking” questions (peppering clients with one closed-end question after the other), which tends to generate defensiveness and/or false reassurances of safety. If a client’s answers are unclear or if you sense some defensiveness, consider asking the same question in a different way later in the interview. Although clients will not always be able or willing to provide greater clarity regarding their suicidality, ambiguous or vague answers are always important to pursue further because they may signal discomfort with the topic, anxiety about disclosure, evasiveness, and/or uncertainty (e.g., “I don’t know,” “I’m not sure”).

### *Screening*

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; it is better to ask them 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 an interview for the study of alcoholism that has been used in research on suicidal thoughts and behaviors, and items 4 and 6 are taken from a national survey that has provided information on suicidal thoughts and behaviors in the general population.

The National Suicide Prevention Lifeline has produced a wallet-sized card for counselors entitled “Assessing Suicide Risk: Initial Tips for

Counselors” that lists five questions counselors can ask about suicide. The card also lists the warning signs contained in “IS PATH WARM” and offers brief advice on actions to take with people who are at risk. The card is available in the TIP and online at <http://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-Wallet-Card-Assessing-Suicide-Risk-Initial-Tips-for-Counselors/SVP13-0153>. Bulk copies (item SVP06-0153) can be ordered at <http://store.samhsa.gov>.

### *Additional options for screening*

Multi-item measures that contain one or more items that ask about suicidal thoughts or behaviors may also be used for screening, and sometimes the client has previously taken such a test and the actual answers will be in the client records. Items that ask about suicidality can be found on several widely used measurement instruments or interview questions—the Beck Depression Inventory-II (BDI-II) and the Patient Health Questionnaire-9 (PHQ-9) are two examples. The BDI-II must be purchased (<http://www.pearsonassessments.com>), but the PHQ-9 is in the public domain (<http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>). Both require users to meet qualification standards to ensure accurate and ethical use. If a client endorses any level of suicidality on the relevant items of any such measure, you

should ask follow-up questions. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, contains useful suicide screening options for persons with co-occurring disorders.

### *Asking follow-up questions*

It is important to ask follow-up questions when a client answers “yes” to a screening question at intake, when you note a warning sign, or at any time during the course of treatment when you suspect the client is suicidal, even if you can’t pinpoint why. Follow-up questions and their answers give you as much information as possible for discussing the situation with your supervisor or team and allow you to convey solid information if referring to another provider.

Sample follow-up questions about suicidal thoughts:

1. Can you tell me about the suicidal thoughts?
2. If the client requires more direction, try some of the following questions:
  - *What brings them on?*
  - *How strong are they?*
  - *How long do they last?*
3. If you do not already know the answers to the following questions, ask:
  - *Have you made a **plan**? (If yes) What is your plan?*

- Do you have access to a **method** of suicide—a gun? A stockpile of drugs or medications?
- 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 follow-up questions to determine data such as the precipitants, strength, and duration of the suicidal thoughts (see sample question 2). 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; note this in discussion with your treatment team or supervisor.

Gathering additional information about suicide attempts is straightforward. Ask the client to explain the attempt through an open-ended question, such as “Please tell me about the attempt”; ask follow-up questions to find out more. If more than one suicide attempt occurred, ask about the

*most recent* attempt and the *most severe* attempt (if different from the most recent act).

The answers to these questions will help characterize the seriousness of suicidal behavior.

Sample follow-up questions about suicide attempts:

1. Please tell me about the attempt.
2. If the client requires more direction, ask questions such as the following:
  - *What brought it on?*
  - *Where were you?*
  - *Were you drinking or high?*
3. If you do not already know:
  - To gather information about **lethality**, ask:  
*What method did you use to try to kill yourself?*  
*Did you receive emergency medical treatment?*
  - To gather information about **intent**, ask:  
*Did you want to die?*  
*How strong was the desire to die?*  
*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 follow-up questions to determine the circumstances of the attempt (e.g., precipitating event, setting, role of acute alcohol or

drug use), and, if information related to **lethality** and **intent** does not come to light spontaneously, always gather these critical pieces of information (see sample question 3).

### *Summary of G: Gather information*

Gathering information consists of collecting relevant facts. Screening questions should be asked of all clients when you note warning sign(s) and whenever 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. Follow-up 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 merely to 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 clients who are suicidal 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 screening and follow-up 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. 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 that require immediate supervision or consultation include:

- Direct warning signs are evident (suicidal communication, seeking access to method, making preparations).



- Follow-up suicide screening questions suggest that there is current risk.
- Follow-up questions to indirect warning signs suggest that there is current risk.
- Additional information (e.g., from the referral source, a family member, or the client's medical record) suggests that there is current risk.

Circumstances during treatment that require immediate supervision or consultation include:

- Emergence (or re-emergence) of direct warning signs.
- Emergence (or re-emergence) of indirect warning signs that, on follow-up 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/family member) suggests current risk.

Circumstances at intake that require regularly scheduled supervision or consultation include:

- One or more indirect warning signs are present, but follow-up questions indicate no reason to suspect current risk for suicidal behavior per se (e.g., 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 suggest 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 suggest current risk for suicidal behavior.
- Additional information (e.g., from the referral source or a family member) suggests that your client has a history of suicidal thoughts or attempts, but there are no accompanying warning signs or other indications to suggest 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 of 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 of 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 of current risk for suicidal behavior.
- Your 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 of current risk for suicidal behavior.

Know who your consultant (supervisor, team, outside consultant) is for issues of suicidality in your program, what your agency policy is regarding acutely suicidal clients, and where such patients should 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, 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. 19 for direct warning signs) or when, at intake, they report having made a recent suicide attempt. Substance abuse relapse during treatment is also an indication for supervisory involvement for clients who have histories 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 (e.g., has persistent suicidal thoughts and a clear plan), there is high seriousness. In contrast, if a client is judged to be unlikely to carry out an attempt (e.g., has fleeting ideation, no clear plan, and no intention to act), there is lower seriousness.

*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. 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 removing a gun from the home and safely storing it elsewhere, and arranging on the spot to have a mental health specialist in your program further evaluate a client. Examples of nonimmediate, but important, actions include referring a client to an outpatient mental health facility for evaluation, scheduling the client to see a psychiatrist, and ordering past mental health records from another provider.

Some interventions are clearly 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 the client as unnecessary or intrusive. Arranging further assessment with an outpatient mental health

treatment 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 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 general, the greater the number of interventions and the more individuals involved, the more intensive the action(s).

### *What actions can you take?*

The list of actions below is not exhaustive but includes the most common actions. At times, one action will suffice, whereas at other times, more than one (and perhaps many) will be required. You and your supervisor or team will strive to take those actions 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). Some actions you might be expected to take include:

- Gathering additional information from the client

to assist in developing a more accurate clinical picture and treatment plan.

- Gathering additional information from other sources (e.g., spouse, other providers).
- Arranging a referral:
  - To a clinician for further assessment of suicide risk (after gathering additional information and reviewing with a clinical supervisor).
  - To a mental health counselor.
  - To a provider for medication management.
  - To an emergency provider (e.g., hospital emergency room) for acute risk assessment.
  - To a mental health mobile crisis team that can provide outreach to clients who cannot or will not come into the agency for screening and assessment.
  - To a more intensive substance abuse treatment setting.
- Restricting access to means of suicide.
- Temporarily increasing the frequency of care, including more frequent telephone check-ins.
- Temporarily increasing the level of care (e.g., refer to day treatment).
- Involving a case manager (e.g., to coordinate care, to check on the client occasionally).
- Involving the primary care provider.
- Encouraging the client to attend (or increase attendance at) 12-Step meetings, such as Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous.



- Enlisting 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.
- Observing the client for signs of a return of risk.
- Creating a safety card with the client in the event of a return of acute suicidality.

*Referring a client who is ambivalent about treatment or is resisting treatment*

It is common to make referrals for further evaluation, treatment of suicide risk, treatment of a mental health condition (e.g., depression), or a combination of services. Sometimes, however, a client will not agree that referral is necessary or simply will not wish to accept it. Discussing the reasons for your actions and listening to and acknowledging client concerns will usually soften the stance of clients who resist referral. Eliciting client input as to what he or she believes would be most helpful and using these suggestions, as appropriate, can also go a long way toward 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 organization’s policy on emergency referrals by reviewing it with them on a regular basis, as appropriate.

*A note on inpatient treatment for suicidality:* It is important that counselors, clients, and their family members know what to expect from inpatient psychiatric hospitalization. Generally, the treatments are short term (5–7 days); if the clinical team concludes that suicidality is substance-induced (roughly 40 percent of admissions are deemed thus), the stay may be shorter. During a brief hospitalization, there is typically only enough time to plan and begin the individualized therapeutic strategies with the client. As a result, most or all of the psychosocial difficulties that prompted admission

will need to be addressed on an ongoing basis when the client returns to regular treatment.

*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., breakup with a partner), increased depression, and so forth. Sometimes, suicidal behavior even occurs in the context of substantial improvement in mood and energy. Therefore, monitoring for signs that suggest the return of suicidal thoughts or behavior is essential.

## Safety Cards and Safety Plans

For all clients who exhibit suicidal risk, create a detailed safety plan with the client in the event of relapse to alcohol or drugs and invite the client to contact you (or an emergency hotline) in the event of acute suicidality. Also consider developing with the client a written safety card that includes, at a minimum:

- A 24-hour crisis hotline 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., 12-Step sponsor, family member).

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

need arises. Counselors with advanced mental health training and experience in working with clients who are suicidal may be in a position to formulate a more detailed safety plan. Such a **safety plan** and an example of its use with a client are described in Part 1, Chapter 2 of the TIP.

There is little empirical evidence to support no-suicide contracts (a client's agreement to contact the counselor or other resource before making a suicide attempt) as a stand-alone intervention. However, a related technique called a "commitment to treatment" agreement focuses the client's attention on specific behaviors (such as attending treatment sessions, setting recovery goals, completing homework assignments, and taking medications as prescribed) that support recovery, reduce suicidal thoughts and behaviors, and may be helpful for suicidal clients. Safety cards focus on preventing or intervening in crises, whereas commitment-to-treatment agreements focus on behaviors that positively support treatment outcome.

Counselors with more experience and training in working with clients who are suicidal can develop an advanced skills safety plan. An example of this type of plan is described in Part 1, Chapter 2 of the TIP; these plans help clients recognize when direct and indirect warning signs are becoming more apparent, develop coping responses, and focus on emotional regulation.

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 fully addressed. 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 another provider that a client has relapsed and may be vulnerable to suicidal thoughts. Extending the action emphasizes the importance of watching for the 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.

- When a referral appointment has been made with a mental health service provider (or other professional), confirm that the client has kept the appointment.
- Follow up with the hospital emergency department on clients referred for acute assessment.
- Coordinate with mental health treatment providers (or other professionals) on an ongoing basis.
- Coordinate with case managers 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 card in the event of a return to suicidality.
- Confirm that the client and, when appropriate, the family, still have an emergency phone number to call in the event of a return to 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 clients who have exhibited suicidality 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. Document the client's eventual progress and status at the point of 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 resulting plan. The plan should make good sense in light of the seriousness of risk.

Case examples follow that illustrate documentation across a continuum of seriousness of suicidality. Counselors, supervisors, or consultants may



provide such documentation. Many programs and State regulatory bodies recommend or mandate a particular format in which this documentation should occur. Generally, such formats accommodate all of the information contained in the suggested GATE protocol.

In the following case examples, the italicized text is the actual note. These examples are ideals; notes made 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 and protective factors) to help you with documentation. Even when using a checklist, a concluding statement and clearly articulated plan are always needed.

### **Documentation example 1**

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

**G**ather 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 ambiva-*

*lent 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.*

**A**ccess 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 man who is separated from his wife and is entering treatment for alcohol dependence. The situation required immediate supervision and an intervention of intermediate intensity.

**G**ather 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.*

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

**C**onclusion: *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.*

**T**ake 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, M.S.W., of the Mental Health Clinic.*

**E**xtend 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 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.

**G**ather 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 heroin earlier this morning. He reported that he held his loaded rifle in his lap last night while high and drunk, contemplating suicide.*

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

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

**T**ake action: *At 11:00 a.m., a hospital security guard and this writer escorted Fernando to the*

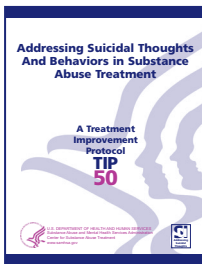
*emergency department, where he was checked in. He was cooperative throughout the process.*

**E**xtend 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.*

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