

Addressing Suicidal Thoughts And Behaviors in Substance Abuse Treatment

**A Treatment
Improvement
Protocol**

**TIP
50**



Substance Abuse and Mental Health Services Administration

SAMHSA

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Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

Treatment Improvement Protocol (TIP) Series

50

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

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Editor's Note On

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

2017

Published in 2009, Treatment Improvement Protocol (TIP) 50 contains much information that remains useful to today's reader. Noted below are topical areas where more current information and resources supplant or add to the content found in the TIP.

Clinical Updates

The Consensus Panel was not reconvened to review and update the clinical information in TIP 50. However, a literature search covering 2009 to mid-2017 found little information that would affect the recommendations in the TIP.

In 2012, the Surgeon General issued a report in partnership with the National Action Alliance for Suicide Prevention—[2012 National Strategy for Suicide Prevention: Goals and Objectives for Action](#).¹ The report identifies actions that behavioral health professionals can take as part of a national effort to reduce suicide. A key concept in the National Strategy is “zero suicide”; this calls on healthcare workplaces to set an explicit goal of full success in preventing suicide among the patients in their care. Funding for healthcare systems to implement “zero suicide” prevention and intervention programs is being made available by the Substance Abuse and Mental Health Services Administration (SAMHSA).²

Another change that has occurred since the TIP's publication is that several states and credentialing organizations have mandated or recommended training to ensure that healthcare professionals assess and address suicide risk.³ Several training models for healthcare professionals are available (see the Resources section of this document).

Statistical Update

When TIP 50 was published in 2009, suicide was the 10th leading cause of death in the United States, with 36,909 suicides reported.⁴ In 2015, suicide was still the 10th leading cause of death, with 44,193 suicides reported.⁵

Associations Between Substance Use Disorders and Suicidality

Research published after TIP 50 became available has added further evidence to the link between substance use disorders and suicidality. Pertinent findings include the following:

- According to an analysis of SAMHSA's 2014 National Survey of Drug Use and Health, which had 41,053 respondents, past-year prescription opioid misuse was significantly associated with past-year frequency of



suicidal ideation (thoughts of suicide); misuse at weekly or more intervals was significantly associated with past-year frequency of suicide planning and suicide attempts.⁶

- In a cohort study using national administrative health records for more than 4.8 million veterans, an existing diagnosis of any substance use disorder and a specific diagnosis of alcohol, cocaine, cannabis, opioid, amphetamine or sedative use disorder were all significantly associated with a higher suicide risk. The authors suggest that the association between substance use disorders and suicide may be partially explained by co-occurring psychiatric disorders.⁷
- A separate analysis of the health records for that same veteran cohort found that even after adjusting for co-occurring psychiatric disorders, tobacco use disorder remained a risk factor for suicide.⁸

Additional Resources

Potentially useful resources that were not included in TIP 50 are listed below.

Web Resources

[American Association of Suicidology](http://www.suicidology.org)

www.suicidology.org

[American Foundation for Suicide Prevention](https://afsp.org)

<https://afsp.org>

[Commission on Accreditation of Rehabilitation Facilities: Quality Practice Notice on Suicide Prevention](http://www.carf.org/QPN_SuicidePrevention_Sept2016)

www.carf.org/QPN_SuicidePrevention_Sept2016

[Sentinel Event Alert: *Detecting and Treating Suicide Ideation in All Settings*](http://www.jointcommission.org/sea_issue_56) (The Joint Commission)

www.jointcommission.org/sea_issue_56

[Suicide Prevention and the Clinical Workforce: Guidelines for Training](http://actionallianceforsuicideprevention.org/resources/suicide-prevention-and-clinical-workforce-guidelines-training) (National Action Alliance for Suicide Prevention)

<http://actionallianceforsuicideprevention.org/resources/suicide-prevention-and-clinical-workforce-guidelines-training>

Products From SAMHSA

[In Brief: Substance Use and Suicide: A Nexus Requiring a Public Health Approach](https://store.samhsa.gov/product/In-Brief-Substance-Use-and-Suicide-/SMA16-4935) (highlights the relationship between substance use and suicide, gives an overview of the issue, and describes evidence-based programs that focus on substance use and suicide prevention)

<https://store.samhsa.gov/product/In-Brief-Substance-Use-and-Suicide-/SMA16-4935>

[National Suicide Prevention Lifeline Wallet Card](https://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-Wallet-Card-Suicide-Prevention-Learn-the-Warning-Signs/SVP13-0126) (lists signs of suicide risk)

<https://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-Wallet-Card-Suicide-Prevention-Learn-the-Warning-Signs/SVP13-0126>

The National Suicide Prevention Lifeline Wallet Card is also available in [Spanish](#)

<https://store.samhsa.gov/product/National-Suicide-Prevention-Lifeline-Suicide-Warning-Signs-wallet-card-Spanish-/SVP11-0126SP>

[SAFE-T Pocket Card](https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/SMA09-4432) (suicide assessment five-step evaluation and triage for clinicians)
<https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/SMA09-4432>

[SAMHSA Suicide Safe Mobile App](https://store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1) (education and support resources for primary care and behavioral health service providers)
<https://store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1>

Notes

- 1 Office of the Surgeon General & National Action Alliance for Suicide Prevention. (2012). *2012 national strategy for suicide prevention: Goals and objectives for action*. Washington, DC: U.S. Department of Health and Human Services.
- 2 Substance Abuse and Mental Health Services Administration. (2017). Cooperative agreements to implement Zero Suicide in health systems [Webpage]. Retrieved July 7, 2017, from www.samhsa.gov/grants/grant-announcements/sm-17-006
- 3 American Foundation for Suicide Prevention. (2016). *State laws: Training for health professionals in suicide assessment, treatment, and management*. Retrieved July 7, 2017, from <http://afsp.org/wp-content/uploads/2016/04/Health-Professional-Training-Issue-Brief.pdf>
- 4 Centers for Disease Control and Prevention. (n.d.). *10 leading causes of death by age group, United States—2009*. Retrieved May 23, 2017, from www.cdc.gov/injury/wisqars/pdf/10lcd-age-grp-us-2009-a.pdf
- 5 Centers for Disease Control and Prevention. (n.d.). *10 leading causes of death by age group, United States—2015*. Retrieved May 23, 2017, from www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2015-a.pdf
- 6 Ashrafioun, L., Bishop, T. M., Conner, K. R., & Pigeon, W. R. (2017). Frequency of prescription opioid misuse and suicidal ideation, planning, and attempts. *Journal of Psychiatric Research*, 92, 1–7.
- 7 Bohnert, K. M., Ilgen, M. A., Louzon, S., McCarthy, J. F., & Katz, I. R. (2017). Substance use disorders and the risk of suicide mortality among men and women in the US Veterans Health Administration. *Addiction*, 112(7), 1193–1201.
- 8 Bohnert, K. M., Ilgen, M. A., McCarthy, J. F., Ignacio, R. V., Blow, F. C., & Katz, I. R. (2014). Tobacco use disorder and the risk of suicide mortality. *Addiction*, 109(1), 155–162.

This publication lists nonfederal resources to provide additional information to consumers. The content and views in these resources have not been formally approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) or the U.S. Department of Health and Human Services (HHS). Listing of these resources does not constitute an endorsement by SAMHSA or HHS.

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Disclaimer

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What Is a TIP?

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

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

Foreword

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

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

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

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How This TIP Is Organized

This TIP is divided into three parts:

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

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

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

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

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

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

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

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

The following topics are addressed in Part 2:

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

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

Part 1

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

Overview of Part 1

Chapter 1: Information You Need to Know

Introduction (pp. 3–4)

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

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

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

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

Chapter 2: Clinical Vignettes Demonstrating How to Apply the Information

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

Chapter 1

Introduction

Did You Know?

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

Who Should Read This Chapter?

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

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

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

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

You Can Do This!

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

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

Consensus Panel Recommendations

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

In particular, the consensus panel recommends the following:

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

Getting Ready To Address Suicidality

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

Be Direct

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

Increase Your Knowledge About Suicidality

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

Do What You Already Do Well

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

Practice, Practice, Practice

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

Get Good Clinical Supervision and Consultation

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

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

Work Collaboratively With Suicidal Clients

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

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

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

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

Ten Points To Keep You on Track

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

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

Point 2: Suicidal crises can be overcome.

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

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

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

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

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

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

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

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

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

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

Point 7: Suicide attempts always must be taken seriously.

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

Point 8: Suicidal individuals generally show warning signs.

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

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

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

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

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

Maintain Positive Attitudes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary

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

Background Information

The Link Between Substance Abuse and Suicidality

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

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

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

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

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

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

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

Types of Suicidal Thoughts and Behaviors

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

Suicidal thoughts

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

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

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

Suicidal behaviors

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

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

Other suicide-related concepts

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

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

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

Other harmful behaviors

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

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

Warning Signs for Suicide

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

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

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

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

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

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

Stressful life events include:

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

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

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

Risk Factors

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

Risk factors for suicidal thoughts and behaviors

These risk factors include:

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

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

Protective Factors

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

The following are known and likely protective factors:

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

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

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

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

Suicide Versus Suicide Attempt

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

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

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

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

Age

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

Gender

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

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

Race and ethnicity

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

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

Reasons for Suicidal Behavior

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

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

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

GATE: Procedures for Substance Abuse Counselors

Gather information

Access supervision

Take responsible action

Extend the action

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

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

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

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

Quick Overview of GATE

G: Gather information

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

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

A: Access supervision and/or consultation

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

T: Take responsible action(s)

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

E: Extend the action(s)

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

Documenting all the actions you have taken is impor-

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

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

Detailed Explanation of GATE

G: Gather information

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

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

Screening

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

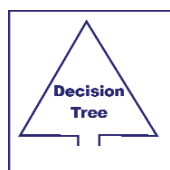
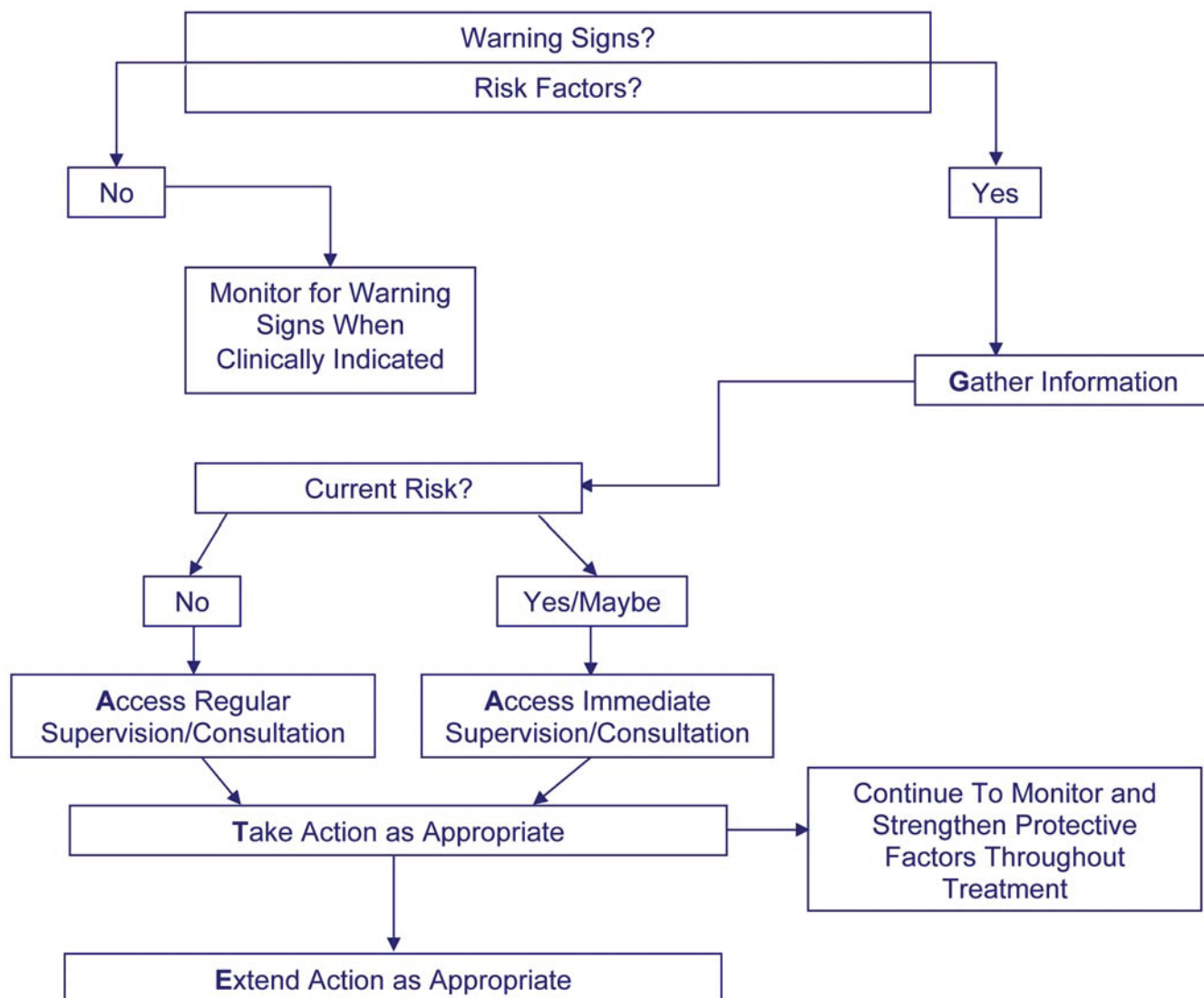


Figure 1.1
Decision Tree
How to Address Suicidal Thoughts and Behaviors
in Substance Abuse Treatment



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

Introducing the topic (use either statement):

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

Screening for suicidal thoughts (ask either question):

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

Screening for suicide attempts (ask either question):

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

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

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

Additional options for screening

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

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

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

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

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

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

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

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

IS PATH WARM?

Ideation—Threatened or communicated
Substance abuse—Excessive or increased

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

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

• Act.

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

Assessing Suicide Risk: Initial Tips for Counselors

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



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

CMHS-SVP-0153

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

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

Asking followup questions

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

Sample followup questions about suicidal thoughts:

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

For example, *What brings them on?*

How strong are they?

How long do they last?

3. If you do not already know:

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

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

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

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

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

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

Sample followup questions about suicide attempts:

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

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

3. If you do not already know:

To gather information about **lethality**:

What method did you use to try to kill yourself?

Did you receive emergency medical treatment?

To gather information about **intent**:

Did you want to die? How much?

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

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

Summary of G: Gather information

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

A: Access supervision or consultation

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary of A: Access supervision or consultation

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

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

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

T: Take responsible action

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

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

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

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

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

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

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

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

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

What actions can you take?

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

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

Safety Cards and Safety Plans

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

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

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

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

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

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

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

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

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

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

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

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

Summary of T: Take responsible action

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

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

E: Extend the action

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

What extended actions can you take?

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

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

Summary of E: Extend the action

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

Documenting GATE

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

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

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

Documentation example 1

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

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

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

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

Documentation example 2

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

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

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

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

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

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

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

Documentation example 3

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

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

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

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

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

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

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

Competencies

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

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

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

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

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

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

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

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

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

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

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

Next Steps

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

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

Chapter 2

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

Vignette 1—Clayton

Overview

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

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

Substance Abuse History

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

Suicide-Related History

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

Learning Objectives

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

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

[Clayton has requested an appointment with his counselor.]

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

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

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

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

COUNSELOR: How much pain have you been having?

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

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

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

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

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

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



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

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

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

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

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

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



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

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

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

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

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

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

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



How To Screen for Suicide

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

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

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

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

CLAYTON: That's okay.

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

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

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

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

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

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

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

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

COUNSELOR: I'm glad you did.

CLAYTON: Me too.

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

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



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

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

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

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

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

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

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

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

CLAYTON: I don't know what you mean.

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

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

COUNSELOR: Anything else?

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

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

CLAYTON: Yeah.



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

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

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

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

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

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



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

[Darren telephones Jill, his clinical supervisor.]

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

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

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



How To Prepare for Suicidal Crises

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

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

[Jill enters room after knocking.]

COUNSELOR: Clayton, have you met Jill?

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

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

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

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

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

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

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

SUPERVISOR: Did someone find you?

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

SUPERVISOR: Was there any followup?

CLAYTON: Nah.

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

CLAYTON: Nah.

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

CLAYTON: Yeah, that says it, I guess.

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

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

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



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

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

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

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

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

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

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

CLAYTON: Yeah, that nails it pretty well.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

CLAYTON: Right.

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

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

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

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

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

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

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

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

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

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

CLAYTON: Okay.

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

BARBARA: Hello?

CLAYTON: Barbara, hi, it's Dad.

BARBARA: Hi, Dad, how are you?

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

BARBARA: Okay.

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

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

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

BARBARA: I think that's pretty scary.

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

BARBARA: I would like to talk to him.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLAYTON: Sure.

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

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

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

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

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

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

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

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

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

COUNSELOR: Clayton, anything else that comes to mind?

CLAYTON: No. Thanks, Barbara.

BARBARA: Okay, Dad, I'll be—

CLAYTON: Don't worry about me.

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

CLAYTON: All right. Thank you. Bye.

BARBARA: Bye.



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

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

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

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

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

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

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

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

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

[Jill leaves the meeting.]

Followup

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

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

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

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

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

Vignette 2—Angela

Overview

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

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

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

Substance Abuse History

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

Suicide-Related History

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

Learning Objectives

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

Meeting Between Angela's Counselor and Her Clinical Supervisor

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

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

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

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

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

Counselor and Angela's Brother

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

WALTER: Sounds good to me.

[Angela joins Lupe and Walter.]

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

ANGELA: Hi, Lupe. Hey, hi Walt!

COUNSELOR: How are you doing?

ANGELA: I'm doing fine.

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

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

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

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

WALTER: Yeah. Tell it to Carla.



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

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

ANGELA: I'm not gonna relapse.

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



How to Incorporate Suicide Prevention in Relapse Planning

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

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

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

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

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

WALTER: Yeah. Okay.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

[Pause while Angela looks away, frustrated.]



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

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

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

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

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

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

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

Resources for Family Members and Friends

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

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

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

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

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

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

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

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

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

Followup at 6 Months

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

Vignette 3—Leon

Overview

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

Substance Abuse History

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

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

Suicide-Related History

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

Learning Goals

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

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

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

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

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

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

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

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

COUNSELOR: And it sounds like you mostly drink alone.

LEON: Yeah.

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

COUNSELOR: Lots of pressure.

LEON: Yeah.

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

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

COUNSELOR: Other pressures?

[Long pause.]

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

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

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

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



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

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

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

[Another long pause.]

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

LEON: Yeah.

[Another long pause.]

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

COUNSELOR: Pills?

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

[Another long pause.]

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

COUNSELOR: Thanks for telling me.

LEON: I don't remember taking them.

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

LEON: Like what do you mean?

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

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

[Long pause.]

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

[Long pause.]

COUNSELOR: Please take your time. This is important.

[Another pause.]

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

COUNSELOR: You're in a lot of pain.

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

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

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



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

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

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

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



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

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

LEON: Yeah, I guess.

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

Decisions the counselor and supervisor reach are:

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

James returns to his session with Leon.]

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

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

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

COUNSELOR: Tell me more about what happened there.

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

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

LEON: All right, I'm listening.

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

LEON: Okay.

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

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

LEON: Whaddya mean?

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

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

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

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

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

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

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

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

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

LEON: We're cool.

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

LEON: Yes, that's right.

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

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

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

LEON: That's not gonna happen.

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

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

COUNSELOR: Do you have transportation to VA tomorrow?

LEON: I have my car.

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

LEON: Okay.



How to Develop a Campus Suicide Prevention Team

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

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

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

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

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

Followup

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

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

Vignette 4—Rob

Overview

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

Substance Abuse History

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

Suicide-Related History

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

Learning Objectives

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

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

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

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

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

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



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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

ROB: That sums it up pretty well.

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

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

COUNSELOR: What plans have you made about killing yourself?

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

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

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

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

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



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

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

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

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

ROB: Did I notice!

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

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

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

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

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

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

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

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

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

ROB Yeah, I can do that.

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

ROB: Okay, cool.

Followup

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

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

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

Vignette 5—Vince

Overview

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

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

A Note on Homicide/Suicide

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

Substance Abuse History

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

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

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

Suicide-Related History

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

Learning Objectives

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

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

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

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

COUNSELOR: You got the letter today?

VINCE: Yeah.

COUNSELOR: Yeah. That is upsetting.

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

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

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

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

VINCE: Yeah, I did get physical.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COUNSELOR: I’m getting that.

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

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

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



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

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

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

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

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

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

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



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

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

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

COUNSELOR: Okay.

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

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

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

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

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

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

VINCE: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

VINCE: Oh, I am. I am mad.

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

VINCE: Where are you talking about sending me?

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

VINCE: Oh, jeez! That's—

COUNSELOR: It sounds like a lot.

VINCE: Yeah.



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

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

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

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

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

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

VINCE: Can she come see me?

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

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

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

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

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

VINCE: Do I have any choice?

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

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

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

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

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

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

Followup

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

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

Vignette 6—Rena

Overview

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

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

Substance Abuse History

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

Suicide-Related History

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

Suicide and American Indian/Alaska Native Populations

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

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

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

Learning Objectives

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

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

COUNSELOR: Hello?

RENA: Uh, Martin, this is Rena.

COUNSELOR: Rena, how are you doing?

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

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



How to Help a Client Develop a Detailed Safety Plan

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

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

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

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

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

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

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

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

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

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

RENA: I wanna die. I wanna die.

COUNSELOR: When did this start?

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

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

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

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

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

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

RENA: Yeah, okay.

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

RENA: Huh, what?

COUNSELOR: Are you by yourself? Are you alone?

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

COUNSELOR: Is anyone else in the house?

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

COUNSELOR: Have you been drinking at all?

RENA: A little.

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

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

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

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

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

RENA: I feel so ashamed.

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



How To Set Up a Hope Box With Clients

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

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

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

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

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

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

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

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

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

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

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

COUNSELOR: Okay.

RENA: It's here.

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

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

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



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

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

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

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

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

RENA: I don't know. Maybe a couple of years ago, Marilyn looks like she's about 13. It looks like we were at a pow-wow.

COUNSELOR: Rena, what's happening in the picture?

RENA: We're all just standing there. I think Frank must have taken it. It's me and my girls.

COUNSELOR: Can you talk a little bit about what was happening then?

RENA: I don't know. All I can think about is who will take care of my girls if I'm gone. I'm so sad and so scared.

COUNSELOR: Can you tell me some more about feeling sad, what that is about?



Master Clinician Note: Trauma, particularly during childhood, is common among people who attempt suicide, particularly those who have made multiple suicide attempts. Traumatic memories can be activated in a number of ways, including both internal and external events. External precipitants include day-to-day stressors. This can include a host of possibilities, but most revolve around interpersonal relationships, particularly if they are abusive in nature. It is more common, though, for internal events to activate the suicidal crisis. These include thoughts, feelings, images, and sensations, some that even the client is not fully aware of at the time. When memories of previous trauma are activated, the net result is often overwhelming shame, subordination, impotence, guilt, helplessness, and feelings of being a burden—all facilitating hopelessness and thoughts of suicide.

RENA: I look at my girls and I think about me when I was their age and I just get sad. That's what I'm feelin' now. I feel like I just wanna kill myself. Just quit.

COUNSELOR: There were some difficult times during that period in your life; there were also some times during that period when you felt better, when things were different. Do you recall any of those times?

RENA: I guess I felt better at school.

COUNSELOR: What was it that you liked about school?

RENA: I could be somebody else. I didn't feel dirty at school. They didn't know.

COUNSELOR: How did you feel at school?

RENA: I don't remember, maybe happy. Maybe okay.

COUNSELOR: Do you recall some of the friends, some of the people you spent time with, that you felt close to?

RENA: Yeah, I had girlfriends.

COUNSELOR: Can you tell me a little bit about them?

RENA: They liked me, and we did things together. And I was a good student. Always obeyed the teachers.

COUNSELOR: What did they like about you? What was it that you recall that they liked about you?

RENA: I can't think of why anybody would like me right now. But back then I guess they liked me because I was a good friend. I was loyal.

COUNSELOR: You know, I remember hearing you describe that in the past that you were loyal, dependable; you were somebody that they could count on and look to for support. Do you remember some of those times?

RENA: Yeah. I took care of my brothers and sisters. And I was loyal to my friends.

COUNSELOR: How do you feel, as you talk about it?

RENA: A little better, I guess.

COUNSELOR: Because your voice sounds sad. You sound a bit tearful.

RENA: I'm more sad than scared right now. I'm so sad. I'm so sad for my children.

COUNSELOR: What is it that you feel sad for, about your children?

RENA: That I might leave them.

COUNSELOR: Do you recall when we talked about the difference between sadness and shame?

RENA: Yeah.

COUNSELOR: What do you remember about those conversations?

RENA: That I've felt so much shame in my life, and that when I feel shame I get really sad.

COUNSELOR: And do you remember some of the differences when we talked about your shame about the abuse? We talked about feeling responsible.

RENA: Yeah, that really helped me.

COUNSELOR: What about that was helpful?

RENA: That when I feel shame, I feel like it's my fault. And when I feel sad, it's just that I feel sad about what happened. That was helpful to me.

COUNSELOR: And do you recall when we talked about feeling responsible for the abuse and blaming yourself? Then we connected this to your feeling that maybe you should die: that killing yourself was attached to feeling responsible for something that I think we both agreed you weren't responsible for.

RENA: Yeah. When I feel shame, I want to hurt myself.

COUNSELOR: Yes, and it sounds to me that this really is sadness. That this is sadness over something that happened many years ago.

RENA: I feel really sad right now. I feel sad that I drank.

COUNSELOR: How sad? Say that again.

RENA: I feel sad that I drink. I feel sad for my children.

COUNSELOR: I think it's important that you've recognized that, that you understand that this sadness is about many different things, and it can feel a little bit overwhelming. Does it feel overwhelming to you?

RENA: The sadness doesn't feel overwhelming; the sadness has been with me so long, it just feels natural, and the scary thoughts feel overwhelming.

COUNSELOR: So, maybe, taking your hope box out and starting this process, kind of disrupts those thoughts a bit and stops those thoughts. Would you agree?



Master Clinician Note: As mentioned above, the hope box provides the client with the opportunity to manage the suicidal crisis both independently and effectively. This is important because it facilitates self-efficacy and empowers the client. For many clients, this is the crux of recovery, moving toward independence and empowerment over their life, to have choices and options and not be limited by past traumatic events. The hope box also provides a tangible process to overcome feelings of shame and helplessness so often associated with suicidality. The personal nature of the hope box is most likely responsible for its potency.

The hope box is one of many more advanced techniques that counselors can use to intervene with clients with suicidal thoughts and behaviors. Another advanced technique described in Rena's vignette is the detailed safety plan. These techniques are somewhat more advanced than the other strategies described in this TIP, and extend somewhat beyond GATE, but are illustrated here for substance abuse counselors with advanced mental health training who wish to incorporate suicide-related treatment into their counseling portfolio. Describing additional intervention techniques is beyond the scope of this TIP. There are many excellent resources for clinicians (see Jobes, 2006; Rudd, 2006; Wenzel, Brown, & Beck, in press).

RENA: Yeah.

COUNSELOR: Rena, could we go back to the hope box and your photograph of you and the girls for just a minute? Can you look at the photograph again and tell me your reaction?

RENA: My girls are so sweet. They look happy.

COUNSELOR: And can you tell me about you right now, what's happening with you?

RENA: I feel calmer. Not so sad. I love my girls. I don't think I could kill myself and leave my girls alone.



Master Clinician Note: In many ways, children are a tangible marker of hope for clients. Children are the client's life legacy. It is important for clients to recognize and understand the impact of suicidal behavior on their children, the vulnerability and risk it can create. Similarly, it is critical to emphasize that in their role as parent, they are protector and nurturer. This is true despite their own history of abuse and neglect. They can stop the cycle of abuse and provide for their children that which they wanted most: safety, protection, and love.

COUNSELOR: Let's talk for a minute, now that those thoughts have calmed down a little bit. Do you feel like you're able to talk about some other things? Because I think maybe we need to take some steps to make sure that you're safe.

RENA: Yeah.



Master Clinician Note: The counselor has worked to establish connection and rapport with Rena and to assess the situation. His perception is that Rena is more grounded now than when she called, but he also is aware that she has been drinking and could rapidly lose her grounding when the telephone connection is ended. He therefore decides it would be best if Rena came to town to the emergency room for an evaluation and possible hospitalization. The counselor now begins to move from gathering information to taking action.

COUNSELOR: I'm a little concerned, and I'll tell you, to be real blunt with you, Rena, I'm very concerned that you're alone, that you feel very sad and depressed, and you've been drinking a bit, and you have your pills available. And you've been having these thoughts about killing yourself, and I'm a little concerned about that, and I think we need to take some steps to make sure that you're okay.

RENA: It scares me to think I might do that.

COUNSELOR: It scares me to think that you might do that, too. What do you think would be the best thing for us to do at this point? Is there anyone around who could help?

RENA: No, Frank's not here. I don't know where the kids are. I think they're just with their friends down the road.

COUNSELOR: I think you told me earlier, and we had identified that your mother, in addition to Frank, was someone that we could count on and talk to in case of emergency, in cases of a crisis. Is that still the case? Do you still feel that your mother is somebody we can count on?

RENA: I haven't talked to her today; I guess she's at home.

COUNSELOR: Now, remind me, how close does your mother live to your house?

RENA: Just over the hill, maybe a quarter of a mile.

COUNSELOR: So, just a short distance away? How would you feel about my talking with your mother and having your mother come down and bring you in so that we can make sure that you're safe?

RENA: I hate her knowing—I don't think that I need to come in. I think I can do this by myself.

COUNSELOR: Can you help me understand your thinking about your ability to do this yourself? What is it that makes you come to the conclusion that you can manage this one on your own?

RENA: I just don't want to upset her.



Master Clinician Note: The counselor doesn't want to pressure Rena unnecessarily; feeling this will just increase her resistance and perhaps invite Rena to become more anxious. Rather, he decides to explore the situation more until he feels Rena may be more open to coming into town.

COUNSELOR: Sounds like a more—

RENA: I've upset her enough. And I've been so proud of not drinkin'. And I don't want to upset her.

COUNSELOR: It sounds like you're worried about you using your mom, somehow, and getting her upset. Do you remember when we looked at this issue about shame and sadness, and we said that when you are feeling shame, you have a tendency not to reach out, not to ask for help. Do you remember those conversations?

Resources on Suicide Among American Indians

Several Web sites provide information on suicide specifically for American Indian populations:

- One Sky Center (<http://www.oneskycenter.org>) has the draft of a 100-page Guide to Suicide Prevention on its Web site. The Guide includes a Community Assessment Tool and lists additional resources.
- The Suicide and Mental Health Association International (https://www.iasp.info/resources/Groups_at_Risk/First_Nations/) Web site has readings and facts about suicide.
- Healing of Nations (<http://www.healingofnations.org>) devotes several pages of its Web site to suicide prevention and crisis intervention.
- The American Indian Health Council (http://www.indianhealth.com/human_services.htm) has a page on suicide prevention.
- The Indian Health Service Web site has descriptions of programs, curricula, and other resources on suicide of particular relevance to American Indians (<http://www.ihs.gov/suicideprevention/>).

RENA: It's never been easy for me to ask for help.



Master Clinician Note: “Shame-based” people often feel they don’t deserve help. Arguing or debating with people about their self-worth and value is most often futile. Rather, the counselor just chooses to address Rena as if she feels worthy, even if she can’t experience that within herself.

COUNSELOR: And that’s why I’m so pleased that you called me, and that you actually used our plan. A part of that plan was to have your mother available as well, and I think that this is one of those times when we need your mother. Let’s not let the shame that’s there for many reasons, and isn’t accurate, block that and stop us from reaching out when we need to reach out. Because I know in the past, your mother’s been willing to help, and I really think that she’ll be willing to help now and won’t think of it as an inconvenience.

RENA: Would you not tell her why, would you not tell her I’ve been drinking?

COUNSELOR: Well, I think I’m going to have to tell her that you’ve been having some trouble. I’m not sure we can get around that. It’s going to be apparent to your mom, and I know that in the past when we talked with your mother about having her involved during crises, she was more than happy to help, and wanted to do things that would help you recover.

RENA: I don’t think I could drive myself.

COUNSELOR: Well, I don’t think you could, either; I think we’re in agreement on that, and that’s why I think I need to go ahead and give your mother a call. So, let me give her a call and have her drive you in.

RENA: Okay, try not to tell her that I’m drinking or that I’m thinking about killing myself.



Master Clinician Note: The most critical thing to remember about crisis phone calls is to remain calm and patient throughout. A calm, patient, and persistent orientation facilitates hope. You should always be oriented toward productive solutions, with the most frequent solution simply being time. In all likelihood, the longer the call continues, the more effectively the crisis will be diffused. The crisis call is about effective regulation of emotions and problem solving. The call provides the client with an opportunity to vent.

It is important not to argue with the client. If the client has not used the hope box, the crisis call is a chance to walk the client through the hope box. It is also critical to make sure that the client's method for suicide has been removed. If the crisis continues unabated, having the client come in for an emergency session or go to the emergency room is advised. Contacting family members during an acute suicidal crisis is also important if initial efforts fail. In most States, it is permissible to violate confidentiality during a suicidal crisis. It is important to also consider having the patient sign crisis management consent forms early in the treatment process, allowing the clinician to contact specific family members if and when a suicidal crisis emerges. This proactive step is particularly important for those who have made multiple suicide attempts. In order to contact family members during a crisis, you need to have access to the appropriate phone numbers, and know which family members offer healthy, supportive relationships. This requires careful planning early in the treatment process.

COUNSELOR: How about if I agree to tell her only what's necessary to make sure that she knows how important it is to get you in so we can make sure you're safe. Would that be agreeable?

RENA: Tell her something like I'm having bad thoughts and I called you.

COUNSELOR: I think we can manage telling her that you're in a position where we're worried about your safety and that she needs to come with you, accompany you and not leave you alone during this time. She was aware that that was a problem for you before. How does that sound to you?

RENA: Okay.

COUNSELOR: Okay. Well, let me walk through with you what I'm going to do, and make sure this is okay with you. I'd like to call your mother and ask her to bring you in. I'm going to give her a time limit: a deadline by which she needs to have you in town. I also will tell her I want her to give me a call when she gets to your house, before the two of you leave for town. Then, if you're not here within an hour and a half, I'm going to have to go ahead and notify the police to come out and make sure that you're safe.

RENA: Oh, please don't call the police. Frank would kill me.

COUNSELOR: Well, at this point, I think that we just need to make sure that you're okay. I don't have any doubt that your mother's going to go ahead and come on down and bring you in, but I just wanted to let you know that we need to have that happen within a certain time limit, just to make sure that everything's okay and that you're safe.

RENA: I don't mean that Frank would really kill me, just that he would be so angry with me.

COUNSELOR: Well, my guess is, he'd want you to be safe as well. And this is one of those times. Do you think you can agree with that?

RENA: I don't want anybody mad at me.

COUNSELOR: Well, let me tell you very clearly, Rena, not only am I not mad at you, I'm actually proud of you for the step that you've taken. This is one of those critical steps in your recovery about overcoming that feeling of shame and reaching out when you need help in order to maintain your recovery and sobriety. This is a step in that direction, and so that was one of our goals. So I'm really proud that you've reached the goal.

RENA: What's going to happen to me when I get to town with you?

COUNSELOR: Well, we're going to sit down and talk with someone else about where you are right now and maybe what the best response is. That may mean that you'll be spending a little bit of time in the hospital to

help you get to a place where you're safer and you can return to outpatient care. Do you have some thoughts or questions about that?

RENA: It scares me that I'm gonna have to go to the hospital.

COUNSELOR: It can be a scary thought. But it also can be a good step for you.

RENA: Okay.

COUNSELOR: So, do we have an agreement?

RENA: Mmm-hmm, yeah.

COUNSELOR: Okay, well, I'm going to put you on hold on the phone for now and call your mother. I'll let you know when I've talked to her and that she is on her way to your house. Are you willing to hold on the phone for now? It will be a few minutes.

RENA: Okay.

Followup

Martin had Rena's mother's telephone number in her case record. He called her and she agreed to go immediately to Rena's home to take her to the hospital emergency department. Rena's mother telephoned when she arrived at Rena's house. About an hour later, she telephoned Martin to confirm that they had reached the hospital. In the interim, Martin had called the hospital emergency admissions department to notify them that Rena would be arriving. He talked with the social worker to explain the situation and to arrange for the social worker to coordinate services with him. Had Martin not been able to contact Rena's mother, he was prepared to telephone the county sheriff's office to bring her to the hospital.

Martin was careful to document all of the activity in Rena's case record, including:

- Providing suicide intervention by telephone.
- Soliciting current risk factors (i.e., emotional pain, pills, drinking, being alone).
- Reviewing previous learning and validating that the process is painful but also underscoring Rena's progress.
- Using the hope box technique to help Rena get grounded and reconnected to positive aspects of her life.
- Eliciting agreement to involve her mother in taking her to the emergency room and providing support.
- Following up with Rena's mother and emergency room staff.

Part 2

Addressing Suicidal Thoughts and Behaviors:

An Implementation Guide for Administrators

An Overview of Part 2

This guide for administrators has two chapters:

Chapter 1 surveys pertinent issues for administrators regarding how suicidal thoughts and behaviors can and should be addressed in substance abuse treatment, including:

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

Chapter 2 presents specific protocols, policies, and procedures useful in:

- Helping an agency become capable of handling suicide prevention and intervention.
- Helping a program develop and improve staff capabilities in working with clients who are suicidal.
- Helping an agency develop and improve its response to suicidal crises.
- Building administrative support for all components of GATE.

Appendix A:

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