Addressing Suicidal Thoughts And Behaviors in Substance Abuse Treatment

A Treatment Improvement Protocol

TIP 50

Substance Abuse and Mental Health Services Administration
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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
www.suicidology.org

American Foundation for Suicide Prevention
https://afsp.org

Commission on Accreditation of Rehabilitation Facilities: Quality Practice Notice on Suicide Prevention
www.carf.org/QPN_SuicidePrevention_Sept2016

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

Suicide Prevention and the Clinical Workforce: Guidelines for 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 (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 (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 (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 (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.

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Chapter 1

The Administrative Response to Suicidality in Substance Abuse Treatment Settings

Introduction

This Treatment Improvement Protocol (TIP) is designed not only to help substance abuse counselors meet the needs of clients with suicidal thoughts and behaviors, but also to provide information and direction to program administrators, clinical supervisors, and other senior staff who are charged with developing and implementing policies and administering programs for substance abuse and co-occurring disorder treatment. This part of the TIP is addressed to you in your role as an administrator. Suicidal thoughts and behaviors are a significant issue for many clients in substance abuse treatment, and, as we will demonstrate in this chapter, affect not only the individual, but also other clients, staff, and program functioning. It is essential that programs provide the structure and resources to address suicidality as it emerges with clients considering treatment or while in treatment.

Suicide is among the leading causes of death for people who abuse alcohol and drugs (Wilcox, Conner, & Caine, 2004). Individuals with substance use disorders are also at increased risk for suicidal ideation and suicide attempts (Kessler, Borges, & Walters, 1999). People with substance use disorders who are in treatment are at especially elevated risk for a number of reasons (Wilcox et al., 2004). They enter treatment at a time when their substance abuse is out of control and when stress from marital, legal, job, health, or interpersonal problems is exceptionally high. Many may have other issues that increase their risk for suicide, including co-occurring mental health problems (e.g., depression, posttraumatic stress disorder, and some personality disorders) and substance-induced effects (e.g., symptoms in the context of drug use, intoxication, or withdrawal), such as substance-induced depression, anxiety, or psychosis.

It is particularly important for you to understand two pivotal areas regarding services for substance abuse clients exhibiting suicidal thoughts and behaviors. First, the role of the substance abuse treatment program is to provide safety for its clients. Recognizing suicidality when it appears, having policies and procedures for addressing suicidal thoughts and behaviors, and ensuring that treatment for the substance use disorder is not lost in the suicidal crisis saves lives and improves treatment continuity for all clients in the treatment setting. As discussed below, few substance abuse treatment programs are capable of meeting all of the treatment needs of clients who are suicidal. Treating suicidal thoughts and behaviors is often beyond the scope of services in substance abuse programs, much as treating substance abuse is beyond the scope of many treatment programs for other life problems. Nevertheless, substance abuse programs have an obligation to recognize suicidal ideation and behaviors, to address those symptoms, and to assist clients in getting the help they need.

Second, it is imperative that counselors have a consistent clinical protocol, supported by strong and effective agency policies and clinical supervision, that allows them to act effectively when clients who are suicidal are identified. To this end, the consensus panel for this TIP developed a protocol with the acronym GATE, which calls for the following steps:

- **G**ather information.
- **A**ccess supervision or consultation.
- **T**ake action to ensure appropriate care and safety for the client.
- **E**xtend the action beyond the immediate situation to promote ongoing treatment and safety.

The role of administrators, senior staff, and clinical supervisors in each step of the GATE process is discussed in Part 2, chapter 2.

Part 1 of this TIP addresses the needs of substance abuse counselors working with clients with suicidal thoughts and behaviors. But without the substantial and knowledgeable support of program administrators like you, the application of skills and information presented in Part 1 is likely to be limited. Helpful choices and strategies may be underused and inconsistently applied. Program administrators have to create, implement, and monitor policies and procedures for addressing the needs of suicidal clients and for supporting counselors in order for an agency to be successful in the prevention of and intervention in suicidal thoughts and behaviors.

Consensus Panel Recommendations for Administrators

The consensus panel that convened to address administrative issues for this TIP made specific recommendations for you. It is obvious that administrators, senior staff, and clinical supervisors play a role in the development, implementation, and ongoing support of each of these recommendations, and that without your support, these recommendations would not be implemented.

- The administrator should be able to articulate the goals and objectives of the program as they relate to suicidality, client safety, and crisis intervention, and must be actively involved in crisis resolution.
- Personnel should be trained to a level of competence within their range of expertise and licensure or certification to manage intervention with clients who are suicidal (see the section on competencies, pp. 25–31).
- Substance abuse programs should have a risk management plan that addresses the needs of clients who are suicidal. This includes, but is not limited to, the following:
  - All clients in substance abuse treatment should be screened for suicidality.
  - The facility should meet all public health and safety codes.
  - Personal safety for clients and staff should be addressed in policies and procedures.
  - Suicidal behaviors that become critical events (i.e., circumstances in which clients or staff are at risk of significant psychological or physical trauma or death) should be investigated by a review panel to identify how the program can be strengthened in the context of these events.
  - Staff should be debriefed after critical events, as this provides an opportunity for positive changes and improvements in client care throughout the organization.
- Substance abuse treatment programs need to have protocols, accessible to all staff, that offer guidelines for addressing the needs of clients who exhibit suicidal thoughts and behaviors. These protocols may include a flowchart highlighting the chain of command in seeking supervision and administrative guidance.
- Personnel should be knowledgeable of the social and medical resources available to persons in suicidal crisis and the procedures or protocols to be followed for their use.
- Community relationships should be developed and maintained that will support interventions with clients who are suicidal within the program or the referral system.
- Substance abuse treatment programs need to have standardized methods of documentation for how suicidal ideation or behavior was identified, supervision or consultation that was sought as a result, actions that were taken, and followup that occurred.
- Crisis services, either as a component in the treatment program or through arrangement with other agencies, should be available 24 hours a day. This includes referral, coordination, and followup, as required by law enforcement; hospital emergency rooms; and any other referral source.

The Benefits of Addressing Suicidality in Substance Abuse Treatment Programs

Historically, misconceptions within agencies (either explicit or implicit) may have hindered effectively addressing suicidal thoughts and behaviors. Examples of these misconceptions and myths include:

- Talking about suicide will put it in the minds of clients.
- Raising the issue of suicidality during early treatment will detract from the business at hand.
- Screening for suicidality is not the job of a substance abuse counselor.

- Once someone enters treatment, they are significantly less likely to have suicidal thoughts or behavior.
- If you don't ask about suicidal thoughts or behaviors, the program and the counselor won't be legally at risk if the patient attempts suicide or dies from suicide.

Mistaken ideas such as these serve to perpetuate ineffective responses to clients with suicidal thoughts and behaviors. Other misconceptions about suicide common among substance abuse treatment providers and the general public are discussed in Part 1, chapter 1 (pp. 6–7). Today, however, it is more widely accepted that proactively addressing suicidality in substance abuse treatment programs is advantageous from a number of perspectives.

First, addressing clients' suicidal thoughts and behaviors in substance abuse treatment *does save lives*. The early action of clinical staff can prevent suicide attempts and suicide deaths.

Second, addressing suicidal thoughts and behaviors of clients in substance abuse treatment *keeps clients from dropping out of treatment*. More often than not, unacknowledged and unaddressed suicidal thoughts and behaviors represent a crisis in the client's life. The client's response to this crisis may be to lose focus on gaining sobriety and to return to familiar but unhealthy coping mechanisms, which may include substance use. Addressing suicidal thoughts and behaviors gives a clear message to clients that these types of problems are not overwhelming to the counselor and that immediate assistance is available. This reassures clients that they and the counselor are working together to get the help they need and that most problems they encounter can be resolved with the help of appropriate treatment.

Third, active suicidality on the part of a client *disrupts treatment* for other clients in the treatment setting. A client's suicidal thoughts and behavior can be deeply upsetting to others in treatment. Many, and perhaps most, substance abuse clients in early recovery can identify with a person with suicidal thoughts. The difficulty with identifying and processing powerful emotions related to suicide and with being able to self-affirm in the face of these emotions, along with the difficulty resulting from overidentification with other clients, all serve to disrupt treatment progress.

Finally, for treatment programs, addressing issues of suicidality leads to positive programmatic efforts through:

- Increasing the competence of staff to address crises.
- Reducing risk management issues related to legal liability.
- Improving program consistency and coordination.
- Increasing staff retention through reducing counselor burnout, lowering staff stress, and promoting a greater sense of counselor and frontline support from administrators.

Why Should Administrators Be Involved in a Clinical Issue?

Suicide Is an Important Programmatic Issue

As previously stated, clients in substance abuse treatment are at elevated risk for suicidal thoughts, suicide attempts, and deaths by suicide. Additionally, research and the experience of clinicians and administrators among the TIP consensus panelists confirms that the suicidal behavior of a client in treatment for substance abuse disrupts treatment for *all* clients. It increases the anxiety of others who may also be having suicidal thoughts, and invites clients and staff to focus on an issue not necessarily related to their primary treatment and recovery goals. In this sense, it occupies valuable client and staff time that could be spent on recovery goals.

Substance abuse programs need to have policies and procedures to address treatment issues raised by suicidality, such as responding promptly and consistently to suicidal crises, gathering additional information, seeking advice and support of other clinical staff and supervisors, making referrals, following up, and documenting activities.

Suicidal behavior creates unique stressors for staff in terms of time, emotional reactions, clinical uncertainty, and the need for additional supervisory consultation. Research supports significant clinician distress when a client dies by suicide (Hendin, Haas, Maltsberger, Szanto, & Rabinowicz, 2004; Hendin,

Lipschitz, Maltsberger, Haas, & Wynecoop, 2000). As with addressing the other needs of clients, administrators need to establish policies and procedures for guiding staff in addressing and resolving suicidal crises. Clear guidelines for accessing supervision and support need to be established, including offering clinical staff opportunities to "debrief" and learn from the experience of the crisis. Suicidal crises in the agency also offer the opportunity to evaluate how current policies and procedures could be strengthened and adapted to better suit current needs.

Issues around suicidality sometimes push the agency toward a crisis state that can potentially disrupt normal patterns of communication, continuity, and governance. You will need to be actively involved in the organization's crisis response to ensure that the agency is strengthened as a result of the experience and that gaps in effective response are identified and addressed. Issues related to suicide often manifest after regular hours or away from primary treatment sites, necessitating new and innovative approaches to addressing the crisis. For instance, the potential for suicidal thoughts and behaviors of clients in intensive outpatient programs may necessitate an on-call system for senior staff and clinical supervisors. For an inpatient setting, a clinical supervisor trained in suicide interventions might need to be on call in the evenings to respond to a suicidal crisis.

Finally, suicidal behavior of clients in treatment poses unique legal and ethical issues for programs. These issues are discussed in some detail later in this chapter.

Levels of Program Involvement and Core Program Components

This TIP identifies three levels of program involvement in suicide prevention and intervention. This chapter describes the programmatic elements that are considered essential to each level. Each level increases the capability of the program to identify clients at risk for suicidal thoughts and behavior, the resources the program possesses to intervene with the client, the programmatic elements in place to provide safety and treatment to people who are suicidal, and the resources the program possesses to intervene in suicidal crisis events.

Level 1 Programs

The TIP consensus panel recommends that, at a minimum, **all programs providing substance abuse treatment to clients** should be **Level 1.** Level 1 programs have the basic capacity to identify clients who are at risk and identify warning signs for suicide as they emerge. Clinical staff have the skills to talk comfortably with clients about their suicidal thoughts and behaviors, are knowledgeable about warning signs and risk factors for suicide among clients in treatment for substance abuse, and, with appropriate supervisory support, can make referrals for formal suicide risk assessment. The program has clear policies and procedures for referral in place, and procedures and protocols for managing suicidal crises in the agency are available to all staff. Some of the characteristics of Level 1 programs include:

- All clinical staff recognize that clients in substance abuse treatment are at increased risk for suicidal thoughts and behaviors.
- All clinical staff have had basic classroom education in risk factors, warning signs, and protective factors for suicide. The educational effort (as with the following two characteristics) focuses on the knowledge, skills, and attitudes described in the professional competencies in Part 1, chapter 1.
- All clinical staff have had basic classroom education in recognizing misconceptions about suicide, have had an opportunity to replace them with accurate and contemporary information, and have explored their own attitudes toward suicide and suicidal behavior.
- All clinical staff have had basic classroom education and clinical supervision in recognizing clients' direct and indirect expressions of suicidal thoughts.
- All clinical staff have the skills to talk with clients about suicidal thoughts and behaviors and collect basic screening information (see the information on screening in Part 1, chapter 1).
- The substance abuse treatment program has basic protocols for responding to clients with suicidal thoughts and behaviors. These protocols reflect established policies and procedures of the agency, including when counselors should obtain consultation from other staff, clinical supervisors, or outside mental health consultants; documentation procedures for recording information in client records; referral procedures; and the steps to be

undertaken to ensure appropriate followup of referrals and other actions.

- The substance abuse treatment program has formalized referral relationships with programs capable of addressing the needs of clients with suicidal thoughts and behaviors and specific protocols for how a referral is made. These formalized referral relationships are documented in writing, specify the conditions under which a referral is made, identify a contact person, specify potential costs and who is responsible for costs of care, and contain any other information relevant to the referral process. These relationships are updated and confirmed on a quarterly basis.
- The program has protocols for managing suicidal crises that are available for all staff. These protocols identify the types of situations that might constitute a crisis, indicate how counselors are to receive clinical supervision or consultation, specify what actions can be taken by the counselor and what actions need to be taken by program administrators, and state what documentation should be made regarding crisis interventions.

The TIP consensus panel recognizes that many substance abuse treatment programs (particularly small, free-standing outpatient clinics; programs in rural and remote locations; and specialized treatment resources) may not possess the resources to provide the more advanced care that a Level 2 program (see below) might offer. At the same time, because the risk factors for suicidal thoughts and behaviors are so high among people in substance abuse treatment, and even higher among specific treatment populations (described in Part 1, chapter 1), the characteristics noted above are essential for high-quality care. All programs should at least meet the above standards. These standards meet the basic criteria of client safety, appropriate documentation, and program responsiveness to issues concerning suicide as they emerge and to suicidal crises.

Level 2 Programs

Some substance abuse treatment programs, particularly those with more staff, more diversified services, and possibly those with administrative links to other programs (for instance, mental health) have the capacity to offer more care for clients with suicidal thoughts and behaviors. Specifically, these programs may be able to maintain continuity of substance abuse treatment on an outpatient or residential basis while concurrently addressing the treatment needs of clients with active warning signs for suicidality. These efforts extend beyond Level 1 services and are termed in this TIP as **Level 2** programs.

Some of the attributes that might be found in Level 2 programs, in addition to those services and resources of Level 1 programs, include:

- The program has at least one staff member with an advanced mental health degree (for instance, licensed Ph.D. psychologist, or licensed clinical social worker) who is specifically skilled in providing suicide prevention and intervention services and in providing clinical supervision to other program staff working with clients with suicidal thoughts and behaviors.
- The program has the capability to continue substance abuse treatment services for clients with suicidal thoughts and behaviors while monitoring those clients for suicidal symptoms and an exacerbation of psychiatric symptoms of depression, anxiety, or other co-occurring disorders.
- The program has formalized ongoing relationships (within the agency or in the community) with mental health professionals trained in suicide intervention to address emergency needs.
- The program can offer consultation services to Level 1 programs on an as-needed basis.

Level 3 Programs

Some substance abuse treatment programs have the capacity to provide services to acutely suicidal clients that allow the client to continue receiving substance abuse treatment while in the midst of a suicidal crisis. The TIP consensus panel has identified these programs as **Level 3**. Most often, the programs that can offer these services are administratively linked to hospitals and inpatient psychiatric services.

In addition to the standards for Level 1 and Level 2 programs, Level 3 programs can offer:

- Programs linked to a mental health or hospital setting that provides security for people who are actively suicidal and have high risk factors.
- Frequent, regular periods of contact with the client (known as suicide watch), or beds (or an area) designated as observation beds (previously known as suicide-watch beds).
- Clinical staff can perform comprehensive suicide assessments in-house that determine level of risk,

treatment needs, and necessity for legal constraint on the client.
- The treatment agency has the appropriate certifications to legally detain clients who are actively dangerous to themselves or others. Such certifications are more commonly held by mental health rather than substance abuse treatment facilities.

Fortunately, the need for Level 3 services is limited and the vast majority of clients with suicidal thoughts and behaviors can be effectively managed and treated for their substance abuse and suicidal thoughts and behaviors in Level 1 and 2 programs. Nevertheless, appropriate resources for people who are acutely suicidal and for whom substance abuse is a closely related disorder are a valuable addition to the treatment continuum of care.

Implementing a Level 1 or Level 2 Program

A variety of decisions and implementation strategies must go into preparing your program to be Level 1 or 2. These issues can be divided into four broad categories:

1. Developing an overall policy regarding the program's approach to addressing suicidality
2. Implementing and revising policies and procedures to reflect the organization's goal to provide quality services to clients who exhibit suicidal thoughts and/or behaviors
3. Establishing a system to monitor and evaluate policies and procedures regarding suicidality and to adapt these as needed.
4. Providing staff development and educational opportunities related to suicide for current and newly hired staff.

The following checklist reflects some of how these issues need to be considered.

1. Do you have a program policy statement about:
   Acknowledgment of suicide as a significant risk in your client population?

   If no, establish a committee to write one.

   If yes, is it fully understood by all staff?

   Risk management for suicide and other high-risk behaviors (see sample policies in Part 2, chapter 2)?

   If no, establish a work group to study the issue and write one.

   If yes, is it fully implemented with all staff?

   Screening for suicide as part of the program's routine protocol?

   If **no**, develop or adapt screening questions in this TIP or other knowledgeable sources, then arrange training for all staff (support, counseling, substance abuse, and clinical supervisory).

   If **yes**, do you have specific questions to explore with clients with suicidal thoughts and behaviors? Has training been completed for all staff? Is the training specific to each staff member's role? Is there a provision for clinical supervision or consultation?

   Provision for services to be provided to suicidal clients?

   If **no**, read this TIP carefully, consult with other community substance abuse and mental health resources about their services, and attend training or hire a trainer for your agency.

   If **yes** and services are provided by referral, does your agency have formal agreements with other agencies or individuals?

   If **yes** and services are provided in-house, what services are available? Who is responsible for overseeing these services? Who is qualified to provide them? Who monitors their use and effectiveness? How do clients access them? Do the policies include involvement of family members or significant others? Do the policies include transportation to other care providers?

   Staff development for services to suicidal clients?
   Does the program have a system in place to orient new employees to the policies and procedures regarding suicidal thoughts and behaviors?

   Are there opportunities for all clinical staff to have refresher or advanced courses emphasizing skills in working with clients with suicidal thoughts and behaviors?

   Provision for agency review of critical events?
   Does the program have a procedure for review of critical events (such as suicidal behavior of clients) to adapt and update policy and procedures? Is a specified individual or position responsible for convening and conducting critical event reviews?

What documentation is necessary?

2. Are these policies implemented as written, reviewed regularly, and revised as necessary?

   If **no,** create a workgroup to explore the gaps in implementation and review. Charge the group with creating a plan to complete the implementation process and systematically review the policies with an eye to making revisions as needed.

   If **yes**, are the policies regarding the likelihood of suicidal thoughts and behaviors, screening, services, followup, and documentation fully integrated into the program? Are they congruent with current staffing? Do they match the current client population?

3. Are these policies and procedures monitored and evaluated?

   If **no,** establish a workgroup (or assign an individual) to devise a method for monitoring and evaluation. Get buy-in from staff members to make needed program improvements.

   If **yes**, is there an individual or work group assigned to monitor and evaluate them? Monitoring should include the outcomes for all positive screens for suicidal thoughts and behaviors. How is the feedback from monitoring and evaluation communicated to program staff so that program improvements can be made?

4. Is there a critical incident review process?

   If **no**, design and develop a process to review events and recommend changes to existing policies and procedures.

   If **yes,** is a critical event committee established to collect data, evaluate them in light of existing policies and procedures, and recommend changes to existing policies and procedures as needed?

The Role of Administrators in Implementing and Supporting Programming for Clients With Suicidal Thoughts and Behaviors

Administrative staff, especially executive directors and program directors, play a particularly important leadership role in creating an environment that fosters rapid identification of and quality services to clients with suicidal thoughts and behaviors. Without the commitment of the program's administrative staff, it is difficult for mid-level staff (clinical supervisors and senior counselors) to implement policy and to support effective clinical practices. Commitment is demonstrated by advocacy of the need for services for suicidal clients, by follow-through on suggestions and plans for programming, and by delivery of a consistent message that fosters support for change and program improvement. Program planning should additionally include input from direct services staff in planning and implementation. Not only does this help mid-level and direct-service staff take ownership of the new initiative; it also prevents a sense that they are being told to add responsibilities to their already heavy workload.

Administrative leadership means communicating a vision of how the program can benefit by providing services to clients who are suicidal. This vision is communicated through explicit goals and a clear statement of how all will benefit from improved services. In this light, it is important that program leaders can communicate in a knowledgeable and articulate manner about suicidality. Treating the issue of suicidality with the importance, priority, and seriousness it deserves communicates your commitment to implementation and ongoing improvement of care.

Finally, leadership needs to inspire others in the organization to become aware of and committed to reducing the incidence of clients' suicidal thoughts and behaviors in the program. Inspiration is communicated through enthusiasm for current and new programmatic elements, optimism about the change process, and an unwillingness to accept anything but

success in the effort. This enthusiasm can be demonstrated by emphasis on suicide prevention in staff meetings, active participation in the planning process, attendance at and participation in training events, and recurring reminders to staff at all levels of the importance of suicide prevention. Such inspiration becomes contagious to other staff and is particularly effective when resistance to change is expressed by frontline staff. Inspiration supports the significance of the effort.

The Role of Mid-Level Staff in Implementing and Supporting Programming for Clients With Suicidal Thoughts and Behaviors

Clinical supervisors and senior counselors play a critical role in responding to clients' suicidal thoughts and behaviors in substance abuse treatment settings. They are typically the "go-to" staff when a counselor suspects that a client is suicidal. More often than not, their responsibility is to make the clinical decisions that affect client care and the overall functioning of the clinical services component of a substance abuse treatment agency. You can ensure that mid-level staff are aware of these responsibilities and adequately trained to carry them out.

Clinical supervisors have the primary responsibility for gathering necessary information from counselors when a client acknowledges suicidal thoughts and/or behaviors. They must be able to make decisions about what and how much additional information to gather from the client, determine what consultation with appropriate mental health professionals is warranted, decide how the substance abuse counselor can prepare a client for a potential referral, evaluate what assistance the counselor needs in making appropriate referrals, and ensure that the treatment plan has been effectively implemented and/or updated. Additionally, it is often the clinical supervisor who has to make important decisions related to legal and ethical issues when a client has suicidal thoughts and behaviors.

Having the responsibility to address all of these issues means that clinical supervisors need to be particularly knowledgeable and skilled in all elements of GATE, the framework for addressing suicidality used in this TIP. They must also have the clinical skills necessary to manage crisis situations and the clinical and personal attitudes to foster effective use of these skills.

In this sense, clinical supervisors and other mid-level clinical staff are liaisons between frontline substance abuse counselors and administrators. Clinical supervisors and senior clinical staff have the responsibility of informing administrators of the effectiveness of established policies and procedures and, because of their unique perspectives, need to be involved in shaping and formulating policies and procedures. Because of their ability to integrate their clinical experience with an understanding of the program's mission, goals, and services, they should have a primary role in planning and adapting policies related to suicide. It is primarily their responsibility to implement policies and procedures developed as a result. Finally, it is their responsibility to keep the awareness of issues related to suicide risk in the agency in the forefront for administrators, frontline staff, and support staff.

Obviously, mid-level staff play a critical role in addressing suicidal thoughts and behaviors in substance abuse programs. But they can only be effective if administrators recognize the responsibility they shoulder and respond with appropriate support and guidance. Such support includes hearing the concerns and needs of clinical supervisors in regularly scheduled staff meetings, supporting training related to suicidality, participating in developing interagency relationships for the consultation and referral of clients who are suicidal, encouraging the development of relationships with professionals outside the agency, supporting clinical supervisors in improving their skills through supervision of supervisors, and encouraging active involvement of supervisors in developing and adapting policies and procedures.

Legal and Ethical Issues in Addressing Suicidality in Substance Abuse Programs

Clients with suicidal thoughts and behaviors raise unique ethical and legal issues for substance abuse treatment programs. While it is the responsibility of counselors to address these concerns, as administra-

tors, you have the responsibility of setting policies and procedures to ensure that the agency is in compliance with applicable legal and ethical standards. At the broadest level, legal and ethical practice issues are measured in the context of a program offering a reasonable standard of care to clients to ensure their safety and appropriate treatment. Maris, Berman, and Silverman (2000b) define standard of care as "the degree of care which a reasonably prudent person or professional should exercise in the same or similar circumstances" (p. 487). The authors elaborate by including "the duty to exercise that degree of skill and care ordinarily employed in similar circumstances by the average clinical practitioner" (p. 488) and "the duty to make reasonable and appropriate decisions using sound clinical judgment" (p. 490).

Carrying out this standard of care inevitably involves both legal and ethical considerations. In this TIP, legal issues are defined as those issues that are subject to laws and legal regulations. Generally, these issues are fairly clear-cut, with examples or illustrations defining what is legal and what is illegal.

Ethical concerns relate to professional standards of care and concern the moral issues that arise in the conduct of professional services. Each profession concerned with substance abuse treatment (e.g., substance abuse counselors, social workers, professional counselors, psychologists, physicians) has a different set of professional standards. Additionally, each professional association, such as the Association for Addiction Professionals, the National Association of Social Workers, the American Counseling Association, the American Psychiatric Association, and the American Psychological Association, has a set of ethical standards to which their membership agrees to adhere. Finally, in States where these professional groups are licensed, the State licensing board may have an additional set of ethical standards to which persons licensed by that group must adhere. (A more detailed discussion of ethical issues begins on p. 103.)

Legal Issues

The legal issues regarding suicidality for substance abuse programs are primarily related to standards of care, maintaining appropriate confidentiality, and obtaining informed consent. Both the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) provide standards of care for clients at risk of suicide that programs must consider for accreditation (e.g., MacNeil, 2007). Additionally, the American Psychiatric Association (2003) and other professional organizations offer practice guidelines for the clinician that set appropriate and reasonable standards of care. While many of these guidelines are for professional activities beyond the scope of substance abuse counselors, they offer a resource for such issues as confidentiality, informed consent, referral procedures, and treatment planning that have relevance to counselors working in substance abuse treatment agencies.

Maris et al. (2000b) points out three common malpractice "failures" for work with suicidal clients.

1. *Failure in assessment*. For substance abuse treatment programs, this means failure to (1) gather information (such as the standard screening questions noted in Part 1, chapter 1), (2) consider that information in treatment planning, (3) recognize warning signs or risk factors as they emerge in treatment, or (4) obtain records from other sources (e.g., previous substance abuse or psychiatric treatment) that would have indicated a significant risk of suicidality.
2. *Failures in treatment*. For substance abuse treatment programs, this might mean failure to (1) consider the impact of an intense substance abuse treatment environment on a client's suicidality, (2) prepare a client for treatment transitions, including administrative discharges, (3) make appropriate referrals for clients with suicidal thoughts and behaviors, and (4) follow up on referrals.
3. *Failure to safeguard*. Substance abuse treatment programs have an obligation to clients to create a physically and psychologically safe environment. Creating this safe environment means observation procedures for clients in inpatient or residential settings who are potentially suicidal, efforts toward weapon removal for both inpatient and outpatient clients, and an awareness of medication use by clients who are potentially suicidal. Informed consent documentation should include an explanation of the limits of confidentiality (i.e., the duty to warn in specific situations). In addition, you should implement a policy and procedure for obtaining a release from clients who are at sig-

nificant risk or have warning signs of suicide to contact a family member or significant other if the counselor, with appropriate clinical supervision, feels the client may be at significant risk of attempting suicide. While the client must have an opportunity to revoke the release, it gives the agency some option with a client who is actively suicidal.

In all situations, failure to document actions makes it more difficult to legally defend one's professional behavior. It is essential to properly document warning signs, risk factors, and protective factors; steps taken to address these signs; the consultation or supervision that was obtained; the referrals that were considered and/or made; the client's response to the referral; and the followup that was conducted. Examples of appropriate documentation are presented in Part 1, chapter 1.

Still another variable for consideration of legal issues is liability, both for the agency and for the practitioner. Both may be held responsible when standards of care are not met. Rudd (2006) distinguishes between malpractice liability as a concern of the institution and professional liability (failure to meet the ethics or standards of practice of one's profession), which is a concern of the individual practitioner.

Part of your job is to protect the program and the practitioner from both types of liability. Programs may be held responsible for meeting standards of care (e.g., identifying clients who are at risk for suicide and taking steps to ensure the safety of those clients), but programs can also be responsible for the actions of counselors employed by the program when those counselors or other professional staff do not adhere to professional standards of practice, commit a violation of law (e.g., confidentiality), or when the program does not provide adequate support (e.g., clinical supervision) to counselors or other professional staff.

Foreseeability

Foreseeability concerns the expectation that a practitioner (substance abuse counselor or mental health professional) should have been able to foresee the potential suicidal risk that a client might experience. Without conducting basic screening for an individual with suicide risk factors, a counselor might be perceived as not taking appropriate steps to foresee suicidality.

In Part 1, chapter 1, the consensus panel recommends that five basic questions be included in initial client interviews and at appropriate followup points to gather information about a client's suicidal thoughts and behaviors. These questions are taken from "Assessing Suicide Risk: Initial Tips for Counselors," reproduced on page 17. Any affirmative answers require followup questioning, a consultation with a clinical supervisor or consultant, and possible further evaluation by staff trained in suicide assessment. Administrators can implement an intake protocol that includes these five questions, which are:

- Are you thinking about killing yourself?
- Have you ever tried to kill yourself before?
- Do you think you might try to kill yourself today?
- Have you thought of ways you might kill yourself?
- Do you have pills or a weapon to kill yourself in your possession or in your home?

It is important to note that most substance abuse counselors do not have the skills to conduct an assessment for suicide risk. Assessments need to be conducted by mental health professionals skilled in suicide assessment because they involve making judgments about risk, treatment options, referral needs, and emergency responses. These judgments are beyond the scope of practice for substance abuse counselors. Most substance abuse counselors are, however, capable of screening for suicidality. Screening involves being sensitive to risk factors and warning signs for suicidality (see the descriptions of risk factors and warning signs in Part 1, chapter 1), and asking appropriate questions (such as those listed in Part 1, chapter 1) in interviews and counseling sessions with clients in treatment for substance abuse. If the screening indicates evidence of suicidal thoughts and/or behaviors, the client can and should be referred for a more structured and detailed suicide risk assessment.

Implementing treatment and referrals to reduce the potential for suicide

Most substance abuse clients with suicidal thoughts and behaviors need specialized care beyond the scope of practice for most substance abuse counselors. In this context, the primary tasks of the substance abuse counselor are to ensure safety of the clients, gather information about suicidal thoughts and

behaviors, obtain supervision or consultation to determine a treatment plan, help clients get to the resources they need for successful treatment of their suicidal thoughts and/or behaviors, and follow up to ensure that proper care has been received and that clients accepted the care. This process is analogous to staff in a social service or health program identifying a client with a substance use disorder, concurrent with other problems that brought them to the social service or health care resource. It is the responsibility of staff in such a program to be aware of warning signs and symptoms of substance abuse, to be able to talk to the client about substance use, to make referrals for appropriate treatment, and to follow up to ensure that treatment was accepted and used. But it is beyond the scope of practice of a social service counselor or nurse in a health clinic, for instance, to actually *provide* the substance abuse treatment.

You have a role in seeing that this chain of events rolls forward in a timely and uninterrupted manner. First, you can ensure that counselors are well trained in gathering information regarding suicidal thoughts and behaviors. This includes developing sensitivity to risk factors and warning signs, becoming comfortable in discussing suicide with clients, and being aware of how one's own attitudes toward suicide affects his or her relationship with people who are suicidal. Second, you need a means of support for counselors working with clients who are suicidal. If the organization does not have a clinical supervision program or staff members with special training and expertise in suicide, the counselor will need assistance from an external consultant. Third, you need to know about and have relationships with community organizations to which clients who are suicidal could be referred or transferred. Developing relationships with other health care facilities, such as mental health clinics and hospitals (preferably formalized through memoranda of understanding) can give a substance abuse treatment team a variety of options for referring clients with suicidal thoughts and behaviors.

The substance abuse counselor's role is pivotal in ensuring that clients receive proper care. But it is equally important that substance abuse counselors, with oversight from their administrators, practice within the scope of their professional competencies and skills. To transcend the limits of acceptable practice creates malpractice liability for counselors and for their agency.

Maintaining safety for clients at risk of suicide

Maintaining safety for clients with suicidal thoughts and behaviors means making reasonable efforts to promote their immediate and long-term well-being. Historically, suicide contracts (sometimes referred to as "no-suicide" contracts) with clients have been used by some clinicians to ensure safety. No-suicide contracts generally specify that clients will not do something that would put them at risk of harm or self-injury. There is often an accompanying agreement that the client will contact the counselor or other professional if they begin having suicidal thoughts or behaviors. There is, however, no credible evidence that these contracts are effective in preventing suicide attempts and deaths (Rudd, Mandrusiak, & Joiner, 2006), and this TIP specifically recommends that agencies refrain from using them.

A more contemporary approach to client contracting is a Commitment to Treatment agreement (see the sample in Part 2, chapter 2). Such treatment agreements can support and enhance engagement with the client, possibly lowering risk, by conveying a message of collaboration.

Another issue of client safety is weapon removal. Every agency should have a written policy and procedure for handling weapons that might be used to cause bodily harm or death. Generally, this policy should promote the client's giving the weapon to a family member or significant other in lieu of giving it to the counselor or other program staff. Significant legal liability can arise if a staff member accepts a gun or other weapon from a client and then refuses to return it, if the weapon is illegal, or if a weapon is kept on the premises of the program with potential availability to other clients.

Efforts to promote client safety are, in part, dependent on the intensity and restrictiveness of the treatment environment. On one end of this continuum of care is outpatient counseling, generally conducted on a once-a-week basis. At the other end of the continuum is a secure, locked, and staff-monitored psychiatric unit. In between are intensive outpatient care, day (or evening) hospitalization, a half-way house environment, and traditional substance abuse inpatient rehabilitation care.

Administrators can establish policies and procedures to match the level on this continuum with the appli-

cable safety needs and concerns for clients with suicidal thoughts and behaviors. For instance, Bongar (1991) cites the following ways to reduce liability of suicide behaviors in an outpatient treatment setting:

- Increase the frequency of visits.
- Increase the frequency of contacts (for instance, telephone calls).
- Obtain consultation with a professional with expertise in suicide.
- Give a maximum of a week's supply of antidepressant medication (or a month's supply of other medication).
- Make sure weapons are placed in the hands of a third party.
- Involve other resources in support (for instance, family members if they can be supportive).
- Give the patient telephone numbers of suicide prevention and crisis centers.
- Know the resources that are available for emergencies and outpatient crises.
- Be reachable (or have another contact) outside of office hours (evenings, weekends, and vacation time).

In an inpatient rehabilitation setting, a different set of safety steps might be taken, including:

- Active visual monitoring of the client.
- Consideration for referral to a more secure psychiatric unit.
- Consultation with a staff or a consultant mental health professional for a suicide risk assessment.
- Monitor dispensing of antidepressant and other potentially fatal medications.
- Searches at intake and during treatment as indicated to ensure that the client does not possess weapons, drugs, or other prohibited items.
- A physical environment free of opportunity for suicidal behaviors (e.g., no sharp objects or bath and shower fixtures from which rope-like material could be suspended).

Release of information and confidentiality Issues

Two recurring issues of concern to substance abuse program administrators in working with clients with suicidal thoughts and behaviors are (1) the circumstances under which information pertaining to treatment can be released and (2) confidentiality, particularly in contacting family and significant others when a client acknowledges suicidal thoughts and behaviors. The consensus panel recommends having clients who are deemed to be at risk for suicidal thoughts and behaviors sign an emergency release of information at the beginning of treatment that allows the program to contact family members in case of an emergency. Clients, in most cases, must still have the right to revoke the consent if they so desire.

Program policies and procedures should be clear that simply acknowledging suicidal thoughts or behaviors is not sufficient cause for violating a client's rights to confidentiality by contacting family members, friends, or another treatment agency without first obtaining a consent for release of information. As in other situations, the release of information must be specific to the situation, the nature of the material released, who can have access to the information, and a timeframe in which the release is valid.

The informed consent documentation signed by the client on admission should include an explanation of the limits of confidentiality (e.g., the duty to warn in specific situations). If a client is at imminent risk of harming herself or himself, first responders (such as police), can be contacted, but the circumstances necessitating the contact need to be fully justified and documented. It should generally be program policy that such contact is only made with the approval of a clinical supervisor or administrator. Some examples of imminent risk include a telephone call from a client saying he has just made a suicide attempt and is in danger, or a client who leaves the agency threatening to kill himself, has identified a method, and seems likely to carry out a suicidal threat.

When working with a client with suicidal thoughts or behaviors, it is good program policy to actively encourage family involvement in treatment and to encourage the client to be open with her or his family about suicidal thoughts and behaviors. As when treating substance abuse, the family members need education and information about suicide, warning signs, and particularly, about what to do when suicidal thoughts or behaviors are present in the client.

As in any other treatment situation, no information regarding a client's condition, treatment plan, or other data should be released without the client's written permission. The only exception is if the client is in imminent danger of harming himself or herself or others in a life-threatening manner. If this happens, refer to State and Federal regulations that address this issue. Administrative staff or senior clin-

ical supervisors should make the decision if a client's right to confidentiality is to be compromised.

A related question concerns the duty to warn when a client is at risk for harming another person. Generally, there is no duty to warn family members if a client is suicidal, unless that behavior threatens to harm another person.

Ethical Issues

A wide variety of ethical issues arises when working with substance abuse clients with suicidal thoughts and behaviors. Additionally, the professional groups that work with this population have differing ethical codes. In fact, even within a profession, counselors working in different States can have different ethical codes depending on where they are licensed or certified. As opposed to legal issues, where there is often a clear guideline for legal versus illegal behavior, ethical issues are often grey areas without defined proscriptions for counselor behavior. Finally, ethical issues often overlap with legal issues. For instance, there are legal concerns about confidentiality of client information and records, but ethical standards also govern counselor behavior in this area. The same is true for responsibility for client safety, how a referral is made and followed up, and in client termination from treatment.

You need to make efforts to ensure agency policy is consistent with the ethical guidelines of professional groups that guide clinical staff practice in the agency. These ethical standards may be promulgated by treatment program associations or organizations for clinical supervisors, counselors, and other treatment personnel. They may be established by regulatory organizations that affect the program. As an example, a program's policy about how counseling services are provided to clients with suicidal thoughts and behaviors needs to be consistent with ethical guidelines about scope of practice for substance abuse counselors who are not specifically trained to treat suicidality. The policy should state that treatment for suicidal clients will be provided by staff with degrees in mental health disciplines who have been trained to treat clients who are suicidal.

Ethical practice has to transcend all levels of organizational behavior. Ethics is often thought of as an issue for frontline staff: counselors, physicians and nurses, psychologists, and social workers. But clinical supervisors also have ethical guidelines (see, e.g., ethical standards of the Michigan Certification Board for Addictions Professionals [http://www.mcbap.com/]), and, at least implicitly, program functioning needs to be guided by ethical practice as well. All these levels need to be consistent in the application of ethical boundaries, for instance, how information about a client who is suicidal is released in a crisis situation, or how decisions are made to transfer a client to another program better able to address acute suicidal thoughts and behaviors.

Malpractice

Malpractice is the intentional or unintentional improper or negligent treatment of a client by a counselor, resulting in injury, damage, or significant loss. It is a growing concern for substance abuse treatment programs. Malpractice is a legal proceeding even though the claim of improper or negligent treatment might have been generated by alleged unethical behavior. (For more detailed information on malpractice, see Falvey, 2002 or Gutheil & Brodsky, 2008.)

Informed consent

A special area of ethical practice with clients with suicidal thoughts and behaviors relates to informed consent for treatment (Rudd, Williamson, & Trotter, in press). Informed consent for substance abuse treatment is an ongoing process in which the client is an active participant in defining what treatment methods and approaches will be undertaken, the expected outcomes of that intervention, the risks and expected efficacy inherent in the care, and alternative treatments that might be used. Clients who evidence suicidal thoughts and behaviors have some special needs for informed consent in addition to those normally given to other clients. You should develop and implement protocols for informed consent applicable specifically to clients who are suicidal. For instance, the client should be clear that if his or her suicidality becomes more overt or debilitating, specialized treatment resources may be required. It is important that the issue of informed consent be raised when treatment is initiated.

Additionally, the program might institute special precautions to protect the safety of the client. It might, in some circumstances, be appropriate to inform the client that the intensity of substance abuse treatment

might cause suicidal thoughts to become more frequent or more intense. This might be the case, for example, when counselors are working with clients with co-occurring substance abuse, suicidal thoughts, and psychological trauma. The protocols might specify what actions can be taken if suicidal thoughts increase, at what point special protective care measures must be taken, and at what point special treatment (such as medication) is indicated.

Admission, transfer, and treatment termination

Ethical issues for substance abuse treatment programs working with clients with suicidal thoughts and behaviors arise around their admission, transfer, and administrative termination. Historically, many substance abuse treatment programs have simply had a policy not to accept clients who exhibit suicidal thoughts or behaviors. The effect of this policy has been that clients who were suicidal continued to be admitted to these programs but could not openly discuss their suicidal thoughts, or they were denied treatment for their substance abuse. Likewise, many of the same clients would be denied treatment by mental health service providers who saw the clients' problem as originating in a substance use disorder.

Fortunately, these practices have been largely discontinued. In fact, many people in the field would find it unethical for a program to deny care to someone who is suicidal unless the program can clearly define how the client's condition is inappropriate for care in the specific program. In that case, the program has an ethical responsibility to help clients find the best care for their needs available in the community.

A related issue of treating substance abuse clients with suicidal ideation or behavior is when they need to be transferred to another treatment facility that can offer safer or more intense care, often for co-occurring disorders (such as depression) that accompany the substance use disorder and suicidality. Substance abuse treatment programs need to have clear policies and guidelines stipulating that a referral for more intensive care does not necessarily mean the end of a client's involvement with the program. The client may need to return to the program when less intensive care is warranted. In effect, transfer does not mean discharge.

Likewise, clients cannot be discharged if they are discovered to have suicidal thoughts and behaviors. It is unethical and may be illegal to discharge a client in clear distress without guaranteed and subsequently confirmed followup with an appropriate provider. Programs have an obligation to provide services to that client either directly through the resources of the program or by referral or transfer to another program better able to treat the client. From an ethical standpoint, this should be made an organizational policy.

If clients complete substance abuse treatment and are discharged from their intensive substance abuse treatment program but still have some detectable level of suicidal thoughts and behaviors, specific efforts should be made to ensure that treatment for that client continues, either in a specialized program for clients who are suicidal or in a continuing care extension of the substance abuse program.

Additional training

An ethical issue for substance abuse programs is in providing training for counselors in suicidality. Counselors should not be expected to address suicidal thoughts and behaviors without additional training. The consensus panel strongly recommends that administrators help counselors get additional training to address the competencies listed in Part 1, chapter 1, including these knowledge, skills, and attitudinal domains:

- Gathering information.
- Accessing supervision and consultation.
- Taking responsible action.
- Extending the responsible action with follow-up and documentation.
- Basic knowledge about the role of warning signs, risk factors, and protective factors.
- Empathy for clients who are suicidal.
- Cultural competence issues in recognizing and addressing the needs of clients who are suicidal.
- Legal and ethical issues in addressing suicidality in the agency.

It is insufficient to simply train counselors to recognize suicidality or in facts about suicide and substance abuse. The above competencies need to be considered in preparing counselors to work with people who are suicidal in the context of substance abuse treatment. A variety of training materials can be

used in addition to the material in this TIP. The Suicide Prevention Resource Center (SPRC) produces a variety of workshops and training materials for counselors (http://www.sprc.org) through its Training Institute. The Addiction Technology Transfer Centers (ATTCs), funded by SAMHSA (http://www.healtheknowledge.org/), offer a variety of training opportunities. Courses in Counseling Suicidal Clients and Crisis Intervention are currently being offered by email correspondence and on the Internet. Finally, a variety of State training programs, including summer institutes on alcohol and drug problems, present workshops for substance abuse counselors working with suicidal clients.

In summary, substance abuse treatment programs face a variety of ethical issues in treating substance abuse clients who evidence suicidal thoughts and/or behaviors. Program administrators need to address these ethical concerns in agency policies and to translate those policies into specific procedures for mid-level supervisory staff, for substance abuse counselors, and for other staff members.

Chapter 2

Building a Suicide Prevention- and Intervention-Capable Agency

Introduction

The previous chapter presented an orientation for administrators about how suicide affects a substance abuse treatment program. It focused on several conceptual issues, including why a program administrator should be concerned with suicide, levels of agency preparedness to address suicide, and the legal and ethical considerations of working with clients in substance abuse treatment who have suicidal thoughts and behaviors.

This chapter presents four programming and implementation issues of primary concern to administrators and provides the tools you will need to:

- Help an agency become suicide prevention and intervention capable.
- Help a program develop and improve staff capabilities in working with suicidal clients.
- Help an agency develop and enhance its response system to suicide crises.
- Build administrative support for all components of GATE (**G**athering information, **A**ccessing supervision, **T**aking action, and **E**xtending the action).

Community-based substance abuse treatment programs come in a wide variety of sizes and orientations, with major differences in staff and other features. Given their size, staffing, orientation, and other features, not all substance abuse treatment programs will be able to provide all of the necessary services to all clients with suicidal thoughts and behaviors. In addition, some high-risk clients may be inappropriate for a given agency.

To further complicate matters, clients come into substance abuse treatment with a variety of needs and levels of risk. In the past, many agencies simply declined to treat anyone who might be a suicidal risk. However, such an option no longer exists, and such a general declaration now seems irresponsible and possibly programmatically unethical. With this in mind, substance abuse treatment programs now have to decide:

- Which clients who are suicidal they can adequately serve.
- Which clients will need to be linked with an agency that can better meet their needs.

Substance abuse treatment programs also need to strive to improve their services to a point where clients with elevated risk may be accommodated and treated (Level 2). Such an orientation is within the realm of most programs today. Such a shift does, however, require your knowledgeable commitment along with a plan for design, implementation, and evaluation of services and training of clinical supervisors, substance abuse counselors, and other treatment staff.

As noted before, the accrued benefits of becoming a Level 2 substance abuse treatment program are:

- Clients can remain in substance abuse treatment even though co-occurring problems like suicidality are present. Staying in treatment for substance use disorders may be critical for the client's recovery and rehabilitation.
- The Level 2 substance abuse program can be responsive to a variety of crisis states related to suicide that might otherwise disrupt functioning for the client who is suicidal, other clients, and program staff.
- The responsiveness of the program to issues of suicidality may increase the capacity of the program to respond to other client crises that present in the treatment program.
- Being a Level 2 substance abuse treatment program means staff have additional skills and diversity that can benefit the overall treatment program.
- Being Level 2 allows the program to treat clients who have specific co-occurring mental disorders who would otherwise have to be referred, thereby

potentially increasing program effectiveness and building financial benefits to the program.
- Most important, being a Level 2 program helps identify clients with suicidal thoughts and behaviors who would otherwise be undetected. Being a Level 2 program, in fact, has the potential to save lives.

This TIP recognizes that not all programs can treat clients with elevated risk of suicide. A Level 2 program has specially trained staff, being able to address and monitor suicidality onsite for many clients rather than through referral, and being prepared to coordinate treatment for a variety of co-occurring disorders often implicated in suicide risk (e.g., depression, borderline personality disorder, PTSD, anxiety disorders). Some programs are too small to have this capacity, others too specialized (such as many halfway houses). For these programs, being Level 1, and having working relationships with other agencies in the community for consultation, supervision, and referral may be sufficient.

Being a Level 2 program begins with your recognition of the need and value of addressing suicidal thoughts and behaviors in the program in a comprehensive way. This process requires three basic steps.

1. Organizational assessment
2. Organizational planning
   - Organizing a team or workgroup to address planning
   - Deciding on specific targets for change
   - Determining how and when to begin implementation
3. Program implementation
   - Adapting existing policies and programs
   - Implementing and integrating new programmatic elements

A valuable resource for administrators working in substance abuse treatment settings is *The Change Book* (Addiction Technology Transfer Center, 2004), which describes the organizational change process used in this TIP. In addition, you may want to review *Implementation Research: A Synthesis of the Literature* (Fixsen, Naoom, Friedman, Blase, & Wallace, 2005) for more information on the scientific basis for various implementation practices.

Organizational Assessment

Historically, organizational change in substance abuse treatment settings has tended to occur as a result of pressure from the outside: mandates from funding resources, rules and regulations from State agencies, or standards from accrediting bodies. But more and more, as programs and management become increasingly skilled and sophisticated, the perception of organizational assessment and change as an ongoing, internal, data-based, quality improvement-focused process has evolved. Research (e.g., Ogbonna & Harris, 1998; Schneider, 2002) supports that successful interventions and positive evolution of organizations depend not only on the quality of the intervention, but also on the organizational culture.

Gathering Data on the Effects of Suicidality on the Program

To get a snapshot of your organization's current ability to address suicidal thoughts and behaviors, you will need to consider your responses to the questions below.

Clients with suicidal thoughts and behaviors:
- How are clients with suicidal thoughts and behaviors currently identified in the treatment population? Does the program only identify clients who are in an obvious, self-disclosed suicidal crisis? Are screening questions for suicide routinely asked in clinical interviews? If not, a study of current clients might be considered in which the five screening questions recommended in this TIP (see Part 1, chapter 1, p. 17) are asked of all clients.
- What might you do to identify those clients whose suicidality is "under the program radar"? Are counselors aware of risk factors and warning signs of suicidality that might encourage them to explore suicidality in more detail with high-risk clients?
- How do suicidal thoughts and behaviors among clients in your program affect treatment in your program? Do clients with suicidal thoughts and behaviors have their treatment interrupted by referral to other programs? Do staff routinely dismiss suicidality as merely representing a defense against doing the work of recovery? Do clients experience their suicidality as a disruption to their

substance abuse treatment? Do clients experience their disclosure of suicidal thoughts and behaviors and subsequent referral to another program for treatment as "punishment" for their disclosure?
- What is the impact of client suicidality on the performance of treatment staff? Do staff feel prepared to screen and respond to clients with suicidal thoughts and behaviors? Are staff prepared to manage individuals who are suicidal not only for the clients' own safety, but also in ways that minimize any impact on other clients? Do staff feel prepared to address this issue in their day-to-day practice?

The current organizational response to clients with suicidal thoughts and behaviors:
- What is the current organizational response to clients who are suicidal? Are there clear policy and procedure statements for managing clients with identified suicidal thoughts and behaviors?
- Do staff consistently document current and past suicidal thoughts and behaviors of clients?
- Do treatment records indicate that most clients with suicidal thoughts and behaviors are referred for specialized consultations when needed for services or treatment planning?
- Are the client's suicidal thoughts and behaviors and the organization's response (including consultations) integrated as a clinical issue into the treatment plan?
- What is the typical treatment response to clients who are experiencing a suicidal crisis? Are they able to maintain their substance abuse treatment while their suicidality needs are addressed?
- How would clinical staff (including clinical supervisors) define the optimal response to the variety of treatment issues raised by clients who are suicidal?

The impact of suicidal clients on program staffing:
- If the program is to become Level 2, how will that change affect staffing patterns, clinical practices, and staff morale?
- Are staff fearful of working with clients who are suicidal because of legal and malpractice consequences?
- Do staff believe that they have sufficient skills and knowledge to screen for suicidality and talk comfortably about suicidality with clients? Do they know about treatment resources for suicidality? Can training and clinical support in the form of supervision and consultation be developed and/or enhanced to help clinical staff feel more positive about the change?
- Is there a mechanism within the program to offer debriefing and professional support to counselors after serious adverse events (e.g., suicide attempt at the facility, suicide attempt by a client that led to significant injury regardless of where the attempt occurred, suicide death)?
- Is the staff resistant to this organizational change? If so, will it be helpful to have this information up front so that staff needs can be addressed and accommodated?

The organizational culture, including attitudes about suicide:
- Is suicide treated as a serious problem in the agency?
- Do staff at any level of the organization have negative attitudes toward suicide? If so, can administrators expect resistance to the effort to become a Level 2 program?
- Will attitudes such as "people who are suicidal do not belong in substance abuse treatment" or "working with people who are suicidal is dangerous and a real source of legal liability" or "clients who are suicidal will disrupt treatment for everyone else in the program" be barriers to effective change? Does the organizational change process need to be prepared to confront these attitudes?
- Does the organization have good relationships with mental health agencies, hospitals, and other places where clients with suicidal thoughts and behaviors can be referred?
- Is it feasible to include staff from all levels of the organization in the change process to promote ownership of the changes by all staff?

A good source of information on addressing suicidal thoughts and behaviors is to consider what other programs in your area are already doing and the efforts they made to arrive at their current level of competence in meeting the needs of clients who are suicidal. The goal of organizational change is not to duplicate services or to create overlapping, competitive environments. At the same time, each program should be able to offer services to its client population without automatically referring clients out who present with complicating difficulties (passing the buck).

Additionally, the experience of other programs in your area in organizational change regarding suicidality may provide valuable information in planning your own change process.

Other good resources for strengthening the capacity of a substance abuse treatment program to be Level 2 include Shea (2002) and Jobes (2006). The Suicide Prevention Resource Center (http://www.sprc.org) can provide helpful guidelines to assist substance abuse programs in becoming Level 2.

As these kinds of data are being gathered, the information has to be organized, placed in the context of the organizational goals to address suicidality, and integrated into steps in the planning process. Generally, data will come in various forms: some solid numbers, some impressions, some as summaries of the reactions of a variety of staff. It must be noted that data-gathering is not a static, one-time process but an evolving effort that needs to be part of the total, ongoing change effort. A method for documenting the implementation of policies toward becoming Level 2 and of assessing adherence to policies should be implemented.

Organizational Planning for Becoming a Level 2 Program

Once data have been collected and the problem has been defined and described, the next step is to *organize a team or work group* to address the issue of planning the change. TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008), describes the process of team development that can be applied to organizational planning for addressing suicidality:

1. Identify one person to lead the effort. This person must have the backing of senior administration and the respect of clinical staff.
2. Obtain the commitment of the chief executive officer of the agency to articulate the vision for implementation throughout the agency, with all stakeholders, and to the public.
3. Convene an implementation work group consisting of key leaders from different stakeholder groups: consumer leaders, family leaders, team leaders, clinical leaders, and program and administrative leaders. Some stakeholders will serve as ongoing members of the work group while information from others may be solicited through focus groups.
4. Identify the program oversight committee to which the work group will report. For example, if your agency has a quality improvement committee, the work group may report its findings, recommendations, strategic plans, and modifications to that committee. This is one way to initiate and sustain implementation of program changes.

Some issues specific to suicide should be included in the planning process. For instance, depending on your program's current level of competence in suicidality, local mental health providers who have specialized knowledge and skills in addressing suicidal thoughts and behaviors should be invited into the planning process. Their knowledge of the needs of individuals with suicidal thoughts and behaviors and their awareness of community resources might prove helpful. If you anticipate that the management of clients' suicidal thoughts and behaviors will involve referral to other agencies, those agencies might need to be involved in the program planning stages.

The organizational work group should be able to *arrive at specific targets for change.* Some examples of targets for clients with suicidal thoughts and behaviors might include:

- Screening all new clients for suicidal thoughts and behaviors.
- Increasing the number of clients who are able to stay active in substance abuse treatment while their suicidal thoughts and/or behaviors are monitored and addressed entirely within the program or conjointly by another agency that is taking the lead in addressing suicidality.
- Increasing the skills of frontline substance abuse counselors in working with GATE: their comfort and skill levels in screening for suicidality and talking with clients about their suicidal thoughts and behaviors, their willingness to seek supervision or consultation on suicide-related issues, their ability to effectively make appropriate referrals to other resources for suicidal clients and to follow up with clients who have been referred.
- Increasing the capacity of clinical supervisors in the program to address the supervision needs of frontline counselors regarding suicide.
- Improving the connection between policies and procedures in the program and the actual needs of frontline counselors and clients.

The third step in organizational planning is *deciding how and when to start the implementation process.* Most programs find it more productive to make organizational changes in incremental steps, observing and evaluating the changes as they occur, rather than in one large leap. Larger changes tend to be more difficult to integrate into the existing system, and it is harder to correct the missteps that inevitably occur in the process. The timing of implementation is also important. Basically, should initiate change when the organizational system is most likely to be able to integrate the changes without distracting from the program's mission. Making too many changes too quickly can disrupt normal functioning and hinder the integration of new efforts. Ill-timed change can create more resistance than would have otherwise occurred. The implementation should have a system to monitor milestones so as to ensure sustainability.

Program Implementation

Adapting Existing Policies and Programs

It is quite possible that your program already has a variety of policy statements and programmatic elements that relate to client suicidality. For instance, your program probably has a policy about how to handle weapons that are brought onsite, what actions are to be taken when weapons are discovered, and who is to be notified. You also probably have policy statements that indicate what actions are to be taken when a client acknowledges active suicidal thoughts, intent, or behavior. You have policies concerning who can be contacted in client emergencies and when police or other first responders can be notified.

You already have program policy and programmatic elements that, while not being specific to suicidal clients, may be directly translatable to suicidal crises and to care for clients who acknowledge suicidal thoughts and behaviors. For instance, you probably have policies related to the care of clients with co-occurring disorders, such as a "no wrong door" policy, or programmatic elements such as one or more clinicians who are specially trained in working with clients with co-occurring disorders.

Implementing new policies and programmatic elements, therefore, is more often a case of adapting existing policies and procedures to meet the needs of clients with suicidal thoughts and behaviors. The organizational planning group mentioned earlier could review current program policies and procedures to see how they need to be adapted and revised. The work group might also be charged with examining how issues of client suicidality can be integrated into current policies for co-occurring disorders, crisis management in the program, contact with family and significant others in emergencies, and making referrals to other, specialized resources.

Implementing and Integrating New Programmatic Elements

It may be the case, however, that new policies and programmatic elements need to be incorporated into

Sample Policy 1
Topic: Clinical staff training and competence
Policy Statement: All clinical staff will receive training in suicidality and its impact on substance abuse treatment and can demonstrate basic competence in screening clients with substance use disorders for suicidal thoughts and behaviors.
Procedures: 1. All clinical and support staff will participate in a 1-day training session covering suicidality and its impact on substance abuse treatment retention and outcomes, attitudes toward clients with suicidal thoughts and behaviors, and intervention resources for clients who are suicidal. 2. The clinical supervisor of new employees will provide site-specific information on the procedures for screening and referring individuals who are experiencing suicidal thoughts and behaviors. 3. Clinical competence checklists completed at hire and annually thereafter will ensure that all clinical staff members have a basic knowledge of the benefits of addressing suicidal symptoms, understanding protocols for detecting client suicidality, and awareness of appropriate referral procedures.

Sample Policy 2

Topic: Screening and referral of clients with substance use disorders and suicidal thoughts and behaviors

Policy Statement: All clients will be screened for suicidality and will be monitored and/or referred as needed.

Procedures:

1. During the intake process, all clients will be screened for suicidal thoughts and behaviors using a standard protocol in which all counselors are trained.
2. Individuals demonstrating suicidal thoughts and behaviors will, after appropriate clinical supervision or consultation, be referred for assessment by a qualified mental health professional (QMHP) as needed.
3. All screening results, consultation sessions with the clinical supervisor, and referrals (and ongoing communications) to a QMHP will be documented in the client's record.
4. The counselor providing services to clients with suicidal thoughts and behaviors will provide the client with an emergency contact list that includes agency personnel, emergency mental health providers, and a suicide hotline. The client can refer to this list if his or her symptoms worsen outside business hours or when substance abuse counselors are not available.

Sample Policy 3

Topic: Individual client observation in a residential facility

Policy Statement: Special procedures will be instituted for clients in crisis who require hourly monitoring.

Provisions will be made for observation and/or a treatment area for clients who are displaying a level of emotional or psychological crisis and may need to be separated from their treatment unit for a period of time up to 48 hours. Each transfer or observation must result in a psychological or psychiatric consult. An observation checklist will be completed every hour during a client's stay in observation. This is not designed to assess for suicidality, but to identify symptoms that may require additional professional re-assessment.

Intent:

This policy is *not* designed to replace the policy for suicidal patients. This facility is not dually licensed as a psychiatric or mental health facility; therefore patients who have been assessed as being capable of carrying out suicidal or homicidal ideation or intent will be transferred to an acute stabilization unit.

It is the intent of this policy to address the needs of crisis stabilization that do not meet the criteria for hospitalization or involuntary admission to an acute care hospital. Clients will receive the appropriate level of ongoing observation and treatment for their individual needs, such as the patient who is evaluated as not being a threat to himself or others yet manifests a level of emotional or psychological crisis. This process will allow clients to have a quiet space to focus on their immediate stabilization and ensure that the treatment unit is not harmed by these crisis situations.

Procedure:

1. The client's counselor, unit Clinical Coordinator, and/or the Executive Director are responsible for the initial assessment and ongoing decision for observation of all clients, whether this occurs on the treatment unit or in the Medical Unit.
2. During client crisis, a psychologist, psychiatrist, Masters-level counselor or a nurse will perform assessment and re-assessment.
3 The Medical Unit, staffed with nurses and support staff is the first choice for crisis stabilization up to 48 hours. Clients in the Medical Unit or observation area will remain on the census of their treatment unit.
   - The Coordinator or Director of the treatment unit will call the charge nurse of the Medical Unit to make the initial request for observation.
   - The charge nurse will make every attempt to accommodate the request to observe the patient if there is a bed available and the acuity of the rest of the clients allows staff to observe. (Other staff members may be used if staffing is an issue.) The admissions schedule for the unit will be evaluated to assess bed availability.

- On approval, the client treatment unit staff will transport the client to the Medical Unit and provide a staff member to remain on the unit for the duration of the observation and assist either the Medical Unit staff or observe the client, depending on the needs of the Medical Unit and the client. The staff member may be requested by the nurse to be present on the Medical Unit a number of hours or for the entire shift.
- It is preferred that the staff member accompanying the client has rapport with the client or clinical credentials to assist the client in stabilization.

4. If the Medical Unit is unable to accept the client for observation, the following options exist. The Director or on-call coordinator will make the determination as to the next best option based on the individual case.
   - The coordinator may use other units or programs in the agency. It is recommended that the client be moved from his or her treatment unit to a safe and available dormitory area. The door alarms on either side of the area should be set in order to monitor the client's whereabouts during observation.
   - Other available areas should be safe, with priorities for units with lower census, first floor rooms, gender-separate areas, quiet and comfortable, and those that do not interfere with the programs.
   - To best use available staff in monitoring the client on an individual basis, staff should preferably be of the same sex and have some existing rapport with the patient.
   - Staff should be equipped with a communication device and have surrounding staff aware of the location of the observation as well as the need to relieve or assist the observer if needed. Hourly communication is required.
   - Staff observing the patient are to be trained in both de-escalation of clients as well as the purpose and process of observing. This training includes the use of an hourly checklist and protocol for contacting professional staff if needed.

the treatment program. New policies may need to be specific to suicide or may address larger issues in the program, such as clinical supervision, how emergencies are handled, or screening for a variety of co-occurring disorders. Every substance abuse treatment program should, at the least, have a policy statement that acknowledges that suicide is a significant issue for clients in substance abuse treatment and that the program has a role in identifying suicidality among its clients by screening all clients for suicidality and a responsibility to help those clients get the services they need, either through program staff or referral. The policy should then elaborate on procedures for addressing those issues.

New programmatic elements that might need to be instituted include training for all clinical supervisors regarding when services for clients with suicidal thoughts and behaviors can be provided in-house, how referrals are made, and managing suicidal crises in the agency.

Helping Your Program Develop and Improve Capabilities in Working With Clients Who Are Suicidal

Well-written policies and implementation plans to address suicidal thoughts and behaviors will be ineffective without clinical and support staff who have the training, skills, and motivation to carry them out. It is your responsibility to ensure that staff are prepared to address these needs.

Part 1, chapter 1 lists eight core competencies for substance abuse counselors working with clients who are suicidal. These competencies offer a good baseline for defining the knowledge, skills, and attitudes required of frontline counselors. In addition, senior counseling staff and clinical supervisors should be skilled in recognizing and managing suicidal crises, using consultations with external experts, and working with clients who are suicidal and resistant to counseling interventions. (See vignettes 5 and 6 in Part 1, chapter 2. Vince and Rena are clients who require more advanced skills.) The checklist below reflects some of the skills applicable to senior clinical staff and clinical supervisors that extend beyond the eight competencies mentioned above.

Checklist: Characteristics and Competencies of Clinical Supervisors

Attitudes

____ Clinical supervisors have the basic characteristics needed to provide services to treat clients with suicidal thoughts and behaviors and to supervise others to manage such clients
____ Clinical supervision extends beyond talking about treatment to directly observing and coaching counselors
____ Awareness of compassion fatigue or vicarious trauma in counselors and when to facilitate help for counselors experiencing these symptoms

Knowledge

Clinical supervisors need to have all of the training of frontline counselors. In addition, they need the following knowledge specific to supervision:

____ The role of clinical supervision in substance abuse treatment
____ How to train frontline substance abuse counselors in screening of suicidal clients
____ When a client with suicidal thoughts and behaviors needs additional services beyond the qualifications of substance abuse counselors
____ The role of transference and countertransference in the counseling and supervisory relationship
____ How to recognize resistance to change among clinical staff and strategies to address it
____ Change processes, process steps, and strategies for supporting them

Supervisory Skills

____ Articulates his or her approach and philosophy to clinical supervision as it relates to approaches described in the literature
____ Identifies and responds to variations in learning styles among counselors
____ Is comfortable with and able to resolve conflict among team members
____ Models advanced counseling skills, including development of therapeutic alliance, termination, and managing client resistance
____ Uses direct observation or taping to conduct supervisory sessions
____ Can teach and model skills in a variety of approaches to counseling that are applicable to substance abuse clients with suicidal thoughts and behaviors
____ Can determine when referral to a QMHP for a suicide assessment is required
____ Facilitates referrals to QMHPs both within and outside the treating agency
____ Provides incentives through encouragement and support for counselors to enhance skills in treating clients who are suicidal
____ Can assess counselor competence and develop professional learning plans and supervisory interventions

It is important that training reflect the skills needed by substance abuse counselors. This TIP emphasizes that the role of the substance abuse counselor in working with clients with suicidal thoughts and behaviors is to screen, obtain supervision or consultation, take appropriate action (including potentially making a referral), monitor (under clinical supervision), and follow up with clients who are suicidal. Treating suicidality is beyond the scope of practice for most substance abuse counselors, as it requires advanced training in mental health disciplines and, preferably, advanced training in assessment, treatment, and intervention. Trainers should understand the needs and limits of practice of substance abuse counselors and not offer skills that most counselors are not prepared to use.

Rather than a one-time training, the training plan for developing skills in working with clients who are suicidal in substance abuse treatment needs to be ongoing. Shorter training sessions extending over several weeks are preferable to a single full-day session. Regardless of the format for initial training, followup refresher programs lasting 2 hours and emphasizing actual experiences of the participants in working with clients who are suicidal are essential. Training should emphasize building on existing skills and applying existing skills (for instance, in making referrals) to clients who are suicidal, rather than introducing new skills sets. For instance, if counselors in Program A have already received extensive training in motivational interviewing (MI), then the skills training for addressing suicidal thoughts and behaviors should

emphasize MI methods (e.g., Gathering information from clients who may be at risk in a manner that does not create defensiveness).

In addition to didactic training sessions, other ways to stimulate dialog and the development of clinical skills for use with clients who are suicidal are:

- Have the topic be a regular agenda item in treatment team meetings and include all high-risk clients in the discussion.
- Have a brown-bag lunch with a senior staff member as trainer.
- Designate one senior counselor or clinical supervisor in a treatment unit to be the "go-to person" on suicide and give that person time (on the job) to take an online or continuing education course.
- Peer review accompanying group supervision.
- Make it a topic of the month for clinical supervision for all counselors.
- Have a training session on treatment planning for suicidal clients.
- Have pairs of counselors role play various parts of GATE.
- Keep GATE active as a clinical tool by having annual 1-hour refreshers on suicide and the use of GATE.

Helping Your Agency Develop and Improve Its Response to Suicidal Crises

Suicide risk management too often is reactionary and reserved for clients in acute, suicidal crisis. However, most clients experiencing suicidal thoughts and behaviors are not in an acute crisis and do not warrant crisis management. Indeed, most situations can be managed adequately in a matter-of-fact, methodical manner that is not crisis driven. This TIP encourages programs to screen, educate, and intervene early when clients experience suicidal thoughts and/or behaviors, and to take action across the continuum of risk. By doing so, you are likely to prevent many situations from erupting into full blown crises, and be more effective in managing suicide risk within your agency.

That said, there will inevitably be situations that arise suddenly and unpredictably where a crisis response is required. Programs should have specific policies that address those crisis situations. Three examples of suicidal crises are the vignettes of Clayton, Vince, and Rena in Part 1, chapter 2. Clayton reveals suicide ideation and acknowledges that he as taken a gun in his house out of safekeeping and examined it while thinking of suicide. Vince receives news that his wife has filed an order of protection against him, and he rapidly spirals into a preoccupation with suicide. He also alludes to potential violence towards his wife and her lawyer. Rena begins drinking, re-experiences childhood trauma, finds herself losing her psychological supports, and begins to have intense thoughts of suicide. These are just a few of the myriad circumstances that can occur even in the face of the best treatment and organizational planning and for which specific agency policies and procedures need to be in place.

Policy and procedure for suicidal crises are often best considered in the context of larger issues of crisis management in the agency. CSAT is developing a tool entitled "Crisis Management: A Guide for Substance Abuse Counselors" that addresses this issue. The kinds of crises that can occur in a program include active suicidality on the part of a client, aggressiveness, violence, threats of violence toward others, death of a client, severe injuries or health crises with clients, and special protective issues for children and adolescents at risk for endangerment or abuse. In addition to providing a rationale for crisis management, the tool offers specific advice on what steps counselors should plan for, the varieties of contact information front line staff should have available in crisis situations, and the importance of documentation.

Some of the components of effective policy and procedures for suicidal crises that need to be considered include:

- Defining a situation requiring a crisis response (compared with a non-crisis event).
- Specific actions that the counselor or treatment provider should take to ensure the client's safety (e.g., taking action to reduce availability of methods of suicide).
- Who should be notified and how quickly that notification should take place.
- What kinds of consultation or clinical supervision should occur and how it should be requested.
- The situations under which significant others or first responders should be notified and how pertinent confidentiality regulations can be upheld.

- How a client's possession of a weapon or other suicide method (such as medication) should be addressed by the counselor and/or the clinical supervisor or other senior staff.
- How clients should be monitored during the crisis (e.g., the policy might specifically state that clients should not be left alone in an office, the waiting room, or other unsecured areas without supervision). A policy of physical restraint needs to be clearly stated.
- How staff who greet clients and receive incoming telephone calls are to respond to crisis calls or events in the agency.
- How a counselor can access immediate help by telephone or other emergency notification process
- How emergency referrals should be made, who should actually make the referral, and what kind of information should be released to the referral program or institution.
- How to address a client's resistance to receiving care for suicidality or resistance to accepting referral for consultation or treatment.
- How clients should be transported to other programs or resources.
- What followup contact should be made with other programs or resources after the referral.
- What kinds of documentation should occur throughout this process.

Program policies should specifically state that it is not the counselor's role to make a final determination of whether the client is at acute or imminent risk for suicide. This judgment needs to be left to providers with the necessary training and education. It is the counselor's role to help the client get to the appropriate resources where those kinds of evaluations can be made.

Specific agency policies should spell out how clinical supervisors should address suicidal crises. Such policies might indicate when the supervisor should step in and become actively involved in the client's care (as opposed to being a resource for the counselor); when program senior administration should be notified; when first responders (such as police and emergency medical services) should be contacted; and the types of incident documentation the supervisor needs to prepare and file.

As mentioned earlier, the Commitment to Treatment Statement (see figure 1 below) is one procedure that can be adopted when suicidal thoughts and behaviors are noted. Having both the client and counselor sign

Figure 1. Sample Commitment to Treatment Statement

I, _____, agree to make a commitment to the treatment process. I understand that this means that I have agreed to be actively involved in all aspects of treatment, including:

1. Attending sessions (or letting my counselor know when I can't make it).
2. Setting goals.
3. Voicing my opinions, thoughts, and feelings honestly and openly with my counselor (whether they are negative or positive, but most importantly my negative feelings).
4. Being actively involved during sessions.
5. Completing homework assignments.
6. Taking my medications as prescribed.
7. Experimenting with new behaviors and new ways of doing things.
8. Implementing my crisis response plan when needed.

I also understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount of energy and effort I make. If I feel that treatment is not working, I agree to discuss it with my counselor and attempt to come to a common understanding as to what the problems are and identify potential solutions. In short, I agree to make a commitment to living. This agreement will apply for the next 3 months, at which time it will be reviewed and modified.

Signed _____ Date _____

Witness _____

Adapted from Rudd, 2006.

the statement helps promote engagement in treatment.

A related technique is a safety card, which gives clients resources to use in a crisis (see p. 21 in Part 1, chapter 1). Counselors might want to use both techniques.

The goal of agency policy for managing clients who are acutely suicidal is to give enough direction to clinicians and clinical supervisors to guide them in crisis situations, while at the same time not attempting to anticipate every kind of crisis situation related to suicidal thoughts and behaviors. Counselors and supervisors need to be able to use their clinical training, experience, and judgment to address specific situations. Policy needs to guide how the counselor's and supervisor's clinical skills are used.

Finally, every serious adverse event (e.g., suicide attempt at the facility, suicide attempt by a client that leads to significant injury regardless of where the attempt occurred, suicide death) should result in a debriefing and postvention that considers how the event unfolded, how the specific action steps facilitated or hindered resolution of the crisis, how policy worked (or didn't work) to address the crisis, and how policy and procedure can be improved to further enhance the capability of the agency in responding to crises.

Postvention refers to dealing with the aftermath of suicide with survivors who may be family, friends, fellow students, teachers, coworkers, supervisors, fellow patients, counselors, physicians, or any other people who knew the individual and may be affected by the suicide. Additionally, the postvention needs to address how the emotional and psychological responses of the staff involved in the situation were considered. Staff should emerge from the postvention feeling supported and capable and guided by agency policy, senior administration, and clinical supervisors. They should feel their emotional responses to the event were addressed and that they had an opportunity to resolve unfinished business that may have arisen during the crisis. Counselors who provided direct services to clients who died by suicide may also benefit from counseling to help them work through the situation, ideally by a provider experienced in postvention. Counselors who have experienced a suicide in their personal life may especially benefit. Time is often an ally in the healing process.

Building Administrative Support for All Levels of GATE

This TIP has advocated a protocol, GATE, that recognizes the skills of substance abuse counselors and how those skills can be applied in substance abuse treatment settings with clients who are experiencing suicidal thoughts and behaviors. The protocol emphasizes screening for suicidality, obtaining supervision or consultation, taking appropriate actions, and following up on the actions taken.

GATE recognizes that two components frequently addressed in training for suicide prevention and intervention are beyond the skill level of many substance abuse counselors and should be left to persons in mental health disciplines with advanced training and skills in suicidology. These two components are:

1. Suicide assessment, in which the extent of suicidal thinking and behavior is determined, an assessment of risk for self-injury or death may be undertaken, and clinical diagnoses (such as depression and trauma syndromes) may need to be made.
2. Treatment of suicidal states, which may include addressing co-occurring disorders, prescribing medication, decisions about hospitalization, challenging suicidal beliefs, and other treatment methods beyond the scope of most substance abuse counselors.

It is imperative that administrators, senior organizational policymakers, and clinical supervisors recognize the strengths and limitations of practice of substance abuse counselors and not ask staff to practice in areas beyond the scope of their skills and knowledge. That said, it is also important that substance abuse counselors be supported by administration in their efforts to address the needs of suicidal clients.

Gathering Information

Because of the elevated risk of suicidality among clients in substance abuse treatment, it is important for programs to have a clear policy statement affirming that all clients entering substance abuse treatment are screened for suicidal thoughts and behaviors. There should also be procedures for screening for suicidality when client risk factors increase, such as

Figure 2. Gathering Information Regarding Suicidality

Check all that apply

Warning Signs	Risk Factors	Protective Factors
Direct warnings: ___ Suicidal communication ___ Seeking a method of suicide ___ Making preparations for suicide Indirect warnings: ___ I= Ideation ___ S= Substance Abuse ___ P= Purposelessness ___ A= Anxiety ___ T= Trapped ___ H= Hopelessness ___ W= Withdrawal ___ A= Anger ___ R= Recklessness ___ M= Mood Changes	___ History of attempt ___ Family history of suicide ___ Mood disorder ___ Substance use disorder ___ Anxiety disorder ___ Psychotic disorder ___ Select personality disorder ___ Child abuse ___ Stressful life circumstances ___ Aggressive or impulsive ___ Avoidant or isolated ___ Rigid or inflexible ___ Firearm ownership or access ___ Minority sexual orientation ___ Chronic pain	___ Religious attendance ___ Internalized teachings against suicide ___ Child in the home ___ Childrearing responsibilities ___ Intact marriage ___ Trusting relationship with a provider ___ Treatment adherent ___ Employed ___ Trait optimism ___ Abstinent from substances

Summary: _____

_____

_____

Plan: _____

_____

_____

Counselor signature:_____Date:_____

Counselor signature:_____Date:_____

after a substance use relapse, after an emotional crisis, or during a treatment transition.

The procedure should spell out a specific screening mechanism or protocol and should specify actions to be taken if suicidality is detected. If there are positive answers to any of the screening questions, follow-up questions should be asked to gather further information (see the section on Gathering Information in Part 1, chapter 1, pp. 15–18).

An example of a checklist for gathering information regarding suicidality is presented in figure 2. Note that the information obtained is the basis for making a plan for addressing suicidal thoughts and behaviors.

Clinical supervisors should make sure that all clinical staff are aware of the policy and that the policy procedures are followed. Clinical supervisors should conduct a periodic review of all staff to ensure that all clinical staff are current on suicide policy in the agency. Procedures for documentation of screening and actions taken as a result of screening should be standardized to ensure that appropriate documentation occurs. Clinical supervisors should be responsible for ensuring that documentation efforts are carried out by counselors.

Accessing Supervision and/or Consultation

Clinical supervision or consultation from persons knowledgeable and skilled in addressing suicidal behavior is essential for quality care of clients with suicidal thoughts and behaviors. Substance abuse

counselors working with clients who are suicidal need to have a clear understanding, guided by agency policy and procedure, of when and how to access supervision and consultation. They need to know when to seek immediate supervision versus supervision at some later time, what kinds of information need to be brought to the supervisor's attention, and how to access supervision or consultation in crisis situations. Even counselors with substantial experience and training in addressing suicidal thoughts and behavior need to have an opportunity to access consultation for treatment planning, and program policy should reflect this. In some settings, the treatment group may serve as an adjunct or alternative to more formal clinical supervision. Where work groups are used as a primary support system for counselors, policy should define how the group is used and how consultation is documented.

Administrators have an essential responsibility to ensure that supervision or consultation (either in the program or from outside consultants) is available and accessible and that program policy defines the role of the supervisor or consultant. The policy should be clear about the circumstances in which a counselor should obtain consultation and make provisions to ensure that consultation is immediately available in crisis situations. It should also differentiate the roles that supervisors might play in intervening with suicidal clients (in addition to roles as a consultant or teacher) and specify which actions (such as contacting first responders outside the program) can only be taken by or with approval of a senior staff person or clinical supervisor.

Supervisors can only undertake such roles with adequate training and knowledge (of suicidality, treatment, and community resources) and with a sense of competence to respond to crises and to the concerns of the counselor. In addition, clinical supervisors have to be able to respond sensitively and professionally to the emotional needs of counselors who may find their work with clients with suicidal thoughts and behaviors to be emotionally provocative and stressful.

Taking Action

All counselor actions with clients who are suicidal should be guided by and in concert with established program policies and procedures. These policies, while unique to each program, will, for the most part, have consistent points across a variety of agencies.

Some of the common points might be:

- That clients with suicidal thoughts and behaviors will not automatically be excluded from treatment for acknowledging their suicidal thoughts or behaviors.
- That all efforts will be made to help these clients stay in substance abuse treatment as long as their safety can be maintained.
- That all clients entering the program will be screened for suicidality.
- That potential warning signs that emerge during the course of treatment will be followed up.
- That all counselors will be trained in identifying and responding to suicidal thoughts and behaviors of clients in the program.
- That the program will strive to ensure that clients receive the best care available for their suicidal thoughts and behaviors, whether that care is provided in the program or by referral.

There should be a "check off" procedure so counselors are not left on their own to make care decisions for clients at acute risk. Some of the levels of care that might be considered include:

- Observation.
- Contact with the client's family and/or significant others.
- Arrangements for disposal of suicide weapons in the possession of the client.
- Referral for assessment or for more intense care
- Referral for hospitalization as required for safety.

The 24-Hour Suicide Assessment Tool (see figure 3) is an example of a tool for rating a client's current suicidal thoughts and behaviors. It rates the areas of suicidal ideation, behavior, general mood, and cognition/perception. Although this tool is more appropriate for an inpatient psychiatric setting, it can be adapted to a variety of substance abuse treatment settings—especially therapeutic communities, detoxification centers, and residential rehabilitation environments. Such a tool can be used to help guide staff to seek more intensive levels of mental health care. It should be noted that this instrument was developed by a community agency for residential treatment settings. The tool has not undergone extensive field testing.

Figure 3. 24-Hour Suicide Assessment Tool

Assessment Category	No Monitoring	Suicide Alert—Watch (Minimum 15 min.)	Level II—Observation (Minimum 15 min.)	Level I—Precaution (Constant Observation—1:1)
• Suicidal ideation • Thoughts • Plans • Method	• Verbalizes no current ideation • None to occasional suicidal thoughts with no plan	• Verbalizes current suicidal ideation • Frequent suicidal ideation • Has no plan or vague plan • Method unavailable or nonlethal	• Verbalizes current suicidal ideation • Frequent suicidal ideation • Has specific plan • Method unavailable or available and non-lethal	• Verbalizes current suicidal ideation • Frequent suicidal ideation • Specific plan and available method • Attempt within last 24 hours
Behavior cues • Impulse control • Behavioral activity • Preparation for death (suicide note, giving away belongings)	• Adequate impulse control • Consistent in behavior patterns	• Inconsistent impulse control • Some changes in usual behavior patterns	• Unpredictable at times or inconsistent impulse control • Distinct changes in behavior patterns	• Impulsive and unpredictable behavior • Sudden or abrupt change in behavior • Marked increase or decrease in behavior • Death preparation
Mood or affect • Predominant mood or affect • Mood stability • Tolerance of feelings	• Signs of mild depression • Indicators of hopefulness • Mood stable • Feelings tolerable	• Signs of moderate depression • Indicators of helplessness • Some mood fluctuations • Some anxiety, agitation•Feelings periodically distressing	• Signs of moderate depression • Indicators of helplessness and hopelessness • Labile mood • Moderate anxiety • Increased affective distress	• Severe depression • Indicators of helplessness and hopelessness • Calm resolution • Severe anxiety • Unbearable psychological pain
Cognition/ Perception	• Problem solving intact • Accurate perception of reality	• Limited problem solving • Inconsistent or narrowed perception	• Poor problem solving • Impaired reality testing	• Unable to problem solve • Psychotic with command hallucinations • Sees no alternative to suicide

1. The nurse will complete the Suicide Assessment Tool (SAT) when the client is admitted.
2. Results of the SAT will be communicated to the physician within 4 hours on determination of the level of suicide precaution warranted.
3. The nurse will complete a new SAT at least every 24 hours for all suicide alerts.
   - Suicide Alert—Watch: The nurse will document in progress notes once per shift the condition of the client. Designated staff will do safety checks a minimum of every 15 minutes.
   - Level II—Observation: The nurse will document in progress notes the condition of the client a minimum of every 4 hours. Designated staff will do safety checks a minimum of every 15 minutes.
   - Level I—Precaution (constant observation, 1:1): The nurse will document in progress notes the client's condition a minimum of every 2 hours. Designated staff assigned for constant observation.
4. The attending physician will review the results of the SAT level of monitoring determined every 24 hours.
5. The physician will order to continue or discontinue the monitoring precaution either in writing or verbally.

_____ _____
Nurse Signature Date

_____ _____
Physician Signature Review Date

_____ _____
Client Name Unit

Treatment programs should have a policy on referrals for clients who are suicidal or those needing other specialized services. An example is provided in sample policy 4 (p. 122). The specifics of such a policy will depend on State laws and regulations.

Documenting the clinical actions taken with clients who are suicidal is critical, so counselors need to be given the time to complete this important task. Forms for use in these situations should be developed to ensure that all necessary information is obtained (additional information on documentation can be found in Part 1, chapter 1).

Counselors should also be able to look to you for guidance and support with clients who are suicidal but resist treatment. Senior clinical staff, clinical supervisors, and administrators should be prepared to work with the counselor (and the client if necessary) to resolve some of the resistance and help the client accept appropriate treatment. Several of the vignettes in Part 1, chapter 2 illustrate counselors working with resistant clients. The collaboration of senior clinical staff and clinical supervisors with counselors in these client situations enables counselors to develop their clinical skills with clients who are showing resistance and improve services to clients with a variety of needs.

As the program becomes more experienced in working with clients with suicidal thoughts and behaviors, it can be expected that a more consistent repertoire of responses to suicidality will evolve. This does not mean that responses to clients will become stereotyped, but rather that experience will create more options and greater versatility in care.

Extending the Action and Following Up

It is important for counselors and program administrators to understand that program responsibilities do not end with a client's referral to another agency. Both the counselor and administrators continue to have a responsibility to ensure that the client follows through on the referral, that the referring agency accepts the client for treatment, and that treatment is actually implemented. You also have an ethical responsibility to ensure that the client's substance abuse treatment needs do not get lost in the process of referral. Such monitoring requires oversight by the substance abuse program with specific staff (perhaps clinical supervisors) to ensure this continuum of treatment.

Administrators can assign clinical supervisors the job of making sure that the tasks involved in extending care beyond the immediate actions are carried out. These tasks include:

- Following up on referrals.
- Case management as required, monitoring that clients are following a treatment plan established by the counselor and the clinical supervisor or by the treatment team.
- Checking in with the client and significant others (if warranted) to ensure that care is progressing.
- Continued observation and monitoring for suicidal thoughts and behaviors that may re-emerge after the initial crisis has passed.

An organized system of followup by the supervisor, such as a checklist of clients with suicidal ideation or behavior may be required. Clinical supervision training may need to emphasize the need for such followup.

Finally, the program needs to have a standardized system of documenting followup. Often, programs are not as consistent with documentation of followup actions as they are with documentation of clinical interventions undertaken by the counseling staff. Most charting in client records is oriented to responses to specific client behaviors or problems rather than to follow up on those behaviors or problems. As a result, program policy needs to describe how the followup documentation should occur and who in the program is responsible for the documentation. Furthermore, a senior-level staff member should review the documentation for oversight and quality assurance purposes.

Sample Policy 4

Topic: Criteria for and transfer to psychiatric facility

Policy Statement: Clients meeting the criteria for transfer to a psychiatric facility will be transferred either voluntarily or involuntarily.

Criteria for Transfer

Occasionally, clients of our treatment program have co-occurring psychiatric symptoms or conditions in addition to their substance use disorder. There are occasions when clients who experience significant psychiatric symptoms may require transfer to a psychiatric facility for evaluation or treatment.

Criteria for transfer include:

1. A clear and present danger to themselves or to others in the form of suicidality, homicidality, or the intent to harm another
2. Significant psychotic behavior
3. Overt aggressive behavior endangering self or others

Process for Hospital Admission

Voluntary Admission

1. The patient is willing to sign voluntarily for admission to psychiatric facility.
2. The unit and/or on-call clinical supervisor, along with counseling staff, will determine the appropriate facility and arrange for discharge from the agency and transportation to the facility.

Involuntary Commitment

Counseling staff working with a client who is suicidal or otherwise dangerous to him- or herself or others will review the client's condition with the clinical coordinator or the Executive Director and then contact the on-call clinical supervisor who will initiate the following process. Medical staff will consult with the medical director or on-call physician prior to initiating this process.

1. Contact the County Crisis Intervention Unit at [phone number] and inform them that we would like to admit the patient as an involuntary hospital admission. A delegate will be assigned to assist with the involuntary process, to interview the client, and to authorize the warrant for transportation.
2. The staff member who witnessed the suicidal behavior or heard the suicidal statements should be present to offer that information to the delegate when they arrive.
3. After the delegate arrives and it is determined that the patient will need admission to a psychiatric facility, the delegate will contact an ambulance for transportation of the patient and when appropriate, will assist them in making those arrangements.
4. If the patient is physically unmanageable or dangerous, the police will be contacted to ensure the safety of the client and to assist in the process.

Before all admissions to a psychiatric facility, the following must be completed:

1. Have available client demographics, including insurance information, and clinical information.
2. Notify parents of an adolescent or the emergency contact for an adult that a transfer to a psychiatric facility is occurring.

Appendix A: Bibliography

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SAMHSA TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening in-struments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted fre-quently. The Keys allow you, the busy clinician or program administrator, to locate information easily and to use this information to enhance treatment services.

Ordering Information

Publications may be ordered or downloaded for free at http://store.samhsa.gov. To order over the phone, please call 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

TIP 1 **State Methadone Treatment Guidelines**—Replaced by TIP 43

TIP 2 **Pregnant, Substance-Using Women**—Replaced by TIP 51

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Helping Yourself Heal: A Recovering Woman's Guide to Coping With Childhood Abuse Issues

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TIP 59 Improving Cultural Competence

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

This TIP is divided into three parts that are bound and produced separately.

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, Part 1, is for substance abuse counselors. It provides the "what" and "why" and "how" of working with clients in substance abuse treatment with suicidal thoughts and behaviors. It covers background information about suicide and substance use disorders, including risk factors and warning signs for suicide and a four-step process for addressing suicidal thoughts and behaviors in substance abuse treatment, summarized by the acronym GATE (Gather information, Access supervision, Take responsible action, and Extend the action). It also includes a set of competencies counselors should incorporate to work effectively with clients who are suicidal. Chapter 2 of *Part 1* represents the heart of the "how-to" for counselors. It consists of representative vignettes of counseling sessions with clients who have suicidal thoughts and behaviors. Master clinician notes help you understand the client and his or her issues related to suicide, and present approaches you can take in your counseling work with clients with suicidal thoughts and behaviors. "How-to" notes describe specific counseling techniques.

Addressing Suicidal Thoughts and Behaviors: An Implementation Guide for Administrators, Part 2, clarifies why program administrators should be concerned about this clinical issue. It will help you understand how administrators can provide support for programs and counselors as they use GATE to address clients' suicidal thoughts and behaviors. It is hoped that this knowledge will enable treatment programs to treat substance abuse while concurrently addressing the specific needs of those who have warning signs for suicide.

Addressing Suicidal Thoughts and Behaviors: A Review of the Literature, Part 3, is for clinical supervisors, interested counselors, and administrators. It consists of three sections: an analysis of the available literature on suicidal thoughts and behaviors in clients with substance use disorders, an annotated bibliography of the literature most central to the topic, and a bibliography of other available literature. *Part 3* is available only online at *http://www.kap.samhsa.gov*.

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