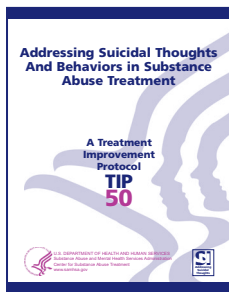


# Quick Guide

## *For Administrators*

### **Based on TIP 50**

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



# Contents

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Why a Quick Guide? .....	2
What Is a TIP?.....	3
TIP 50 Is Organized Into Three Parts .....	4
Introduction .....	5
Levels of Program Involvement and Core Program Components .....	10
Implementing and Supporting Programming for Clients With Suicidal Thoughts and Behaviors.....	21
Legal and Ethical Issues in Addressing Suicidality in Substance Abuse Programs .....	26
Implementing Treatment and Referrals To Reduce the Risk of Suicide....	33
Maintaining Safety for Clients at Risk of Suicide.....	36
Release of Information and Confidentiality Issues.....	40
Ethical Issues .....	43

# **Quick Guide**

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## ***For Administrators***

### **Based on TIP 50**

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

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

## WHY A QUICK GUIDE?

This Quick Guide accompanies the treatment improvement guidelines set forth in *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*, number 50 in the Treatment Improvement Protocol (TIP) series. It summarizes the information in TIP 50 designed to meet the needs of the busy behavioral health program administrator for concise, easily accessible “how-to” content.

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

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

## WHAT IS A TIP?

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

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

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

Other TIPs of interest to readers include:

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

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

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

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

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

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## INTRODUCTION

### **The Benefits of Addressing Suicidality in Substance Abuse Treatment Programs**

Misconceptions or myths within agencies (either explicit or implicit) can hinder effective treatment of suicidal thoughts and behaviors. Examples include:

- Talking about suicide will put the idea 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.
- Upon entering treatment, clients are significantly less likely to have suicidal thoughts or behaviors.
- If you don't ask about suicidal thoughts or behaviors, you and your program won't be legally at risk if the patient attempts suicide or dies from suicide.

Mistaken ideas such as these perpetuate ineffective responses to clients with suicidal thoughts and behaviors. 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 the suicidal thoughts and behaviors of clients in substance abuse treatment *keeps clients from dropping out of treatment*. Unacknowledged and unaddressed suicidal thoughts and behaviors often represent crises in the clients' lives. Clients may respond to crises by losing focus on gaining abstinence and returning 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 assistance is available. This reassures clients that they and the counselor are working together to get the help the clients need and that most problems they encounter can be resolved with 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 behaviors can be deeply upsetting to others in treatment. Many substance abuse treatment clients in early recovery can identify with a person who has suicidal thoughts. The difficulty of identifying and processing powerful emotions related to suicide and of 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.

Fourth, addressing issues of suicidality leads to positive programmatic efforts through:

- Increasing the competence of staff to address other personal, family, and interpersonal crises.
- Reducing risk-management issues related to legal liability.
- Improving program consistency and coordination.
- Increasing staff retention by reducing counselor burnout, reducing staff stress, and promoting a greater sense of counselor and front-line support from administrators

### **Suicide Is an Important Programmatic Issue**

Clients in substance abuse treatment are at risk for suicidal thoughts, suicide attempts, and death by suicide. Additionally, the research and experience of clinicians and administrators on the TIP consensus panel confirm 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 causes 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.

To address treatment issues raised by suicidality, substance abuse programs need to have policies and procedures detailing how to respond promptly and consistently to suicidal crises, gather additional information, seek advice and support from other clinical staff and supervisors, make referrals, follow up with clients and their families, and document 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 the significant clinician distress that arises when a client dies by suicide. As with addressing the other needs of clients, administrators must 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 opportunities for clinical staff to debrief and learn from the crisis. Suicidal crises in the agency also offer the opportunity to evaluate how existing 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. As an administrator

or senior staff member, you 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 in 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 suicidal crises.

Suicidal behavior of clients in treatment poses unique legal and ethical issues for programs. These issues are addressed in some detail later in this Quick Guide.

## LEVELS OF PROGRAM INVOLVEMENT AND CORE PROGRAM COMPONENTS

TIP 50 identifies three levels of program involvement in suicide prevention and intervention: suicide-aware, suicide-capable, and suicide-enhanced. This section describes the programmatic elements essential to each level. Each level increases the capability of the program to identify clients at risk for suicidal thoughts and behaviors, the resources the program possesses to intervene with the clients, and the programmatic elements in place to provide safety and treatment to people who are suicidal.

### Suicide-Aware Programs

The TIP consensus panel recommends that, at a minimum, **all programs providing substance abuse treatment to clients should be suicide-aware**. Suicide-aware programs have the basic capacity to identify clients who are at risk and to identify warning signs for suicide as they emerge. Clinical staff members 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,

available to all staff, clear policies and procedures for referral and for managing suicidal crises in the agency.

Suicide-aware programs include some of these characteristics:

- All clinical staff members recognize that clients in substance abuse treatment are at high risk for suicidal thoughts and behaviors, and all clinical staff members have:
  - Basic classroom education in risk factors, warning signs, and protective factors for suicide. Educational efforts focus on the knowledge, skills, and attitudes described in the “Competencies” section in Part 1, Chapter 1, of TIP 50.
  - Basic classroom education in recognizing misconceptions about suicide. They also have had an opportunity to replace misconceptions with accurate and contemporary information and have explored their own attitudes toward suicide and suicidal behavior.
  - Basic classroom education and clinical supervision in recognizing clients’ direct and indirect expressions of suicidal thoughts.
  - The skills to talk with clients about suicidal thoughts and behaviors and collect basic screening information (see screening information in Part 1, Chapter 1, of TIP 50).

- 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 steps to ensure appropriate follow-up on referrals and other actions.
  - Formalized referral relationships with programs capable of addressing the needs of clients with suicidal thoughts and behaviors, along with specific protocols for how to make a referral. These relationship agreements 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 regular basis.
  - Protocols available to all staff members for managing suicidal crises. These protocols identify the types of situations that might constitute a crisis, indicate how counselors are to receive clinical supervision or consultation, specify which actions the counselor can take and which actions need to be taken by program

administrators, and state how to document crisis interventions.

The TIP consensus panel recognizes that many substance abuse treatment programs (particularly small, freestanding 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 suicide-capable program might offer. Nevertheless, because risk factors for suicidal thoughts and behaviors are prevalent among people in substance abuse treatment, and even more so among specific treatment populations (described in Part 1, Chapter 1, of TIP 50), the program characteristics noted in this section are essential for high-quality care. All programs should at least meet the standards of a suicide-aware program. 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.

### **Suicide-Capable Programs**

Some substance abuse treatment programs—particularly those with larger staff, more diversified services, and possibly administrative links to other programs (e.g., 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 suicide-aware services and characterize **suicide-capable** programs.

In addition to the services and resources of suicide-aware programs, suicide-capable programs include the following attributes:

- At least one staff member with an advanced mental health degree (e.g., a Ph.D. in psychology, a Master's in social work) who is specifically skilled in providing suicide prevention and intervention services and in providing clinical supervision to other program staff members working with clients who have suicidal thoughts and behaviors.
- The ability to continue substance abuse treatment for clients with suicidal thoughts and behaviors while monitoring them for suicidal symptoms and exacerbated symptoms of depression, anxiety, or other co-occurring disorders.
- Formalized ongoing relationships (within the agency or in the community) with mental health professionals trained in suicide intervention to address emergency needs.
- Consultation services offered to suicide-aware programs on an as-needed basis.



## **Suicide-Enhanced Programs**

Some substance abuse treatment programs have the capacity to provide services to clients who are acutely suicidal, allowing them to continue receiving substance abuse treatment while in the midst of a suicidal crisis. The TIP consensus panel has identified these programs as **suicide-enhanced**. Most often, the programs that can offer these services are administratively linked to hospitals and inpatient mental health services.

In addition to the standards for suicide-aware and suicide-capable programs, suicide-enhanced programs can offer:

- Links to a mental health or hospital setting that provides security for people who are actively suicidal and have significant risk factors.
- Frequent, regular periods of contact with the client (known as suicide watch) or beds (or an area) designated for observation (previously known as suicide-watch beds).
- Comprehensive in-house suicide assessments to determine level of risk, treatment needs, and necessity for legal constraint on the client.
- The appropriate certifications to legally detain clients who are actively dangerous to themselves or others. Such certifications are more commonly held by mental health than by substance abuse treatment facilities.

Fortunately, the need for suicide-enhanced 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 suicide-aware and suicide-capable programs. Nevertheless, appropriate resources for people who are acutely suicidal and for whom substance abuse is a closely related problem are a valuable asset to the community.

### **Implementing a Suicide-Aware or Suicide-Capable Program Is a Valuable Addition to the Treatment Continuum of Care**

A variety of decisions and implementation strategies must go into preparing a program to be suicide-aware or suicide-capable. 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 how these issues need to be considered:

1. Do you have a program policy statement about:
  - Acknowledgment of suicide as a high 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, of TIP 50)?
    - If **no**, establish a workgroup to study the issue and write one.
    - If **yes**, is it fully implemented with all staff members?
  - Screening for suicide as part of the program's routine protocol?
    - If **no**, develop or adapt screening questions in this Quick Guide, the complete TIP 50 on which it is based, or other credible sources, then arrange training for all staff members (support, counseling, and clinical supervisory).
    - If **yes**, does the screening policy provide specific questions to explore with clients who have suicidal thoughts and behaviors? Have all staff members completed training? Is the training specific to each staff member's role? Is

there a provision for clinical supervision or consultation?

- Services to be provided to suicidal clients?
  - If **no**, read this Quick Guide 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 participation of family members or significant others? Do the policies include transportation to other care providers?
- Staff development for provision of services to clients who are suicidal?
  - Does the program have a system in place to orient new employees to 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?
- Agency review of critical events?
  - Does the program have a procedure for reviews of critical events (such as suicidal behavior of clients) to adapt and update policies 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 suicidal thoughts and behaviors, screening, services, follow-up, and documentation fully integrated into the program? Are they congruent with current staffing? Do they match the needs of the current client population?

3. Are these policies and procedures monitored and evaluated?
  - If **no**, establish a workgroup (or assign an individual) to devise methods for monitoring and evaluating. Get buy-in from staff members to make needed program improvements.
  - If **yes**, is there an individual or workgroup 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**, develop a process to review events and recommend changes to existing policies and procedures.
  - If **yes**, is there a critical event committee to collect data, evaluate them in light of existing policies and procedures, and recommend changes as needed?

## **IMPLEMENTING AND SUPPORTING PROGRAMMING FOR CLIENTS WITH SUICIDAL THOUGHTS AND BEHAVIORS**

### **Role of Administrators**

Administrative staff members, especially executive directors and program directors, play important leadership roles in creating an environment that fosters rapid identification of—and provision of quality services to—clients with suicidal thoughts and behaviors. Without the commitment of the program’s administrative staff, midlevel staff members (clinical supervisors and senior counselors) have difficulty implementing policies and supporting effective clinical practices. Administrative commitment is demonstrated by advocating for services for suicidal clients, by following through on suggestions and plans for programming, and by delivering 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. This not only helps midlevel and direct-service staff members take ownership of new initiatives, but also prevents them from feeling as if they have been told to add more responsibilities to their already heavy workload.

Administrative leadership means communicating a vision of how the program can benefit from provid-

ing 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.

Leadership needs to inspire others in the organization to become aware of and committed to reducing the impact of clients' suicidal thoughts and behaviors in the program and increasing the capacity of the program to respond to clients' suicidality. Inspiration is communicated through enthusiasm for current and new programmatic elements, optimism about the change process, and an unwillingness to accept anything but success. To demonstrate this enthusiasm, emphasize suicide prevention in staff meetings, actively participate in the planning process, attend and participate in training events, and regularly remind staff at all levels of the importance of suicide prevention. Such inspiration is contagious to other staff members and is particularly effective when front-line staff members express resistance to change. Inspiration supports the effort's significance.



## **Role of Midlevel Staff**

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 midlevel staff are aware of these responsibilities and are adequately trained to carry them out.

Clinical supervisors have the primary responsibility of gathering necessary information from counselors when a client acknowledges suicidal thoughts and/or behaviors. They must be able to decide what and how much additional information to gather from the client, what consultation with appropriate mental health professionals is warranted, how the substance abuse counselor can prepare a client for a potential referral, and what assistance the counselor needs in making appropriate referrals, while also ensuring that the treatment plan is effectively implemented and/or updated. Additionally, clinical supervisors often have to make important decisions about 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 (see p. 25 in TIP 50), the framework for addressing suicidality used in this Quick Guide and the source 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 midlevel clinical staff members are the liaisons between front-line 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 shap-

*GATE, a four-step process for addressing suicidal thoughts and behaviors in substance abuse treatment, is described in detail in TIP 50 on pages 14–25:*

- *Gathering information*
- *Accessing supervision and consultation*
- *Taking responsible action*
- *Extending the responsible action with follow-up and documentation*

ing and formulating new 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. It is also their responsibility to keep issues related to suicide risk in the agency at the forefront of administrator, front-line staff, and support staff awareness.

Obviously, midlevel staff members 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 by providing supervision to them, and encouraging active involvement of supervisors in developing and adapting policies and procedures.

## **LEGAL AND ETHICAL ISSUES IN ADDRESSING SUICIDALITY IN SUB- STANCE ABUSE PROGRAMS**

Clients with suicidal thoughts and behaviors raise unique legal and ethical issues for substance abuse treatment programs. Although it is the responsibility of counselors to address these concerns, as an administrator, 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 (2000)<sup>1</sup> 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) and, further, “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).

<sup>1</sup> Maris, R. W., Berman, A. L., & Silverman, M. M. (2000). Suicide and the law. In R. W. Maris, A. L. Berman, & M. M. Silverman (Eds.), *Comprehensive textbook of suicidology* (pp. 480–506). New York: The Guilford Press.

Carrying out this standard of care inevitably involves legal and ethical considerations. This Quick Guide defines legal issues as those subject to laws and legal regulations. Generally, these issues are fairly clear-cut, with examples or illustrations that define what is legal and what is illegal.

Ethical concerns relate to professional standards of care and comprise the moral and value 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 its membership agrees to adhere. In States where these professional groups are licensed, the State licensing board may have an additional set of ethical standards to which people licensed by that group must adhere.

## Legal Issues

Regarding suicidality, legal issues for substance abuse programs relate primarily to standards of care, maintaining appropriate confidentiality, and obtaining informed consent. Both the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities provide standards of care for clients at risk for suicide that programs must consider for accreditation. Additionally, the American Psychiatric Association and other professional organizations offer practice guidelines for the clinicians that set appropriate and reasonable standards of care. Although many of these guidelines are for professional activities beyond the scope of substance abuse counselors, they offer resources for such issues as confidentiality, informed consent, referral procedures, and treatment planning that are relevant to counselors working in substance abuse treatment agencies.

Maris and colleagues (2001) note three common areas of malpractice in working with suicidal clients:

1. *Failures in assessment.* For substance abuse treatment programs, this means failure to:
  - Gather information (e.g., via the standard screening questions noted in Part 1, Chapter 1, of TIP 50).
  - Consider that information in treatment planning.

- Recognize warning signs or risk factors as they emerge in treatment.
  - Obtain records from other sources (e.g., previous substance abuse or mental health treatment) that would have indicated a risk of suicidality.
2. *Failures in treatment.* For substance abuse treatment programs, this might mean failure to:
- Consider the impact of an intense substance abuse treatment environment on a client's suicidality.
  - Prepare a client for treatment transitions, including administrative discharges.
  - Make appropriate referrals for clients with suicidal thoughts and behaviors.
  - Follow up on referrals.
3. *Failure to safeguard.* Substance abuse treatment programs are obligated to create a physically and psychologically safe environment for clients. This means having 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). You should also implement a

policy and procedure for obtaining a release from clients who are at significant risk or have warning signs of suicide to contact a family member or significant other if the counselor, with appropriate clinical supervision, believes the client may attempt suicide. Although the client must have an opportunity to revoke the release, it gives the agency options 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, protective factors, and steps taken to address them; consultation or supervision obtained; referrals considered and/or made; client response to the referrals; and follow-up. Part 1, Chapter 1, of TIP 50 provides examples of appropriate documentation.

Another legal variable to consider is liability both for the agency and for the practitioner. Both may be held responsible when standards of care are not met. Part of your job is to protect the program from liability and individual counselors and supervisors from professional malpractice. Programs may be held responsible for not meeting standards of care (e.g., identifying clients at risk for suicide and taking steps to ensure their safety), as well as for the actions of employees who do not



adhere to professional standards of practice or who break the law (e.g., confidentiality). Programs can also be held accountable for failing to 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. By not conducting basic screening for suicide risk factors, a counselor might be perceived as failing to take appropriate steps to foresee suicidality.

On page 17 of TIP 50, the consensus panel recommends five basic questions to include in initial client interviews and at appropriate follow-up points to gather information about a client's suicidal thoughts and behaviors. Affirmative answers require follow-up questioning, consultation with a clinical supervisor or consultant, and possible further evaluation by staff trained in suicide assessment. You can implement an intake protocol that includes these five questions:

- 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?

Most substance abuse counselors do not have the skills to conduct a suicide risk assessment. 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. However, substance abuse counselors are, with training, 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, of TIP 50), asking appropriate questions (such as the five screening questions noted previously), and then following up on positive responses. If the screening indicates suicidal thoughts and/or behaviors, the client should be referred for a more structured and detailed suicide risk assessment.

## **IMPLEMENTING TREATMENT AND REFERRALS TO REDUCE THE RISK OF 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 the resources they need for successful treatment, and follow up to ensure that proper care has been received.

This process is analogous to staff in a social service or mental health program identifying a client with a substance use disorder concurrent with other problems that brought them to the social service or healthcare 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 clients about substance use, to make referrals for appropriate treatment, and to follow up to ensure that treatment was accepted or completed. 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 discussing suicide with clients, and being aware of how one's own attitudes toward suicide affect one's relationships with people who are suicidal.

Second, counselors need a means of support for 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, counselors 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 for administrators to oversee

substance abuse counselors to ensure that they practice within the scope of their professional competencies and skills. To transcend the limits of acceptable practice creates malpractice liability for counselors and their agencies.

## **MAINTAINING SAFETY FOR CLIENTS AT RISK OF SUICIDE**

Maintaining safety for clients with suicidal thoughts and behaviors means making all reasonable efforts to promote their immediate and long-term well-being. Historically, some clinicians have used suicide contracts (also called “no-suicide” contracts) with clients to ensure safety. 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 clients will contact their counselors or other professionals 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, and TIP 50 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, of TIP 50), which can support and enhance engagement with the client, possibly lower risk, and convey 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 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, or if the weapon is illegal, or if a weapon is kept on the premises of the program and is potentially available to other clients.

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

You can establish policies and procedures to match the levels on this continuum with the applicable safety needs and concerns for clients with suicidal thoughts and behaviors. For instance, Bongar (1991)<sup>2</sup>, in a seminal work on suicide prevention, found that to reduce the likelihood of sui-

<sup>2</sup> Bongar, B. (1991). *The suicidal patient: Clinical and legal standards of care*. Washington, DC: American Psychological Association.

cidal behaviors in an outpatient treatment setting, clinicians can:

- Increase the frequency of visits.
- Increase the frequency of contacts (e.g., telephone calls).
- Consult with a professional who has 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 (e.g., family members who can be supportive).
- Give the patient telephone numbers for 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, safety steps might include:

- Active visual monitoring of the client.
- Considering referral to a more secure psychiatric unit.
- Consulting with a staff or consultant mental health professional for suicide risk assessment.



- Monitoring the dispensation of antidepressant and other potentially fatal medications.
- Searching at intake and during treatment for weapons, drugs, or other prohibited items.
- Providing a physical environment as free as possible from opportunity for suicidal behaviors (e.g., no sharp objects, no 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 who have suicidal thoughts and behaviors are the circumstances under which information pertaining to treatment can be released and confidentiality, particularly in contacting family and significant others when clients acknowledge 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 clearly indicate 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 the client's consent for release of information. As in other situations, the release must specifically identify the reason for the request, the type of documents relevant to the client's situation, the people who

will receive the information, and the time period relevant to the client's situation.

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 who has 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 the client exhibits suicidal thoughts or behaviors.

As in any other treatment situation, no information about a client's condition, treatment plan, or other data should be released without the client's written permission—except if the client is in imminent danger of harming himself, or others in a life-threatening manner.

If this happens, refer to State and Federal regulations that address this issue. Only administrative staff or senior clinical supervisors should decide whether to compromise a client's right to confidentiality.

A related concern is the duty to warn when a client is at risk of harming another person. Although there is probably no duty to warn family members if a client is suicidal unless that behavior threatens to harm another person, the concept of duty to warn is a complex issue subject to change; supervisors or administrators should seek legal advice in such situations.

## **ETHICAL ISSUES**

A wide variety of ethical issues arise when working with substance abuse clients who have suicidal thoughts and behaviors, and 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, for which there are often clear guidelines for legal versus illegal behavior, ethical issues are often gray areas without defined proscriptions for counselor behavior. Nevertheless, 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 ensure that agency policy is consistent with the ethical guidelines of the professional groups that guide clinical practice in your agency. Ethical standards may be established by regulatory organizations that affect the program and may be promulgated by associations or organizations for clinical supervisors, counselors, and other treatment personnel. For example, a program's policy

about provision of counseling services to clients with suicidal thoughts and behaviors should be consistent with ethical guidelines about scope of practice for substance abuse counselors not specifically trained to treat suicidality; it should state that only staff members with mental health degrees who have been trained to treat clients who are suicidal will provide such services.

Ethical practice must pervade all levels of organizational behavior. Ethics is often thought of as an issue for front-line staff: counselors, physicians, nurses, psychologists, and social workers. However, clinical supervisors should also follow ethical guidelines, and, at least implicitly, program functioning needs to be guided by ethical practice as well. Ethical boundaries should be applied consistently across all levels of practice—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. However, claims of improper or negligent treatment can be generated by unethical behavior.

## **Informed Consent**

In providing services to clients who have suicidal thoughts and behaviors, a special area of ethics relates to informed consent for treatment. Informed consent for substance abuse treatment is an ongoing process in which clients actively participate to define what treatment methods and approaches to undertake, the expected outcomes of those interventions, the risks and expected efficacy inherent in the care, and alternative treatments that might be used. Clients with suicidal thoughts and behaviors have needs for informed consent beyond those normally present in other clients. You should develop and implement protocols for informed consent applicable specifically to clients who are suicidal. For instance, clients should understand that if their suicidality becomes overt or debilitating, specialized treatment resources and/or referral may be required. The issue of informed consent should be raised when treatment is initiated.

Additionally, the program can 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 could cause suicidal thoughts to become more frequent or more intense. This might be the case, for example, when working with clients who have co-occurring substance abuse, suicidal thoughts, and psychological trauma. Protocols can specify what actions to take if suicidal thoughts increase, when to use protective care measures, and when special treatment (e.g., medication) is indicated.

### **Admission, Transfer, and Treatment Termination**

For substance abuse treatment programs, ethical issues arise around the admission, transfer, and administrative termination of clients who have suicidal thoughts and behaviors. Historically, many substance abuse treatment programs have had a policy not to accept clients who exhibit suicidal thoughts or behaviors. Thus, clients who were suicidal were either admitted to these programs but could not openly discuss their suicidal thoughts or were denied treatment for their substance abuse altogether. Many of these clients were also denied treatment by mental health service providers who saw the clients' problem as originating from a substance use disorder.

Fortunately, these practices have largely been 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 could clearly define the client's condition as inappropriate for care in the specific program. In such cases, the program has an ethical responsibility to help clients find the best care for their needs available in the community.

A related issue arises when substance abuse treatment clients who have suicidal ideation or behavior need to be transferred to another treatment facility that can offer safer or more intense care, often for disorders (e.g., depression) co-occurring with their substance use disorder and suicidality. Substance abuse treatment programs must have clear policies and guidelines stipulating that referral to more intensive care does not signify the end of a client's involvement with the program per se. The client may return to the program when less intensive care is warranted. In effect, transfer does not mean that the client cannot be readmitted in the future.

Likewise, a client cannot be discharged if he or she is found to have suicidal thoughts and behaviors. It is both unethical and illegal to discharge a client in clear distress without guaranteed and subsequently confirmed follow-up with an appropriate provider. Programs are obligated to provide services to that client either directly or by referral

or transfer to another program better able to treat the client. Ethically, this should be made an organizational policy.

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

### **Additional Training**

Another ethical issue for substance abuse programs involves provision of suicidality training for counselors. Counselors should not be expected to address suicidal thoughts and behaviors without specialized training. The consensus panel strongly recommends that administrators help counselors get training to address the competencies listed in Part 1, Chapter 1, of TIP 50, including the following 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 of warning signs, risk factors, and protective factors

- Empathy for clients who are suicidal
- Cultural competence in recognizing and addressing the needs of clients who are suicidal
- Legal and ethical issues in addressing suicidality in the agency

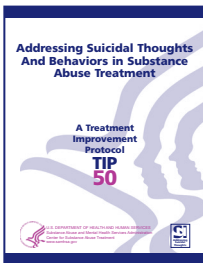
It is insufficient to train counselors simply to recognize suicidality or to know certain facts about suicide and substance abuse. The above competencies need to be considered in preparing counselors to work with people who are suicidal in the context of substance abuse treatment. A variety of training materials can be used in addition to the material in this Quick Guide and its source (TIP 50). The Suicide Prevention Resource Center produces a variety of workshops and training materials for counselors (<http://www.sprc.org>) through its Training Institute. The Addiction Technology Transfer Centers funded by SAMHSA (<http://www.attcelearn.org/>) offer a variety of training opportunities as well. Courses in counseling suicidal clients and in crisis intervention are currently being offered by email correspondence and on the Internet. Additionally, 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 clients who evidence suicidal thoughts and/or behaviors. Program administrators must address these ethical concerns in agency policies and translate those policies into specific procedures for midlevel supervisory staff, substance abuse counselors, and other staff members.

# Ordering Information

## **TIP 50** *Addressing Suicidal Thoughts And Behaviors in Substance Abuse Treatment*

### Other TIP 50–Related Products



### *Quick Guide for Administrators*

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**TIP 25:** *Substance Abuse Treatment and Domestic Violence (SMA 12-4076)*

**TIP 36:** *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues (SMA 12-3923)*

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